FPD WAW FEDERAL PUBLIC DEFENDER Western District of Washington

To: CJA Panel Attorneys
From: Michael Filipovic, Natalie Harmon, Jenn Kaplan
Re: COVID-19 Memorandum for CJA Panel Attorneys
Date: March 17, 2020

I. INTRODUCTION

In light of the COVID-19 global pandemic, FPD is working to ensure that clients' health and safety are protected. We always prioritize keeping clients out of custody, and due to the increased risk of infection for people in custody, this is more important than ever. We are issuing this memorandum to provide guidance on avoiding and deferring custody during this outbreak.

We also encourage CJA counsel to continue working on their cases to the extent possible and to find creative ways to continue investigating, researching, and advocating for their clients. This memorandum will include suggestions from FPD about ways to stay engaged with your cases while teleworking and social distancing.

II. GENERAL ORDER 02-20

The district court issued a General Order 02-20, regarding courthouse closures, continuances, and hearings during the pandemic, on March 17, 2020. It is attached to this memorandum as **Appendix A**. It dictates that all trials and grand jury proceedings scheduled before June 1, 2020 are continued; all initial appearances and detention hearings will be conducted by phone or video conference with the defendant's permission unless otherwise directed by the court; and that individual judges may continue to conduct emergency matters after considering the public health situation.

Counsel should familiarize themselves with the new procedures as they contemplate filing motions related to the considerations outlined below. Due

to the rapidly-changing situation, counsel should call the FPD duty attorney for up-to-date information and advice on these issues.

III. DETENTION CONSIDERATIONS

Public health experts have advised that being in custody increases risk of infection. As such, if there is a credible argument to be made to avoid or defer incarceration, counsel should request that relief.

A. Waiving Presence/Telephonic Hearings

Attached as **Appendix B** to this memorandum is a chart outlining what hearings may be conducted outside a client's presence or telephonically, pursuant to the relevant statutes and Federal Rules of Criminal Procedure. Counsel who intend to seek relief pursuant to the guidance below should be aware of what hearings may be conducted in which manner. Appendix B also includes template notice and consent forms for videoconference hearings developed by the District of Oregon's FPD.

B. Detention Hearings and Reopening Detention Proceedings

Counsel should endeavor to address detention at initial appearance if possible and request to move the initial appearance by an hour or two to complete a detention investigation rather than continuing the detention hearing to another day. Counsel should include arguments about the dangers of incarceration at detention hearings. Counsel should review their cases in which the clients were detained and consider moving to reopen the detention proceedings, citing the COVID-19 pandemic as new information that was unavailable at the time of the initial proceedings. FPD has devised three template motions—for new arrests of high-risk clients, new arrests of nonhigh-risk clients, and temporary release of detained clients. These three templates share the same six exhibits. They are all attached as **Appendix C**, except for the Exhibit F, which is the above-mentioned General Order and is already included as Appendix A. Additional resources, including a standing order from the Northern District of California to reconsider all detention orders, are included as **Appendix D**. Please supplement them with any information you have about your clients' specific risk factors, and please share relevant research with our community.

C. Time Served Recommendations

For in-custody clients facing sentencing who have plausible time-served recommendations, counsel should attempt to persuade the court to proceed with sentencing rather than to delay. Information about the risk of incarceration during the COVID-19 pandemic should be included as an 18 U.S.C. § 3553 sentencing factor. Attached as **Appendix E** is an order from a case in the Northern District of California with useful language for time-served sentencings.

D. Deferring Self Reporting

For clients with sentencing pending, counsel should ask for a self-report date 6 months in the future in order to avoid custody during the height of the pandemic and should seek leave to further extend the self-report date as necessary. Counsel should seek permission for clients who were already scheduled to self-report to extend their reporting date.

E. Preliminary Hearings

For in-custody clients charged by criminal complaint, counsel should not waive preliminary hearings. Counsel should file written submissions, acknowledging the crisis and lack of grand jury availability, but arguing that the remedy is not detention.

F. Creative, Zealous, and Collaborative Advocacy

Given the acute personal and public health risk associated with incarceration, keeping clients out of custody may be a matter of life and death. This is a situation where counsel should think outside the box, argue forcefully, and share successful strategies within our community.

IV. TRULINKS

FPD ordinarily does not permit its staff to use the Trulinks email system for client correspondence and recommends that CJA attorneys avoid it as well because it is not confidential. During this period of restricted in-person and telephonic access to clients, FPD is attempting to work out a memorandum of understanding with the US Attorney's Office to make Trulinks confidential. More information about this evolving situation will be disseminated as it becomes available.

V. TELEWORKING ON CJA CASES

The FPD has moved to a mandatory telework program during this outbreak. The FDC has suspended legal visitation, and the court's calendars are skeletal. However, FPD strongly encourages CJA attorneys to continue working on their cases. In addition to typical discovery review, motions practice, and trial preparation, now would be a good time to:

-Learn how to use Skype, Zoom, FaceTime, and other teleworking tools, if they are not already in your wheelhouse, and use them to conduct meetings with experts, co-counsel, appropriate witnesses, and other individuals who you would otherwise have convened with in person.

-Hire an investigator, paralegal, or other expert as needed. Pursuant to General Order 06-19, attached as **Appendix F,** prior authorization is not needed for up to $2600 of paralegal or investigator services, so long as the hourly rate falls within the Ninth Circuit CJA Policies & Procedures Manual, appendix 2, rates. CJA staff will remain available to assist with expert services requests while teleworking.

-Request medical, legal, educational, and other essential records. It is anticipated that there will be a backlog of records requests when the pandemic is over; get into queues early.

-Seek approval to assist your clients on ancillary matters by emailing a letter addressed to the court to Natalie Harmon.

-Consult with an immigration attorney about the consequences of your client's conviction.

-Build rapport with clients' family members and begin sentencing mitigation investigations.

-Think creatively about motions practice and do deep dives into complex legal areas that affect your cases.

-Work with CJA Resource Counsel Jenn Kaplan and 9th Circuit Case Managing Attorney Blair Perilman to budget cases where attorney time will exceed 300 hours.

-Submit your overdue CJA 20 invoices.

Appendix A

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

In Re:

COURT OPERATIONS UNDER THE EXIGENT CIRCUMSTANCES CREATED BY COVID-19 AND RELATED CORONAVIRUS

GENERAL ORDER NO. 02-20

This General Order is being issued in response to the developing outbreak of Coronavirus Disease 2019 (COVID-19) and in conjunction with the Court's March 6, 2020, General Order, which limited in-Court appearances and continued all jury matters.

In response to the continued spread of COVID-19, President Trump has declared a national emergency and issued guidelines directing at-risk individuals including those 60 and older, to stay home and away from other people, and encouraging everyone to work from home whenever possible, to avoid discretionary travel, and to avoid social gatherings in groups of more than ten people. Governor Inslee has also declared a state of emergency. The Centers for Disease Control and Prevention ("CDC") and other health authorities have advised people to take precautions to reduce the possibility of exposure to the COVID-19 virus and to slow the spread of the disease. In particular, the CDC is recommending that people attempt to keep physical distance between themselves and other people. This technique, known as social distancing, is especially important for people who have a higher health risk should they

contract the disease. The CDC is recommending employers attempt to minimize exposure between employees and the public and to consider the public health and safety when scheduling group or public events. Additionally, there is recent evidence indicating that COVID-19 may be spread by persons who are asymptomatic.

Given this guidance, and to protect the safety and health of all those entering and working in the Courthouse, the Court ORDERS, effective immediately:

1. The Seattle and Tacoma Courthouses will be closed to the public except as stated below. This temporary closure will last at least 30 days and may be continued based on public health guidance.
2. All civil and criminal hearings and trial dates in these Courthouses scheduled to occur before June 1, 2020, are continued pending further order of the Court. The Court may proceed with video/telephonic conferences as appropriate and at the discretion of individual judges. Scheduling orders in cases may need to be amended as appropriate on a case-by-case basis. This paragraph does not apply to Bankruptcy Court hearings, which are addressed below.
3. All grand jury proceedings scheduled before June 1, 2020, are continued.
4. With regard to criminal matters, due to the Court's reduced ability to obtain an adequate spectrum of jurors and the effect of the above public health recommendations on the availability of witnesses, counsel and Court staff to be present in the courtroom, the time period of the continuances implemented by this General Order will be excluded under the Speedy Trial Act, as the Court specifically finds that the ends of justice served by ordering the continuances outweigh the best interests of the public and any defendant's right to a speedy trial, pursuant to 18 U.S.C. §3161(h)(7)(A). For the same

reasons, the Court finds under 18 U.S.C. § 3060(C) extraordinary circumstances exist, and justice requires delay of all criminal preliminary hearings during the time period of the continuances implemented by this order.

5. All criminal initial appearances and detention hearings will be conducted via video/telephone conference with the defendant's permission, unless directed otherwise by the Court.
6. Due to the nature of bankruptcy proceedings, the Bankruptcy Court will continue with scheduled non-evidentiary hearings telephonically as posted on the Bankruptcy Court's website (www.wawb.uscourts.gov) and announced by the individual bankruptcy judge. All evidentiary hearings and trial dates scheduled to occur before June 1, 2020, are continued pending further order. These may proceed with video/telephonic conferences as appropriate and at the discretion of individual judges. Scheduling orders in cases may need to be amended as appropriate on a case-by-case basis.
7. Individual judges may continue to conduct emergency matters in the Seattle and Tacoma Courthouses if necessary after considering the above public health situation. Those required to attend these matters will be permitted to enter the Courthouses.
8. This Order does not affect the Court's consideration of civil or criminal motions that can be resolved without oral argument. Attorneys and pro se parties are encouraged to continue to file documents with the Court electronically through CM/ECF.
9. Staff in each of the Clerks' Offices will be available by telephone, mail will be received, and new filings will be processed. However, the Court's intake window will be closed. Those wishing to make in-person filings will be directed to leave such materials at established drop off points near the entrance to the courthouses.

10. All five Probation and Pretrial Offices will be closed. However, drug testing will continue as directed by U.S. Probation and Pretrial. A duty officer will be able to answer telephonic questions.

If you have a scheduled appointment or are otherwise required to appear at the courthouse but are denied entry, you should proceed as follows:

- If you are represented by an attorney, please contact your attorney;
- If you are an attorney or a pro se litigant and you are scheduled to appear in court before a judge, please contact that judge's chambers or courtroom deputy (see court websites at www.wawd.uscourts.gov/judges and www.wawb.uscourts.gov/chambers-information);
- For all other matters or questions, please contact the Clerk's Office at (206) 370-8400 (Seattle) or (253) 882-3800 (Tacoma). For questions related to bankruptcy court please contact the Bankruptcy Court Clerk's Office at 206-370-5200 (Seattle) or 253-882-3900 (Tacoma).

This Order amends and supersedes the Court's previous General Order 01-20 related to COVID-19. The Court will vacate or amend this General Order no later than April 15, 2020.

Dated this 17 day of March 2020.

RICARDO S. MARTINEZ
CHIEF UNITED STATES DISTRICT JUDGE

Appendix B

VIDEO CONFERENCES AND APPEARANCE WAIVERS
What The Rules And Cases Say

HEARING	Waive Appearance?	Appear By Video?	Other Notes
Initial appearance Rule 5(f) Rule 43	No	Yes, explicit in Rule 5	Rule 5 requires defendant's consent; commentary to Rule 43 states written consent
Detention Hearing	?	Yes, implied	A detention hearing is part of the initial appearance and thus video is authorized by Rule 5; does not appear reason to treat differently even if held on a different day
Arraignment Rule 10(f)	Yes if by indictment Yes if for misdemeanor No if on felony Information (Rule 7(b) requires presence to waive indictment)	Yes, explicit in Rule 10(c)	Because initial appearance and arraignment usually occur together, the authority to waive appearance at arraignment is likely only relevant for superseding indictments or indictments brought after appearance on an Information. NOTE: A written waiver of appearance is required; must state defendant received indictment and requests entry of not guilty plea
Revocation of pretrial release 18 U.S.C. 3148	No	No	18 U.S.C. 3148 (shall be brought before a judicial officer for a hearing")

HEARING	Waive Appearance?	Appear By Video?	Other Notes
Plea Rule 11 Rule 43(b)(2)	Yes, if a misdemeanor offense No otherwise	Yes, if a misdemeanor offense No otherwise	Rule 43(a)(1) requires the defendant's presence for these proceedings. "Presence" means physical presence. *United States v. Bethea,* 888 F.3d 864 (7th Cir. 2018); *United States v. Williams,* 641 F.3d 758, 764-65 (6th Cir. 2011). Rule 11 requires that the court "address the defendant personally in open court" to advise the defendant of his or her rights and to determine that the plea is knowing and voluntary. Note: Rule 43 requires written consent to video appearance in misdemeanor cases
Sentence Rule 43(b)(2)	Yes, if this is a non-capital case and the defendant is "voluntarily absent"after having been present at the plea Yes in misdemeanor cases	Yes, by implication from rule allowing absence	The Ninth Circuit has said presence at sentencing is "required" but can be waived by voluntary absence. *United States v. Ornelas*, 828 F.3d 1018, 1021 (9th Cir. 2016). Note some courts state the defendant must be physically present when being sentenced (or resentenced) for a felony offense. Rule. 43(a)(1); *United States v. Torres-Palma,* 290 F.3d 1244, 1245-48 (10th Cir. 2002); *United States v. Lawrence,* 248 F.3d 300, 302-04 (4th Cir. 2001). Note: Rule 43 requires written consent to appear by video in misdemeanor cases; may want to use writing in felony cases.

HEARING	Waive Appearance?	Appear By Video?	Other Notes
Sentence reduction or correction Rule 43(b)(4)	Yes, explicit	Yes by implication from rule allowing absence	
Supervised release violation Rule 32.1	No for initial appearance; Yes for later hearings	Probably at initial appearance, because not explicitly prohibited and rule does not require "presence"; further video is allowed for IA under Rule 5. Defendant can waive revocation hearing itself, so by implication could appear by video at hearing.	Rule 32.1(if a warrant, "must be taken without unnecessary delay before a magistrate judge"; if a summons, "proceed under this rule"). Rule 32.1(b) ("Unless waived by the person, the court must hold the revocation hearing within a reasonable time in the district having jurisdiction.") Rule 32.1(c) (before modifying conditions, "the court must hold a hearing, at which the person has the right to counsel and an opportunity to make a statement and present any information in mitigation" unless waived)

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

***** DIVISION**

UNITED STATES OF AMERICA, **Plaintiff,** **v.** ***,** **Defendant.**	**Case No. *:*** **NOTICE OF DEFENDANT'S CONSENT TO VIDEO TELECONFERENCE**

Pursuant to Rule 43 of the Federal Rules of Criminal Procedure, and as reflected in the attached consent, the defendant in this case hereby consents and requests that all hearings or proceedings at which the defendant's physical presence would normally be required be conducted by video conference, to the extent permissible and practicable.

Respectfully submitted on March 13, 2020.

/s/ Lisa Hay
Lisa Hay
Federal Public Defender

CONSENT TO VIDEO CONFERENCE

I, _____, as the defendant in the case captioned *United States v.* _____, Case No. ____:___-cr-_____, after being advised by counsel of my right to be physically present during certain hearings and proceedings in this case, do hereby consent and request that those hearings and proceedings be conducted by video teleconference.

DATED: _____, 2020 _____
Name

_____
Counsel Advising Defendant

Appendix C

JUDGE NAME

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

UNITED STATES OF AMERICA, Plaintiff, v. CLIENT NAME, Defendant.	No. CASE NO. MOTION AND MEMORANDUM IN SUPPORT OF PRETRIAL RELEASE AND IN SUPPORT OF COMMUNITY EFFORTS TO LIMIT THE SPREAD OF COVID-19

I. Introduction

Defendant requests release pursuant to 18 U.S.C. § 3142, on his personal recognizance, on an unsecured appearance bond, or on whatever combination of conditions the Court deems appropriate. [Name of Client] presents a greater danger to the community by [his or her] detention than if released to the community. [Name of client] presents a minimal risk, if any, for violence to members of the community, and any concerns about flight risk pale when weighed against the risks our community faces during this crisis.

As this Court is certainly aware, and as detailed below, this country is undergoing a serious pandemic. In every aspect of society, individuals and officials are recognizing that "business as usual" must be dramatically altered; otherwise, the impact of the pandemic will be far worse than with such changes. As numerous news reports reflect, and also as detailed below, officials around the country are recognizing that the

criminal justice system is an area requiring immediate systemic change in response to the crisis. The threat to the jail population (and thus, indirectly, to the community as a whole) has led jail officials to reduce inmate populations through early release and led prosecuting agencies both to rely on summonses, rather than arrests, and to forestall charges on less serious cases.[1] That includes the King County prosecutor.[2] Moreover, Name of Client is at particular risk because of his/her **[brief description of condition].**

II. Factual Background

A. The COVID-19 Outbreak

The defense recognizes that the Court, like nearly everyone, has been exposed to a wide variety of news reports about COVID-19. However, given the varying information that has been dispensed, it seems worth briefly reviewing what is known. COVID-19 is highly contagious and may be spread by asymptomatic individuals. It has no known vaccination or cure and has killed thousands. As of March 16, 2020, the new strain of coronavirus, which causes COVID-19, has infected over 181,904 people, leading to at least 7,139 deaths worldwide.[3] On March 11, 2020, the World Health Organization officially classified COVID-19 as a pandemic.[4] The first case of COVID-19 in the United States was found in Snohomish County, Washington. The first death presumed to be from COVID-19 was also in the Seattle area – in Kirkland, Washington. On February 29, 2020, hours after Washington state health officials announced that death, Governor Jay Inslee declared a state of emergency, directing agencies to use all

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[1] Salvador Hernandez, *Los Angeles Releasing Inmates Early Over Fears Of Coronavirus In Jails*, BuzzFeed News (Mar. 16, 2020), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release.

[2] Emily Bazelon, *Our Courts and Jails Are Putting Lives at Risk*, New York Times (March 13, 2020), at https://www.nytimes.com/2020/03/13/opinion/coronavirus-courts-jails.html.

[3] https://www.worldometer.info/coronavirus/coronavirus-cases (updating regularly).

[4] *WHO Characterizes COVID-19 as a Pandemic*, World Health Organization (March 11, 2020) *at* https://bit.ly/2W8dwpS.

resources needed to respond to the outbreak.[5] On March 11, 2020, Governor Inslee issued a ban on gatherings and events of more than 250 people in the same counties, in an effort to try to contain the COVID-19 outbreak. One day later, on March 12, 2020, the governor announced the closure of all public and private K–12 schools in King, Snohomish, and Pierce Counties until at least April 27, 2020, affecting 600,000 students.[6] Most recently, on March 15, 2020, the governor signed an emergency declaration temporarily shutting down bars, restaurants, and places of entertainment and recreation statewide, and capping all public gatherings at 50 people.[7]

According to the CDC and epidemic experts from around the world, a possible scenario—based on the characteristics of the virus, including estimates of how transmissible it is and the severity of the illness it can cause—is that "[b]etween 160 million and 214 million people in the U.S. could be infected over the course of the epidemic," and "[a]s many as 200,000 to 1.7 million people could die." [8] Experts have also made clear that the assumptions fueling these staggering numbers can be mitigated by appropriate interventions to slow transmission. As one expert, Dr. Carter Mecher, a senior medical adviser for public health at the Department of Veterans Affairs and a former director of medical preparedness policy at the White House during the Obama and Bush administrations, observed: "A fire on your stove you could put out with a fire

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[5] *Gov. Jay Inslee Declares State of Emergency for Coronavirus Response*, KUOW (Feb. 29, 2020) *at* https://www.seattletimes.com/seattle-news/health/jails-and-courthouses-across-washington-look-for-ways-to-protect-employees-jurors-and-inmates-from-coronavirus/.

[6] *New, Drastic Changes Implemented in Response to Coronavirus*, KIRO 7 News (March 13, 2020) at https://www.kiro7.com/news/local/coronavirus-all-k-12-schools-king-snohomish-pierce-counties-be-closed-through-april-24/XIDPHMLVOJAAREQ5YCL75367PU/ (updating regularly).

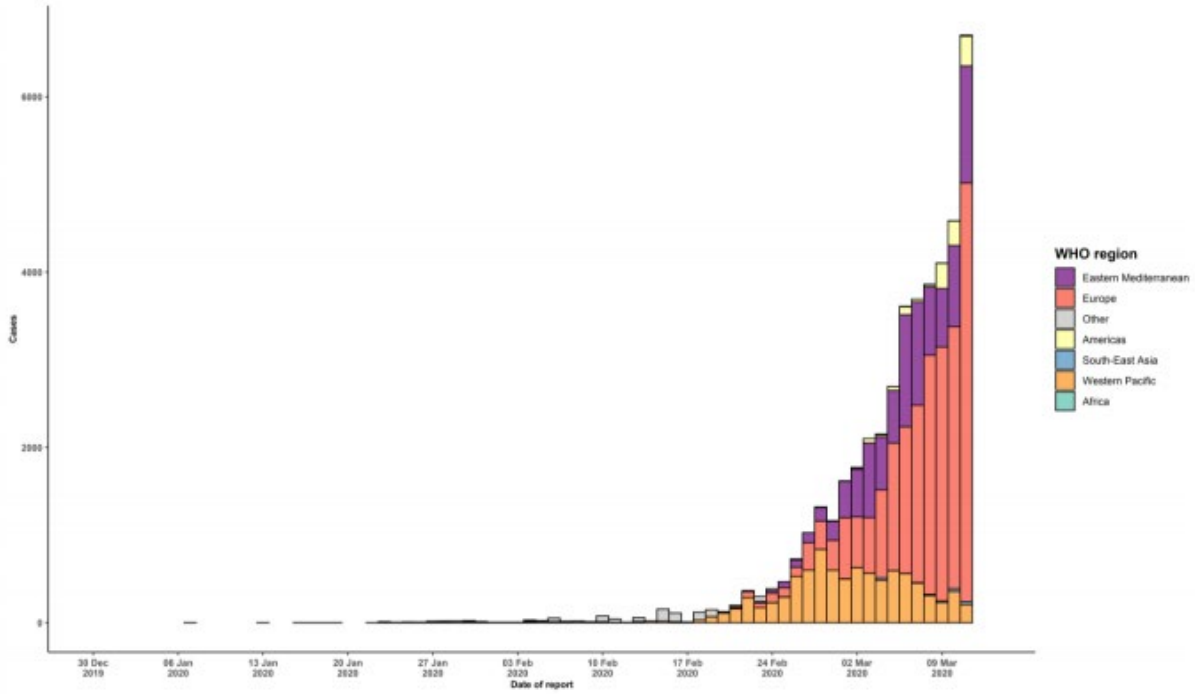
[7] *Washington State to Shut Down Restaurants, Bars, and Cap Gatherings at 50 to Stop Spread of Coronavirus*, The Seattle Times (March 16, 2020) at https://www.seattletimes.com/seattle-news/king-county-and-washington-state-to-act-on-bars-restaurants-and-gatherings/.

[8] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths*, The New York Times (March 13, 2020) at https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

extinguisher, but if your kitchen is ablaze, that fire extinguisher probably won't work." *Id.* Thus, "[c]ommunities that pull the fire extinguisher early are much more effective." *Id*.

The graph below, showing the epidemic curve of the disease, serves as evidence of the need to act forcefully and immediately to change "business as usual."[9]

Figure 2. Epidemic curve of confirmed COVID-19 cases reported outside of China (*n*= 44 067), by date of report and WHO region through 12 March 2020



The CDC has issued guidance that individuals at higher risk of contracting COVID-19—adults over 60 years old and people with chronic medical conditions such as lung disease, heart disease, and diabetes—take immediate preventative actions, including avoiding crowded areas and staying home as much as possible.[10] Meanwhile,

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[9] *Coronavirus disease2019 (COVID-19)Situation Report –48*, CDC (March 8, 2020), at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200308-sitrep-48-covid-19.pdf?sfvrsn=16f7ccef_4.

[10] *People at Risk for Serious Illness from COVID-19*, CDC (March 12, 2020) *at* https://bit.ly/2vgUt1P. Other conditions listed by CDC include blood disorders, kidney disease,

the number of COVID-19 cases in Washington continues to grow. On March 13, 2020, the Department of Public Health announced 36 new cases and one death. The King County total is now at 27 deaths with 270 total cases. Including the King County deaths, three deaths in Snohomish County, and one Grant County death, the statewide COVID-19 death total is at least 50 and the statewide case number, as reported by the Department of Health and local health districts, is at least 905 and growing.[11] In light of the confirmed cases in Seattle and surrounding areas that indicate broad community spread, every necessary action must be taken to protect vulnerable populations and, in turn, the broader community inside and outside the FDC.

COVID-19 is an extremely dangerous disease. The best estimate for its overall fatality rate—i.e., its fatality rate among all demographics—is 0.3-3.5%, "which is 5-35 times the fatality associated with influenza infection." Beyrer Dec. ¶ 5;[12] *see also* Nick Wilson et al., *Case-Fatality Risk Estimates for COVID-19 Calculated by Using a Lag Time for Fatality*, 26(6) EID Journal (prepublication June 2020).[13] Fatality rates vary wildly, however, depending on both environmental and demographic risk factors.

The death rate for those deemed at-risk is even higher. It increases rapidly with age. Across all age groups, COVID-19 kills:

- 13.2% of people with cardiovascular disease

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liver disease, compromised immune system, current or recent pregnancy (two weeks), endocrine disorders, and neurological conditions. *Appendix A to CDC's recommendations for 30 day Mitigation Strategies for Santa Clara County, California, based on current situation with COVID-19 Transmission and affected health care facilities*, CDC, *at* https://www.cdc.gov/coronavirus/2019-ncov/downloads/Santa-Clara_Community_Mitigation.pdf.

[11] *New, Drastic Changes Implemented in Response to Coronavirus*, KIRO 7 News (March 13, 2020) at https://www.kiro7.com/news/local/coronavirus-all-k-12-schools-king-snohomish-pierce-counties-be-closed-through-april-24/XIDPHMLVOJAAREQ5YCL75367PU/ (updating regularly).

[12] Declaration of Chris Beyrer, MD, MPH, Professor of Epidemiology, Johns Hopkins Bloomberg School of Public Health, attached as Exhibit A.

[13] Available at https://wwwnc.cdc.gov/eid/article/26/6/20-0320_article.

- 9.2% of people with diabetes
- 8.4% of people with hypertension
- 8% of people with chronic respiratory disease
- 7.6% of people with cancer[14]

B. "An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues."[15]

"If you think a cruise ship is a dangerous place to be during a pandemic, consider America's jails and prisons." *Id*. According to the CDC, the virus is mainly spread person-to-person "[b]etween people who are in close contact with one another (within about 6 feet)" and "[t]hrough respiratory droplets produced when an infected person coughs or sneezes."[16] The spread can be slowed, public health professionals say, if people practice "social distancing" by avoiding public spaces and generally limit their movement. "Social distancing" is not an option at the FDC. Like most prisons, inmates housed at the FDC are in closed quarters and forced to share bathrooms, laundry, and meal areas. The cell toilets rarely have lids and the tank often doubles as the sink for handwashing. Air circulation is uniformly poor. "Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities." Beyrer Dec., Exhibit A, ¶ 13. These deficiencies now represent a threat not only to those being housed there but to the community at large.

"According to health experts, it is not a matter of if, but when, this virus breaks out of jails and prisons."[17] Conditions of pretrial confinement create the ideal

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[14] World Health Organization, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* at 12 (Feb. 28, 2020), at https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf.

[15] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[16] *How COVID-19 Spreads*, https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html (last accessed on March 13, 2020).

[17] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction*

environment for the transmission of a highly contagious disease such as COVID-19.[18] Inmates do not live under quarantine: people cycle in and out of BOP pretrial facilities daily from all over the world and the country, and people who work in the facilities leave and return daily, without screening. And all of these individuals potentially carry viral conditions from the FDC back to their homes and communities, and then return back, bringing new germs with them. "It is therefore an *urgent priority* in this time of national public health emergency to reduce the number of persons in detention as quickly as possible." Beyrer Dec., Exhibit A, at ¶ 17 (emphasis added).

Further, incarcerated people have poorer health than the general population, and even at the best of times medical care is limited in federal pretrial detention centers.[19] Many people who are incarcerated also have chronic conditions, such as diabetes or HIV, which make them vulnerable to severe forms of COVID-19. According to public health experts, incarcerated individuals "are at special risk of infection, given their living situations," and "may also be less able to participate in proactive measures to keep themselves safe"; "infection control is challenging in these settings."[20] Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[21] In China, officials have confirmed the coronavirus spreading at a rapid pace in Chinese prisons, counting 500 cases.[22]

Continues, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[18] Joseph A. Bick (2007). Infection Control in Jails and Prisons. *Clinical Infectious Diseases* 45(8):1047-1055, *at* https://doi.org/10.1086/521910.

[19] Laura M. Maruschak et al. (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. NCJ 248491. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, *at* https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf

[20] "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), *at* https://bit.ly/2W9V6oS.

[21] *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) at https://bit.ly/2TNcNZY.

[22] Rhea Mahbubani, *Chinese Jails Have Become Hotbeds of Coronavirus As More Than 500*

Secretary of State Mike Pompeo has called for Iran to release Americans detained there because of the "deeply troubling" "[r]eports that COVID-19 has spread to Iranian prisons," noting that "[t]heir detention amid increasingly deteriorating conditions defies basic human decency."[23]

Extreme measures are necessary because as Dr. Homer Venters, former chief medical officer of the New York City jail system, made clear: "Coronavirus in these settings will dramatically increase the epidemic curve, not flatten it, and disproportionately for people of color."[24] The critical point from health experts is that slowing the rate of infection ("flattening the curve") is critical to avoid overtaxing health resources (which, if it occurs, would of course lead to more deaths for any given infection rate).[25]

C. Conditions at the FDC Contribute to Fueling the Pandemic

The FDC houses 684 total people with a capacity for 1000. Those numbers are obviously not stagnant, given that people continue to be detained and released. Such turnover is particularly frightening in a pandemic. The particular conditions in which the majority of the people are housed offer no protections for those either detained or those who come in regular contact with inmates, including FDC staff. Inmates are housed in small two-person cells with a shared toilet and sink. Individuals not in the special housing unit are only allowed outside of their cells for approximately two or

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Cases Have Erupted, Prompting the Ouster of Several Officials, Business Insider (Feb. 21, 2020) at https://bit.ly/2vSzSRT.

[23] Jennifer Hansler and Kylie Atwood, *Pompeo calls for humanitarian release of wrongfully detained Americans in Iran amid coronavirus outbreak*, CNN (Mar. 10, 2020) at https://cnn.it/2W4OpV7.

[24] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[25] *See* PBS News Hour graph, "One simple chart explains how social distancing saves lives" (Mar. 13, 2020), at https://www.pbs.org/newshour/science/one-simple-chart-explains-how-social-distancing-saves-lives, attached as Exhibit B.

three hours a day, with the upper and lower tiers of each unit alternating the hours they are allowed out of cells for group meals, showers, and accessing the phones and computers. Individuals must often stand in line in close proximity to one another to await their turn for these resources. Groups of 30 or more individuals must share their meals together without the ability to separate. On March 3, 2020, after multiple inmates in the same housing unit began exhibiting flu-like symptoms, the FDC made the decision to go into a 48-hour lockdown, including shutting down all social and legal visits. Although initially the FDC did not have the COVID-19 tests kits they needed to test those in the affected unit, the FDC eventually received the kits. But during the days-long waiting period for the results, those in the affected unit were denied basic hygiene necessities such as showering. There were also reports that individuals did not have access to soap or hand sanitizers. Access to legal calls was also suspended, and all social and legal visitation was shut down pending the test results. Limited legal visitation for non-quarantined inmates was not resumed until March 6, 2020. The quarantine was lifted on March 10, 2020. As of March 13, 2020, legal visits are allowed only on a case-by-case basis. Further, according to George Cho, BOP's Supervisory Attorney, should "additional FDC SeaTac inmates exhibit flu-like symptoms in the near-future, thus again necessitating quarantining and COVID-19 testing, FDC SeaTac will again implement all necessary measures to protect the safety and security of both the institution and the outside community."[26] Given the speed with which COVID 19 is spreading in our community, it will only be a short matter of time before a staff member or inmate tests positive and the facility returns to an all-out lockdown and quarantine.

The FDC's strategy appears primarily to be a reactive one—quarantining if inmates "exhibit flu-like symptoms in the near-future"—it is highly unlikely the FDC's tactic for stemming the spread of COVID-19 will work. There is significant controversy

[26] March 9, 2020, email from George Cho, attached as Exhibit C.

over the incubation and appropriate quarantine periods for the disease, insufficient knowledge about how it spreads, and few treatments that appear successful. "The largest study of coronavirus patients so far suggests it could take up to 24 days after exposure for symptoms to show."[27] The CDC's website gives detailed instructions on the complex steps health care professionals must follow in order to properly quarantine infected individuals, including systems that prisons do not have and cannot accommodate, such as negative air pressure circulation systems, HEPA air filtration, and specific air circulation protocols.[28] The CDC has also detailed clinical care guidance for the disease, although much remains unknown about its incubation period, modes of transmission, and potential treatment protocols.[29] It is unknown whether any of the FDC's personnel have received training in these procedures. Thus, there is a significant likelihood that prison personnel will themselves become infected and thereafter transmit the disease to the broader community. Indeed, lawyers who are at high risk because of age or underlying medical conditions have been advised not to enter the facility, and more recently there is close to a 100% prohibition on face to face client meetings at the FDC.[30] In order to assist in minimizing the transmission of COVID 19 by legal staff into the FDC, the FPD has instituted a temporary policy of prohibiting any lawyers or staff members from entering that facility unless personally approved by the Federal Defender.

As additional people are arrested who have been out in the community as the coronavirus spreads, if they are not symptomatic, they will be brought into the FDC and

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[27] Aylin Woodward, *2 Studies of Coronavirus Patients Suggest the Disease's Incubation Period Could Be Longer than the Standard Quarantine Period of 14 Days*, Business Insider (Feb. 21, 2020) at https://www.businessinsider.com/wuhan-coronavirus-symptoms-24-days-after-infection-2020-2.

[28] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html.

[29] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[30] March 5, 2020, email from George Cho, attached as Exhibit D.

held with the existing population, potentially bringing the virus (now officially named "SARS-CoV-2"[31]) into this population held in large numbers, close quarters, and low sanitary conditions.

D. Detaining John Doe Puts Not Only Him, But Other FDC Inmates, Jail and Court Personnel, and the Broader Community, at Greater Risk.

[Discuss here the factors that show client to be a part of the at-risk population. See footnote 7 and accompanying text.] Clearly, detaining John Doe poses significant health risk to him, given the likelihood that COVID-19 will spread within FDC, and given his [condition], putting him at particular risk.

But the risk is not limited to him. If he currently has SARS-CoV-2 but is asymptomatic, detaining him risks exposing the entire FDC inmate population to the disease. That, in turn, risks exposing FDC personnel, along with all court staff who come in contact with either Mr. Doe or any person infected by him. And if he contributes to an outbreak of COVID-19 within FDC, that will increase the demand on the community's medical resources, reducing their availability to the community at large. Finally, if he contributes to the spread of the virus within the FDC, then if an infected but asymptomatic inmate is released, that obviously will hasten the spread of the virus and the disease within the broader community.

But the harm to others does not depend on the assumption that John Doe currently is infected with the virus. Any increase in FDC's population increases the odds that the infection will spread if any other inmate is, or becomes, infected, leading to the exact same harms discussed above to inmates, BOP and court staff, and the community.

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[31] World Health Organization, "Naming the coronavirus disease (COVID-19) and the virus that causes it," at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it.

III. The Bail Reform Act Requires John Doe's Release

Responsible relevant parties, recognizing these extraordinary circumstances, have acknowledged that increasing the population of detention centers like the FDC presents a danger not only to inmates but to the broader community.

Just this month, 24 elected prosecutors from around the country, including Cy Vance, the district attorney of New York, and district attorneys in Mississippi and Texas, sent out a joint statement "Addressing the Rights and Needs of Those in Custody."[32] Recommendations made in that Joint Statement include: "Reduc[ing] the prison population to minimize sharing of cells[,]" and *immediately* "[i]dentify[ing] and releas[ing]" "individuals who are elderly," and "[p]opulations that the CDC has classified as vulnerable (those with asthma, cancer, heart disease, lung disease, and diabetes.)" The Statement also recommends, among others, that "[p]eople incarcerated for technical violations of probation and parole be released." *Id.*

Prosecutors and law enforcement are already taking some of these proactive measures to mitigate the spread of the coronavirus. San Francisco District Attorney Chesa Boudin has directed his prosecutors not to oppose motions to release pretrial detainees facing misdemeanor charges or drug-related felony charges if the person is deemed to pose no threat to public safety, and has directed his staff to "strongly consider" credit for time served in plea deals so that more people can be released.[33] Officials in Los Angeles County, the largest county prison system in the U.S., are also releasing inmates and making fewer arrests to reduce the risk of a coronavirus outbreak in the prison systems. As Los Angeles Sheriff Alex Villanueva recently explained to reporters, these measures are necessary because "Our population within our jails is a

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[32] Joint Statement From Elected Prosecutors on COVID-19 and Addressing the Rights and Needs of Those in Custody (March 2020), attached as Exhibit E.

[33] *San Francisco Officials Push to Reduce Jail Population to Prevent Coronavirus Outbreak* (Mar. 12, 2020), at http://sfpublicdefender.org/news/2020/03/san-francisco-officials-push-to-reduce-jail-population-to-prevent-coronavirus-outbreak-the-appeal/.

vulnerable population just by who they are, where they are located, so we're protecting that population from potential exposure."[34] Sheriff Villanueva stated his office has reduced the inmate population from 17,076 to 16,459, a reduction of more than 600 inmates, in about two weeks. *Id.*

On March 17, 2020, Chief Judge Ricardo Martinez issued General Order 02-20.[35] That Order recognized the various facts discussed above, including the need for minimal contact between people. Chief Judge Martinez took the extraordinary steps of continuing all civil and criminal hearings through May, continuing grand jury hearings, delaying all preliminary hearings, finding excludable time under the Speedy Trial Act, closing the two courthouses except for emergency matters scheduled by individual judges "if necessary after considering the above public health situation," and closing all Probation and Pretrial offices.

If these emergency changes are warranted (and they most definitely are), dramatic changes in release versus detention are equally warranted. This Court has the authority to swiftly mitigate the present danger. As an initial matter, "[u]nder the Bail Reform Act of 1984, as amended, Congress has determined that any person charged with an offense under the federal criminal laws shall be released pending trial, subject to appropriate conditions. . . ." *United States v. Santos-Flores*, 794 F.3d 1088, 1090 (9th Cir. 2015). And, "[o]nly in rare cases should release be denied, and doubts regarding the propriety of release are to be resolved in favor of the defendant." *Id*. (citing *United States v. Motamedi*, 767 F.2d 1403, 1405 (9th Cir. 1985)). *See also United States v. Salerno*, 481 U.S. 739, 755 (1987) (suggesting that "detention prior to trial or without

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[34] Salvador Hernandez, Los Angeles Releasing Inmates Early Over Fears of Coronavirus in Jails, BuzzFeed News (Mar. 16, 2020), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release.

[35] General Order 02-20, W.D. Wash. (Mar. 17, 2020), attached as Exhibit F.

trial is the carefully limited exception" to liberty before trial). One charged with a crime is, after all, presumed innocent. *Stack v. Boyle*, 342 U.S. 1, 4 (1951). A single individual unnecessarily detained before trial is one individual too many, and the increasing use of the practice places tremendous wear on our constitutional system. *United States v. Montalvo-Murillo*, 495 U.S. 711, 723–24 (1990) (Stevens, J., dissenting, joined by Brennan and Marshall, JJ.).

The courts have long recognized that there is no greater necessity than keeping a defendant alive, no matter the charge. As former Federal District Court Judge Weinstein for the Eastern District of New York stated: "We do not punish those who have not been proven guilty." *United States v. Scarpa*, 815 F. Supp. 88 (E.D.N.Y. 1993) (pretrial defendant with AIDS facing murder charges released on bail because of the "unacceptably high risk of infection and death on a daily basis inside the MCC").

The United States Constitution affords pretrial detainees greater protection from dangerous conditions of confinement than those sentenced after conviction. *See*, *e.g.*, *Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 934 (N.D. Cal. 2015) ("A jail violates both [the Fourteenth and Eight Amendments] if it incarcerates inmates under conditions posing a substantial risk of serious harm to their health or safety . . . and if [government] acted with deliberate indifference, that is, with conscious disregard for that risk[.]"); *Morales Feliciano v. Rossello Gonzalez*, 13 F. Supp. 2d 151, 210 (D.P.R. 1998) ("The failure to screen incoming [inmates] for infectious diseases including tuberculosis" violates the Constitution).

This Court should consider the "total harm and benefits to prisoner and society" that detention of John Doe will yield, relative to the heightened health risks posed to John Doe, and that posed to the other inmates, court and BOP staff, and the community, during this rapidly encroaching pandemic. *See Davis v. Ayala*, 135 S. Ct. 2187, 2209 (2015) (Kennedy, J., concurring) (calling for heightened judicial scrutiny of the

projected impact of jail and prison conditions on a defendant); *United States v. Mateo*, 299 F. Supp. 2d 201, 212 (S.D.N.Y. 2004) (reducing sentence where defendant's pretrial conditions were "qualitatively more severe in kind and degree than the prospect of such experiences reasonably foreseeable in the ordinary case").

All provisions of the Bail Reform Act impose a test of "reasonableness" when a court makes release decisions. *See* § 3142(b) (release on personal recognizance or unsecured appearance bond); § 3142(c)(1) (release on conditions); § 3142(d)(2) (temporary detention); and § 3142(e) (detention). *See also United States v. Hir*, 517 F.3d 1081, 1092 n. 9 (9th Cir. 2008) ("We note that the Bail Reform Act contemplates only that a court be able to 'reasonably assure,' rather than guarantee, the safety of the community. *See United States v. Tortora*, 922 F.2d 880, 884 (1st Cir.1990) ('Undoubtedly, the safety of the community can be reasonably assured without being absolutely guaranteed.... Requiring that release conditions *guarantee* the community's safety would fly in the teeth of Congress's clear intent that only a limited number of defendants be subject to pretrial detention.')") (emphasis in *Tortora*).

When evaluating reasonable assurance of the community's safety, the Court needs to determine the extent to which *detention* threatens the community's safety, as well as the extent to which release poses a threat. For the reasons discussed in Part II.C, *supra*, given that we are in the midst of a world-wide pandemic, that former risk is significant, and must be an important factor in the Court's consideration. **[Include only if a presumption applies:]** Even where a rebuttable presumption of risk to the community applies under §§ 3142(e)(2) or (3), the risk to the community from *detention* is an important consideration in determining whether a presumption of danger from release has been rebutted.

Furthermore, the Act specifically directs courts to consider the defendant's "physical . . . condition" when making a release decision. *See* § 3142(g)(3)(A). Here,

John Doe's condition means (a) detaining him poses a significant risk to him; (b) he has every incentive to comply with the requirements of release, since any violation risks putting him at far more risk to his health, by being detained in FDD, and (c) he increases the risk those who come in contact with him and other inmates, in addition to the general population, as discussed above.

Finally, the latest General Order means that any defendants who are detained will be detained for several months, perhaps longer, without an indictment. *See* Exhibit F, ¶ 3. That is all the more reason to favor release over detention.

IV. Conditions of Release Are Available that Allow John Doe to Be Safe From the Risks of Incarceration at FDC Also Reasonably Ensuring Any Danger to the Community.

[Discuss here the factors you normally would argue.]

[Describe specific release conditions proposed]

Even if these factors would not normally lead this Court to order release, the present emergency conditions call for a cessation of "business as usual." Just as restaurants and sporting events must close, the balancing of interests in weighing detention and release decisions must be altered. Under the conditions proposed, the community's safety will reasonably be assured, while avoiding the increased risk to the community (and to Mr. Doe) from incarceration. Mr. Doe will not be left to his own devices, but will be supported and monitored by Pretrial Services. Since 2009, Pretrial Services' data has found that only 2.9% of defendants in the highest risk category were re-arrested for a violent crime while on release.[36] In 2017, the pretrial release rate for the Western District of Washington was 72.15% and the overall revocation rate was 8.89%. **[Include if relevant:]**The elderly and chronically ill, no matter what crime they

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[36] Thomas H. Cohen, Christopher T. Lowenkamp, and William E. Hicks, *Revalidating the Federal Pretrial Risk Assessment Instrument (PTRA): A Research Summary* (September 2018) *at* https://www.uscourts.gov/sites/default/files/82_2_3_0.pdf.

are accused of, pose a lower risk of violating supervision, particularly during a global pandemic during which even leaving the house will endanger their lives.

V. The Court Should Deny any Government Request for a Continuance of the Detention Hearing.

When the Government has requested a continuance of the detention hearing, such a continuance has generally been granted almost automatically. But the Bail Reform Act does not provide for automatic continuances for either party. In this highly unusual period, a continuance should not be granted.

The Act generally requires that detention hearings "shall be held immediately upon the person's first appearance before the judicial officer[.]" 18 U.S.C. § 3142(f)(2). The Act then provides an exception to that requirement:

> unless that person, or the attorney for the Government, seeks a continuance. Except for good cause, a continuance on motion of such person may not exceed five days (not including any intermediate Saturday, Sunday, or legal holiday), and a continuance on motion of the attorney for the Government may not exceed three days (not including any intermediate Saturday, Sunday, or legal holiday). During a continuance, such person shall be detained . . .

This "unless" provision does not mean that either party is *automatically* entitled to a continuance. It means that the first provision – making an immediate hearing mandatory – is excused if a party seeks a continuance. In short, if such a request is made, nothing is required, neither a same-day detention hearing nor a continuance; either is within the judicial officer's discretion.

It is also clear from the statute that even when a continuance is granted, three days is a maximum (absent a showing of good cause), not an automatic period. There is nothing to prevent the Court from granting a shorter continuance. *See*, *e.g.*, *United States v. Bundy*, No. 2:16-CR-0046-GMN-PAL, 2016 WL 3456911, at *2 (D. Nev. June 20, 2016) (stating, in the context of a defense request, but equally applicable to Government requests, that, "[f]rom the plain language of the statute, it is clear that a

[particular length] continuance is not an entitlement, but rather, a discretionary maximum amount of time the Court may continue the detention hearing upon a . . . motion."). That continuance could be one of a few hours, rather than even a day, given the health risks to numerous portions of the populations, as detailed in Part II.C, since the defendant must be detained until the continued hearing.

VI. Conclusion

For all of the above reasons, John Doe should be granted release on appropriate conditions.

DATED this ___ day of _____ 2020.

Respectfully submitted,

s/ *Attorney Name*
Attorney for Client Name

JUDGE NAME

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

UNITED STATES OF AMERICA, Plaintiff, v. CLIENT NAME, Defendant.	No. CASE NO. MOTION AND MEMORANDUM IN SUPPORT OF PRETRIAL RELEASE AND IN SUPPORT OF COMMUNITY EFFORTS TO LIMIT THE SPREAD OF COVID-19

I. Introduction

Defendant requests release pursuant to 18 U.S.C. § 3142, on his personal recognizance, on an unsecured appearance bond, or on whatever combination of conditions the Court deems appropriate. [Name of Client] presents a greater danger to the community by [his or her] detention than if released to the community. [Name of client] presents a minimal risk, if any, for violence to members of the community, and any concerns about flight risk pale when weighed against the risks our community faces during this crisis.

As this Court is certainly aware, and as detailed below, this country is undergoing a serious pandemic. In every aspect of society, individuals and officials are recognizing that "business as usual" must be dramatically altered; otherwise, the impact of the pandemic will be far worse than with such changes. As numerous news reports reflect, and also as detailed below, officials around the country are recognizing that the

criminal justice system is an area requiring immediate systemic change in response to the crisis. The threat to the jail population (and thus, indirectly, to the community as a whole) has led jail officials to reduce inmate populations through early release and led prosecuting agencies both to rely on summonses, rather than arrests, and to forestall charges on less serious cases.[1] That includes the King County prosecutor.[2]

II. Factual Background

A. The COVID-19 Outbreak

The defense recognizes that the Court, like nearly everyone, has been exposed to a wide variety of news reports about COVID-19. However, given the varying information that has been dispensed, it seems worth briefly reviewing what is known. COVID-19 is highly contagious and may be spread by asymptomatic individuals. It has no known vaccination or cure and has killed thousands. As of March 16, 2020, the new strain of coronavirus, which causes COVID-19, has infected over 181,904 people, leading to at least 7,139 deaths worldwide.[3] On March 11, 2020, the World Health Organization officially classified COVID-19 as a pandemic.[4] The first case of COVID-19 in the United States was found in Snohomish County, Washington. The first death presumed to be from COVID-19 was also in the Seattle area – in Kirkland, Washington. On February 29, 2020, hours after Washington state health officials announced that death, Governor Jay Inslee declared a state of emergency, directing agencies to use all resources needed to respond to the outbreak.[5] On March 11, 2020, Governor Inslee

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[1] Salvador Hernandez, *Los Angeles Releasing Inmates Early Over Fears Of Coronavirus In Jails*, BuzzFeed News (Mar. 16, 2020), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release.

[2] Emily Bazelon, *Our Courts and Jails Are Putting Lives at Risk*, New York Times (March 13, 2020), at https://www.nytimes.com/2020/03/13/opinion/coronavirus-courts-jails.html.

[3] https://www.worldometer.info/coronavirus/coronavirus-cases (updating regularly).

[4] *WHO Characterizes COVID-19 as a Pandemic*, World Health Organization (March 11, 2020) *at* https://bit.ly/2W8dwpS.

[5] *Gov. Jay Inslee Declares State of Emergency for Coronavirus Response*, KUOW (Feb. 29,

issued a ban on gatherings and events of more than 250 people in the same counties, in an effort to try to contain the COVID-19 outbreak. One day later, on March 12, 2020, the governor announced the closure of all public and private K–12 schools in King, Snohomish, and Pierce Counties until at least April 27, 2020, affecting 600,000 students.[6] Most recently, on March 15, 2020, the governor signed an emergency declaration temporarily shutting down bars, restaurants, and places of entertainment and recreation statewide, and capping all public gatherings at 50 people.[7]

According to the CDC and epidemic experts from around the world, a possible scenario—based on the characteristics of the virus, including estimates of how transmissible it is and the severity of the illness it can cause—is that "[b]etween 160 million and 214 million people in the U.S. could be infected over the course of the epidemic," and "[a]s many as 200,000 to 1.7 million people could die." [8] Experts have also made clear that the assumptions fueling these staggering numbers can be mitigated by appropriate interventions to slow transmission. As one expert, Dr. Carter Mecher, a senior medical adviser for public health at the Department of Veterans Affairs and a former director of medical preparedness policy at the White House during the Obama and Bush administrations, observed: "A fire on your stove you could put out with a fire extinguisher, but if your kitchen is ablaze, that fire extinguisher probably won't work."

2020) *at* https://www.seattletimes.com/seattle-news/health/jails-and-courthouses-across-washington-look-for-ways-to-protect-employees-jurors-and-inmates-from-coronavirus/.

[6] *New, Drastic Changes Implemented in Response to Coronavirus*, KIRO 7 News (March 13, 2020) at https://www.kiro7.com/news/local/coronavirus-all-k-12-schools-king-snohomish-pierce-counties-be-closed-through-april-24/XIDPHMLVOJAAREQ5YCL75367PU/ (updating regularly).

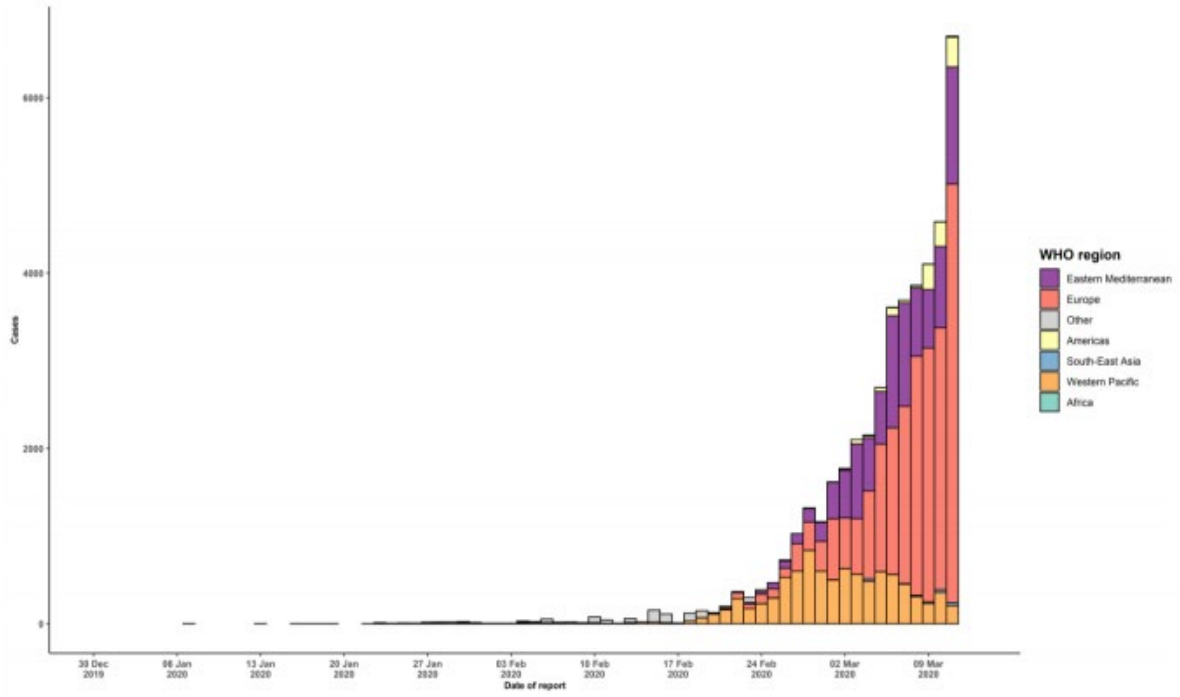
[7] *Washington State to Shut Down Restaurants, Bars, and Cap Gatherings at 50 to Stop Spread of Coronavirus*, The Seattle Times (March 16, 2020) at https://www.seattletimes.com/seattle-news/king-county-and-washington-state-to-act-on-bars-restaurants-and-gatherings/.

[8] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths*, The New York Times (March 13, 2020) at https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

Id. Thus, "[c]ommunities that pull the fire extinguisher early are much more effective." *Id*.

The graph below, showing the epidemic curve of the disease, serves as evidence of the need to act forcefully and immediately to change "business as usual."[9]

Figure 2. Epidemic curve of confirmed COVID-19 cases reported outside of China (*n*= 44 067), by date of report and WHO region through 12 March 2020



The CDC has issued guidance that individuals at higher risk of contracting COVID-19—adults over 60 years old and people with chronic medical conditions such as lung disease, heart disease, and diabetes—take immediate preventative actions, including avoiding crowded areas and staying home as much as possible.[10] Meanwhile, the number of COVID-19 cases in Washington continues to grow. On March 13, 2020, the Department of Public Health announced 36 new cases and one death. The King

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[9] *Coronavirus disease2019 (COVID-19)Situation Report –48*, CDC (March 8, 2020), at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200308-sitrep-48-covid-19.pdf?sfvrsn=16f7ccef_4.

[10] *People at Risk for Serious Illness from COVID-19*, CDC (March 12, 2020) *at* https://bit.ly/2vgUt1P.

County total is now at 27 deaths with 270 total cases. Including the King County deaths, three deaths in Snohomish County, and one Grant County death, the statewide COVID-19 death total is at least 50 and the statewide case number, as reported by the Department of Health and local health districts, is at least 905 and growing.[11] In light of the confirmed cases in Seattle and surrounding areas that indicate broad community spread, every necessary action must be taken to protect vulnerable populations and, in turn, the broader community inside and outside the FDC.

COVID-19 is an extremely dangerous disease. The best estimate for its overall fatality rate—i.e., its fatality rate among all demographics—is 0.3-3.5%, "which is 5-35 times the fatality associated with influenza infection." Beyrer Dec. ¶ 5;[12] *see also* Nick Wilson et al., *Case-Fatality Risk Estimates for COVID-19 Calculated by Using a Lag Time for Fatality*, 26(6) EID Journal (prepublication June 2020).[13] Fatality rates vary wildly, however, depending on both environmental and demographic risk factors.

The death rate for those deemed at-risk is even higher. It increases rapidly with age. Across all age groups, COVID-19 kills:

- 13.2% of people with cardiovascular disease
- 9.2% of people with diabetes
- 8.4% of people with hypertension
- 8% of people with chronic respiratory disease
- 7.6% of people with cancer[14]

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[11] *New, Drastic Changes Implemented in Response to Coronavirus*, KIRO 7 News (March 13, 2020) at https://www.kiro7.com/news/local/coronavirus-all-k-12-schools-king-snohomish-pierce-counties-be-closed-through-april-24/XIDPHMLVOJAAREQ5YCL75367PU/ (updating regularly).

[12] Declaration of Chris Beyrer, MD, MPH, Professor of Epidemiology, Johns Hopkins Bloomberg School of Public Health, attached as Exhibit A.

[13] Available at https://wwwnc.cdc.gov/eid/article/26/6/20-0320_article.

[14] World Health Organization, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* at 12 (Feb. 28, 2020), at https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf.

B. "An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues."[15]

"If you think a cruise ship is a dangerous place to be during a pandemic, consider America's jails and prisons." *Id*. According to the CDC, the virus is mainly spread person-to-person "[b]etween people who are in close contact with one another (within about 6 feet)" and "[t]hrough respiratory droplets produced when an infected person coughs or sneezes."[16] The spread can be slowed, public health professionals say, if people practice "social distancing" by avoiding public spaces and generally limit their movement. "Social distancing" is not an option at the FDC. Like most prisons, inmates housed at the FDC are in closed quarters and forced to share bathrooms, laundry, and meal areas. The cell toilets rarely have lids and the tank often doubles as the sink for handwashing. Air circulation is uniformly poor. "Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities." Beyrer Dec., Exhibit A, ¶ 13. These deficiencies now represent a threat not only to those being housed there but to the community at large.

"According to health experts, it is not a matter of if, but when, this virus breaks out of jails and prisons."[17] Conditions of pretrial confinement create the ideal environment for the transmission of a highly contagious disease such as COVID-19.[18] Inmates do not live under quarantine: people cycle in and out of BOP pretrial facilities daily from all over the world and the country, and people who work in the facilities leave and return daily, without screening. And all of these individuals potentially carry

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[15] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[16] *How COVID-19 Spreads*, https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html (last accessed on March 13, 2020).

[17] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[18] Joseph A. Bick (2007). Infection Control in Jails and Prisons. *Clinical Infectious Diseases* 45(8):1047-1055, *at* https://doi.org/10.1086/521910.

viral conditions from the FDC back to their homes and communities, and then return back, bringing new germs with them. "It is therefore an *urgent priority* in this time of national public health emergency to reduce the number of persons in detention as quickly as possible." Beyrer Dec., Exhibit A, at ¶ 17 (emphasis added).

Further, incarcerated people have poorer health than the general population, and even at the best of times medical care is limited in federal pretrial detention centers.[19] Many people who are incarcerated also have chronic conditions, such as diabetes or HIV, which make them vulnerable to severe forms of COVID-19. According to public health experts, incarcerated individuals "are at special risk of infection, given their living situations," and "may also be less able to participate in proactive measures to keep themselves safe"; "infection control is challenging in these settings."[20] Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[21] In China, officials have confirmed the coronavirus spreading at a rapid pace in Chinese prisons, counting 500 cases.[22] Secretary of State Mike Pompeo has called for Iran to release Americans detained there because of the "deeply troubling" "[r]eports that COVID-19 has spread to Iranian prisons," noting that "[t]heir detention amid increasingly deteriorating conditions defies basic human decency."[23]

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[19] Laura M. Maruschak et al. (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. NCJ 248491. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, *at* https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf

[20] "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), *at* https://bit.ly/2W9V6oS.

[21] *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) at https://bit.ly/2TNcNZY.

[22] Rhea Mahbubani, *Chinese Jails Have Become Hotbeds of Coronavirus As More Than 500 Cases Have Erupted, Prompting the Ouster of Several Officials*, Business Insider (Feb. 21, 2020) at https://bit.ly/2vSzSRT.

[23] Jennifer Hansler and Kylie Atwood, *Pompeo calls for humanitarian release of wrongfully detained Americans in Iran amid coronavirus outbreak*, CNN (Mar. 10, 2020) at

Extreme measures are necessary because as Dr. Homer Venters, former chief medical officer of the New York City jail system, made clear: "Coronavirus in these settings will dramatically increase the epidemic curve, not flatten it, and disproportionately for people of color."[24] The critical point from health experts is that slowing the rate of infection ("flattening the curve") is critical to avoid overtaxing health resources (which, if it occurs, would of course lead to more deaths for any given infection rate).[25]

C. Conditions at the FDC Contribute to Fueling the Pandemic

The FDC houses 684 total people with a capacity for 1000. Those numbers are obviously not stagnant, given that people continue to be detained and released. Such turnover is particularly frightening in a pandemic. The particular conditions in which the majority of the people are housed offer no protections for those either detained or those who come in regular contact with inmates, including FDC staff. Inmates are housed in small two-person cells with a shared toilet and sink. Individuals not in the special housing unit are only allowed outside of their cells for approximately two or three hours a day, with the upper and lower tiers of each unit alternating the hours they are allowed out of cells for group meals, showers, and accessing the phones and computers. Individuals must often stand in line in close proximity to one another to await their turn for these resources. Groups of 30 or more individuals must share their meals together without the ability to separate. On March 3, 2020, after multiple inmates in the same housing unit began exhibiting flu-like symptoms, the FDC made the

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https://cnn.it/2W4OpV7.

[24] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[25] *See* PBS News Hour graph, "One simple chart explains how social distancing saves lives" (Mar. 13, 2020), at https://www.pbs.org/newshour/science/one-simple-chart-explains-how-social-distancing-saves-lives, attached as Exhibit B.

decision to go into a 48-hour lockdown, including shutting down all social and legal visits. Although initially the FDC did not have the COVID-19 tests kits they needed to test those in the affected unit, the FDC eventually received the kits. But during the days-long waiting period for the results, those in the affected unit were denied basic hygiene necessities such as showering. There were also reports that individuals did not have access to soap or hand sanitizers. Access to legal calls was also suspended, and all social and legal visitation was shut down pending the test results. Limited legal visitation for non-quarantined inmates was not resumed until March 6, 2020. The quarantine was lifted on March 10, 2020. As of March 13, 2020, legal visits are allowed only on a case-by-case basis. Further, according to George Cho, BOP's Supervisory Attorney, should "additional FDC SeaTac inmates exhibit flu-like symptoms in the near-future, thus again necessitating quarantining and COVID-19 testing, FDC SeaTac will again implement all necessary measures to protect the safety and security of both the institution and the outside community."[26] Given the speed with which COVID 19 is spreading in our community, it will only be a short matter of time before a staff member or inmate tests positive and the facility returns to an all-out lockdown and quarantine.

The FDC's strategy appears primarily to be a reactive one—quarantining if inmates "exhibit flu-like symptoms in the near-future"—it is highly unlikely the FDC's tactic for stemming the spread of COVID-19 will work. There is significant controversy over the incubation and appropriate quarantine periods for the disease, insufficient knowledge about how it spreads, and few treatments that appear successful. "The largest study of coronavirus patients so far suggests it could take up to 24 days after exposure for symptoms to show."[27] The CDC's website gives detailed instructions on

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[26] March 9, 2020, email from George Cho, attached as Exhibit C.

[27] Aylin Woodward, *2 Studies of Coronavirus Patients Suggest the Disease's Incubation Period Could Be Longer than the Standard Quarantine Period of 14 Days*, Business Insider (Feb. 21, 2020) at https://www.businessinsider.com/wuhan-coronavirus-symptoms-24-days-after-infection-2020-2.

the complex steps health care professionals must follow in order to properly quarantine infected individuals, including systems that prisons do not have and cannot accommodate, such as negative air pressure circulation systems, HEPA air filtration, and specific air circulation protocols.[28] The CDC has also detailed clinical care guidance for the disease, although much remains unknown about its incubation period, modes of transmission, and potential treatment protocols.[29] It is unknown whether any of the FDC's personnel have received training in these procedures. Thus, there is a significant likelihood that prison personnel will themselves become infected and thereafter transmit the disease to the broader community. Indeed, lawyers who are at high risk because of age or underlying medical conditions have been advised not to enter the facility, and more recently there is close to a 100% prohibition on face to face client meetings at the FDC.[30] In order to assist in minimizing the transmission of COVID 19 by legal staff into the FDC, the FPD has instituted a temporary policy of prohibiting any lawyers or staff members from entering that facility unless personally approved by the Federal Defender.

As additional people are arrested who have been out in the community as the coronavirus spreads, if they are not symptomatic, they will be brought into the FDC and held with the existing population, potentially bringing the virus (now officially named "SARS-CoV-2"[31]) into this population held in large numbers, close quarters, and low sanitary conditions.

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[28] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html.

[29] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[30] March 5, 2020, email from George Cho, attached as Exhibit D.

[31] World Health Organization, "Naming the coronavirus disease (COVID-19) and the virus that causes it," at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it.

D. Detaining John Doe Puts Not Only Him, But Other FDC Inmates, Jail and Court Personnel, and the Broader Community, at Greater Risk.

Clearly, detaining John Doe poses significant health risk to him, given the likelihood that COVID-19 will spread within FDC. But the risk is not limited to him. If he currently has SARS-CoV-2 but is asymptomatic, detaining him risks exposing the entire FDC inmate population to the disease. That, in turn, risks exposing FDC personnel, along with all court staff who come in contact with either Mr. Doe or any person infected by him. And if he contributes to an outbreak of COVID-19 within FDC, that will increase the demand on the community's medical resources, reducing their availability to the community at large. Finally, if he contributes to the spread of the virus within the FDC, then if an infected but asymptomatic inmate is released, that obviously will hasten the spread of the virus and the disease within the broader community.

But the harm to others does not depend on the assumption that John Doe currently is infected with the virus. Any increase in FDC's population increases the odds that the infection will spread if any other inmate is, or becomes, infected, leading to the exact same harms discussed above to inmates, BOP and court staff, and the community.

III. The Bail Reform Act Requires John Doe's Release

Responsible relevant parties, recognizing these extraordinary circumstances, have acknowledged that increasing the population of detention centers like the FDC presents a danger not only to inmates but to the broader community.

Just this month, 24 elected prosecutors from around the country, including Cy Vance, the district attorney of New York, and district attorneys in Mississippi and Texas, sent out a joint statement "Addressing the Rights and Needs of Those in Custody."[32] Recommendations made in that Joint Statement include: "Reduc[ing] the

[32] Joint Statement From Elected Prosecutors on COVID-19 and Addressing the Rights and

prison population to minimize sharing of cells[,]" and *immediately* "[i]dentify[ing] and releas[ing]" "individuals who are elderly," and "[p]opulations that the CDC has classified as vulnerable (those with asthma, cancer, heart disease, lung disease, and diabetes.)" The Statement also recommends, among others, that "[p]eople incarcerated for technical violations of probation and parole be released." *Id.*

Prosecutors and law enforcement are already taking some of these proactive measures to mitigate the spread of the coronavirus. San Francisco District Attorney Chesa Boudin has directed his prosecutors not to oppose motions to release pretrial detainees facing misdemeanor charges or drug-related felony charges if the person is deemed to pose no threat to public safety, and has directed his staff to "strongly consider" credit for time served in plea deals so that more people can be released.[33] Officials in Los Angeles County, the largest county prison system in the U.S., are also releasing inmates and making fewer arrests to reduce the risk of a coronavirus outbreak in the prison systems. As Los Angeles Sheriff Alex Villanueva recently explained to reporters, these measures are necessary because "Our population within our jails is a vulnerable population just by who they are, where they are located, so we're protecting that population from potential exposure."[34] Sheriff Villanueva stated his office has reduced the inmate population from 17,076 to 16,459, a reduction of more than 600 inmates, in about two weeks. *Id.*

Needs of Those in Custody (March 2020), attached as Exhibit E.

[33] *San Francisco Officials Push to Reduce Jail Population to Prevent Coronavirus Outbreak* (Mar. 12, 2020), at http://sfpublicdefender.org/news/2020/03/san-francisco-officials-push-to-reduce-jail-population-to-prevent-coronavirus-outbreak-the-appeal/.

[34] Salvador Hernandez, Los Angeles Releasing Inmates Early Over Fears of Coronavirus in Jails, BuzzFeed News (Mar. 16, 2020), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release.

On March 17, 2020, Chief Judge Ricardo Martinez issued General Order 02-20.[35] That Order recognized the various facts discussed above, including the need for minimal contact between people. Chief Judge Martinez took the extraordinary steps of continuing all civil and criminal hearings through May, continuing grand jury hearings, delaying all preliminary hearings, finding excludable time under the Speedy Trial Act, closing the two courthouses except for emergency matters scheduled by individual judges "if necessary after considering the above public health situation," and closing all Probation and Pretrial offices.

If these emergency changes are warranted (and they most definitely are), dramatic changes in release versus detention are equally warranted. This Court has the authority to swiftly mitigate the present danger. As an initial matter, "[u]nder the Bail Reform Act of 1984, as amended, Congress has determined that any person charged with an offense under the federal criminal laws shall be released pending trial, subject to appropriate conditions. . . ." *United States v. Santos-Flores*, 794 F.3d 1088, 1090 (9th Cir. 2015). And, "[o]nly in rare cases should release be denied, and doubts regarding the propriety of release are to be resolved in favor of the defendant." *Id*. (citing *United States v. Motamedi*, 767 F.2d 1403, 1405 (9th Cir. 1985)). *See also United States v. Salerno*, 481 U.S. 739, 755 (1987) (suggesting that "detention prior to trial or without trial is the carefully limited exception" to liberty before trial). One charged with a crime is, after all, presumed innocent. *Stack v. Boyle*, 342 U.S. 1, 4 (1951). A single individual unnecessarily detained before trial is one individual too many, and the increasing use of the practice places tremendous wear on our constitutional system. *United States v. Montalvo-Murillo*, 495 U.S. 711, 723–24 (1990) (Stevens, J., dissenting, joined by Brennan and Marshall, JJ.).

[35] General Order 02-20, W.D. Wash. (Mar. 17, 2020), attached as Exhibit F.

The courts have long recognized that there is no greater necessity than keeping a defendant alive, no matter the charge. As former Federal District Court Judge Weinstein for the Eastern District of New York stated: "We do not punish those who have not been proven guilty." *United States v. Scarpa*, 815 F. Supp. 88 (E.D.N.Y. 1993) (pretrial defendant with AIDS facing murder charges released on bail because of the "unacceptably high risk of infection and death on a daily basis inside the MCC").

The United States Constitution affords pretrial detainees greater protection from dangerous conditions of confinement than those sentenced after conviction. *See*, *e.g.*, *Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 934 (N.D. Cal. 2015) ("A jail violates both [the Fourteenth and Eight Amendments] if it incarcerates inmates under conditions posing a substantial risk of serious harm to their health or safety . . . and if [government] acted with deliberate indifference, that is, with conscious disregard for that risk[.]"); *Morales Feliciano v. Rossello Gonzalez*, 13 F. Supp. 2d 151, 210 (D.P.R. 1998) ("The failure to screen incoming [inmates] for infectious diseases including tuberculosis" violates the Constitution).

This Court should consider the "total harm and benefits to prisoner and society" that detention of John Doe will yield, relative to the heightened health risks posed to John Doe, and that posed to the other inmates, court and BOP staff, and the community, during this rapidly encroaching pandemic. *See Davis v. Ayala*, 135 S. Ct. 2187, 2209 (2015) (Kennedy, J., concurring) (calling for heightened judicial scrutiny of the projected impact of jail and prison conditions on a defendant); *United States v. Mateo*, 299 F. Supp. 2d 201, 212 (S.D.N.Y. 2004) (reducing sentence where defendant's pretrial conditions were "qualitatively more severe in kind and degree than the prospect of such experiences reasonably foreseeable in the ordinary case").

All provisions of the Bail Reform Act impose a test of "reasonableness" when a court makes release decisions. *See* § 3142(b) (release on personal recognizance or

unsecured appearance bond); § 3142(c)(1) (release on conditions); § 3142(d)(2) (temporary detention); and § 3142(e) (detention). *See also United States v. Hir*, 517 F.3d 1081, 1092 n. 9 (9th Cir. 2008) ("We note that the Bail Reform Act contemplates only that a court be able to 'reasonably assure,' rather than guarantee, the safety of the community. *See United States v. Tortora*, 922 F.2d 880, 884 (1st Cir.1990) ('Undoubtedly, the safety of the community can be reasonably assured without being absolutely guaranteed.... Requiring that release conditions *guarantee* the community's safety would fly in the teeth of Congress's clear intent that only a limited number of defendants be subject to pretrial detention.')") (emphasis in *Tortora*).

When evaluating reasonable assurance of the community's safety, the Court needs to determine the extent to which *detention* threatens the community's safety, as well as the extent to which release poses a threat. For the reasons discussed in Part II.C, *supra*, given that we are in the midst of a world-wide pandemic, that former risk is significant, and must be an important factor in the Court's consideration. **[Include only if a presumption applies:]** Even where a rebuttable presumption of risk to the community applies under §§ 3142(e)(2) or (3), the risk to the community from *detention* is an important consideration in determining whether a presumption of danger from release has been rebutted.

And in evaluating reasonable assurances, the Court also needs to consider the risk to John Doe in detaining him. As discussed above, those risks are considerable for any person detained at FDC.

Finally, the latest General Order means that any defendants who are detained will be detained for several months, perhaps longer, without an indictment. *See* Exhibit F, ¶ 3. That is all the more reason to favor release over detention.

IV. Conditions of Release Are Available that Allow John Doe to Be Safe From the Risks of Incarceration at FDC Also Reasonably Ensuring Any Danger to the Community.

[Discuss here the factors you normally would argue.]

[Describe specific release conditions proposed]

Even if these factors would not normally lead this Court to order release, the present emergency conditions call for a cessation of "business as usual." Just as restaurants and sporting events must close, the balancing of interests in weighing detention and release decisions must be altered. Under the conditions proposed, the community's safety will reasonably be assured, while avoiding the increased risk to the community (and to Mr. Doe) from incarceration. Mr. Doe will not be left to his own devices, but will be supported and monitored by Pretrial Services. Since 2009, Pretrial Services' data has found that only 2.9% of defendants in the highest risk category were re-arrested for a violent crime while on release.[36] In 2017, the pretrial release rate for the Western District of Washington was 72.15% and the overall revocation rate was 8.89%. **[Include if relevant:]**The elderly and chronically ill, no matter what crime they are accused of, pose a lower risk of violating supervision, particularly during a global pandemic during which even leaving the house will endanger their lives.

V. The Court Should Deny any Government Request for a Continuance of the Detention Hearing.

When the Government has requested a continuance of the detention hearing, such a continuance has generally been granted almost automatically. But the Bail Reform Act does not provide for automatic continuances for either party. In this highly unusual period, a continuance should not be granted.

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[36] Thomas H. Cohen, Christopher T. Lowenkamp, and William E. Hicks, *Revalidating the Federal Pretrial Risk Assessment Instrument (PTRA): A Research Summary* (September 2018) *at* https://www.uscourts.gov/sites/default/files/82_2_3_0.pdf.

The Act generally requires that detention hearings "shall be held immediately upon the person's first appearance before the judicial officer[.]" 18 U.S.C. § 3142(f)(2). The Act then provides an exception to that requirement:

> unless that person, or the attorney for the Government, seeks a continuance. Except for good cause, a continuance on motion of such person may not exceed five days (not including any intermediate Saturday, Sunday, or legal holiday), and a continuance on motion of the attorney for the Government may not exceed three days (not including any intermediate Saturday, Sunday, or legal holiday). During a continuance, such person shall be detained . . .

This "unless" provision does not mean that either party is *automatically* entitled to a continuance. It means that the first provision – making an immediate hearing mandatory – is excused if a party seeks a continuance. In short, if such a request is made, nothing is required, neither a same-day detention hearing nor a continuance; either is within the judicial officer's discretion.

It is also clear from the statute that even when a continuance is granted, three days is a maximum (absent a showing of good cause), not an automatic period. There is nothing to prevent the Court from granting a shorter continuance. *See*, *e.g.*, *United States v. Bundy*, No. 2:16-CR-0046-GMN-PAL, 2016 WL 3456911, at *2 (D. Nev. June 20, 2016) (stating, in the context of a defense request, but equally applicable to Government requests, that, "[f]rom the plain language of the statute, it is clear that a [particular length] continuance is not an entitlement, but rather, a discretionary maximum amount of time the Court may continue the detention hearing upon a . . . motion."). That continuance could be one of a few hours, rather than even a day, given the health risks to numerous portions of the populations, as detailed in Part II.C, since the defendant must be detained until the continued hearing.

VI. Conclusion

For all of the above reasons, John Doe should be granted release on appropriate conditions.

DATED this ___ day of _____ 2020.

Respectfully submitted,

s/ *Attorney Name*
Attorney for Client Name

JUDGE NAME

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

UNITED STATES OF AMERICA, Plaintiff, v. CLIENT NAME, Defendant.	No. CASE NO. EMERGENCY MOTION FOR TEMPORARY RELEASE DUE TO COVID-19 CRISIS PURSUANT TO 18 U.S.C. § 3142(i)

I. Introduction

[Name of Client] presents a greater danger to the community by [his or her] continued detention at the Federal Detention Center, SeaTac (FDC) than if released to the community. [Name of client] presents a minimal risk, if any, for violence against members of the community, and any concerns about flight risk pale when weighed against the risks to the broader community during this escalating crisis.

[Name of client] should be temporarily released on an appearance bond with conditions set by the Court. If a hearing is necessary, the defendant and counsel both agree to appear telephonically. The Court is requested to consider the Pretrial Services report and [list all supporting documents here].

John Doe, who is a pretrial defendant detained at the FDC, is within the group of people the Centers for Disease Control and Prevention (CDC) has categorized as most at risk for contracting COVID-19, a dangerous illness spreading rapidly across the

world, through Washington State, and within the Seattle metropolitan area. The Bail Reform Act provides for the "temporary release" of a person in pretrial custody "to the extent that the judicial officer determines such release to be necessary for preparation of the person's defense **or for another compelling reason."** 18 U.S.C. § 3142(i) (emphasis added). The health risk to John Doe, because of his [age/condition], given the conditions at the FDC as described in detail below, necessitates his temporary release on bail until this pandemic has ended. **[Explain in one sentence where client will live, under what conditions: e.g. home detention, electronic monitoring.]**

II. Factual Background

A. Changed Circumstances: The Coronavirus Pandemic

The defense recognizes that the Court, like nearly everyone, has been exposed to a wide variety of news reports about COVID-19. However, given the varying information that has been dispensed, it seems worth briefly reviewing what is known. COVID-19 is highly contagious and may be spread by asymptomatic individuals. It has no known vaccination or cure and has killed thousands. As of March 16, 2020, the new strain of coronavirus, which causes COVID-19, has infected over 181,904 people, leading to at least 7,139 deaths worldwide.[1] On March 11, 2020, the World Health Organization officially classified COVID-19 as a pandemic.[2] The first case of COVID-19 in the United States was found in Snohomish County, Washington. The first death presumed to be from COVID-19 was also in the Seattle area – in Kirkland, Washington. On February 29, 2020, hours after Washington state health officials announced that death, Governor Jay Inslee declared a state of emergency, directing agencies to use all resources needed to respond to the outbreak.[3] On March 11, 2020, Governor Inslee

[1] https://www.worldometer.info/coronavirus/coronavirus-cases (updating regularly).
[2] *WHO Characterizes COVID-19 as a Pandemic*, World Health Organization (March 11, 2020) *at* https://bit.ly/2W8dwpS.
[3] *Gov. Jay Inslee Declares State of Emergency for Coronavirus Response*, KUOW (Feb. 29, 2020) *at* https://www.seattletimes.com/seattle-news/health/jails-and-courthouses-across-

issued a ban on gatherings and events of more than 250 people in the same counties, in an effort to try to contain the COVID-19 outbreak. One day later, on March 12, 2020, the governor announced the closure of all public and private K–12 schools in King, Snohomish, and Pierce Counties until at least April 27, 2020, affecting 600,000 students.[4] Most recently, on March 15, 2020, the governor signed an emergency declaration temporarily shutting down bars, restaurants, and places of entertainment and recreation statewide, and capping all public gatherings at 50 people.[5]

According to the CDC and epidemic experts from around the world, a possible scenario—based on the characteristics of the virus, including estimates of how transmissible it is and the severity of the illness it can cause—is that "[b]etween 160 million and 214 million people in the U.S. could be infected over the course of the epidemic," and "[a]s many as 200,000 to 1.7 million people could die." [6] Experts have also made clear that the assumptions fueling these staggering numbers can be mitigated by appropriate interventions to slow transmission. As one expert, Dr. Carter Mecher, a senior medical adviser for public health at the Department of Veterans Affairs and a former director of medical preparedness policy at the White House during the Obama and Bush administrations, observed: "A fire on your stove you could put out with a fire extinguisher, but if your kitchen is ablaze, that fire extinguisher probably won't work."

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washington-look-for-ways-to-protect-employees-jurors-and-inmates-from-coronavirus/.

[4] *New, Drastic Changes Implemented in Response to Coronavirus*, KIRO 7 News (March 13, 2020) at https://www.kiro7.com/news/local/coronavirus-all-k-12-schools-king-snohomish-pierce-counties-be-closed-through-april-24/XIDPHMLVOJAAREQ5YCL75367PU/ (updating regularly).

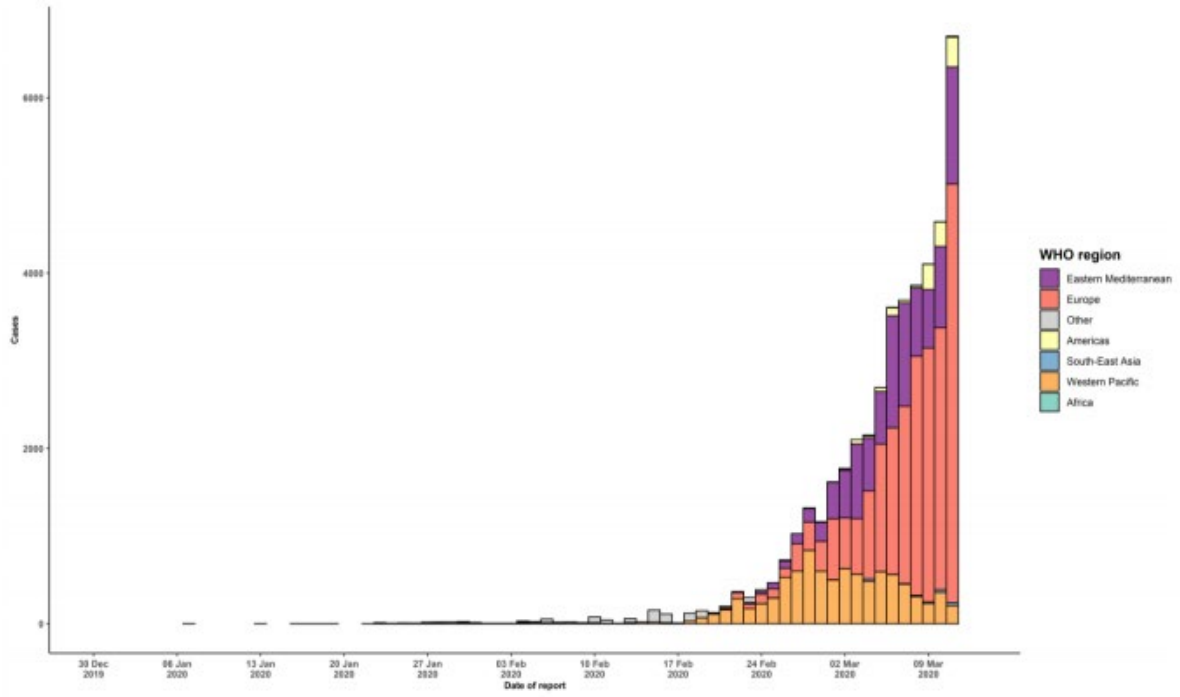
[5] *Washington State to Shut Down Restaurants, Bars, and Cap Gatherings at 50 to Stop Spread of Coronavirus*, The Seattle Times (March 16, 2020) at https://www.seattletimes.com/seattle-news/king-county-and-washington-state-to-act-on-bars-restaurants-and-gatherings/.

[6] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths*, The New York Times (March 13, 2020) at https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

Id. Thus, "[c]ommunities that pull the fire extinguisher early are much more effective." *Id*.

The graph below, showing the epidemic curve of the disease, serves as evidence of the need to act forcefully and immediately to change "business as usual."[7]

Figure 2. Epidemic curve of confirmed COVID-19 cases reported outside of China (*n*= 44 067), by date of report and WHO region through 12 March 2020



The CDC has issued guidance that individuals at higher risk of contracting COVID-19—adults over 60 years old and people with chronic medical conditions such as lung disease, heart disease, and diabetes—take immediate preventative actions, including avoiding crowded areas and staying home as much as possible.[8] Meanwhile, the number of COVID-19 cases in Washington continues to grow. On March 13, 2020, the Department of Public Health announced 36 new cases and one death. The King

[7] *Coronavirus disease2019 (COVID-19)Situation Report –48*, CDC (March 8, 2020), at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200308-sitrep-48-covid-19.pdf?sfvrsn=16f7ccef_4.

[8] *People at Risk for Serious Illness from COVID-19*, CDC (March 12, 2020) *at* https://bit.ly/2vgUt1P.

County total is now at 27 deaths with 270 total cases. Including the King County deaths, three deaths in Snohomish County, and one Grant County death, the statewide COVID-19 death total is at least 50 and the statewide case number, as reported by the Department of Health and local health districts, is at least 905 and growing.[9] In light of the confirmed cases in Seattle and surrounding areas that indicate broad community spread, every necessary action must be taken to protect vulnerable populations and, in turn, the broader community inside and outside the FDC.

COVID-19 is an extremely dangerous disease. The best estimate for its overall fatality rate—i.e., its fatality rate among all demographics—is 0.3-3.5%, "which is 5-35 times the fatality associated with influenza infection." Beyrer Dec. ¶ 5;[10] *see also* Nick Wilson et al., *Case-Fatality Risk Estimates for COVID-19 Calculated by Using a Lag Time for Fatality*, 26(6) EID Journal (prepublication June 2020).[11] Fatality rates vary wildly, however, depending on both environmental and demographic risk factors.

The death rate for those deemed at-risk is even higher. It increases rapidly with age. Across all age groups, COVID-19 kills:

- 13.2% of people with cardiovascular disease
- 9.2% of people with diabetes
- 8.4% of people with hypertension
- 8% of people with chronic respiratory disease
- 7.6% of people with cancer[12]

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[9] *New, Drastic Changes Implemented in Response to Coronavirus*, KIRO 7 News (March 13, 2020) at https://www.kiro7.com/news/local/coronavirus-all-k-12-schools-king-snohomish-pierce-counties-be-closed-through-april-24/XIDPHMLVOJAAREQ5YCL75367PU/ (updating regularly).

[10] Declaration of Chris Beyrer, MD, MPH, Professor of Epidemiology, Johns Hopkins Bloomberg School of Public Health, attached as Exhibit A.

[11] Available at https://wwwnc.cdc.gov/eid/article/26/6/20-0320_article.

[12] World Health Organization, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* at 12 (Feb. 28, 2020), at https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf.

B. "An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues."[13]

"If you think a cruise ship is a dangerous place to be during a pandemic, consider America's jails and prisons." *Id*. According to the CDC, the virus is mainly spread person-to-person "[b]etween people who are in close contact with one another (within about 6 feet)" and "[t]hrough respiratory droplets produced when an infected person coughs or sneezes."[14] The spread can be slowed, public health professionals say, if people practice "social distancing" by avoiding public spaces and generally limit their movement. "Social distancing" is not an option at the FDC. Like most prisons, inmates housed at the FDC are in closed quarters and forced to share bathrooms, laundry, and meal areas. The cell toilets rarely have lids and the tank often doubles as the sink for handwashing. Air circulation is uniformly poor. "Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities." Beyrer Dec., Exhibit A, ¶ 13. These deficiencies now represent a threat not only to those being housed there but to the community at large.

"According to health experts, it is not a matter of if, but when, this virus breaks out of jails and prisons."[15] Conditions of pretrial confinement create the ideal environment for the transmission of a highly contagious disease such as COVID-19.[16] Inmates do not live under quarantine: people cycle in and out of BOP pretrial facilities daily from all over the world and the country, and people who work in the facilities leave and return daily, without screening. And all of these individuals potentially carry

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[13] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[14] *How COVID-19 Spreads*, https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html (last accessed on March 13, 2020).

[15] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[16] Joseph A. Bick (2007). Infection Control in Jails and Prisons. *Clinical Infectious Diseases* 45(8):1047-1055, *at* https://doi.org/10.1086/521910.

viral conditions from the FDC back to their homes and communities, and then return back, bringing new germs with them. "It is therefore an *urgent priority* in this time of national public health emergency to reduce the number of persons in detention as quickly as possible." Beyrer Dec., Exhibit A, at ¶ 17 (emphasis added).

Further, incarcerated people have poorer health than the general population, and even at the best of times medical care is limited in federal pretrial detention centers.[17] Many people who are incarcerated also have chronic conditions, such as diabetes or HIV, which make them vulnerable to severe forms of COVID-19. According to public health experts, incarcerated individuals "are at special risk of infection, given their living situations," and "may also be less able to participate in proactive measures to keep themselves safe"; "infection control is challenging in these settings."[18] Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[19] In China, officials have confirmed the coronavirus spreading at a rapid pace in Chinese prisons, counting 500 cases.[20] Secretary of State Mike Pompeo has called for Iran to release Americans detained there because of the "deeply troubling" "[r]eports that COVID-19 has spread to Iranian prisons," noting that "[t]heir detention amid increasingly deteriorating conditions defies basic human decency."[21]

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[17] Laura M. Maruschak et al. (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. NCJ 248491. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, *at* https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf

[18] "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), *at* https://bit.ly/2W9V6oS.

[19] *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) at https://bit.ly/2TNcNZY.

[20] Rhea Mahbubani, *Chinese Jails Have Become Hotbeds of Coronavirus As More Than 500 Cases Have Erupted, Prompting the Ouster of Several Officials*, Business Insider (Feb. 21, 2020) at https://bit.ly/2vSzSRT.

[21] Jennifer Hansler and Kylie Atwood, *Pompeo calls for humanitarian release of wrongfully detained Americans in Iran amid coronavirus outbreak*, CNN (Mar. 10, 2020) at

Extreme measures are necessary because as Dr. Homer Venters, former chief medical officer of the New York City jail system, made clear: "Coronavirus in these settings will dramatically increase the epidemic curve, not flatten it, and disproportionately for people of color."[22] The critical point from health experts is that slowing the rate of infection ("flattening the curve") is critical to avoid overtaxing health resources (which, if it occurs, would of course lead to more deaths for any given infection rate).[23]

C. Conditions at the FDC Contribute to Fueling the Pandemic

The FDC houses 684 total people with a capacity for 1000. Those numbers are obviously not stagnant, given that people continue to be detained and released. Such turnover is particularly frightening in a pandemic. The particular conditions in which the majority of the people are housed offer no protections for those either detained or those who come in regular contact with inmates, including FDC staff. Inmates are housed in small two-person cells with a shared toilet and sink. Individuals not in the special housing unit are only allowed outside of their cells for approximately two or three hours a day, with the upper and lower tiers of each unit alternating the hours they are allowed out of cells for group meals, showers, and accessing the phones and computers. Individuals must often stand in line in close proximity to one another to await their turn for these resources. Groups of 30 or more individuals must share their meals together without the ability to separate. On March 3, 2020, after multiple inmates in the same housing unit began exhibiting flu-like symptoms, the FDC made the

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https://cnn.it/2W4OpV7.

[22] Dr. Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (March 16, 2020) at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.amp.html.

[23] *See* PBS News Hour graph, "One simple chart explains how social distancing saves lives" (Mar. 13, 2020), at https://www.pbs.org/newshour/science/one-simple-chart-explains-how-social-distancing-saves-lives, attached as Exhibit B.

decision to go into a 48-hour lockdown, including shutting down all social and legal visits.

Although initially the FDC did not have the COVID-19 tests kits they needed to test those in the affected unit, the FDC eventually received the kits. But during the days-long waiting period for the results, those in the affected unit were denied basic hygiene necessities such as showering. There were also reports that individuals may not have had access to soap or hand sanitizers. Access to legal calls was also suspended, and all social and legal visitation was shut down pending the test results. Limited legal visitation for non-quarantined inmates was not resumed until March 6, 2020. The quarantine was lifted on March 10, 2020. As of March 13, 2020, legal visits are allowed only on a case-by-case basis. Further, according to George Cho, BOP's Supervisory Attorney, should "additional FDC SeaTac inmates exhibit flu-like symptoms in the near-future, thus again necessitating quarantining and COVID-19 testing, FDC SeaTac will again implement all necessary measures to protect the safety and security of both the institution and the outside community."[24] Given the speed with which COVID-19 is spreading in our community, it will only be a short matter of time before a staff member or inmate tests positive and the facility returns to an all-out lockdown and quarantine.

And, because the FDC's strategy appears primarily to be a reactive one—quarantining if inmates "exhibit flu-like symptoms in the near-future"—it is highly unlikely the FDC's tactic for stemming the spread of COVID-19 will work. There is significant controversy over the incubation and appropriate quarantine periods for the disease, insufficient knowledge about how it spreads, and few treatments that appear successful. "The largest study of coronavirus patients so far suggests it could take up to 24 days after exposure for symptoms to show."[25] The CDC's website gives detailed

[24] March 9, 2020, email from George Cho, attached as Exhibit C.

[25] Aylin Woodward, *2 Studies of Coronavirus Patients Suggest the Disease's Incubation Period Could Be Longer than the Standard Quarantine Period of 14 Days*, Business Insider

instructions on the complex steps health care professionals must follow in order to properly quarantine infected individuals, including systems that prisons do not have and cannot accommodate, such as negative air pressure circulation systems, HEPA air filtration, and specific air circulation protocols.[26] The CDC has also detailed clinical care guidance for the disease, although much remains unknown about its incubation period, modes of transmission, and potential treatment protocols.[27] It is unknown whether the FDC's personnel have received training in these procedures. Thus, there is a significant likelihood that prison personnel will themselves become infected and thereafter transmit the disease to the broader community. Indeed, lawyers who are at high risk because of age or underlying medical conditions have been advised not to enter the facility, and more recently there is close to a 100% prohibition on face-to-face client meetings at the FDC.[28] And in order to minimize the transmission of COVID-19 by legal staff into the FDC, the FPD has instituted a temporary policy of prohibiting any lawyers or staff members from entering that facility unless personally approved by the Federal Defender.

As additional people are arrested who have been out in the community as the coronavirus spreads, if they are not symptomatic, they will be brought into the FDC and held with the existing population, potentially bringing the virus (now officially named "SARS-CoV-2"[29]) into this population held in large numbers, close quarters, and low sanitary conditions.

(Feb. 21, 2020) at https://www.businessinsider.com/wuhan-coronavirus-symptoms-24-days-after-infection-2020-2.

[26] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html.

[27] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[28] March 5, 2020, email from George Cho, attached as Exhibit D.

[29] World Health Organization, "Naming the coronavirus disease (COVID-19) and the virus that causes it," at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it.

III. Under these Extraordinary Conditions, the Bail Reform Act Requires John Doe's Temporary Release.

Responsible relevant parties, recognizing these extraordinary circumstances, have acknowledged that increasing the population of detention centers like the FDC presents a danger not only to inmates but to the broader community.

Just this month, 24 elected prosecutors from around the country, including Cy Vance, the district attorney of New York, and district attorneys in Mississippi and Texas, sent out a joint statement "Addressing the Rights and Needs of Those in Custody."[30] Recommendations made in that Joint Statement include: "Reduc[ing] the prison population to minimize sharing of cells[,]" and *immediately* "[i]dentify[ing] and releas[ing]" "individuals who are elderly," and "[p]opulations that the CDC has classified as vulnerable (those with conditions, including asthma, cancer, heart disease, lung disease, and diabetes.)" The prosecutors' Joint Statement also recommends, among others, that "[p]eople incarcerated for technical violations of probation and parole be released." *Id.*

Prosecutors and law enforcement are already taking some of these proactive measures to mitigate the spread of the coronavirus. San Francisco District Attorney Chesa Boudin has directed his prosecutors not to oppose motions to release pretrial detainees facing misdemeanor charges or drug-related felony charges if the person is deemed to pose no threat to public safety, and has directed his staff to "strongly consider" credit for time served in plea deals so that more people can be released.[31] Officials in Los Angeles County, the largest county prison system in the U.S., are also releasing inmates and making fewer arrests to reduce the risk of a coronavirus outbreak

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[30] Joint Statement From Elected Prosecutors on COVID-19 and Addressing the Rights and Needs of Those in Custody (March 2020), attached as Exhibit E.

[31] *San Francisco Officials Push to Reduce Jail Population to Prevent Coronavirus Outbreak* (Mar. 12, 2020), at http://sfpublicdefender.org/news/2020/03/san-francisco-officials-push-to-reduce-jail-population-to-prevent-coronavirus-outbreak-the-appeal/.

in the prison systems. As Los Angeles Sheriff Alex Villanueva recently explained to reporters, these measures are necessary because "Our population within our jails is a vulnerable population just by who they are, where they are located, so we're protecting that population from potential exposure."[32] Sheriff Villanueva stated his office has reduced the inmate population from 17,076 to 16,459, a reduction of more than 600 inmates, in about two weeks. *Id.*

On March 17, 2020, Chief Judge Ricardo Martinez issued General Order 02-20.[33] That Order recognized the various facts discussed above, including the need for minimal contact between people. Chief Judge Martinez took the extraordinary steps of continuing all civil and criminal hearings through May, continuing grand jury hearings, delaying all preliminary hearings, finding excludable time under the Speedy Trial Act, closing the two courthouses except for emergency matters scheduled by individual judges "if necessary after considering the above public health situation," and closing all Probation and Pretrial offices.

If these emergency changes are warranted (and they most definitely are), dramatic changes in release versus detention are equally warranted. This Court has the authority to swiftly mitigate the present danger. A "judicial officer may, by subsequent order, permit the temporary release of the person, in the custody of a United States marshal or another appropriate person, to the extent that the judicial officer determines such release to be necessary for preparation of the person's defense or for another compelling reason." 18 U.S.C. § 3142(i). The circumstances that existed when John Doe was ordered detained have now changed. There is a pandemic that poses a direct

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[32] Salvador Hernandez, Los Angeles Releasing Inmates Early Over Fears of Coronavirus in Jails, BuzzFeed News (Mar. 16, 2020), at https://www.buzzfeednews.com/article/salvadorhernandez/los-angeles-coronavirus-inmates-early-release.

[33] General Order 02-20, W.D. Wash. (Mar. 17, 2020), attached as Exhibit F.

risk to John Doe that is far greater if he continues to be detained during this public health crisis.

John Doe is vulnerable because he is [fill in facts: over the age of 60/has a serious medical condition.] [If applicable. If not, delete but file the motion anyway.]

As an initial matter, "[u]nder the Bail Reform Act of 1984, as amended, Congress has determined that any person charged with an offense under the federal criminal laws shall be released pending trial, subject to appropriate conditions. . . ." *United States v. Santos-Flores*, 794 F.3d 1088, 1090 (9th Cir. 2015). And, "[o]nly in rare cases should release be denied, and doubts regarding the propriety of release are to be resolved in favor of the defendant." *Id*. (citing *United States v. Motamedi*, 767 F.2d 1403, 1405 (9th Cir. 1985)). *See also United States v. Salerno*, 481 U.S. 739, 755 (1987) (suggesting that "detention prior to trial or without trial is the carefully limited exception" to liberty before trial). One charged with a crime is, after all, presumed innocent. *Stack v. Boyle*, 342 U.S. 1, 4 (1951). A single individual unnecessarily detained before trial is one individual too many, and the increasing use of the practice places tremendous wear on our constitutional system. *United States v. Montalvo-Murillo*, 495 U.S. 711, 723–24 (1990) (Stevens, J., dissenting, joined by Brennan and Marshall, JJ.). Due to the crucial interests involved, it follows that a "case-by-case" approach is required at any stage of the case in assessing the propriety of pretrial detention. *See, e.g., United States v. Gelfuso*, 838 F.2d 358, 359–60 (9th Cir. 1988) (concluding due process analysis for evaluating propriety of prolonged pretrial detention requires "assessment on a case-by-case basis").

The courts have long recognized that there is no greater necessity than keeping a defendant alive, no matter the charge. As former Federal District Court Judge Weinstein for the Eastern District of New York, stated: "We do not punish those who have not been proven guilty. When we do punish, we do not act cruelly. Continued

incarceration of this terminally ill defendant threatens both of these fundamental characteristics of our democracy." *United States v. Scarpa*, 815 F. Supp. 88 (E.D.N.Y. 1993) (pretrial defendant with AIDS facing murder charges released on bail because of the "unacceptably high risk of infection and death on a daily basis inside the MCC"). *See also United States v. Adams*, No. 6:19-mj-00087-MK, 2019 WL 3037042 (D. Or. July 10, 2019) (defendant charged with violation of the Mann Act and possession of child pornography and suffering from diabetes, heart conditions, and open sores released on home detention because of his medical conditions); *United States v. Johnston*, No. 17-00046 (RMM), 2017 WL 4277140 (D.D.C. Sept. 27, 2017) (defendant charged with violation of the Mann Act and in need of colon surgery released to custody of his wife for 21 days); *United States v. Cordero Caraballo*, 185 F. Supp. 2d 143 (D.P.R. 2002) (badly wounded defendant released to custody of his relatives).

The United States Constitution affords pretrial detainees greater protection from dangerous conditions of confinement than those sentenced after conviction. *See Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 934 (N.D. Cal. 2015) ("A jail violates both [the Fourteenth and Eight Amendments] if it incarcerates inmates under conditions posing a substantial risk of serious harm to their health or safety . . . and if [government] acted with deliberate indifference, that is, with conscious disregard for that risk[.]"); *Morales Feliciano v. Rossello Gonzalez*, 13 F. Supp. 2d 151, 210 (D.P.R. 1998) ("The failure to screen incoming [inmates] for infectious diseases including tuberculosis" violates the Constitution).

This Court should consider the total harm and benefits to prisoner and society that continued pretrial imprisonment of John Doe will yield, relative to the heightened health risks posed to John Doe during this rapidly encroaching pandemic. *See Davis v. Ayala*, 135 S. Ct. 2187, 2209 (2015) (Kennedy, J., concurring) (calling for heightened

judicial scrutiny of the projected impact of jail and prison conditions on a defendant); *United States v. Mateo*, 299 F. Supp. 2d 201, 212 (S.D.N.Y. 2004) (reducing sentence where defendant's pretrial conditions were "qualitatively more severe in kind and degree than the prospect of such experiences reasonably foreseeable in the ordinary case"). **[Add if not yet indicted:]** The latest General Order means that any defendants who are detained will be detained for several months, perhaps longer, without an indictment. *See* Exhibit E, ¶ 3. That is all the more reason to favor release over detention.

IV. Conditions of Release Are Available that Allow John Doe to Be Treated Humanely While Also Ameliorating Any Danger to the Community.

From John Doe's perspective his life—not only his liberty—is on the line, creating a powerful incentive to abide by any release conditions the Court may impose and changing the calculus that initially led to the denial of bail in this case. **[address specific concerns that led client to be detained]**

Critically, during this temporary release, John Doe will not be left to his own devices, but will be supported and monitored by Pretrial Services. Since 2009, Pretrial Services' data has found that only 2.9% of defendants in the highest risk category were re-arrested for a violent crime while on release.[34] In 2017, the pretrial release rate for the Western District of Washington was 72.15% and the overall revocation rate was 8.89%. The elderly and chronically ill, no matter what crime they are accused of, pose a lower risk of violating supervision, particularly during a global pandemic during which even leaving the house will endanger their lives.

[Describe specific release conditions proposed]

[34] Thomas H. Cohen, Christopher T. Lowenkamp, and William E. Hicks, *Revalidating the Federal Pretrial Risk Assessment Instrument (PTRA): A Research Summary* (September 2018) *at* https://www.uscourts.gov/sites/default/files/82_2_3_0.pdf.

Even if these factors would not normally lead this Court to order release, the present emergency conditions call for a cessation of "business as usual." Just as restaurants and sporting events must close, the balancing of interests in weighing detention and release decisions must be altered.

V. Conclusion

John Doe is among the vulnerable population at heightened risk of getting very sick from this illness. For all of the above reasons, John Doe should be granted temporary release on bond.

DATED this ___ day of March 2020.

Respectfully submitted,

s/ *Attorney Name*
Attorney for Client Name

Declaration for Persons in Detention and Detention Staff
COVID-19

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

I, Chris Beyrer, declare as follows:

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

The nature of COVID-19

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

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

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

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

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

The risks of COVID-19 in detention facilities

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

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

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

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

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

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

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

Executed this 16th day of March, 2020.

Professor Chris Beyrer[1]

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

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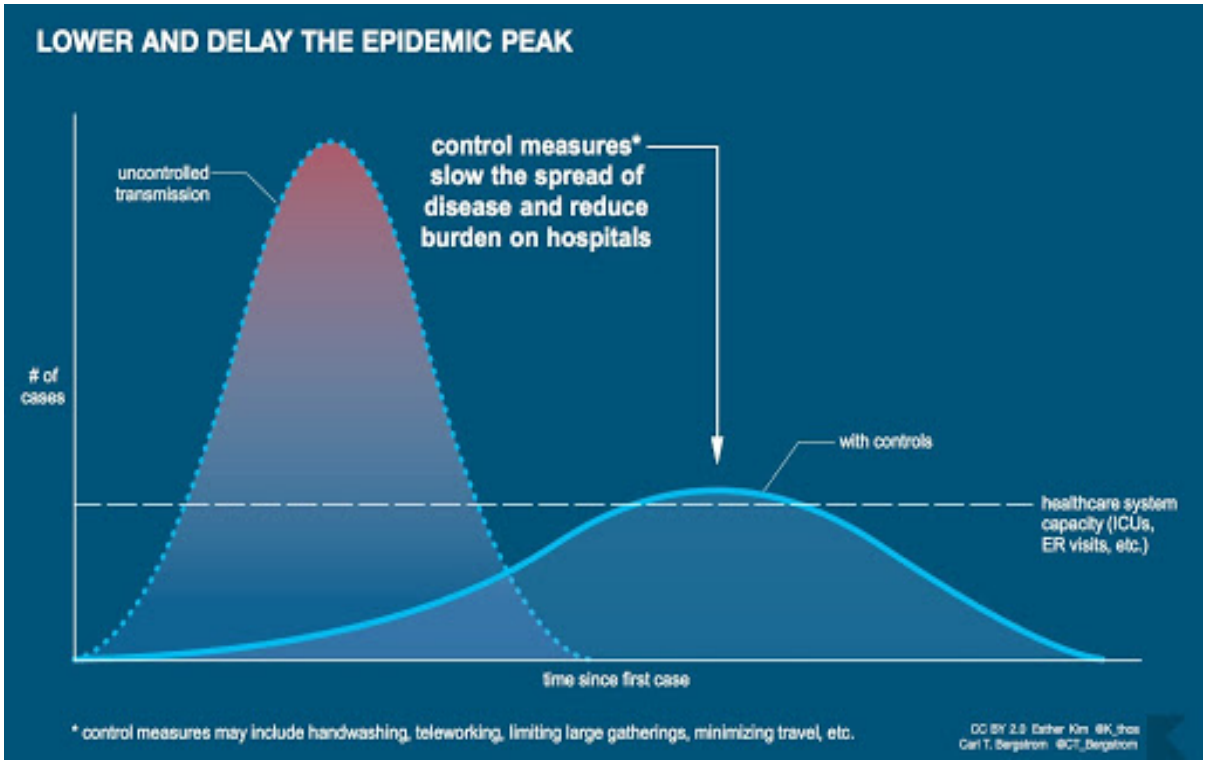
LOWER AND DELAY THE EPIDEMIC PEAK
uncontrolled transmission
control measures* slow the spread of disease and reduce burden on hospitals
# of cases
with controls
healthcare system capacity (ICUs, ER visits, etc.)
time since first case
* control measures may include handwashing, teleworking, limiting large gatherings, minimizing travel, etc.
CC BY 2.0 Esther Kim @K_thos
Carl T. Bergstrom @CT_Bergstrom

From: George Cho <gcho@bop.gov>
Sent: Thursday, March 5, 2020 3:44 PM
To: Michael Filipovic <Michael_Filipovic@fd.org>; Jacob Green <Jacob.Green@usdoj.gov>; Micki Brunner <Micki.Brunner@usdoj.gov>; Sarah Vogel <Sarah.Vogel@usdoj.gov>; Tessa Gorman <Tessa.Gorman@usdoj.gov>; Brian Tsuchida <Brian_Tsuchida@wawd.uscourts.gov>; Laurie Cuaresma <Laurie_Cuaresma@wawd.uscourts.gov>; Michelle Peterson <Michelle_L_Peterson@wawd.uscourts.gov>; Ricardo Martinez <Ricardo_Martinez@wawd.uscourts.gov>; Theresa Fricke <Theresa_Fricke@wawd.uscourts.gov>; Timothy Farrell <Tim_Farrell@wawd.uscourts.gov>; Traci Whiteley <Traci_Whiteley@wawd.uscourts.gov>; Connie Smith <Connie_Smith@wawp.uscourts.gov>
Subject: FDC SeaTac Update

All,

Today, Thursday, 03/05/20, FDC SeaTac successfully conducted modified operations on all of its housing units (i.e. showers, laundry, and social mail delivery). In addition, all pre-trial inmates, including those in quarantine, were offered the opportunity to make a legal telephone call. Addressing a separate inquiry from Jennifer Wellman, special/legal mail has not been suspended or interrupted and continues to be processed and delivered during this institutional lock down.

Inmates not quarantined in the affected housing unit are still currently allowed to leave the institution via court-line for hearings in both Seattle and Tacoma. FDC SeaTac currently remains on lock down, with no social or legal visitation allowed at this time, pending the complete testing results for COVID-19.

However, tomorrow, 03/06/20, FDC SeaTac will resume limited legal visitation for non-quarantined inmates only. Attorneys may contact the FDC SeaTac Front Lobby Officer by either telephone, 206-870-5700, or by utilizing our online Inmate Attorney Visit Request system, https://www.bop.gov/locations/legalVisit.jsp?name=set, to confirm that their client is not currently quarantined and, thus, available for a legal visit. That said, FDC SeaTac strongly encourages attorneys at higher risk of severe illness (i.e. over age 60, underlying health conditions, pregnant, etc.) and/or feeling sick to refrain from legal visitation at this current time, if at all possible.

Thank you for your continued patience and understanding during these extenuating circumstances. I will continue to update you all and, specifically, let you know once the complete COVID-19 testing results are received.

If you have any issues or concerns, please feel free to contact me directly.

George Y. Cho
Supervisory Attorney
U.S. Department of Justice
Federal Bureau of Prisons
FDC SeaTac Consolidated Legal Center
Direct: (206) 870-1057
E-mail: george.cho@usdoj.gov

From: George Cho [mailto:gcho@bop.gov]
Sent: Monday, March 9, 2020 3:54 PM
Subject: FDC SeaTac Update (03-09-20)

All,

Today, 03-09-20, all pending FDC SeaTac inmate COVID-19 tests results came back NEGATIVE.

Accordingly, all FDC SeaTac housing units will be lifted from quarantine tomorrow, 03-10-20. USMS court-line, for both Tacoma and Seattle, will resume in full for all housing units and inmates, including those previously quarantined, unless a specific court-line defendant exhibits flu-like symptoms.

However, if additional FDC SeaTac inmates exhibit flu-like symptoms in the near-future, thus again necessitating quarantining and COVID-19 testing, FDC SeaTac will again implement all necessary measures to protect the safety and security of both the institution and the outside community.

With regards to FDC SeaTac legal visitation, it will also commence in full starting tomorrow, 03-10-20, again for all housing units and inmates, including those previously quarantined. FYI, four (4) legal visits have been successfully conducted today, thus far.

However, Front Lobby staff will be asking all visiting attorneys, to include support staff, COVID-19 self-assessment questions upon entry (i.e. recent foreign travel and/or any flu-like symptoms). Any visiting attorneys and/or support staff who positively self-identify for COVID-19 will be strongly encouraged to postpone their legal visit.

Lastly, due to the limited current staff resources, plus the fact that there were zero (0) legal visits over this past weekend, FDC SeaTac will be temporarily suspending legal visitation on the weekends (i.e. Saturdays and Sundays) only. Social visitation, in its entirety, will remain suspended as well, while the State of Washington remains in this current State of Emergency.

FDC SeaTac will continue to conduct modified operations on all of its housing units, but begin the process of resuming full operations tomorrow. This will include allowing more extensive access to showers, laundry, legal/social mail delivery, legal calls, and social telephone calls/electronic messaging (i.e. e-mail). FYI, inmates in non-quarantined units were allowed limited access earlier today to social telephone and e-mail.

I will continue to provide updates in the future as necessary. Please feel free to contact me if you have any issues or concerns, thank you all for your patience and understanding during this time of crisis.

George Y. Cho
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JOINT STATEMENT FROM ELECTED PROSECUTORS
ON COVID-19 AND ADDRESSING THE RIGHTS AND NEEDS OF THOSE IN CUSTODY
March 2020

COVID-19 has the world on high alert. In recognition that the coronavirus is spreading quickly among high concentrations of people in close proximity, schools are being shut down, conferences rescheduled, international travel is being restricted, and cruise ships -- the early incubators of the virus -- are being quarantined. Those measures are all sensible, but they also drive home how little attention is being paid to the millions of people in the most overcrowded conditions that are ripe for the spread of this contagious and deadly virus: the people behind bars in America's jails, prisons, and immigration detention centers.

There are 2.3 million adults and children locked up in the United States in various systems of confinement, including state and federal prisons, local jails, youth correctional facilities, and immigration detention centers. Far more cycle in and out of jail on a daily basis; there are 10.6 million jail admissions every year.

Our country's jail and prison populations have exploded over the last few decades, a result of people being prosecuted more often for less serious behavior; an increase in the severity of sentences imposed; and our cash-based pretrial detention system, which keeps hundreds of thousands of people in jail prior to any determination of guilt and merely because they can't afford to pay bail. Recently, immigration detention has reached record proportions, despite apprehensions at the border being far below historic highs. The result of these practices is overcrowded jail, prison and immigration detention facilities that force people together in close quarters without access to proper hygiene or medical care, sometimes living barracks-style in gyms or other open spaces, breathing the same recycled air for up to 23 hours per day. These conditions are fertile ground for the spread of a virus like COVID-19.

We, as elected prosecutors, have an obligation to protect the safety and wellbeing of *everyone* in our community, regardless of their race, ethnicity, or country of origin. Those obligations extend behind prison walls. And they require elected prosecutors to step up in this time of growing public health concerns to address the needs and rights of individuals in these facilities.

An outbreak of the coronavirus in these custodial facilities would not only move fast, it would potentially be catastrophic. According to the Center for Disease Control, the elderly and people with underlying medical conditions are more susceptible to falling severely ill with COVID-19. Both populations are, unfortunately, well represented among incarcerated people. People over the age of 55 make up the fastest growing demographic of those imprisoned. From 1999 to 2016, the number of people age 55 or older in state and federal prisons increased 280 percent and it is estimated that by 2030, there will be over 400,000 people in our prisons over the age of 50. Similarly, jails and prisons house disproportionately large numbers of people with chronic

illnesses and complex medical needs that many facilities are already ill-equipped to treat. And at least 57 ICE detention centers have already experienced outbreaks of infectious diseases like mumps that have presented challenging health issues.

If these facilities become breeding grounds for the coronavirus, it will not only impact those incarcerated, but our entire community. Jails and prisons cycle large numbers of people in and out of close, unsanitary quarters on a daily basis. Many people are arrested and booked into jail on the same day, while others are released within a short time back to their community. People leave immigration detention and return to communities in the US or to vulnerable refugee shelters and encampments along the border. All of these facilities rely on services and support from vendors and medical professionals, employ staff who come and go, and appropriately provide access for legal counsel and family members to visit. And people with severe conditions who need intensive medical treatment are often removed from these facilities to be treated in local hospitals.

Most states and localities recognize the present danger and are considering stopgap solutions, including temporary release for certain populations. Some have also instituted more extreme measures such as locking down jails. These ad hoc responses underscore the urgent need for the broader and long-overdue reforms we were elected to carry out and are deeply committed to -- advancing fairness and equity and addressing overincarceration.

To that end, we believe that the current crisis creates an even more pressing need for elected prosecutors, public health officials, and other leaders to work together to implement concrete steps in the near-term to dramatically reduce the number of incarcerated individuals and the threat of disastrous outbreaks. And we are equally committed to not eroding the rights and safety of those in custody, even as we take steps to address the current health crises. We also recognize that there is no singular "right" approach on how to handle what is a rapidly evolving situation and that the dynamics in each jurisdiction will vary. Nonetheless, we believe that the principles set forth below are vitally important ones to consider and to implement to the fullest extent possible.

Achieving Reductions in Detention and Incarcerated Populations

First and foremost, we urge local officials to stop admitting people to jail absent a serious risk to the physical safety of the community. Policymakers, prosecutors and criminal justice leaders should also take steps to dramatically reduce detention and the incarcerated population. To that end, we believe that elected prosecutors should work with public health officials and other leaders in their communities to implement and advocate for the following reforms:

- Adopt cite and release policies for offenses which pose no immediate physical threat to the community, including simple possession of controlled substances.
- Release all individuals who are being detained solely because they can't afford cash bail, unless they pose a serious risk to public safety.
- Reduce the prison population to minimize sharing of cells and ensure that there are sufficient medical quarantine beds, and enough staff, to promote the health and safety of staff, those incarcerated, and visitors.

- Identify and release the following people immediately, unless doing so would pose a serious risk to the physical safety of the community:
    - Individuals who are elderly;
    - Populations that the CDC has classified as vulnerable (those with asthma, cancer, heart disease, lung disease, and diabetes);
    - People in local jails who are within 6 months of completing their sentence; and
    - People incarcerated due to technical violations of probation and parole.
- Put in place procedures and advocate for reforms that enable past lengthy sentences to be revisited and support release for those individuals who can safely return to the community.

Humane Conditions of Confinement

For those who must remain incarcerated, every effort should be made to ensure they have access to good healthcare, as defined by public health officials, and that their basic human rights are being met. It is critical to balance the precautions necessary to protect against any spread of the virus with the constitutional rights of those in custody. To that end, government officials and criminal justice leaders should work together, and with corrections and public health officials, to:

- Eliminate medical co-pays for anyone in confinement;
- Maintain access to counsel and preserve family visitation rights as long as possible and with precautions (such as glass wall barriers) that can address concerns around the introduction and spread of the virus in correctional facilities;
- Make phone calls free and increase teleconferencing capacity and means to help people stay connected to family and counsel; and
- Ensure that containment measures do not result in the denial of due process (for instance, avoid postponing court appearances and trials when doing so would violate speedy trial guarantees and do not creating barriers that inhibit access to counsel).

Protecting Immigrant Communities and Reducing Immigration Detention

Additionally, the federal government should take the following actions to end the spread of COVID-19 among immigrant communities:

- Suspend new detentions of suspected non-citizens unless there are compelling public safety reasons that support the need for ongoing detention;
- Immediately release all people under the age of 21 in immigration detention unless there are compelling public safety reasons that support the need for ongoing detention; and
- Direct the Department of Homeland Security to honor the sensitive locations policy and not conduct immigration enforcement operations in or around hospitals or medical clinics.

Health Care Measures and Protections for Confined Individuals

Prosecutors should also work with public health, corrections, immigration and government leaders to:

- Avoid the use of widespread lock-downs or solitary confinement as a containment measure and implement more targeted quarantines to control the spread of infection;
- Educate people in custody and staff about the virus and the measures they can take to minimize their risk of contracting or spreading the virus;
- Implement a humane plan for housing of persons who are not released but who are sick. In particular, patients should receive medical care in a hospital, rather than in a detention or corrections facility -- where treatment and housing poses a risk to both the patient and detention staff;
- Encourage and direct detention and corrections employees to stay home, with pay, if they feel sick; and
- Provide free soap and CDC-recommended hand sanitizer, increased medical care, comprehensive sanitation and cleaning of facilities and other safety measures as recommended by the CDC for those who remain incarcerated or detained.

Finally, elected prosecutors must be leaders and collaborate with, and where helpful convene, public health experts and the officials responsible for detention and custodial facilities to ensure that all members of their community are protected and *no one* is forgotten. They should also work with these partners to release to the public the plans and procedures in place to address COVID-19 within jails, correctional facilities and detention centers.

Even after the urgent threat of the coronavirus subsides, these sensible and smart policies should remain. The United States is an international outlier in its rate of incarceration -- we put far too many people behind bars for far too long, and fail to provide adequate care to those we incarcerate. That's a humanitarian crisis with or without COVID-19. We need to make deflection and diversion the presumptive default to shrink our rate and length of incarceration. We need to stop criminalizing immigrants. And we need to address the underlying inequities, public health system inadequacies, and racial biases that bring far too many people into contact with the justice system.

We are facing a serious threat as a country, but it also presents a unique opportunity to come together and swiftly address these longstanding systemic problems. These reforms are long overdue and they will help make our entire country more just, safe, and healthy.

Signed,

Diana Becton, District Attorney, Contra Costa County, California

Buta Biberaj, Commonwealth's Attorney, Loudoun County, Virginia

Chesa Boudin, District Attorney, City and County of San Francisco, California

John Choi, County Attorney, Ramsey County, Minnesota

David Clegg, District Attorney, Ulster County, New York

Shameca Collins, District Attorney, Sixth Judicial District, Mississippi

Scott Colom, District Attorney, Sixteenth Judicial District, Mississippi

John Creuzot, District Attorney, Dallas County, Texas

Satana Deberry, District Attorney, Durham County, North Carolina

Parisa Dehghani-Tafti, Commonwealth's Attorney, Arlington County and the City of Falls Church, Virginia

Michael Dougherty, District Attorney, Twentieth Judicial District, Colorado

Mark Dupree, District Attorney, Wyandotte County, Kansas

Kim Gardner, Circuit Attorney, City of St. Louis, Missouri

Sarah F. George, State's Attorney, Chittenden County, Vermont

Eric Gonzalez, District Attorney, Kings County, New York

Mark Gonzalez, District Attorney, Nueces County, Texas

Andrea Harrington, District Attorney, Berkshire County, Massachusetts

Jim Hingeley, Commonwealth's Attorney, Albemarle County, Virginia

Natasha Irving, District Attorney, Prosecutorial District Six, Maine

Justin F. Kollar, Prosecuting Attorney, County of Kauaʻi, Hawaiʻi

Lawrence S. Krasner, District Attorney, Philadelphia, Pennsylvania

Stephanie Morales, Commonwealth's Attorney, Portsmouth, Virginia

Marilyn Mosby, State's Attorney, Baltimore City, Maryland

Karl Racine, Attorney General, District of Columbia

Rachael Rollins, District Attorney, Suffolk County, Massachusetts

Daniella Shorter, District Attorney, Twenty-Second Judicial District, Mississippi

Carol Siemon, Prosecuting Attorney, Ingham County, Michigan

David Soares, District Attorney, Albany County, New York

David Sullivan, District Attorney, Northwestern District, Massachusetts

Cyrus R. Vance, District Attorney, New York County, New York

Lynneice Washington, District Attorney, Jefferson County, Bessemer Division, Alabama

Appendix D

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CRIMINAL CASE STANDING ORDER RE: PROCEDURE FOR REVIEW OF DETENTION ORDERS IN LIGHT OF CORONAVIRUS PANDEMIC	Magistrate Judge Nat Cousins Effective March 16, 2020

I am issuing this criminal standing order on March 16, 2020, in response to the coronavirus pandemic. It applies to every open criminal case in which I have ordered a criminal defendant to be detained and that defendant is presently held in custody awaiting trial. Most detainees in this District are presently housed at Santa Rita Jail in Alameda County, California. Defendants detained by other judges are not covered by this standing order. A copy of this order will also be provided to the offices of the Federal Public Defender, the United States Attorney, the CJA attorney coordinator, U.S. Pretrial Services, and posted publicly on the Court's web page.

Under the Bail Reform Act, 18 U.S.C. § 3145(f)(2), a detention hearing may be reopened at any time before trial if the judicial officer finds that information exists that was not known to the movant at the time of the detention hearing and that has a material bearing on the issue whether there are conditions of release that will reasonably assure the appearance of such person as required and the safety of any other person and the community. Two of the detention or release factors (among others) to be considered by the judicial officer are (1) the person's "physical and mental condition" (3145(g)(3)(A)) and (2) the nature and seriousness of the danger to any person or the community that would be posed by the person's release (3145(g)(4)).

The Crime Victims' Rights Act, 18 U.S.C. § 3771, also provides crime victims the

statutory right to be reasonably protected from the accused, to reasonable notice of any public court proceeding involving the crime or release of the accused, the right to be reasonably heard and not excluded from public court proceedings, the right to be treated with fairness and respect, the right to confer with the attorney for the Government in the case, the right to proceedings free from unreasonable delay, and the right to be informed of the rights under the Act. The Court shall ensure the crime victim is afforded the rights described in the Act. 18 U.S.C. § 3771(b)(1).

This standing order sets forth the procedure for any request to reopen a detention hearing on the basis of the physical and mental condition of the accused. This public health crisis is serious and urgent. Counsel should not delay in evaluating whether any defendant should have his or her detention hearing reopened.

1. Counsel for the Government and accused must confer first in an effort to determine if they agree.

2. The Government must provide notice and an opportunity to confer and be reasonably heard to any crime victim.

3. Any stipulation or motion to reopen must be filed in the ECF system.

4. The motion should state whether the defendant waives personal presence at the hearing.

5. Copies of the motion to reopen must be provided to Pretrial Services and to Clerk's Office Manager Snooki Puli at Snooki_Puli@cand.uscourts.gov. This may be by email.

6. Unless otherwise ordered, no hearing will be held in person. Counsel, clients, and crime victims will be allowed to participate by telephone or video to the extent practicable.

IT IS SO ORDERED.

Date: March 16, 2020

Nathanael M. Cousins
United States Magistrate Judge

The New York Times | https://nyti.ms/3d4c4uY

An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues

The conditions inside, which are inhumane, are now a threat to any American with a jail in their county — that's everyone.

By Amanda Klonsky
Dr. Klonsky leads a prison education organization.

March 16, 2020, 5:00 a.m. ET

If you think a cruise ship is a dangerous place to be during a pandemic, consider America's jails and prisons. The new coronavirus spreads at its quickest in closed environments. And places like nursing homes in affected areas have begun to take precautions at the behest of families and experts. As this new disease spreads, it has become equally important for all of us to ask what steps are being taken to protect the health of people in jails and prisons, and the staff who work in them.

The American criminal legal system holds almost 2.3 million people in prisons, jails, detention centers and psychiatric hospitals. And they do not live under quarantine: jails experience a daily influx of correctional staff, vendors, health care workers, educators and visitors — all of whom carry viral conditions at the prison back to their homes and communities and return the next day packing the germs from back home. How will we prevent incarcerated people and those who work in these institutions from becoming ill and spreading the virus?

This week, the Harris County Juvenile Court in Houston announced that the court wing will be fully closed to all until further notice, after officials reported that a person who had been in the court may test positive for coronavirus. And an employee at a correctional facility in Pennsylvania also tested positive for Covid-19. Thirty-four inmates and staffers there are now in quarantine. On Friday, the Federal Department of Correction announced that incarcerated people at all 122 federal correctional facilities across the country will not be allowed visits from family, friends or attorneys for 30 days, in response to the threat of the coronavirus. But this ethical sacrifice raises more questions than it answers about the broader set of changes that will be required to limit this contagion while protecting the rights of incarcerated people.

In America's jails and prisons, people share bathrooms, laundry and eating areas. The toilets in their cells rarely have lids. The toilet tank doubles as the sink for hand washing, tooth brushing and other hygiene. People bunked in the same cell — often as many as four — share these toilets and sinks. Meanwhile, hand sanitizer is not allowed in most prisons because of its alcohol content. Air circulation is nearly always poor. Windows rarely open; soap may only be available if you can pay for it from the commissary.

These deficiencies, inhumane in and of themselves, now represent a threat to anyone with a jail in their community — and there is a jail in every county in the United States. According to health experts, it is not a matter of if, but when, this virus breaks out in jails and prisons. People are constantly churning through jail and prison facilities, being ushered to court hearings, and then being released to their communities — nearly 11 million every year.

"We should recall that we have 5,000 jails and prisons full of people with high rates of health problems, and where health services are often inadequate and disconnected from the community systems directing the coronavirus response," said Dr. Homer Venters, former chief medical officer of the New York City jail system. "Coronavirus in these settings will dramatically increase the epidemic curve, not flatten it, and disproportionately for people of color."

Jails are particularly frightening in this pandemic because of their massive turnover. While over 600,000 people enter prison gates annually, there are about 612,000 people in jail on any given day. More than half of the people in jail are only in there for two to three days. In some communities, the county jail or prison is a major employer. Jail staff members are also notoriously underpaid, may not have paid sick leave and are more likely to live in apartments, in close and frequent contact with neighbors. They return home daily to aging parents, pregnant partners or family members with chronic conditions.

Our penal system should have received more comprehensive guidance and material support from the Department of Justice, far earlier in this crisis. Like much of the federal level response, it is falling short.

Encouragingly, others have taken the lead. The San Francisco district attorney, Chesa Boudin, together with the public defender, Manohar Raju, were the first to take proactive steps to release as many people as safely possible who are at heightened risk from coronavirus. Mr. Boudin directed his prosecutors not to oppose release motions for misdemeanor or nonviolent felony pretrial detainees where the person poses no threat to public safety.

“We are trying to absorb information from countries who have experienced the Covid-19 pandemic before us,” said Dr. Alysse Wurcel, an infectious diseases physician at Tufts Medical Center and at six county jails in eastern Massachusetts. “But since the United States has the highest incarceration rate in the world, it is difficult to extrapolate the potential impact.”

American officials can learn from the harrowing story of South Korea’s Daenam Hospital. In late February, South Korea had already reported more than 3,150 confirmed cases, and of these, 101 were from patients in the Daenam psychiatric ward. Seven of these patients have now died. All but two patients in the ward contracted Covid-19. The ward was put on lockdown, in an attempt to confine the spread of the virus. Instead, the lockdown issued was a death sentence to many inside.

Across the United States, activists for prisoners’ rights have repeatedly requested plans to protect against an outbreak in prisons. Still, only a few jurisdictions have released plans. Some make good sense — one from the New York City Department of Correction includes screening people for flulike symptoms before placing them in group holding cells, and sending people who have flulike symptoms to a communicable diseases unit for treatment.

But those steps do not go far enough, nor do they affirmatively indicate an understanding of the ways this virus spreads: Will the incarcerated laborers now creating “NYS Clean,” the New York State government-manufactured hand sanitizer, be wearing N95 masks and gloves? The plan indicates that people incarcerated in dormitories on Rikers Island are being asked to sleep head to toe and three feet apart in the bunks, as if this short distance could prevent the spread of the virus if it’s present. It won’t.

There are yet more reasons to be concerned. With about 40 percent of incarcerated people suffering from a chronic health condition, the overall health profile of people in jails and prisons is abysmal. And the older prison population is among the most vulnerable to severe complications from Covid-19. There are 274,000 people aged 50 or older in state and federal prisons in the United States. If this group were separated from the rest of the U.S. prison population, they would be the seventh-largest prison system in the world.

Aging people who are released after serving long sentences have a recidivism rate close to zero. Governors and other public officials should consider a one-time review of all elderly or infirm people in prisons, providing immediate medical furloughs or compassionate release to as many of them as possible.

It is also critical that jails take swift action to reduce the number of people in confinement. Local law enforcement can safely reduce these numbers in several ways: These include reclassifying misdemeanor and lower-level felony offenses that do not threaten public safety into non-jailable offenses, using citations instead of arrests for all low-level crime and indefinitely postponing all parole and probation office visits.

This crisis demands that prison and jail staff members be trained in methods to prevent transmission. And the diagnostic tests for the virus, which have been extremely slow to roll out, should make their way to jails and prisons too. Incarcerated people who test positive for the coronavirus should be offered immediate access to free, high-quality health care. And anyone in jail in pretrial detention (which means they haven’t been convicted of anything and most likely just cannot afford bail), who can be safely released, should be released. To do anything less than all of this — out of hate, apathy or spite — will endanger us all.

Dr. Amanda Klonsky (@amandaklonsky1), a scholar of education and mass incarceration, is the chief program officer for a prison education organization.

The New York Times | https://nyti.ms/3b2RJnR

'We Are Not a Hospital': A Prison Braces for the Coronavirus

In places where social distancing is impossible and medical care strained, bars won't stop the infection's spread.

By Danielle Ivory

Published March 17, 2020 Updated March 18, 2020, 1:29 p.m. ET

Packed into a crowded federal prison complex with not enough masks, soap or hand sanitizer, and the sole doctor out sick, corrections workers in Tallahassee, Fla., were worried.

Then on Monday, a new inmate arrived and was immediately put into quarantine. And on Tuesday, a bus with almost a dozen inmates from a U.S. Immigration and Customs Enforcement detention center showed up.

They were scheduled for quarantine, too. And all had elevated temperatures.

"I just delivered hand sanitizer to the unit that the inmates will be housed in," said Kristan Morgan, a nurse practitioner at the prison who checked the new arrivals' temperatures. "Staff are starting to get fearful."

In jails and prisons across the country, concerns are rising of a coronavirus outbreak behind bars. Already, cases have been reported. On Friday, someone who works in a Washington State prison tested positive for the virus, and the day before, the sheriff in Hancock County, Ind., said a staff member at the local jail was being isolated at home after a positive test. On Tuesday night, New York State confirmed that an employee at the Sing Sing Correctional Facility had tested positive.

In New York City, the Department of Correction over the weekend announced its first death from the virus: David Perez, 56, an investigator who was based in the department's headquarters in Queens. Mr. Perez had not had contact with inmates for weeks, according to a person familiar with the matter.

To try to prevent an outbreak in the federal prison system that holds more than 175,000 people, the Bureau of Prisons has suspended all visits for 30 days, including most by lawyers. It has also barred transfers of inmates between facilities, with few exceptions. The bureau said the densely packed nature of prisons "creates a risk of infection and transmission for inmates and staff."

Many state prison systems and local jails, where a vast majority of imprisoned people are held, also suspended visits last week. A jail in Santa Clara County, Calif., placed inmates in quarantine after a visitor tested positive for the virus.

In other countries where the pandemic is more widespread, both prisoners and guards have fallen sick. The coronavirus swept through Chinese prisons in late February, with reports of more than 500 cases spreading across at least four facilities in three provinces. And Iran temporarily freed about 70,000 prisoners earlier this month to help curb the epidemic there.

Advocates in the United States have sounded alarms over whether correctional facilities here are adequately prepared to stop an outbreak within their walls. Much of the advice given by the federal Centers for Disease Control and Prevention — such as staying six feet away from others and routinely disinfecting surfaces — can be nearly impossible to follow behind bars.

As the outbreak continued to spread on Tuesday, public defender groups in New York City called for the release of detainees in the city jails, including on Rikers Island, who are being held on parole violations, are over 50 or have pre-existing health conditions. "The city must take basic and humane steps to prevent suffering and loss of life," said Tina Luongo, the chief criminal defender of the Legal Aid Society.

The union for the city's corrections officers countered that "instead of recklessly letting inmates out," the city should "bring in more masks, gloves, hand sanitizers and other vital supplies" for jail employees. A spokesman for the union said that corrections officers were given 3,000 masks, but they need 10,000.

More than a dozen employees of the federal prison system, including staff in New York and Texas, told The New York Times that their facilities were also ill-prepared for a coronavirus outbreak, or even a quarantine. One prison worker at a facility in Texas said that medical supplies and staff were short, even without an outbreak, and that if the prison had multiple cases, some would need to be sent to a nearby hospital for treatment.

"I can't imagine a local hospital giving inmates preference if they get to the point they have to make hard decisions on saving lives," the worker said, but added that the prison simply would not be able to handle a surge. "We don't have ventilators on hand at all. We are not a hospital. We don't have the medical staff."

In late February, Jeffrey Allen, the Bureau of Prisons' medical director, sent a memo to all clinical directors at federal prisons across the country, urging them to screen incoming inmates for the virus and to establish "baseline" supplies like gloves, surgical and N95 masks, and gowns.

In Tallahassee, the placement of new inmates directly into quarantine ramped up the concerns of staff members who were already nervous about their ability to contain an outbreak. Seven employees described the situation to The Times. Some spoke on the condition of anonymity because they feared retaliation from the Bureau of Prisons, while others are protected by their status in the prison employees' union. The bureau did not authorize them to speak.

Ray Coleman, a teacher at the prison complex, and other employees said the agency quarantined the new inmates in a unit away from the general population, but where they would still have close contact with prison employees.

Mr. Coleman said that prison officials told him on Tuesday that the bureau was planning to send more new inmates this week; they would also be placed in quarantine, he was told, likely in a special housing unit nicknamed "the SHU" that is generally reserved for inmates who get into trouble or need protection. Inmates in the unit are not usually allowed to roam freely outside of their cells, and may bathe and exercise on a limited basis.

When they do leave their cells — to shower, for example, on Mondays, Wednesdays and Fridays — they must be closely accompanied by prison staff.

"We can't escort an inmate with a six-foot rule," said Yamira Richardson, a correctional officer who is currently working in the SHU. She worries about being exposed and then transmitting the virus to co-workers, inmates or family members.

"A lot of us are parents," said Ms. Richardson, who is also a steward in the local union. "A lot of us are caregivers to parents and elderly relatives."

Ms. Richardson and other employees said they were also concerned about staffing. If employees must stay home because they are sick, the already understaffed prison will suffer, they said.

The Bureau of Prisons declined to make Erica Strong, the prison complex's warden, available for an interview. A bureau spokesperson said there were no known cases of the coronavirus in the federal prison system but did not respond to specific questions, instead providing a statement that the suspension of inmate transfers announced last week had exceptions.

"Admission of new inmates will continue," the statement said, adding that the inmates received by the Tallahassee prison complex had been approved. "Out of an abundance of caution, these inmates were screened and placed on observation."

The statement said that an ample amount of cleaning, sanitation and medical supplies was on hand and ready to be distributed or moved to any facility as deemed necessary.

On March 13, Ms. Strong sent a memorandum to all staff members at the prison complex, assuring them that surgical and N95 masks, gloves and medical gowns would be "available at all departments."

Mr. Coleman, who is president of the prison's local union, replied in a series of memos that the gear was not widely available, and that N95 masks on back order had a projected shipping date of March 20 or later. He laid out a list of units with little or no protective gear — including the education department, the psychology department and the SHU. He noted that some areas did not have hand soap.

He said that because of a lack of supplies, the medical unit was reusing masks that are supposed to be used only once.

Ms. Morgan, the nurse practitioner who is also the vice president of the local prison union, said the complex had struggled to get basic supplies like hand sanitizer and was expecting to have to ration masks. Most of the ones on hand are either too small or too large for most prison workers, she added. "We don't know if or when we are going to get more."

No inmates at the complex have been tested for the coronavirus, Ms. Morgan said — largely because there are no tests available at the prison, and it is unclear how oral and nasal swabs would be transferred off-site for testing. Medical staff have been told that they may need to report to work after hours to screen incoming inmates in the future.

The Bureau of Prisons considers a temperature of 100.4 to be the threshold for a fever, according to its visitor screening documents. Ms. Morgan was working when the bus of ICE inmates arrived on Tuesday. She said the inmates' temperatures were in the 99.3 to 101.2 range, all of which she considered to be high.

Jan Ransom and Nicholas Bogel-Burroughs contributed reporting.

The Coronavirus Outbreak

How Is the U.S. Being Affected?

Updated March 17, 2020

- The coronavirus has now been identified in all 50 U.S. states, and more than 100 deaths in the country have been linked to the illness. We are tracking every case.
- On day one of the shelter-in-place order in the Bay Area, the distinction between essential and nonessential was blurred.
- College students are being sent home. Graduation is cancelled. Some students are taking it into their own hands.
- The coronavirus has descended on a rural town in Kentucky. 6 residents are sick. bullet: In jails and prisons across the country, concerns are rising of a

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U.S. House of Representatives
Committee on the Judiciary
Washington, DC 20515–6216
One Hundred Sixteenth Congress

March 12, 2020

The Honorable William P. Barr
Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530

Dear Attorney General Barr:

This week, the World Health Organization declared the novel coronavirus (or COVID-19) a global pandemic. Reports indicate that the virus has infected at least 125,000 people worldwide and has led to over 4,300 deaths to date. I write to inquire about the measures taken by the Department of Justice to ensure the health and welfare of prisoners in the custody of the Bureau of Prisons (BOP) and the U.S. Marshals Service (USMS) during this crisis. I write also to inquire about measures taken to ensure the health and welfare of staff and correctional officers who assist in housing and transporting prisoners in the custody of the BOP and the USMS.

I am especially concerned because the incarcerated and justice-involved populations contain a number of groups that may be particularly vulnerable to COVID-19. In particular, health conditions that make respiratory diseases more dangerous are far more common in the incarcerated population than in the general U.S. population.

I also believe it would be important, at this time, for DOJ to consider measures that can be taken to reduce the number of prisoners in government custody. Specifically, I believe DOJ should consider directing U.S. Attorney's Offices, wherever possible, to not seek the detention of individuals at their initial appearance in court, decline prosecuting minor, non-violent offenses, and decline pursuing supervised release and probation revocations that involve technical and minor violations.

Because of my concerns about these serious issues, I ask the following:

1. Has the Justice Department given any direction or guidance to the BOP and the USMS for dealing with COVID-19? If so, please provide the specific text of the guidance provided.

2. Whether in response to direction or guidance from DOJ or not, have the BOP and the USMS developed their own policies and procedures regarding COVID-19? Please provide copies of any and all such policies and procedures.

    a. If so, have these policies and procedures been distributed to each facility, including contract facilities?

b. What specific measures have been taken to ensure that these policies and procedures are being implemented in contract facilities that are not BOP-run?

i. If these policies and procedures are not being implemented in contract facilities, please explain why not and what, if any, alternative measures are being taken to ensure the health and welfare of inmates who are incarcerated in those contract facilities.

3. Have the BOP and the USMS, respectively, designated point persons within their agencies to address COVID-19? Please provide the name and title of each person so designated and their qualifications for the position.

4. Have additional precautionary measures been taken with respect to sanitation and hygiene, including frequent cleaning and ready availability of soap and tissues?

5. Is there a comprehensive testing protocol being implemented across the board in BOP facilities and contract facilities? If not, why not?

6. Are inmates entering BOP and contract facilities being tested at the time of intake? If not, why not? Conversely, are inmates being tested at the time of their release from BOP or contract facilities?

7. At this time, are any prisoners in the custody of BOP and the USMS being monitored for signs of infection?

8. Are testing kits being made available to the BOP and contract facilities? If so, how quickly are test results being released?

9. What measures have been taken to ensure that any prisoners testing positive for COVID-19 are isolated and treated? What about those who have exposed to those who test positive?

10. What protocols exist, once a positive case is discovered, to ensure that the rest of the prisoners in the facility are not exposed? Are any special measures being taken to ensure high-risk prisoners are not exposed?

11. What is the protocol for deciding when to transport a prisoner with COVID-19 for care at a hospital?

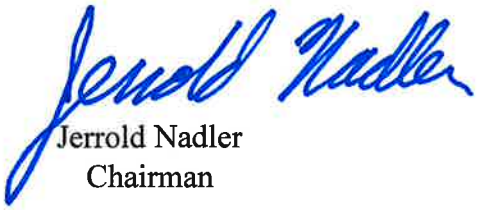
12. What protocols exist with regards to attorney and family visits? How are attorneys and family members being notified if a client or family member, respectively, tests positive for COVID-19?

13. What is the protocol for transporting inmates to court for hearings?

14. Are specific measures being taken to ensure staff at the facilities (whether BOP-run or contract facilities) have leave available if they develop symptoms of COVID-19? Are special measures being taken to ensure staffing levels are adequate at all times?

Because of the urgency of this matter, I ask that you respond in writing as soon as possible,

Sincerely,



Jerrold Nadler
Chairman

cc: Jim Jordan
Ranking Member

ORIGINAL ARTICLE
METHAMPHETAMINES AND PULMONARY DISEASE

Methamphetamine use association with pulmonary diseases: a retrospective investigation of hospital discharges in California from 2005 to 2011

Halley Tsai[1], Justin Lee[2], Haley Hedlin[2], Roham T. Zamanian[1,3,4] and Vinicio A. de Jesus Perez[1,3,4]

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ABSTRACT

Background: Methamphetamine can have acute and long-term adverse health consequences. Our objective was to determine whether methamphetamine use is associated with more hospitalisation codes for asthma exacerbation, chronic obstructive pulmonary disease (COPD) exacerbation, pneumonia and acute respiratory failure (ARF).

Methods: The Health Care Utilization Project (HCUP) database includes retrospective inpatient discharge abstracts from 2005 through 2011 from the California state inpatient databases (SIDs). ICD-9 codes were used to identify hospitalisations for asthma exacerbation, COPD exacerbation, acute pneumonia, ARF and methamphetamine use from discharges with complete demographic data and ages 18 to 75 years. Adjusted rate ratios comparing methamphetamine users with nonusers were estimated separately for each pulmonary disease diagnosis by sex using negative binomial regression models.

Results: We included 21 125 249 inpatient discharges from 2005 through 2011 in California in our analysis; 182 766 (0.87%) had methamphetamine use. The rate ratio comparing pneumonia in discharges with methamphetamine use *versus* those without were 1.40 (95% CI 1.18, 1.67) for women and 1.18 (95% CI 1.04, 1.35) for men; comparing ARF 1.77 (95% CI 1.59, 1.98) for women and 1.24 (95% CI 1.12, 1.37) for men; and comparing COPD exacerbation 1.40 (95% CI 1.18, 1.67) for women and 0.90 (95% CI 0.79, 1.02) for men.

Conclusions: A positive association was found when comparing inpatient hospital discharge diagnoses for methamphetamine use and those for pneumonia and ARF in both sexes. This association was not seen when comparing discharge diagnoses for methamphetamine and those for asthma exacerbation in both sexes or COPD exacerbation in men. While future investigation for is warranted, this finding may help to further characterise the pulmonary toxicity of methamphetamine.

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A positive association was found when comparing inpatient hospital discharge diagnoses for methamphetamine use and those for pneumonia and respiratory failure in both sexes http://bit.ly/2Jem87z

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This article has supplementary material available from openres.ersjournals.com.

Access to the HCUP database must be requested through the HCUP Central distributor: https://www.hcup-us.ahrq.gov/tech_assist/centdist.jsp.

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Introduction

The methamphetamine epidemic in the United States has been widely characterised as a significant public health concern. Methamphetamine is a psychostimulant of the phenethylamine and amphetamine classes of drugs and is a sympathomimetic that accentuates catecholaminergic and serotonergic neurons [1]. Its precursor forms were initially used to treat asthma and sinus congestion (ephedrine) [2], and as a weight loss aid (fen-phen) [3]. The discovery of its stimulant effects in the early 20th century led to its widespread use as a performance-enhancer, then subsequently as a recreational drug of abuse in purified forms. Specifically, methamphetamine is sold illicitly as a powder or crystalline ("ice" or "crystal") form, intended for inhalation *via* smoking, the most common route of ingestion [1].

According to recent estimates [4] from 2012 in the United States, over 12 million people over the age of 12 years have used methamphetamine in their lifetimes, 1.2 million people reported having used in that past year, and 440 000 used it in that past month. According to the National Institute on Drug Abuse 2012 data, methamphetamine use was greatest in the western part of the United States and parts of the Midwest, and users were predominately White [5]. Outside of the United States, amphetamine-type stimulants, of which methamphetamine is the most common, are the second-most used class of illicit drugs worldwide [6]. Furthermore, the World Drug Report of 2013 estimates that methamphetamine use appears to be growing, further suggesting its use as a growing epidemic [7].

Because of the increased rates of methamphetamine use, there has been subsequent investigation into its toxic effects on health. In 2010, Volkow *et al.* [8] showed that the highest uptake of methamphetamine was in the lungs, liver, and kidney, suggesting its widespread organ distribution and potential for toxicity. Previously reported associations have been predominantly in the cardiac and respiratory systems, namely cardiomyopathy, acute coronary syndrome, and aortic dissection, as well as pulmonary arterial hypertension [9–11]. Small studies also exist to suggest the possible associations between methamphetamine use and barotrauma, cardiogenic pulmonary oedema, pulmonary haemorrhage, pulmonary granulomatosis, noncardiogenic pulmonary oedema, aspiration pneumonia, excessive bronchial reactivity, and hypersensitivity pneumonitis [12]. However, there is a paucity of investigation towards the scope of pulmonary toxicity that may be related to methamphetamine use.

Thus, the goal of this study was to determine whether methamphetamine use was associated with more hospitalisation codes for adults which capture four common pulmonary diseases: acute exacerbations of asthma, acute exacerbations of chronic obstructive pulmonary disease (COPD), pneumonia and acute respiratory failure. Our target of study focused on the data collected from California, a state that has been the focus of methamphetamine-related research in the past [13].

Materials and methods

Study design and population

A retrospective observational study design was used to analyse California state inpatient databases (SIDs) obtained from the Healthcare Cost and Utilization Project (HCUP; www.hcup-us.ahrq.gov/tech_assist/citations.jsp) from 2005 through 2011 for diagnosis of methamphetamine use and asthma exacerbation, COPD exacerbation, pneumonia and respiratory failure. Inpatient hospital discharges were included in the study population if patients were over 18 years old and were not missing data for key demographic variables (age, sex, estimated median household income of residents in the patient's ZIP code).

Outcomes

Primary outcomes were discharge diagnoses of four common pulmonary diseases: acute exacerbations of asthma, COPD, pneumonia and acute respiratory failure. The relevant diagnoses were defined by International Classification of Diseases, Ninth Revision (ICD-9) codes documented in the top 10 diagnoses for each discharge (table 1). Specific ICD-9 codes were chosen to capture discharge diagnoses of acute exacerbations of asthma and COPD, respiratory failure and diagnoses consistent with community-acquired pneumonia. Discharges with more than one of the diagnoses of interest were classified as having each of the diagnoses.

Independent variable and covariates

The exposure of interest was methamphetamine use (ICD-9 codes 304.40 to 304.42 and 305.70 to 305.72) in the top 10 diagnoses for each discharge. The selected methamphetamine use diagnoses included unspecified, continuous or episodic abuse or dependence. ICD-9 codes for patients in remission of methamphetamine abuse were excluded. In addition, we identified tobacco use (ICD-9 codes 305.1, 989.84, V15.82) as a possible confounder. The use of ICD-9 tobacco use codes for identifying smokers in a clinical population, while insensitive, has been supported in the literature [14]. Age, sex, race and median household income were used as demographic covariates. Age (18 to 25, 26 to 35, 36 to 45, 46 to 55, 56 to

TABLE 1 List of International Classification of Diseases (ninth revision) codes used to define exposures, outcomes and covariates

Diagnosis	Diagnosis code	Description
Methamphetamine	304.40	Amphetamine and other psychostimulant dependence, unspecified
	304.41	Amphetamine and other psychostimulant dependence, continuous
	304.42	Amphetamine and other psychostimulant dependence, episodic
	305.70	Amphetamine or related acting sympathomimetic abuse, unspecified
	305.71	Amphetamine or related acting sympathomimetic abuse, continuous
	305.72	Amphetamine or related acting sympathomimetic abuse, episodic
Asthma	493.01	Extrinsic asthma with status asthmaticus
	493.02	Extrinsic asthma with (acute) exacerbation
	493.11	Intrinsic asthma with status asthmaticus
	493.12	Intrinsic asthma with (acute) exacerbation
	493.91	Asthma, unspecified type, with status asthmaticus
	493.92	Asthma, unspecified type, with (acute) exacerbation
COPD	491.21	Obstructive chronic bronchitis with (acute) exacerbation
	491.22	Obstructive chronic bronchitis with acute bronchitis
Pneumonia	481.0	Pneumococcal pneumonia (*Streptococcus pneumoniae* pneumonia)
	482.2	Pneumonia due to *Haemophilus influenzae*
	482.30	Pneumonia due to *Streptococcus*, unspecified
	482.31	Pneumonia due to *Streptococcus*, group A
	482.32	Pneumonia due to *Streptococcus*, group B
	482.39	Pneumonia due to other *Streptococcus*
	482.40	Pneumonia due to *Staphylococcus*, unspecified
	482.41	Methicillin susceptible pneumonia due to *Staphylococcus aureus*
	482.42	Methicillin resistant pneumonia due to *Staphylococcus aureus*
	482.49	Other *Staphylococcus* pneumonia
	482.84	Pneumonia due to Legionnaires' disease
	483.0	Pneumonia due to *Mycoplasma pneumoniae*
Respiratory failure	518.81	Acute respiratory failure
Tobacco	305.1	Tobacco use disorder
	989.84	Toxic effect of tobacco
	V15.82	Personal history of tobacco use
Cocaine	304.20	Cocaine dependence, unspecified
	304.21	Cocaine dependence, continuous
	304.22	Cocaine dependence, episodic
	305.60	Cocaine abuse, unspecified
	305.61	Cocaine abuse, continuous
	305.62	Cocaine abuse, episodic

65, 66 to 75 years) and race (White, Hispanic, other/missing) were grouped together for the analysis while sex and median household income quartiles [1–4] were used as documented in the database. On the basis of published demographic data, age ranges were centred above and below age 35 years, the median age of methamphetamine abusers, with a standard deviation of approximately 6 years and range from approximately age 20 to 70 years [13, 15].

Cocaine is also a sympathomimetic drug whose abuse has been documented to provoke and/or exacerbate the four lung diseases presented here [12, 16–20]. To serve as a comparison with a well-studied toxin, cocaine abuse and dependence (ICD-9 codes 304.20 to 304.22 and 305.60 to 305.62) in the top 10 diagnoses was considered as the exposure in sensitivity analyses.

Statistical analysis

Rates of discharge diagnoses are presented as the number of discharges having that diagnosis in the numerator and the total number of discharges in the denominator.

Negative binomial regression models were used to estimate rate ratios (RR) with 95% confidence intervals (CIs) of pulmonary disease diagnoses between methamphetamine and nonmethamphetamine users. Models were adjusted for age group, race, median household income quartile and smoking. Given the

known disparity in disease risk by sex [21–23], we fitted separate models for each pulmonary disease diagnosis by sex to estimate the RR of the disease in methamphetamine *versus* nonmethamphetamine users separately by sex. The same methods were applied in an analysis considering cocaine use as the exposure to provide a comparison with a well-studied toxin.

All statistical tests were performed at the 0.05 significance level and R [24] (version 3.3.1) was used for all analyses. The "MASS" [25] package (version 7.3–47) in R was used to fit the negative binomial regression models.

Results

Screening the California HCUP SID between 2005–2011 resulted in a total of 27 907 535 discharge abstracts that were available for analysis. Abstracts that reflected children (age <18 years, n=5 594 831) or those with missing age (n=266 198) were excluded from further analysis. For the remaining abstracts, we excluded those with either missing sex (n=341 540), income (n=563 735) or both (n=15 982). This resulted in 21 125 249 discharge abstracts with complete demographic data for inclusion in our study, of which 182 766 carried a top-10 discharge diagnosis of methamphetamine abuse or dependence based on our inclusion criteria (figure 1).

With regard to ethics approval and consent to participate, all the data used in the study were obtained from the HCUP database.

Demographics

Table 2 summarises demographic data of the discharge diagnoses that were included in the study. The median age was 37 years (interquartile range (IQR) 28–47) in methamphetamine use discharges and 57 (IQR 37–75) for nonmethamphetamine use discharges. Methamphetamine use discharges tended to be male (n=106 665, 58%) compared with nonuse (n=7 982 930, 38%). A co-diagnosis of methamphetamine and tobacco use (n=68 312, 37%) occurred more frequently compared with diagnoses of tobacco use without methamphetamine use diagnosis (n=3 028 832, 14%). Rates of discharge diagnoses for both methamphetamine and nonmethamphetamine use in smokers and nonsmokers are presented by age and sex in supplementary figure 1 and 2.

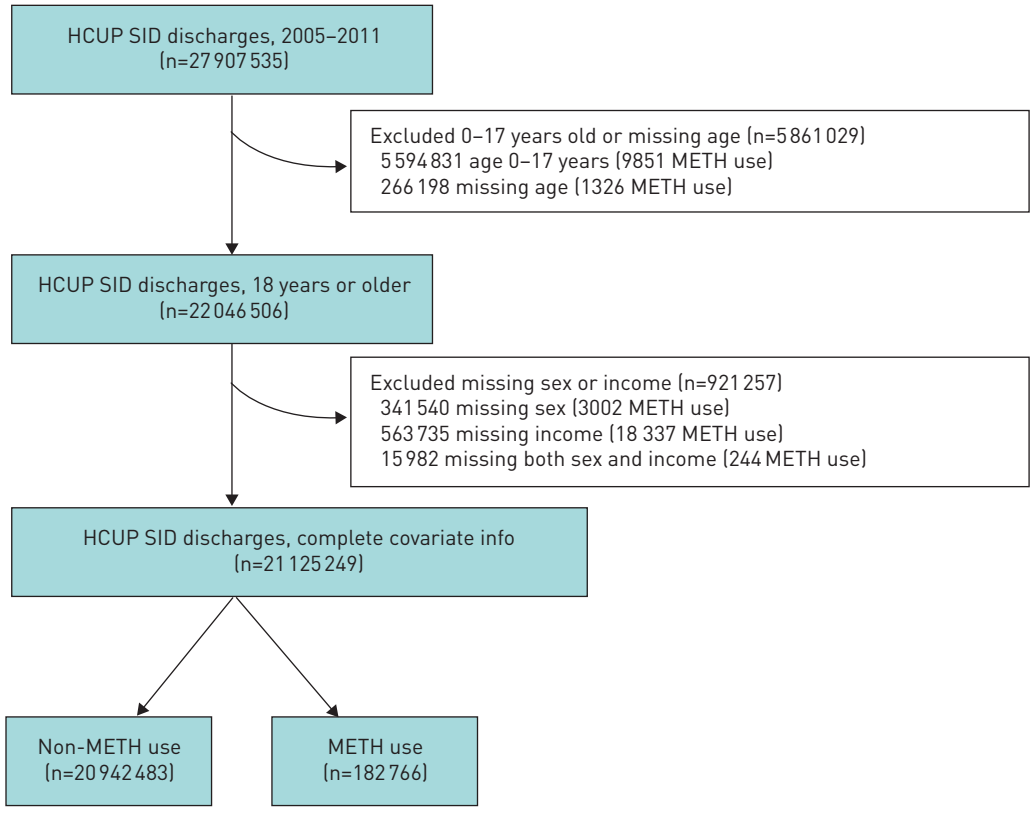

FIGURE 1 Number of discharges included and excluded in analysis. HCUP: Healthcare Utilization Project; SID: state inpatient database; METH: methamphetamine.

TABLE 2 California state inpatient database characteristics 2005–2011

	Meth discharges (n=182 766)	Nonmeth discharges (n=20 942 483)	SMD
Age group			1.229
18–25 years	32 151 (18%)	1 862 559 (8%)	
26–35 years	48 357 (26%)	3 008 855 (14%)	
36–45 years	51 283 (28%)	2 329 449 (11%)	
46–55 years	38 918 (21%)	2 790 528 (13%)	
56–65 years	10 540 (6%)	2 991 208 (14%)	
66–75 years	1517 (1%)	7 959 884 (36%)	
Age years median (IQR)	37 (28, 47)	57 (37, 75)	1.065
Sex			0.414
Male	106 665 (58%)	7 982 930 (36%)	
Female	76 101 (42%)	12 959 553 (59%)	
Race			0.127
White	104 846 (57%)	11 150 306 (53%)	
Hispanic	46 532 (26%)	5 186 339 (25%)	
Black	12 550 (7%)	1 679 988 (8%)	
Other/missing	18 838 (10%)	2 925 850 (14%)	
Median household income quartile by patient ZIP code			0.279
Quartile 1	65 813 (36%)	5 785 651 (26%)	
Quartile 2	53 387 (29%)	5 312 536 (24%)	
Quartile 3	39 373 (22%)	5 237 059 (24%)	
Quartile 4	24 193 (13%)	4 607 237 (21%)	
Smoking	68 312 (37%)	3 028 832 (14%)	0.542
Pulmonary disease diagnoses			
Asthma	1076 (1%)	106 712 (0.5%)	0.011
COPD	2083 (1%)	519 148 (2%)	0.101
Pneumonia	898 (0.5%)	99 947 (0.5%)	0.002
Respiratory failure	4031 (2%)	463 840 (2%)	0.001
More than one of above	690 (0.4%)	93 378 (0.4%)	0.01

Due to rounding, some percentages may not sum to 100%. Meth: methamphetamine; SMD: standardised mean difference; IQR: interquartile range.

Outcomes

Discharges abstracts that included ICD-9 codes for methamphetamine use were 0.66 (95% CI 0.57, 0.77; p<0.001) times as likely to have a simultaneous principal hospital discharge abstract for acute exacerbations of asthma compared with discharge abstracts without methamphetamine use in women and 0.71 (95% CI 0.61, 0.82; p<0.001) times as likely in men (figure 2). For COPD, the risk of having a principal hospital discharge abstract for acute exacerbations were 1.23 (95% CI 1.06, 1.42; p=0.01) times as likely in discharges with methamphetamine use *versus* nonmethamphetamine use in women and 0.90 (95% CI 0.79, 1.02; p=0.10) in men. We documented a RR for having a hospital discharge abstract for acute pneumonia in methamphetamine use *versus* nonmethamphetamine use of 1.40 (95% CI 1.18, 1.67; p<0.001) in women and 1.18 (95% CI 1.04, 1.35; p=0.01) in men. Finally, the risk in methamphetamine use discharges of also having a discharge diagnosis of acute respiratory failure was 1.77 (95% CI 1.59, 1.98; p<0.001) times the risk in nonmethamphetamine use discharges in women and 1.24 (95% CI 1.12, 1.37; p<0.001) in men. Similar results were found when adjusted for a confounder of malnutrition, and results are presented in Supplementary Figure 3.

Role of cocaine in discharge for lung diseases

In our analysis, we found similarities between cocaine use and methamphetamine use discharges associated with each of the four lung diagnoses (figure 3). In particular, we found a RR for asthma exacerbations of 0.87 (95% CI 0.75, 1.02; p=0.08) when comparing discharges with cocaine use *versus* discharges without cocaine use in men and 0.71 (95% CI 0.60, 0.83; p<0.001) in women. Compared with discharges with methamphetamine use, the RR for COPD exacerbations in discharges with cocaine use was higher in women (RR: 2.46; 95% CI 2.11, 2.86; p<0.001) and men (RR: 1.69; 95% CI 1.47, 1.94; p<0.001). For pneumonia, discharges with cocaine use were 1.84 (95% CI 1.55, 2.20; p<0.001) times as likely to have a pneumonia diagnosis compared with discharges without use in women and 0.88 (95% CI

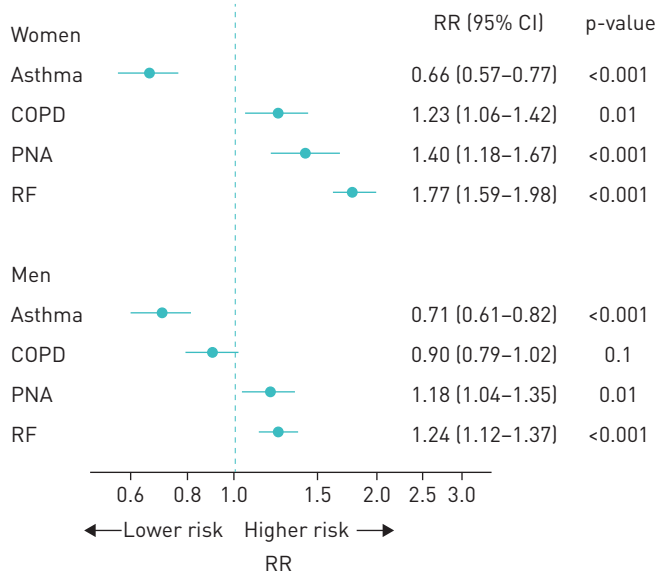

FIGURE 2 Rate ratio (RR) point estimates and 95% confidence intervals for each disease in methamphetamine *versus* nonmethamphetamine discharges for females and males. Models adjusted for race, median household income, age and smoking status. COPD: chronic obstructive pulmonary disease; PNA: pneumonia; RF: respiratory failure.

0.76, 1.02; p=0.08) in men; for acute respiratory failure, the RR was 1.73 (95% CI 1.53, 1.95; p<0.001) in women and 1.05 (95% CI 0.94, 1.16; p=0.39) in men.

Discussion

Our findings suggest that California inpatient hospitalisation discharge abstracts from the years 2005 through 2011 that include a code for methamphetamine use have an increased likelihood of also including a code for COPD exacerbation, acute pneumonia or acute respiratory failure when compared with discharge abstracts that do not include a code for methamphetamine use.

In our analysis, we found negative associations in both sexes between diagnosis codes for methamphetamine use and acute asthma exacerbation. This would suggest a decreased likelihood of

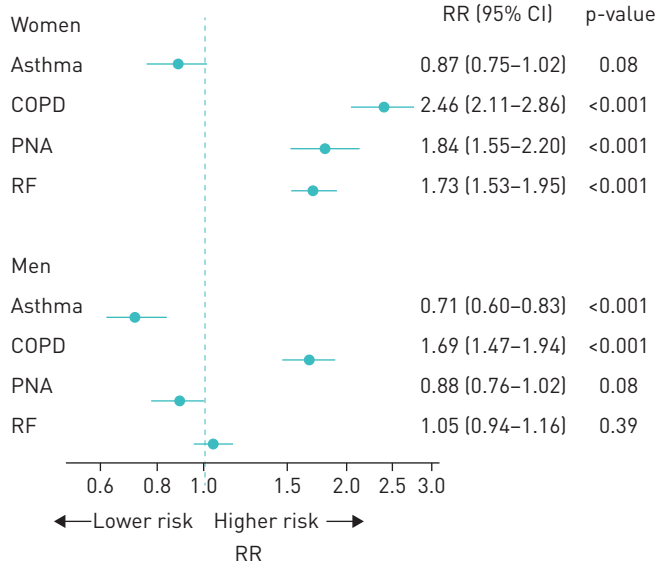

FIGURE 3 Rate ratio (RR) point estimates and 95% confidence intervals (CI) for each disease in cocaine *versus* noncocaine discharges for females and males. Models adjusted for race, median household income, age, and smoking status. COPD: chronic obstructive pulmonary disease; PNA: pneumonia; RF: respiratory failure.

concurrent discharge abstract diagnoses of methamphetamine use and acute asthma exacerbation that is contrary to our hypothesis that methamphetamine use may increase the risk of exacerbation. To our knowledge, there are no previously published data on the inhaled effects of methamphetamine with regards to airways diseases such as asthma. It is possible that this effect reflects a decreased likelihood for patients with concurrent discharge diagnoses to seek medical care, due to socioeconomic factors or mental health barriers that limit access to medical care. Another explanation for the RR being lower for asthma (and higher for COPD in women) may be that asthma is more commonly misdiagnosed as COPD in the presence of methamphetamine use. Finally, we acknowledge that the findings may reflect a limitation of the study design using ICD-9 codes as surrogates for exposure to methamphetamine and diagnosis of asthma exacerbation.

We identified a statistically significant positive association between diagnosis codes for methamphetamine use and acute COPD exacerbation in women. Surprisingly, there is scant literature regarding inhaled illicit drug use and rates of COPD exacerbation. While "crack" cocaine has been linked to increased risk of asthma exacerbations [26], most studies have failed to find inhaled marijuana to be a risk factor for development of COPD or increased rate of exacerbations [27]. To our knowledge, there are no published studies investigating a link between COPD and methamphetamine use. It is unclear why this positive association is seen in women but not is not statistically significant in men. In the original landmark TORCH COPD study, women did report more exacerbations and worse dyspnoea scores than men [22] thus, perhaps there was an increased propensity for women methamphetamine abusers to seek medical care for a concurrent COPD exacerbation.

The association between diagnosis codes for methamphetamine use and codes for the adverse pulmonary outcomes of COPD exacerbation, acute pneumonia or acute respiratory failure is in concordance with known pulmonary complications of acute respiratory failure related to another similar inhaled stimulant, "crack" cocaine [26]. Furthermore, there is some literature that describes a disruption by methamphetamine exposure on host immunity, placing methamphetamine users at increased risk for acquisition of diverse pathogens [28]. While much of the existing literature addresses increased rates of opportunistic infections and fungal infections such as histoplasmosis, methamphetamine has been reported to reduce T-cell infiltrates in the lungs, dampening the protective immune response against respiratory pathogens including community-acquired bacteria [29]. Also, the intoxicating effects of methamphetamine predisposes users to engage in risky behaviour and subsequently increases the risk of acquiring transmissible microbes or developing immunodeficiency (*e.g.* HIV and AIDS) [28]. Another interpretation of this association is the possibility that patients who are afflicted by substance abuse may have poorer access to general outpatient medical care, and in turn present to the hospital more acutely and would require inpatient stay for their acute illness.

Lastly, as the specific ICD-9 code for "acute respiratory failure" is broad, it may encompass all forms of respiratory failure, including pulmonary oedema (cardiogenic or noncardiogenic), acute respiratory distress syndrome or diffuse alveolar damage, all entities which have been linked to methamphetamine use in case reports [30]. It has been described during investigation of the link between methamphetamine use and pulmonary hypertension that methamphetamine exposure potentiates DNA damage in hypoxic cells, increasing mitochondrial reactive oxygen species [31]. As acute lung injury and acute respiratory distress syndrome have been shown to arise from free radical formation [32], it is possible that methamphetamine use *via* free radical formation may contribute to noncardiogenic pulmonary oedema and capillary leak [33].

Limitations to this study include that this was a retrospective study that used data collected from a database originally created for billing purposes. Because the database was not designed for the purpose of research, there was limited information available on potential confounders and some confounder data were missing. It is possible that the missingness differs by methamphetamine exposure. Other than adjusting for obvious confounders that were available information from the database, including malnutrition (supplementary figure 3), there are probably other confounders that were not addressed (geographic location, domestic conditions, psychosocial environment, access to healthcare). This work presents several comparisons and the p-values should only be considered as descriptive measures that are not adjusted for the multiple tests performed. Additionally, by limiting our analysis to hospitalisation discharges, we cannot be certain whether the observed associations hold in the general population.

Furthermore, the use of ICD-9 codes as accurate surrogates for exposure (methamphetamine and tobacco) and disease state (asthma exacerbation, COPD exacerbation, pneumonia, respiratory failure) is dependent on the coders' accuracy in documenting the pertinent clinical problems for a given hospital discharge abstract. Misclassification is likely to attenuate the true RRs. Due to the nature of the dataset utilised, analysis was performed on discharge abstracts rather than on an individual basis because not all records could be linked to an individual. As a result, the temporality of the exposure is unknown in this study; for

example, in the absence of urine toxicology data confirming methamphetamine exposure, a methamphetamine use ICD-9 code may still be documented based on history of use.

Future directions of investigation include validating this research question in the general population and further stratifying those with simultaneous diagnoses of methamphetamine use and community-acquired pneumonia by co-diagnosis of immunocompromised state such as HIV or AIDS based on proposed mechanisms of methamphetamine and infectious diseases. Many of the discharge abstracts available in the dataset are those of the oldest patients. Future research should evaluate whether the associations observed here vary by age. Furthermore, as recreational methamphetamine production has become purer over time [34], an analysis stratified by year of discharge may provide insight into changes in the relationship between methamphetamine use and lung disease over time.

Conclusion

When adjusted for age, race, economic quartile and tobacco smoking, discharge diagnoses with methamphetamine use diagnoses are associated with higher rates of concurrent diagnoses of community-acquired pneumonia and acute respiratory failure among men and women, and acute COPD exacerbation among women when compared with those with no methamphetamine use diagnosis. Further investigation is necessary to elucidate a potential mechanism on how methamphetamine use leads to development of these common pulmonary diagnoses. We hope that this study brings awareness to the growing methamphetamine epidemic and its potential for lung injury beyond the pulmonary vasculature and the cardiopulmonary system, namely the airways and lung parenchyma. Lastly, there is also potential for further investigation with regards to the healthcare cost of the methamphetamine epidemic and utilisation of services of the healthcare system.

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Conflict of interest: None declared.

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Appendix E

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. DANILLO BUSTILLO-SEVILLA, Defendant.	Case No. 20-cr-00021-VC-1 **ORDER RE SENTENCING HEARING**

In light of the current public health crisis, there will be no in-person hearings in the courtroom of the undersigned judge until further order. Most hearings will be continued. Those that can't be continued will be conducted by telephone.

In this case, the defendant is in custody at the Santa Rita Jail in Dublin, CA. He has pleaded guilty to a street-level drug crime, and he is scheduled to be sentenced on Monday, March 23, 2020. The defendant is seeking a "time served" sentence—that is, a sentence equal to the amount of time he has already spent in custody. The government has expressed an intent to seek a longer prison sentence.

If the defendant is indeed correct that a sentence of time served is warranted, a delay in his sentencing hearing would cause him to be held for longer than necessary at the Santa Rita Jail. However, as mentioned, it is not appropriate to conduct an in-person sentencing hearing under current health conditions. It may also be difficult or impossible to secure the defendant's participation by telephone or videoconference from the jail.

Fortunately, under Rule 43(c)(1)(B) of the Federal Rules of Criminal Procedure, the defendant has the option of waiving his presence at the sentencing hearing. The applicable

provision states as follows: "A defendant who was initially present at trial, or who had pleaded guilty or nolo contendere, waives the right to be present . . . in a noncapital case, when the defendant is voluntarily absent during sentencing."

Some courts have interpreted this language as permitting sentencing to proceed without the defendant only if he has absconded. *See, e.g.*, *United States v. Jones*, 410 F. Supp. 2d 1026, 1033 (D.N.M. 2005) (holding that Rule 43(c)'s waiver provisions do not permit a defendant to waive the presence requirement, even for medical reasons); *United States v. Walker*, Cr. No. 15-2846 JCH, at *8 (D.N.M. Oct. 6, 2016). But the rule doesn't say that, even though it easily could have. Courts apply traditional rules of statutory interpretation to the Federal Rules of Criminal Procedure. *United States v. Petri*, 731 F.3d 833, 839 (9th Cir. 2013). This means that if the rule is unambiguous, the Court must interpret it according to its plain meaning. *See Carlisle v. United States*, 517 U.S. 416, 424 (1996). By its language, the rule is not limited to situations where the defendant's flight caused him to be "voluntarily absent," so the better interpretation is that sentencing may proceed whenever the Court has assured itself that the defendant's absence is indeed voluntary. Indeed, the Ninth Circuit has interpreted the rule this way in another context. *See United States v. Mitchell*, 502 F.3d 931, 987 (9th Cir. 2007) (holding that Rule 43 allowed an in-custody defendant to waive his right to be present at the penalty phase of trial by his "voluntary absence," even when his interests would have been served by his presence).

At any rate, courts should resolve any doubts about the scope of the waiver provision to permit voluntary waiver of presence in the midst of a pandemic that has prevented the normal operation of the courts. When the text of a criminal procedure rule is ambiguous, courts should interpret it "to provide for the just determination of every criminal proceeding, to secure simplicity in procedure and fairness in administration, and to eliminate unjustifiable expense and delay." Fed. R. Crim. P. 2; *Carlisle*, 517 U.S. at 424 ("Rule [2] . . . sets forth a principle of interpretation to be used in construing ambiguous rules, not a principle of law superseding clear rules that do not achieve the stated objectives. It does not, that is to say, provide that rules shall be construed to mean something other than what they plainly say."). That principle of

interpretation would support the application of the waiver provision under these circumstances. *Cf. In re United States*, 597 F.2d 27 (2d Cir. 1979) ("We hold that a judge may in those exceptional circumstances exercise his discretion to accept a waiver of appearance from a defendant in a criminal trial where the choice of absence, a long continuance, or severance is exigent."). If a defendant asks for a sentence of time served and voluntarily waives his appearance in a situation where the hearing would otherwise be delayed because of a public health crisis, the interests of justice, fairness, and efficiency are promoted by finding that the waiver provision applies.

Accordingly, unless the Court is informed by defense counsel beforehand that the defendant will not waive his appearance at the sentencing hearing (in which case it will be continued), the hearing shall take place as scheduled, but telephonically. During the hearing, defense counsel should be prepared to convey whether his client has waived his appearance. This waiver need not be in writing. *See* Fed. R. Crim. P. 43(c)(1)(B) (containing no writing requirement); *United States v. Ornelas*, 828 F.3d 1018, 1021 (9th Cir. 2016) ("Thus, under Rule 43, so long as the defendant's absence is "voluntary," the district court may proceed with trial and sentencing in absentia.").

Furthermore, because it is a serious matter for a defendant to waive appearance at a sentencing hearing, if the Court develops a view during the hearing that a sentence of greater than time served may be warranted, it will give defense counsel the opportunity to request that the hearing be continued until such time as the defendant is able to participate.

IT IS SO ORDERED.

Dated: March 15, 2020

VINCE CHHABRIA
United States District Judge

Appendix F

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

IN THE MATTER OF CJA APPOINTED COUNSEL OBTAINING PARALEGAL AND INVESTIGATION SERVICES WITHOUT PRIOR AUTHORIZATION.	)	General Order No. 06-19

Pursuant to 18 U.S.C. § 3006A(e)(2), CJA appointed counsel are required to obtain prior authorization from the District Court for any service provider fees in excess of $900.00 per case. For the efficiency of counsel and the Court, the Court hereby authorizes CJA counsel to utilize the services of paralegals, investigators, and interpreters up to $2600.00 for each service provider type without further Order of the Court. CJA counsel and service providers shall otherwise comply with 18 U.S.C. § 3006A(e)(2), and agree to be bound by the presumptive hourly rates established by the Ninth Circuit Judicial Council.

This General Order is consistent with the recommendation of the Judicial Council of the Ninth Circuit Court of Appeals contained in the Criminal Justice Act Policies and Procedures, adopted on October 20, 2016.

IT IS SO ORDERED.

DATED: July 1, 2019

RICARDO S. MARTINEZ
CHIEF UNITED STATES DISTRICT JUDGE