EXHIBIT 1

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

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

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. In 2017-2018, I volunteered to run monthly AIDS awareness programming at Danbury FCI and FSL federal prisons for women in Danbury, Connecticut. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

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

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

5. I am being paid $200 per hour for my time reviewing materials and preparing this report.

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

7. I have been asked by the Public Defender Service for the District of Columbia to review and comment on materials in connection with a case to be filed on behalf of certain incarcerated individuals who are at an increased risk of contracting and developing complications from exposure to COVID-19. I was specifically asked to comment on jail conditions during and preparedness for the COVID-19 pandemic.

8. In addition to my knowledge, training, education, and experience in the field of prison healthcare and infectious diseases, and the resources relied upon by experts in infectious diseases and prison health, I also reviewed specifically the Centers for Disease Control and Prevention (CDC) guidance on management of COVID-19 in correctional facilities (available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html), the Bureau of Prisons (BOP) modified operations plan (available at https://www.bop.gov/coronavirus/covid19_status.jsp), the National Commission on Correctional Health Care (NCCHC) materials on COVID-19 (available at https://www.ncchc.org/COVID-Resources), and the World Health Organization interim guidance on Preparedness, prevention and control of COVID-19 in prisons and other places of detention (available at http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1).

II. Heightened Risk of Epidemics in Jails and Prisons

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

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

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

droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

12. Disciplinary segregation or solitary confinement facilities is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff. Because incarcerated people may perceive quarantine as punitive, or as a living arrangement that allows fewer privileges than their regular housing, incarcerated people may be deterred from self-reporting symptoms to medical staff. As a result, they may remain in congregate settings while infected, potentially transmitting infections to others.

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

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

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

16. Jails and prisons are often poorly equipped to diagnose and manage infectious disease

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

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

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

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

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

20. Safety and security. As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

21. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in

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

2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

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

22. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to nor developed protective responses against this virus. A vaccine is currently in development but will likely not be available for at least another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for use in clinical trials. People in prison and jail will likely have even less access to these novel health strategies as they become available.

23. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially

---

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

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

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

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

when they have not received the influenza vaccine or the pneumonia vaccine.

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

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

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

IV. Risk of COVID-19 in the D.C. Department of Corrections' ("D.C. DOC") Correctional Treatment Facility and Central Detention Facility ("D.C. jails")

27. In making my assessment of the danger of COVID-19 in the District of Columbia jails, I have reviewed the following reports and declarations:
    - **i.** Reports published following local government inspections of the DC jails:
        - District of Columbia Corrections Information Council, "DC Department of Corrections Inspection Report" (published May 21, 2019);
        - Office of the District of Columbia Auditor, "Poor Conditions Persist at Aging D.C. Jail; New Facility Needed to Mitigate Risks" (published February 28, 2019)

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

ii. Report resulting from a non-profit agency inspection of the DC jails:
- Washington Lawyers' Committee for Civil Rights and Urban Affairs, "D.C. Prisoners: Conditions of Confinement in the District of Columbia" (published June 11, 2015)

iii. Declarations from those living and working within the DC jails:
- CTF inmates Keon Jackson and Eric Smith
- CDF inmates D'Angelo Phillips and Edward Banks
- Public Defender Service staff who entered the jail facilities to meet with clients and who have conducted phone interviews with clients regarding conditions within the jails:
  - Division Chief Jonathan Anderson;
  - Supervising Attorney Joseph Wong;
  - Supervising Attorney Ieshaah Murphy;
  - Staff Attorney Daniel Pond;
  - Staff Attorney Rachel Cicurel;
  - Staff Attorney Ronald Resetarits;
  - Staff Attorney Kavya Naini;
  - Investigative Intern Eileen Johnson;
  - Investigative Intern Katherine Kuenzle;
  - Investigative Intern Samuel Cyphers;
  - March 25, 2020 Fraternal Order of Police Department of Corrections Labor Committee Letter to Quincy L. Booth

28. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. In addition, the practices and resources of CDF and CTF with regard to sanitation and other policies, as reflected in the declarations of CDF and CTF inmates who have resided in these facilities in March 2020 and the declarations of the PDS attorneys who have visited these facilities in March 2020, lead me to conclude, in my professional judgment, that the inmates, visitors, and employees of these facilities are at imminent risk of contracting COVID-19. Further, based on these same declarations, it is my professional judgment that, now that there is at least one positive case of COVID-19 within the CDF and CTF facilities, the chances are extremely high that most or all of the other inmates of, visitors to, and employees at that facility will contract it as well. Finally, it is my professional judgment that, because of the high likelihood that inmates, visitors, and employees of CDF and CTF will contract COVID-19, combined with the state of limited medical care for inmates at these facilities, any inmate of these facilities who contracts COVID-19 faces a serious and substantial risk of death from COVID-19. The reasons for this conclusion are detailed as follows.[8]

[8] In the below section, summaries of CDC guidance and general clinic recommendations

a. General Prevention Practices

i. Cleaning and Disinfecting Practices: Because the SARS-CoV-2 virus (that causes COVID-19 disease) can survive on inanimate objects, high-touch surfaces (including doorknobs, light switches, countertops) should be regularly disinfected with bleach. The CDC recommends cleaning and disinfecting, several times per day, surfaces that are not ordinarily cleaned daily, including doorknobs, light switches, countertops, sink handles, recreation equipment, telephones, kiosks. At least several times per day, staff should clean and disinfect shared equipment, including radios, service weapons, keys, and handcuffs.

Even before the COVID-19 pandemic, CDF and CTF facilities were described, in a mix of government reports, audits and declarations, as being unsanitary and unhygienic with crumbling physical infrastructure. These conditions will contribute to the rapid spread of COVID-19 within the facility, in the absence of adequate cleaning and disinfecting protocols. Declarations from people incarcerated at CDF and CTF facilities reflect that inmates are provided with rare bottles of Windex to clear their cells, which contains 4% isopropyl alcohol, as compared to the 70% alcohol-containing products or bleach needed to disinfect, per CDC recommendations. In fact, since Windex contains 28% ammonia, it could actually be harmful if mixed with bleach because the reaction generates chlorine gas that irritates the respiratory tract, eyes, and skin.

ii. Hygiene: Prevention of COVID-19 requires that people have access to soap, private sinks, and clean water for handwashing or alcohol-based hand sanitizers.

Failure to provide CDF and CTF inmates with a consistent and free supply of hygienic products (including soap and hand sanitizer) will increase the rate at which COVID-19 spreads around these facilities, because hand washing is one of the most effective ways to prevent spread of the virus. Yet declarations from people currently incarcerated in these facilities reflect no access to alcohol-based sanitizers and completely inadequate provision of no-cost soap.

iii. Personal protective equipment (PPE): CDC recommends that "all staff and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained correctly to don, doff, and dispose of PPE." In this case, PPE includes gowns, gloves, face masks, respirators, and eye shields or goggles. N95 respirators require special fit testing and people with facial hair need special accommodations because they cannot achieve a tight enough seal with N95 respirators. Inmates involved in cleaning, laundry, and meal service also need to be trained in how to don and doff personal protective equipment.

---

are followed by a discussion in *italics* of how these guidelines apply to the District of Columbia Department of Corrections.

The lack of personal protective equipment ("PPE") for both D.C. DOC staff and inmates, as described in the declarations of inmates and attorneys, will result in increased risk of COVID-19 infection. Even if PPE is accessible for CDF and CTF staff, it does not appear from PDS staff declarations that staff have been using PPE. This is also likely to increase the spread of the virus, as even asymptomatic people can transmit the virus. Of particular concern is the lack of PPE for staff who interact with the many visitors that cycle in and out of the facilities.

Inmates assigned to cleaning duties are also not provided appropriate PPE, resulting in high risk of contracting COVID-19. The DOC Labor Committee Letter reflects that Correctional Officers who requested PPE to extract inmates who are possible COVID-19 infected and bring them to isolation or quarantine were removed from duty. This is completely unacceptable and will undoubtedly result in COVID-19 infections in the facility and harm to inmates and staff. Absent from the documents I reviewed is any mention of planning for shortages for PPE or training staff on how to use PPE. This is critical because, without training, staff risk exposing themselves and inmates to COVID-19 infection when donning and doffing equipment.

b. Screening: COVID-19 is a virus that spreads easily, primarily from person-to-person through respiratory droplets. It is therefore imperative that people entering closed confinement settings like prisons are properly screened to ensure that they do not bring the virus into the facility. Research suggests that people who are ill with COVID-19 and experiencing symptoms are most likely to transmit the virus to others. The virus can be transmitted very efficiently from person to person within 6 feet, putting staff and inmates at risk of becoming infected unless proper infection prevention and control strategies are implemented.

i. Screening Inmates: Current CDC guidance suggests screening should consist of two questions: "1) Today or in the past 24 hours, have you had any of the following symptoms: fever/felt feverish/had chills; cough; difficulty breathing; 2) In the past 14 days have you had contact with a person known to be infected with COVID-19?"

There is no description in any of the documents I reviewed, that inmates are being screened for COVID-19 on intake. After completing screening, people without symptoms or temperature but who have been exposed to COVID-19, should be quarantined for 14 days to monitor for signs and symptoms of infection. Declarations from inmates suggest quarantining after exposure is occurring but for only 1 week. This premature release from quarantine will likely result in people with COVID-19 infection entering the general population in the facility and infecting others. Given that the average person with COVID-19 infection transmits the disease to 2-3 others (in the best of circumstances in the community

where social distancing is possible), this will likely result in the disease spreading through the facility like wildfire.

ii. **Screening Staff:** CDC recommends verbally screening all staff daily on entry into the facility for COVID-19 symptoms and close contact with cases, and temperature checks.

It is unclear from the documents I reviewed whether this is occurring, if at all. Per the DOC Labor Committee Letter, there has been no attempt to reassign staff who are at high-risk for COVID-19 themselves, putting staff at high risk of contracting the disease and transmitting to other staff and inmates residing inside the facility.

iii. **Screening Visitors/Vendors/Contractors:** According to the CDC, visitors and volunteers should also complete verbal screening procedures and temperature checks on entry into the facility.

The screening procedures described in the PDS staff declarations are insufficient to mitigate the risk that the virus will enter. Of particular concern is the lack of PPE for staff who interact with the many visitors that cycle in and out of the facilities delay; the inadequacy of the visitor screening program to identify asymptomatic carriers and the use of faulty equipment to recognize even symptomatic visitors will all but guarantee that someone infected with COVID-19 will enter the facilities. While some attempts have been clearly made to introduce a screening questionnaire, the questions used are outdated because they still focus on travel screening which has become a moot point in light of widespread community outbreaks, and thus do not align with CDC recommendations. The vast deficits in the screening process is especially important in DC jails, where medical care providers and contractors. If a medical care provider is infected with COVID-19, there is still the high likelihood that they will be able to enter the facility and can infect inmates with whom they have direct patient care contact.

c. Social distancing: When containment strategies become overwhelmed, mitigation strategies require people to practice social distancing. CDC recommends the following strategies: Meals can be staggered, and seating be rearranged in dining halls and common areas (like waiting areas) to enable social distancing, such as removing every other seat. Alternatively, meals could be provided in housing units. Mitigation strategies must be in place for other highly congregate settings, such as recreation, group activities, educational classes, vocational training, and religious services.

The lack of ability to practice social distancing in the CDF and CTF is also concerning and will the increase rate of spread of the virus. Continuing programming in groups of 30, as one inmate described in his declaration, will inevitably result in increased spread of the virus. The description by another inmate about inmates dipping their hands and cups into a communal cooler of juice also suggests that D.C. DOC is not enforcing even basic social distancing protocols. This is compounded by congregate housing units, in

which 40-50 men are sleeping in a single unit, many of whom have respiratory symptoms that are consistent with COVID-19 infection. CDF and CTF facilities are described, in a mix of government reports, audits and declarations as poorly ventilated with overwhelmingly communal shared spaces that are poorly ventilated. This scenario makes social distancing practices impossible, contributing to the rapid spread of COVID-19 once it enters a facility. The ventilation conditions described in the District of Columbia's Auditor's report is also concerning and will increase the rate of spread of the virus. The Department of Corrections' response to the Auditor's report includes D.C. DOC's own conclusion that the "current HVAC system has significant design problems that inhibit proper airflow." Because the virus can spread in an airborne state, ventilation is an important mitigator for the spread of the virus.

d. Management of the disease in the facility: People who have been diagnosed with COVID-19 (either because they exhibit consistent symptoms or because they obtained a positive test), need to be medically isolated to prevent the virus from being transmitted to other people in the facility population. Importantly, medical isolation differs from disciplinary segregation. It should be used as a public health measure that also attends to the medical needs of the individual; not used to deprive them of all freedom of movement. Ideally, people with COVID-19 will be medically isolated near medical units where they can receive clinical care and attention. In people who are older (>65) and with underlying medical conditions, the disease can progress extremely rapidly, so medical attention is critical.

The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected. The descriptions by inmates that there are day-long delays to see medical staff is highly concerning and will increase the risk of infection-related morbidity and mortality. The District of Columbia's Auditor's observation that the Department of Health does not conduct any inspections of the CTF is troubling, as regular compliance checks are essential to determining whether medical care is adequate.

i. **Sufficiency of isolation spaces**: Prisons are built to contain people, not diseases. Given how COVID-19 outbreaks have overwhelmed even the most sophisticated hospital systems nationwide, it is unlikely that the D.C. DOC will be adequately equipped or supported once someone in the facility becomes ill with COVID-19. Even mild disease requires close monitoring and that caregivers and/or healthcare personnel have personal protective equipment (PPE), including gloves, gowns, eye shields, and masks, that are not usually available in the D.C. DOC or are potentially in limited supply. Airborne isolation rooms are specially equipped with negative pressure to allow air flow from outside the room to inside. These negative pressure rooms should be used for people with diagnosed or suspected COVID-19 who have more severe disease or are at high risk of aerosolizing droplets (e.g. they are coughing frequently).

A COVID-19 outbreak poses particular risk to people with underlying chronic health conditions, including heart disease, lung disease, liver disease, pregnancy, diabetes, and suppressed immune systems. They have higher risk of becoming infected with COVID-19 if exposed and higher risk of complications and death if infected. People also need continuous access to treatment for their other underlying health conditions, which are at risk during a COVID-19 pandemic in the context of healthcare understaffing and reduced access to medications (if supply chains are interrupted).

The 2019 D.C. Auditor report suggests there is a single medical isolation space in CTF with negative pressure capacity, located in the Medical 82 unit. The same report noted that, at the time of the audit, the remainder of the 40 beds were nearly entirely filled (at 73% capacity), which would leave few beds available for COVID-19 patients. To say this is unacceptable is an understatement. Given that, as of March 27, 2020 there are around 1600 individuals in D.C. DOC custody, that means approximately 1600 individuals would rely on that single isolation room if they became infected with COVID-19. Clearly demand would outpace need. Individuals who could not be isolated in single spaces could be isolated in cohorts, but only if testing were widely available in the facility, which does not appear to be the case. These issues will culminate in people with COVID-19 infection: 1) remaining in communal settings to easily transmit to everyone in their housing unit or 2) requiring transfer to area hospitals, which will likely also be limited in the context of a community-wide outbreak. Limited bed space may also mean that inmates and staff will be deterred from reporting their symptoms, potentially delaying medical attention and resulting in preventable complications and possibly death.

ii. **Medical care for other health conditions:** Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

The commonplace neglect of, and delay in providing treatment to, individuals with acute pain and serious health needs under ordinary circumstances is also

strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under- prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic. The statement by two inmates that it can take "days" to receive medical attention is strong evidence that D.C. DOC is seriously ill-equipped and under-prepared, as the COVID-19 outbreak will require D.C. DOC to provide medical attention to a large number of people at once.

29. The above examples illustrate that the D.C. DOC remains unprepared to address the current COVID-19 pandemic. As the CDC acknowledges, even a prison operating precisely under its guidelines would be a far more dangerous environment than the community, given the mayor's directive to remain at home and business and school closures in place.

30. D.C. DOC's inability to adequately contain and treat COVID-19 is especially concerning for higher risk individuals, such as older adults and people with chronic illnesses such as diabetes, liver disease, pregnancy, heart disease, and lung disease. People with these particular characteristics are most susceptible to becoming seriously ill or even dying should they become infected with COVID-19.

31. There is true urgency to act on these facts now. Data from the US during other infectious disease outbreaks (e.g. influenza) and data from other countries during COVID-19 show that when prison systems are unprepared for pandemics, people in prison experience much higher rates of morbidity and mortality than even affected communities. Such crises within prisons endanger communities as a whole by increasing the overall number of cases and increasing pressure on hospitals. There is no current approved vaccine or antiviral medication treatment for COVID-19 so public health preparedness is the only tool we have.

32. Inadequate screening and testing procedures in facilities, including failing to test inmates who have demonstrated symptoms of COVID-19, increase the widespread COVID-19 transmission.

V. Conclusion and Recommendations

33. **The declarations provided by people currently incarcerated in CDF and CTF are alarming and make clear that conditions in the DC jails during this pandemic are dangerous.** It is my professional judgment that individuals placed in these jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These significantly higher risks include an elevated risk of serious illness (pneumonia and sepsis) and death. DC jails are ill-equipped to prevent COVID-19 from entering its facilities and woefully unprepared to prevent its spread within the facility.

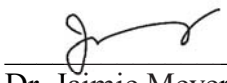
34. Reducing the size of the population in jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large.

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

36. This is especially important for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 65. Nonetheless, it remains the case, given the conditions in the DC jails, that everyone in the CDF and CTF is right now at serious risk of contracting COVID-19 and, if that occurs, of dying from it.

37. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for rapid and severe COVID-19 spread in these facilities is a matter of hours not days. Once a case of COVID-19 is identified in a facility, it is only a matter of time until there is a widespread outbreak. In the past several days, first one, then two, and now four, inmates in D.C. DOC custody have tested positive for COVID-19 with many inmates reportedly in quarantine. More cases are sure to follow because of under-resourced, under-staffed, or minimally implemented infection prevention and control measures.

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



Dr. Jaimie Meyer

March 29, 2020
Wilton, Connecticut

EXHIBIT A

CURRICULUM VITAE

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

Education:

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

Career/Academic Appointments:

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

Board Certification:

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

Professional Honors & Recognition:

International/National/Regional

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

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

Yale University

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

Grants/Clinical Trials History:

Current Grants

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

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

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

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

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

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

Past Grants

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

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

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

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

Pending Grants

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

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

International/National

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

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

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

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

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

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

Regional

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

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

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

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

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

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

International/National

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional

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

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

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

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

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

Professional Service:

Peer Review Groups/Grant Study Sections

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

2019 - present Reviewer, Yale DCFAR Pilot Projects

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

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

Advisory Boards

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

Journal Service

Editor/Associate Editor

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

Reviewer

2019 - present Reviewer, JAIDS

2012 - present Reviewer, Addiction Sci and Clin Pract

2012 - present Reviewer, Addictive Behav Reports

2012 - present Reviewer, AIDS Care

2012 - present Reviewer, Social Science and Medicine

2012 - present Reviewer, SpringerPlus

2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy

2012 - present Reviewer, Women's Health Issues

2012 - present Reviewer, Yale Journal of Biology and Medicine

2012 - present Reviewer, AIMS Public Health

2012 - present Reviewer, American Journal on Addictions

2012 - present Reviewer, American Journal of Epidemiology

2012 - present Reviewer, American Journal of Public Health

2012 - present Reviewer, Annals Internal Medicine

2012 - present Reviewer, BMC Emergency Medicine

2012 - present Reviewer, BMC Infectious Diseases

2012 - present Reviewer, BMC Public Health

2012 - present Reviewer, BMC Women's Health

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

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

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

American College of Physicians

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

American Medical Association

2005 - present Member, American Medical Association

American Medical Women's Association

2011 - present Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

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

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

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

Medical School Committees

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

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

Public Service

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

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

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

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

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

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

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

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

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

Chapters, Books, and Reviews

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

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

Peer-Reviewed Educational Materials

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

Invited Editorials and Commentaries

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

Case Reports, Technical Notes, Letters

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

Scholarship In Press

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

EXHIBIT B

J. MICHAEL HANNON *
DANIEL S. CROWLEY *†‡
PARTNERS

ANN-KATHRYN SO §
TALON R. HURST *§
ERIK H. FAWCETT ||
DAVIS C. RAJTIK †
ASSOCIATES

HANNON LAW GROUP, LLP
COUNSELORS AND ATTORNEYS AT LAW
333 8TH STREET NE
WASHINGTON, DC 20002
EST. MARCH 17, 2006

T (202) 232-1907 | F (202) 232-3704
www.hannonlawgroup.com

WILLIAM CLAYTON BATCHELOR *†
OF COUNSEL

* ALSO ADMITTED IN MARYLAND
† ALSO ADMITTED IN VIRGINIA
‡ ALSO ADMITTED IN MASSACHUSETTS
§ALSO ADMITTED IN NEW JERSEY
|| ADMITTED IN MARYLAND ONLY; UNDER SUPERVISION OF J. MICHAEL HANNON

March 25, 2020

VIA ELECTRONIC TRANSMISSION ONLY

Quincy L. Booth
Office of the Director
D.C. Department of Corrections

IMPLEMENTATION OF MAYOR'S ORDERS ON COVID-19

We present this letter on behalf of the bargaining unit for all D.C. Jail corrections officers, the Fraternal Order of Police Department of Corrections Labor Committee.

INTRODUCTION

Today the Mayor announced the number of positive COVID-19 infected persons in the District of Columbia increased by 46 new cases to a total of 183. Notably, of the new cases 13 are in their 20s, 12 are in their 30s, and only 7 are over the age of 60. The Mayor's update also reports the following:

> With ongoing community transmission, contact tracing is focused on positive cases associated with childcare facilities, schools and universities, healthcare facilities, senior care facilities, *correctional and detention centers*, and facilities serving individuals who are experiencing homelessness. Guidance will be published for healthcare providers, employers and the public to provide information on what to do if you have been diagnosed with or are a contact of someone who has COVID-19.

On March 19, our office sent an email to DOC regarding the quarantine of 50 inmates who came in contact with an infected U.S. Marshal at the Courthouse. (Attachment A). We received no response.

On the same date March 19, we sent a "Request for Information on Potentially Dangerous Conditions at the DOC Facilities" to DOC's General Counsel and to its HR Director. (Attachment B). The next morning, DOC's General Counsel responded: "DOC is preparing a response to your inquires and will contact you as soon as possible." We have received no response.

On March 23, 2020, the FOP/DOC Labor Committee delivered to the DOC leadership and posted throughout the D.C. Jail an Announcement regarding critical actions to be addressed

by the Labor Committee regarding COVID-19, as well as the failure to prosecute an inmate for the brutal beating of a corrections officer. (Attachment C).

Instead of communicating with the Union as requested on March 19, 2020, you issued a notice on the same date of March 23, announced at every roll call, falsely stating: "It has come to the agency's attention that employees of the DOC intend to engage in either a walkout and/or protest on the grounds of the DOC." Rather than communicating honestly with the Union on these critical conditions of work, you threatened the corrections officers with discipline. This action was clearly in retaliation for the Union presenting legitimate concerns about your failure to implement protections for inmates and corrections officers. This is not only an unfair labor practice and a prohibited personnel practice, but also a violation of the District of Columbia Whistleblower Reinforcement Act of 1998.

In the afternoon of yesterday, March 24, you summoned the FOP/DOC Labor Committee President Cpl. Benjamin Olubasusi to your office at the Reeves Center. Without notice to HANNON LAW GROUP, you put Deputy Mayor Kevin Donahue and Mayor Bowser on your speaker phone. The Mayor then falsely warned Cpl. Olubasusi that it is a "crime" for D.C. corrections officers "to walk out of the Jail." You asked Cpl. Olubasusi what the Union wants, as if our communications over the past 5 days were never read.

Also yesterday afternoon, HANNON LAW GROUP participated in a National Conference Call sponsored by the National Fraternal Order of Police on COVID-19. Speakers on the call included high-ranking experts from the Department of Homeland Security, FEMA, and the White House, as well as FOP State Representatives from all 50 states. The purpose of the call is to implement protocols for law enforcement officers and corrections officers nationwide. Highlights from the call are the following:

Increasing infections will reduce the number of officers on duty.

Loss of officers on duty will increase the work load on the uninfected officers.

The resultant lack of officers will lead to additional crime and risk in the corrections system.

PPE equipment is not being provided to officers nationwide.

Because "social distancing" is impossible in law enforcement, the infection rate among officers will be higher than the general population.

Coordination and Communication between and among political leaders and officers is the most important criteria to meet this challenge.

State health departments, which are in control of the distribution of PPE, must make law enforcement and corrections officers a priority group for receipt of PPE and education.

CONDITIONS AT THE D.C. JAIL

The FOP/DOC Labor Committee, its Shop Stewards, and its members walk the line in the D.C. Jail 24/7. You, Director Booth, are miles away at the Reeves Center, and your administrative staff remain behind glass walls and doors in the administrative section of the D.C. Jail, all in splendid isolation from the inmate population, with regular disinfection teams in gowns, gloves and masks. Here is the report of our members on conditions at the Jail:

1. There is no Communication and Coordination between DOC leaders and the FOP/DOC Labor Committee. Labor/Management meetings are repeatedly cancelled, including one meeting scheduled during this critical time period.

2. Inmates coming into the Jail are not screened for symptoms of COVID-19.

3. Corrections Officers receiving and discharging inmates have no PPE; however, they must have direct contact with these inmates.

4. Inmates continue to move within the Jail. Those inmates in the four restricted housing units must be escorted by hand by corrections officers without any PPE. Inmates in non-restricted housing units travel alone through the Jail as required for appointments. At latest count, there were 1,149 inmates in the Central Detention Facility and 509 in the Correctional Treatment Facility.

5. The corrections officers assigned to housing units have no masks, insufficient gloves, no gowns, no disinfectants, and no comprehensive cleaning occurs on a regular basis in these units. In each unit, one corrections officer is required to be out among the inmates at all times, without any protection.

6. Inmates are not required to engage in any of the behaviors which the Mayor recommends for the general population, such as “social distancing”, repeated hand-washing, and health monitoring.

7. Case workers must meet with inmates in small offices with no PPE or other distancing measures.

8. Inmates continue to engage in recreation in a common yard, also without social distancing or other protections from the spread of COVID-19.

9. Corrections officers enter the Jail three shifts a day. There is no distancing at entrances, no distancing at roll calls, no attempt to obtain or record health concerns of each officer.

10. When the D.C. Jail was forced to quarantine 65 inmates who were at risk to exposure to COVID-19 when they were at court, an ERT was designated to remove them from the general population to a “quarantine” housing unit. The

ERT members refused the assignment without provision of gowns and other appropriate PPE protection. They were ordered to remove the inmates with only masks and gloves. During the extraction, one of the members was spit upon by an inmate. Sgt. Alexander and Sgt. Graham were then removed from the ERT team and assigned to another post outside the Jail.

11. These inmates were not "quarantined" in any meaningful manner. They were housed two to a cell, and the corrections officers on the unit were not provided with any PPE or other means for protection against infections.

WHAT DO WE WANT?

Both you and the Mayor asked Cpl. Olubasusi "What do you want?" While this crisis should not be a time of legal technicalities, we choose to view this as a willingness by management to bargain over the terms and conditions of employment of our officers. The following is an enumeration of our requests. This list, as we all know, is subject to change as the pandemic changes.

1. A Daily Meeting among the Labor Committee, its Shop Stewards, its counsel and the DOC Director, Deputy Director, and its counsel to discuss conditions and responses to COVID-19;

2. A COVID-19 Protocol for officers and inmates including the following:

   Restricted movement of inmates

   Distancing among inmates/inmates, officers/officers, and officers/inmates

   Incident Reporting of officers and inmates' symptoms of illness

3. Regular Disinfection of the CDF and CTF

4. Priority for PPE for officers

5. Discontinuation of inmate transport for court appearances

6. 14-day Quarantine for new inmates

7. Establish a quarantine unit

8. Establish an on-site testing unit for those meeting CDC test criteria, including persons living in the household of a corrections officer

9. Treat COVID-19 among officers as duty-connected

In addition, we require production of all videotape and investigative reports of the assault on Officer Sulaimon T. Abiola so that we may investigate the assault and present it to the U.S. Attorney's Office for prosecution. Corporal Ayodeji Falade, Officer Olumide Popoola, Officer John Lewis, Officer Rahsard Roberts, Officer Abdou Alaguitouni and Corporal Damian Barnes and any other suspended officers must be returned to work pending your investigation into the assault.

CONCLUSION

We agree with Mayor Bowser's sentiment that these are difficult times, and we should all be pulling on the same rope. However, cooperation is a two-way street. We note with a great deal of concern that at today's news conference, the Mayor stated that corrections officers do not require PPE because they do not provide medical care.

The District of Columbia cannot treat its corrections officers as chattel. Already, the life expectancy among corrections officers nationwide is among the lowest in law enforcement.

Thank you for your courtesies.

Sincerely,

s/ J. Michael Hannon

J. Michael Hannon

EXHIBIT 2

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

On this 29th day of March, 2020, I hereby declare:

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

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

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

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

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

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

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

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

8. I have reviewed the March 25, 2020, letter sent from the union to the D.C. DOC, spelling out in the public health dangers at the D.C. DOC. If accurate, such conditions heighten the urgency of addressing these problems.

9. For example, if true, the grievance's allegations that correctional officers responsible for receiving and overseeing inmates do not any, or sufficient, personal protective equipment (PPE) for use when indicated,[1] and that officers are not required to participate in social distancing during shift changes, raise serious concerns that those officers may contract and transmit COVID-19 to their co-workers, families, and inmates in the facility. Accordingly, reducing the number of inmates with whom those

[1] Grievance at 3.

correctional officers must interact will reduce the risk that those correctional officers will contract COVID-19 or transmit it to others in the community.

10. I have also reviewed the declarations of four inmates detained in DOC facilities. As with the union's grievance letter, the inmates' allegations, if true, heighten the urgency of taking immediate and aggressive action. For example, the housing of multiple inmates within a single cell and lack of adequate cleaning supplies increases the probability that COVID-19 is already spreading throughout the facilities. Accordingly, housing only one inmate per cell and either providing sufficient cleaning supplies or reducing the amount of space requiring thorough cleaning will decrease the virus's ability to spread within DOC facilities.

11. In light of the conditions described in the documents that I have reviewed, the four confirmed cases of COVID-19 inside of DOC facilities, and the apparent resource-shortages facing the DOC, I am even more firmly convinced that downsizing the inmate population as much as possible will reduce the risk of contraction and transmission of COVID-19—and the attendant risks of serious harm and death—within DOC facilities and the communities around them.

12. Thoughtful downsizing should be implemented in tandem with aggressive, responsive prevention measures that are developed and guided by public health and medical experts.

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

resources (ER beds, general hospital beds, ICU beds)—avoiding disease in this population is a critical contribution to public health overall.

14. Downsizing jail populations by releasing high risk individuals and others the court system deems eligible for release will help to "flatten the curve" overall—both within the jail setting and without. Early reporting on the impacts of COVID-19, based in part on preliminary data emerging from China, seemed to indicate that the virus' impact would remain relatively mild for younger people. Recent data released by the CDC suggests that this initial narrative is incorrect, and that adults aged 20-44 also face a risk of experiencing severe health outcomes as a result of contracting the disease. The CDC released data based on the reported cases in the United States between February 12 and March 16, 2020. This data showed the thirty-eight percent (38%) of the hospitalizations from coronavirus occurred in patients under 55 years old.[2] French health officials have released statements saying that half of intensive care admission in that country involve individuals under 65. In the Netherlands, half of intensive care admissions were for people under the age of 50.[3]

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

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

---

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

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

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

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

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

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

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

e. **Personal Hygiene.** The jail must be required to provide hand soap, disposable paper towels, and access to water to allow residents to wash their hands on a regular basis, **free of charge** and ensure replacement products are available as needed. Correctional staff should be allowed to carry hand sanitizer with alcohol on their person, and residents should be allowed to use hand sanitizer with alcohol when they

are in locations or activities where hand washing is not available.

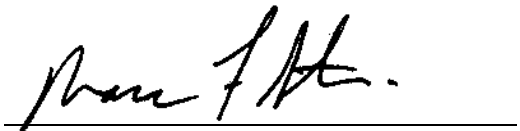
i. Inmates should be permitted access to cleaning supplies so they may clean their individual cells. This will both keep cells cleaner, and also stem panic amongst the incarcerated population.

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

17. The measures I propose above are baseline steps to help slow the spread of COVID-19 in all facilities. However, each correctional facility has its own unique combination of physical structure and layout, operations, policies, logistics, inmate characteristics, and staffing factors that determine what additional measures may be necessary to minimize the spread of COVID-19. Only a public health expert who is able to review a particular facility firsthand can account for all of those factors and provide a meaningful and facility-specific opinion about what additional measures are necessary to reduce the risk of transmission.

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

Executed on March 29, 2020.



Marc Stern, MD MPH

EXHIBIT A

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

March, 2020

marcstern@live.com
+1 (360) 701–6520

SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

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

Regional Medical Director, New York Region, 2000 – 2001

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

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

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

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

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

Acting Facility Medical Director, 1998 – 1999

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

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

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

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

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

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

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

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

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

Staff Physician, 1988 – 1990

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

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

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

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

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

FACULTY APPOINTMENTS

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

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

OTHER PROFESSIONAL ACTIVITIES

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

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

REVIEWER/EDITOR

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

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

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

RECOGNITION

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

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

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

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

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

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

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

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS/ABSTRACTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pristach CA, Donoghue GD, Sarkin R, Wargula C, Doerr R, Opila D, **Stern M**, Single G. *A Multidisciplinary Program to Improve the Teaching Skills of Incoming Housestaff.* Acad Med. 1991;66(3):172–174

Stern MF. *Diagnosing Chlamydia trachomatis and Neisseria gonorrhea Infections.* (letter) J Gen Intern Med. 1991;6:183

Stern MF, Fitzgerald JF, Dittus RS, Tierney WM, Overhage JM. *Office Visits and Outcomes of Care: Does Frequency Matter?* Poster Presentation, Society of General Internal Medicine Annual Meeting, Seattle, May 1991. Clin Res 1991;39:610A

Stern MF. *Cobalamin Deficiency and Red Blood Cell Volume Distribution Width.* (letter) Arch Intern Med. 1990;150:910

Stern M, Steinbach B. *Hypodermic Needle Embolization to the Heart.* NY State J Med. 1990;90(7):368–371

Stern MF, Birkhead G, Huber R, Schwartz J, Morse D. *Feasibility of Hepatitis B Immunization in an STD Clinic.* Oral Presentation, American Public Health Association Annual Meeting, Atlanta, November 1990

EXPERT TESTIMONY

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

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

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

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

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

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

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

EXHIBIT 3

DECLARATION OF RACHEL CICUREL
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Rachel Cicurel. I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since October 3, 2016. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a trial attorney at PDS is to represent people in criminal proceedings in the District of Columbia Superior Court.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. Since March 1, 2020, I have visited CTF two times.

5. While I was in that facility, I observed the following:

    a. On March 1, 2020, I visited CTF. I observed staff at CTF acting in their normal manner regarding entrance protocol and cleanliness. When I entered the facility, I provided my PDS identification card and the required visitor paperwork to the staff behind the first window. I was not asked about my current health or the health of those around whom I had recently been. My temperature was not taken, and I was not asked if I had recently been out of the country. After receiving a visitor pass, I put my personal items and shoes through the metal detector and prepared to be screened. The screening and pat down processes were normal. I did not observe staff members wearing masks. I was permitted to bring in my own cleaning wipes, but did not observe CTF staff wiping down any surfaces or taking any other notable measures to keep the facility particularly clean. Despite the global epidemic, everything at CTF seemed to be business as usual.

    b. On March 3, 2020, I visited CTF. I observed nothing out of the ordinary. The entrance procedures were standard, with no additional screening about my recent whereabouts or current health. The staff were not wearing masks, not wiping down surfaces, and did not appear to be taking any extra measures to keep the facility clean. However, I was allowed to bring my own wipes into CTF with me.

6. Since last visiting CTF, I have spoken further to clients. Through those conversations, I learned the following:

   a. On March 19, 2020, I spoke with Client A at CTF. I learned that Client A was sick with a cough, but that it was taking many days, and sometimes over a week, to obtain a medical visit. I learned that at least 15 to 18 people on the 50-and-over block had coughs or colds. I learned that the 50-and-over block at CTF had been provided with almost no information about coronavirus or how to combat it; specifically, the only instruction given to the 50-and-over block was to wash their hands. Reminders for residents to wash their hands came about once per day. However, the residents had not been given soap or hand sanitizer. Rather, in order to wash their hands, the residents had to purchase their own soap to use. As a result, some residents were using shampoo to wash their hands in lieu of anything else; others had nothing with which to wash their hands. I learned that the common areas were cleaned once each day, but that CTF had no limit imposed regarding how many people could use the common areas at one time. Instead, an entire unit could be in the common area at once. I learned that the residents had been given Windex to clean their cells approximately once every three days, but had not been given any cleaning products with bleach or chemicals strong enough to actually sterilize the cells. When the supplies ran out, the residents had to wait several more days for supplies to be restocked. Meanwhile, only some of the staff were wearing gloves and masks; others were not.

   b. On March 22, 2020, I spoke with Client B at CTF. During the conversation, I could hear Client B's deep, guttural cough, as he had to stop the conversation several times to cough extensively. I learned that a few days prior, Client B had sought medical help for chest pains, a cough, and the chills. At the time, Client B's body ached, and a staff member took Client B to the medical unit. The medical unit determined that Client B also had a fever, but did not test Client B for COVID-19 or quarantine him from other residents. Instead, the medical staff specifically told Client B that he did not have COVID-19, failed to provide an explanation as to how they had come to such a conclusion without testing him, and placed him back in his unit. I also learned that on the unit, none of the residents had been given any soap. Although soap dispensers had been added to the units about two weeks prior, they had been removed the previous week. Residents had been informed that the soap was not for them, but only for staff. Cleaning supplies was also scarce. I learned that whether or not the residents were given supplies to clean depended on which staff members were on duty, and that even when supplies was provided, residents were given three to four cleaning wipes total—not three to four wipes per person, but three to four wipes for the entire unit to share—to clean the unit's common area. The residents were responsible for cleaning their own cells, but had gone days without cleaning supplies. The supplies had run out, but had not yet been replaced.

c. On March 25, 2020, I spoke with Client B at CTF. I learned that Client B had again gone to see the medical unit a few days prior with at least five other men from his unit, all of whom were coughing. At that time, the medical unit checked Client B for the flu by swabbing inside his nose with Q-tips, but did not take his temperature. Despite being sick, Client B had been permitted to continue to work in the kitchen. He had worked at the end of last week, despite having a fever, and at the beginning of this week, despite still being congested, which I could hear in his voice during the conversation. No masks were available to those working in the kitchen even though a group of about 20 people work in the kitchen together, without much space between them, as they prepare three meals each day. Additionally, I learned that Client B's unit was void of any cleaning products, and several days had passed since the residents on his unit had been able to clean. This was particularly concerning because a resident had been quarantined last week, but had already come back to Client B's unit.

d. On March 25, 2020, I also spoke with Client A at CTF. I learned that Client A had been having night sweats and continuing to find himself light-headed. He suffers from asthma, and had put in a medical request for an asthma pump several nights before. However, since he had still not been called to the medical unit, he intended to file a grievance form to attempt to obtain the asthma pump. I learned that residents were not being prevented from, or even advised against, eating or spending time in large groups, and crowds of people had been congregating together. Nonetheless, the common areas were only being cleaned with Windex—nothing stronger and nothing with bleach. I learned that approximately 25 to 30 people on the 50-and-over block had been repeatedly asking staff for soap, but staff were continuously refusing to provide any. No hand sanitizer was available, either, and residents who ran out of soap had to borrow from one another. Additionally, I learned that staff had not been wearing masks or gloves. During our conversation, several staff members were seen wearing neither masks nor gloves. I learned that a sizeable number of residents on the 50-and-over unit had coughs, and several staff members had coughs, as well. Client A could think of four specific officers with coughs and two who were involved in food preparation.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 26th day of March 2020, in Washington, D.C.

Rachel Cicurel
Staff Attorney
Public Defender Service for DC
633 Indiana Ave. NW
Washington, DC

EXHIBIT 4

DECLARATION OF EDWARD BANKS

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

1. My name is Edward Banks. I am 48 years old. I am currently incarcerated at the Central Detention Facility in Washington, D.C., in the Southwest 2 unit. I have been at the jail since August 2019.

2. I am very worried about my risk of contracting coronavirus. I do not believe the jail is taking enough precautions to keep me safe.

3. [redacted]

4. For example, on March 24, 2020, at around 5:30 pm, I had a legal visit in visiting hall 2 at the jail. When I was about to enter the visiting hall, I was patted down by an officer. Before he pat me down, the officer was eating dinner with his bare hands. The officer stopped eating dinner and then pat me down with hands that had just been in or near his mouth.

5. [redacted]

6. Every day, inmates working in food delivery deliver a tray of food to each cell in my unit. They reuse hard plastic trays every day. They put the trays in each slot in our cells with gloves on. The slots that they put the food trays in are slots that inmates use to talk to each other. People put their mouths close to the slots to speak through their cell doors. When food trays get delivered, the hands of the people delivering the food come in contact with surfaces that people put their mouths very close to.

7. There is no hand sanitizer available on our unit.

8. The jail gave us a single bar of soap a couple of weeks ago.

9. The jail is not cleaning our cells. They do not wipe down surfaces with disinfectant.

10. The correctional officers on my unit do not wear masks or gloves regularly.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 25th day of March 2020, in Washington, D.C.

Edward Banks
Central Detention Facility
1901 D Street SE
Washington, DC 20003

EXHIBIT 5

DECLARATION OF KEON JACKSON

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

1. My name is Keon Jackson. I am 36 years old. I am currently incarcerated at the Correctional Treatment Facility in Washington, D.C. I am in the RSAT unit. I got on this unit on February 25, 2020.

2. Our unit has a television and the men on our unit regularly watch the news. We see the situation that is unfolding and we are afraid. We do not think CTF and the Department of Corrections is taking coronavirus seriously. In fact, I know that they are not taking it seriously, because when I and other inmates raise our concerns about the virus, the counselors on our unit tell us that we should stop watching the news. The counselors say that the media is blowing the virus out of proportion.

3. Our unit has "group" sessions every day, usually four times a day for around an hour to an hour and a half. In these group sessions, all of the men on the unit come out of our cells and sit in a circle. We sit in plastic chairs in a big group of around 30 people. In these groups, we have to sit less than a foot apart.

4. I have seen on the news that President Trump and health officials have said that people should not gather in groups of more than 10 people and that we should be six feet apart.

5. Several times I have raised the guidance about not gathering in groups larger than 10 and staying six feet apart with DOC staff and they told me I was hyping this up and told me to stop watching the news.

6. As of March 24, 2020, our unit was still meeting in this large group.

7. In the group sessions that we have every day for several hours, we have many people from outside CTF coming every day. Around five to six people a day come from the outside, including clinicians, people from Narcotics Anonymous, other people who lead programs. These outside participants bring their own pens and papers. In our group sessions, we have to pass these pens and papers around, so that by the end of a session, around 30 men have touched these objects.

8. On March 16, 2020, I was in the RSAT unit and there were several people from outside CTF, like clinicians and programming staff, who had entered the unit. Then I heard an announcement over the CTF loudspeaker asking everyone who had entered the CTF that morning to come back down to security for coronavirus screening. CTF had already let in people from outside the facility into our unit before screening them.

9. I have also seen on the news that people should be washing their hands regularly. On the RSAT unit, we have sinks in our individual cells. As of around March 21, 2020, CTF

officers started locking our cells during group sessions. There is no sink in the RSAT unit common area, so for several hours a day, we are unable to wash our hands.

10. CTF also has not given us the soap or cleaning products we need. March 21st, was the first time CTF gave me a free bar of soap, and I have been on my unit since February 25th. If you can't afford to buy soap at the commissary, you don't have any soap except for the single bar they gave us on March 21st.

11. When I came on the unit in February 25, 2020, there was a hand sanitizer dispenser on the wall that inmates in the RSAT unit could use. Recently though, CTF officials took the dispenser off of the wall and placed it behind glass so that only officers could use hand sanitizer.

12. My unit has also been giving us cleaning supplies but they are watered down. My unit has also been using the same old mops for months and they are molding and stinking up the unit.

13. CTF has not been cleaning the showers any more frequently. They have cleaned the showers in my unit once or twice since I have been on the unit for a month.

14. I am especially worried about my safety at CTF. [redacted]

15. Because I am worried about my safety, I filed an emergency grievance with Director Quincy Booth on March 24, 2020. I want CTF and the Department of Corrections to take the threat the virus poses to us seriously and to do everything they can to keep us safe.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 25th day of March 2020, in Washington, D.C.

Keon Jackson
Correctional Treatment Facility
1901 E Street SE
Washington, DC 20003

EXHIBIT 6

DECLARATION OF ERIC SMITH

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

1. My name is Eric Smith. I am 50 years old. I am currently incarcerated at the Correctional Treatment Facility in Washington, D.C., on the C2B unit.

2. CTF is very unsafe. My unit is especially unsafe.

3. My unit, C2B, is right next door to the unit that CTF has moved people they think have coronavirus into. This unit is not sealed off from our unit. The same air goes back and forth between the quarantine unit and our unit. I know this because I can talk to the people in the quarantine unit from my unit through the vents and I can feel the air traveling back and forth between the units. The ventilation in this facility is very poor.

4. My unit is not at all sealed off from the quarantine unit. There is a locked door separating the units. Both my unit and the quarantine unit have televisions, but there is only one remote for both televisions. CTF staff have been bringing the same remote control back and forth between the quarantine unit and my unit.

5. There is a man on my unit who has been coughing nonstop and CTF staff have not done anything about him. He is coughing and he looks very sick. CTF staff have not come to see him. It takes days before anyone can get medical staff to come see them, even if you say you are having trouble breathing. I have seen these delays on my unit.

6. The sanitation on my unit is very poor, and CTF is not taking measures to improve it. For example, every day they bring a big cooler of juice for people on the unit to drink. All day long inmates dip their cups into the top of the juice cooler to get ice out of it. If anyone on our unit has the virus, all of us either already have it or will get it soon.

7. There is no hand sanitizer on our unit. There used to be a dispenser but now it's behind glass for only staff to use.

8. CTF gave us one bar of soap, once.

Eric Smith

9. I am very worried about getting the virus. I am 50 years old. [redacted] I want the Department of Corrections to ensure my safety.

Executed on the 25th day of March 2020, in Washington, D.C.

Eric Smith
Correctional Treatment Facility
1901 E Street SE
Washington, DC 20003

EXHIBIT 7

DECLARATION OF D'ANGELO PHILLIPS

I, D'Angelo Phillips, certify under penalty of perjury that the following statement is true and correct pursuant to 28 U.S.C. § 1746.

1. My name is D'Angelo Phillips. I am 24 years old. I am currently incarcerated at the Central Detention Facility in Washington, D.C. I am in the Southwest 2 unit.

2. The jail is barely doing anything to protect us from the virus.

3. We have no hand sanitizer at the jail. I have seen one or two staff wearing a mask, but none of the inmates have any masks available to us.

4. I have put in requests to see the medical unit, but it takes days before you get a visit with anyone from the medical unit.

5. I went to Superior Court on March 13, 2020 and I was in the C-10 courtroom. About a week later, the jail said that they were going to quarantine people who had recently been in C-10 because of a Marshal who tested positive for the virus. But they didn't put me in quarantine, even though I was in C-10 on March 13th.

6. The jail did move two people from my unit into the quarantine unit because they suspected they might have the virus. Those two people were gone for about a week but now they are back on the unit.

7. Jail staff is not doing anything additional to clean our unit. Inmate details come in and sweep the unit, but that's it.

8. Since I got to the jail in March, the jail has sprayed mace several times in the facility. This causes everyone to cough and keep coughing until the mace goes away.

9. [redacted]

Executed on the 25th day of March 2020, in Washington, D.C.

D'Angelo Phillips
Central Detention Facility
1901 D Street SE
Washington, DC 20003

EXHIBIT 8

DECLARATION OF DANIEL D. POND
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Daniel D. Pond, I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Community Defender Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since January 9, 2017. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a staff attorney at is to represent clients in a variety of matters, including prisoners' rights issues.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. Since March 1, 2020, I have visited CDF twice and CTF twice.

5. While I was in those facilities, I observed the following:

    a. On March 11, 2020, I visited CDF. I did not observe DOC staff at the entrance monitoring, questioning or taking the temperature of any visitors. My temperature and the temperature of other visitors were not being taken at that time. I did not observe DOC staff wearing masks. I did not observe soap or hand sanitizer for visitors apart from the hand soap in the men's restroom. I did not observe staff wiping down any surfaces. I noticed no differences from any of my previous visits over the years.

    b. On March 12, 2020, I visited CTF. I observed DOC staff at the entrance asking visitors (1) if they had recently had a fever, dry cough or shortness of breath, (2) if they had recently travelled to China, South Korea or Italy, or (3) if they had recently been in contact with a person exhibiting those symptoms or who had travelled to those countries. My temperature and the temperature of other visitors were not being taken at that time. I did not observe DOC staff wearing masks. I did not observe soap or hand sanitizer for visitors apart from the hand soap in the men's restroom. I did not observe staff wiping down any surfaces. No staff, residents or visitors were observing 6 foot social distancing. I did observe posted notifications about slowing the spread of COVID-19, but apart from those posted

notices and the three question form at the entrance, I noticed no differences from any of my previous visits over the years.

c. On March 17, 2020, I visited CTF. I observed DOC staff at the entrance asking visitors (1) if they had recently had a fever, dry cough or shortness of breath, (2) if they had recently travelled to China, South Korea or Italy, or (3) if they had recently been in contact with a person exhibiting those symptoms or who had travelled to those countries. My temperature and the temperature of other visitors were taken before being allowed in. I did observe one or two DOC staff members wearing masks, but dozens of others weren't. DOC staff members who were manning the x-ray machine and conducting pat-downs were wearing latex gloves, but dozens of other staff members weren't. I did not observe soap or hand sanitizer for visitors apart from the hand soap in the men's restroom. I did not observe staff wiping down any surfaces. No staff, residents or visitors were observing 6 foot social distancing. I did observe posted notifications about slowing the spread of COVID-19, but apart from those posted notices and the three question form at the entrance, I noticed no differences from any of my previous visits over the years.

d. On March 17, 2020, I also visited CDF. I observed DOC staff at the entrance asking visitors (1) if they had recently had a fever, dry cough or shortness of breath, (2) if they had recently travelled to China, South Korea or Italy, or (3) if they had recently been in contact with a person exhibiting those symptoms or who had travelled to those countries. My temperature and the temperature of other visitors were taken before being allowed in. I did observe one or two DOC staff members wearing masks, but dozens of others weren't. DOC staff members who were manning the x-ray machine and conducting pat-downs were wearing latex gloves, but dozens of other staff members weren't. I did not observe soap or hand sanitizer for visitors apart from the hand soap in the men's restroom. I did not observe staff wiping down any surfaces. No staff, residents or visitors were observing 6 foot social distancing. I did observe posted notifications about slowing the spread of COVID-19, but apart from those posted notices and the three question form at the entrance, I noticed no differences from any of my previous visits over the years.

6. While I was in those facilities, I conducted legal visits with my clients. Through those meetings, I learned the following:

a. Cells were not being cleaned or disinfected by staff, professional deep cleaners, or residents working detail. Residents were responsible for all the cleaning, washing and disinfecting of their own cells. For residents with cellmates, it proved difficult to properly clean and disinfect cells if the cellmate had not bought in to the necessity of the cleaning. If residents did not proactively wash, clean and disinfect

their own cells their cells would not be washed, cleaned or disinfected at all. Clients I spoke with had soap, but it was soap that they purchased themselves from commissary, not provided to them by DOC. Disinfectant was not provided or available to any of the residents I spoke with. Luckily none of my clients were sick at that time. Common areas were not being cleaned any more often or thoroughly than any other more 'normal' time. No one in either facility was practicing 6 foot social distancing.

b. Through my discussions with clients at both facilities I learned that although there is a high level of awareness about COVID-19 among staff and residents in the DOC, at the time of my visits and conversations no concrete action was being taken whatsoever to keep people healthy apart from screening visitors at the entrance.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 26th day of March 2020, in Washington, D.C.

Daniel D. Pond
Staff Attorney
Public Defender Service for DC
633 Indiana Ave. NW
Washington, DC

EXHIBIT 9

DECLARATION OF **SAMUEL CYPHERS**
INVESTIGATIVE INTERN AT THE PUBLIC DEFENDER SERVICE

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

1. My name is **SAMUEL CYPHERS**. I make these statements based upon my personal knowledge.

2. I am an investigative intern for the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since **February 3, 2020.** PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as an investigative intern at PDS is to assist in the preparation of trial cases through witness interviews, investigation, and reviewing records.

3. As part of my duties as an investigative intern at PDS, I regularly conduct legal visits with people in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. Since March 1, 2020, I have visited **CDF and CTF one time each.**

5. While I was in those facilities, I observed the following:

    a. On **March 10, 2020,** I visited **CTF**. I observed the standard screening process for entering the facility. I was not asked any additional questions about my health or recent travel, nor was I screened for symptoms of COVID-19. Within the facility, I did not see any staff members with masks or gloves. I did not see any soap or hand sanitizer for visitors. I did not see staff members wiping down surfaces. Everything appeared to be functioning the same way I had seen it function in February. I did not observe any precautions being taken to prevent the spread of COVID-19.

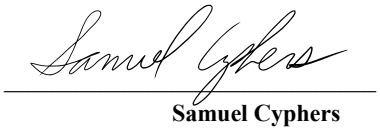
    a. On **March, 20, 2020,** I visited **CDF**. I observed two people sitting before the security checkpoint wearing gloves, but not masks. I did not see any readily available soap or hand sanitizer in the lobby area. I observed 5 to 6 people exit from the security checkpoint. None of these people had on gloves or masks. The DOC employee who brought me records likewise lacked gloves or a mask. After she gave me the records, she re-entered the facility without being screened. I do not know what the protocol to enter the facility is because I did not seek entrance past the lobby.

6. I conducted a legal visit with a PDS client who is currently incarcerated at CTF via phone. Through that meetings, I learned the following:

a. Client said there are between 5 and 8 people on his unit that are currently ill, and several of them are coughing. Client said all the people who are sick on his unit, including himself, went to medical together on Friday, March 20, and on Sunday, March 22. Client said cleaning products, including soap and disinfectant, are no longer available to residents at CTF. Client said the last time they were able to clean their cells was days before March 25.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the **26** day of March 2020, in Washington, D.C.



Samuel Cyphers
Investigative Intern
Public Defender Service for DC
633 Indiana Ave. NW
Washington, DC

EXHIBIT 10

DECLARATION OF JOSEPH WONG
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Joseph Wong. I make these statements based upon my personal knowledge.

2. I am a supervising attorney in the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since February of 2020 and as a PDS staff attorney since October of 2013. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a trial attorney at PDS is to represent people in criminal proceedings in the District of Columbia Superior Court.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

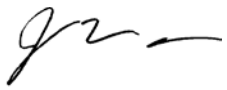
4. Since March 1, 2020, I have visited CDF one time.

5. While I was in CDF, I observed the following:

    a. On 3/11/20, I visited CDF. I observed that there were no changes to the protocol for entering the facility. Visitors were not asked any questions about their health or screened in any way, nor were the security staff engaged in any visible precautions such as wearing masks or gloves or sanitizing surfaces. The process included security staff going through personal belongings of visitors prior by hand and patting down visitors with their hands. I do not recall the officers conducting the pat downs or searching through personal belongings wearing gloves. I do not recall observing any available soap or hand sanitizer stations for visitors.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 25th day of March 2020, in Washington, D.C.



Joseph Wong
Supervising Attorney
Public Defender Service for DC
633 Indiana Ave. NW

Washington, DC

EXHIBIT 11

DECLARATION OF RONALD B. RESETARITS
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Ronald B. Resetarits. I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since September 2014. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a trial attorney at PDS is to represent people in criminal proceedings in the District of Columbia Superior Court.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. On March 11, 2020, I entered CDF to conduct several legal visits. When I entered CDF, there was no screening or questionnaire related to COVID-19. I saw no changes at all related to COVID-19 when I entered the jail for my legal visits on March 11, 2020. When I was finished with my legal visits and exited the jail, I saw that jail officials were setting up a table in the jail entrance area.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 25th day of March 2020, in Washington, D.C.

Ronald B. Resetarits
Staff Attorney
Public Defender Service for DC
633 Indiana Ave. NW, Washington, DC

rresetarits@pdsdc.org

202-824-2406

EXHIBIT 12

DECLARATION OF EILEEN JOHNSON
INVESTIATIVE INTERN AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Eileen Johnson. I make these statements based upon my personal knowledge.

2. I am an investigative intern for the Parole Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since December of 2019. Prior to joining the parole division, I was an investigative intern for the Trial Division at PDS from 6/15/2019 to 11/15/2019. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as an investigative intern at PDS is to assist in the preparation of parole cases through witness interviews, investigation, client meetings, and record collection and review.

3. As part of my duties as an investigative intern at PDS, I regularly conduct legal visits with people in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. Since March 1, 2020, I have visited CDF three times and CTF two times.

5. While I was in those facilities, I observed the following:

    a. On March 17, 2020 around 8:30 AM, I visited CDF. In the entrance area, there was a table set up with two men who were asking visitors to fill out forms in order to enter. On the form, I had to check off that I hadn't been having any symptoms and that I hadn't had any contact with anyone who had traveled outside the country. I observed one of the men that was sitting at the table eating as he gave out the forms. I don't remember whether either was wearing a mask or gloves. Right outside the door to enter security, there was a nurse stationed who was taking temperatures with a forehead thermometer. As I proceeded to the nurse's station, I witnessed an argument break out between the nurse and the woman who usually sits on the third floor visiting room. The woman is older and has short hair. I saw the nurse try to take the woman's temperature. As soon as the nurse brought the thermometer close to the woman's face, the woman yelled at her, asking why she was getting so close to her face without wearing gloves. I observed the nurse not wearing gloves. I can't recall if she was wearing a mask. I then heard the nurse yell back that she didn't need to wear gloves because she

wasn't touching anyone. The woman said she did not believe the nurse and continued to yell at her and to refuse the thermometer. She then commented that she was going to report the nurse for not wearing gloves. The nurse did not put on gloves and the woman proceeded into the security area. The nurse then commented to me that taking temperatures was only a "cosmetic" step anyway and that the jail was doing it only to make visitors *feel* safer. I felt uncomfortable with the nurse getting so close to my face without wearing gloves but I let her take my temperature so that I would be allowed to enter the facility. I observed her continue to take temperatures without gloves and never saw her look at the thermometer to actually check the temperature reading. I then proceeded into the security area. The scanner seemed to be broken so I was instructed to place my items in a bin. A CO then went through the bin. I can't remember if the CO was wearing gloves. I entered the scanner as usual. I observed one security officer wearing a mask in the lobby area. I did not observe any other COs wearing masks inside the facility. There was a hand sanitizer dispenser in the lobby that I used before starting my visit. I then proceeded to the second floor to start my visit. Because it was before 9, my partner and I were the first ones to that floor. When we got there, we observed a female CO wiping down the area where the CO sits in the visiting area. She told us to sit down and we waited for approximately ten minutes while she cleaned every inch of her station. I did not see this CO or any other CO wipe down any other surfaces during my visit. The CO then assigned us to room 2. Before leaving the lobby, I commented to the CO that I had brought my own wipes to wipe down our visiting room, just as she had wiped down her area. She responded that that was a good idea on my part. When we got to the visiting room, I wiped down the table and all three chairs with the wipes I had brought. There was no hand sanitizer or other cleaning product in my visiting room or in any of the others that I could see. I did not observe any hand sanitizer or other cleaning product in the waiting area of the second floor. In between clients, I went to the bathroom on the second floor. There was soap in the bathroom. After concluding my visits, I left the second floor and went to the first floor to wait for Ms. Boykin to come down with the medical records I had requested. While waiting, the female CO that was wearing the mask started to speak to me and another CO about how she was worried about coronavirus. She said she was really scared because she heard a CO had died of coronavirus somewhere else and that she did not feel safe from the virus. After getting the records from Ms. Boykin, I departed the facility around 1 PM.

b. On March 11th, 2020, around 9 AM, I went to CTF for a parole final revocation hearing. I did not have to do anything out of the ordinary in order to enter CTF. Final revocation hearings happen in an area of the jail near the activity center and below the basketball courts, judging by the noise. I observed hand sanitizer in the large room where the legal team waits. There was also soap in the bathroom. There was no hand sanitizer in the client holding rooms when I entered them to meet with my client. There was no hand sanitizer in the smaller room where the

hearing took place. I did not observe any staff members wiping down any surfaces.

c. On March 10th, 2020, around 5 PM, I went to CDF for a client visit. I had not been expecting to go on the visit so I did not bring any cleaning supplies. I felt uncomfortable using the visiting room without cleaning it first. During my time at CDF that day, I did not observe any staff members wearing a mask or gloves. I saw hand sanitizer in the lobby but did not see it on the visiting floor or in the visiting rooms. I did not observe any COs wiping down any surfaces.

d. On March 2nd, 2020, around 11 AM, I went to CDF for a client visit. I did not observe any surfaces being wiped down. There was hand sanitizer in the lobby but not anywhere else in the facility. I did not have to do anything out of the ordinary to enter the facility.

e. On March 2nd, 2020, around 1 PM, I visited a client at CTF. I did not observe any staff members wearing masks in the entrance or security areas. I did not observe any COs wearing gloves. I did not observe any hand sanitizer in the entrance or security areas. I did not observe any COs wiping down any surfaces. I proceeded to the second floor visiting area. I wanted to wash my hands because I had come to CTF from the jail but was told there was no bathroom on that floor. I did not see any hand sanitizer to use so I did not clean my hands.

6. While I was in those facilities, I conducted legal visits with PDS clients. Through those meetings, I learned the following:

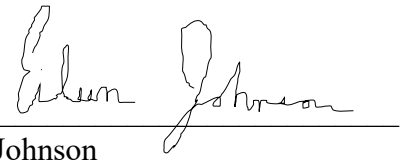
a. According to one client at CDF, multiple people were sick on his tier. He said that he had to buy cleaning products because what was provided was not effective. This client works in the kitchen and thus touches the food of hundreds of people each day. He was dressed in his white work uniform when I met with him and was not wearing a mask. I did not ask if he had access to a mask for his kitchen work.

7. As a parole division intern, I frequently communicate closely with family members of PDS clients. Through conversations with family members, I learned the following.

a. On March 8th, 2020, I received an email from a client's girlfriend. In her email she said, "I know you are aware of the virus going around, inmates are sick of [sic] there and not being treated properly. They have nothing to sanitize there [sic] area. I'm afraid of him getting sick being over there." I followed up by text message to get more information and received the following information from the client's girlfriend: "Some of the guys have the flu and other cold like symptoms…The other guys haven't been tested so no telling what they have." On March 20th, 2020, she reached out to me again, texting, "There [sic] planning on being on lockdown and he hasn't been released…He said it's sick people in there and it's hot in there. I'm really scared for him I don't want him to catch anything."

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 25th day of March 2020, in Washington, D.C.



Eileen Johnson
Investigative Intern
Public Defender Service for DC
633 Indiana Ave. NW

Washington, DC

EXHIBIT 13

DECLARATION OF **Katherine Kuenzle**
INVESTIATIVE INTERN AT THE PUBLIC DEFENDER SERVICE

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

1. My name is **Katherine Kuenzle.** I make these statements based upon my personal knowledge.

2. I am an investigative intern for the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since **02/03/2020.** PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as an investigative intern at PDS is to assist in the preparation of trial cases through witness interviews, investigation, and reviewing records.

3. As part of my duties as an investigative intern at PDS, I conduct phone calls with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. While I was conducting a phone call with a PDS client who is a resident of CTF, I learned the following:
    a. Client went to medical twice in one week because he had a fever, cough, sore throat, and chills. During client's first trip to medical on a Friday, client's temperature was taken. However, when client returned to medical the second time on a Sunday, despite still complaining of a fever, client's temperature was not taken. Instead, medical checked for the flu by putting a q-tip in client's nsoe.
    b. Despite having a fever, cough, sore throat, and chills, client still worked in the kitchen preparing 3-4 meals a day without a mask on a Friday and the following Tuesday. Client worked in the kitchen with 20 other people who were unable to maintain a far distance between each other.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the **26th** day of March 2020, in Washington, D.C.

Katherine Kuenzle

Katherine Kuenzle
Investigative Intern
Public Defender Service for DC
633 Indiana Ave. NW
Washington, DC

EXHIBIT 14

DECLARATION OF KAVYA L. R. NAINI
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Kavya Naini. I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Special Litigation Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since October 2019. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. One of my responsibilities as a staff attorney in the Special Litigation Division is to represent people in criminal and post-conviction proceedings in the District of Columbia Superior Court.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. Since March 1, 2020, I have visited CTF at least 5 times (confirmed visits on 3/1, 3/5, 3/12, 3/13, 3/20).

5. While I was in those facilities, I observed the following:

    a. On March 1, 5, and 12, I did not see any noticeable difference in CTF operations. I was not screened when entering the facility. The visiting areas were full of individuals. On March 5, my visit overlapped with a social visit and the visiting area was full of families and friends visiting their loved ones – including my client, who had a visit from his elderly mother and friend. On each of those visits, residents were forced to wait in the back sitting next to each other while they waited to be escorted to their units.

    b. On March 13, I visited CTF in the early morning around 8:30am. When I arrived, there were two individuals right by the front door, and one asked me if I had traveled to countries with COVID-19 in the past 30 days or had any symptoms associated with COVID-19. I was allowed to enter. Apart from this initial screen, there were no noticeable changes in CTF's operations. No one was wearing gloves or masks, and I did not see people wiping down surfaces. There was a hand sanitizer dispenser in the visiting area that was available to everyone.

    c. On March 20, I visited CTF in the late morning. I observed that there were two stations set up when you entered the facility. The first station was right by the entrance and had two DOC staff members seated in close proximity to each other,

neither was wearing a mask. One of them used a forehead thermometer to check my temperature. When I asked my temperature, she said that it was 93 degrees. About 10 feet away, there was a second station with three staff members seated at it. All three were seated next to each other. Only one was wearing gloves. There was a sheet of paper on the table along with some pens. I filled out the sheet of paper which asked questions about COVID symptoms and if I had been to high-risk countries in the past thirty days. When I answered no and signed the paper. The employee with gloves fastened a wristband on my right wrist. I did not see her change her gloves at any point before or after our interactions. I asked the employees how they were doing, and they said they were fine for now but seemed nervous about what was coming.

After finishing the initial screen, I entered the facility. I submitted my legal visit form to the employee in the front office, who was in close physical conversation with another employee. Neither were wearing masks or gloves. I went through the security check. Neither employee running the conveyor machine or the body scanner was wearing gloves or a mask. I was able to carry my small bottle of hand sanitizer with me.

I went upstairs to see my clients. There was a hand sanitizer dispenser near the door of the visiting area. I handed my sheets to the employee at the front desk in the visiting area. The employee was not wearing gloves or a mask. My clients were brought up one by one. But after my visit with one was over, my two clients had to squeeze by each other in a tight hallway of space to enter the bigger visiting area. My first client used the hand sanitizer dispenser when he first came into the visiting area, and I gave my second client some hand sanitizer from my bottle when he came into the legal visiting room.

There was nobody else in the visiting area except for me, my client, and the lady at the front desk for the large portion of our visit. I was there for about 3.5 hours. Most of the time was spent in one of the small legal visit rooms, but in my time there, I did not see staff wiping down any surfaces. I saw nobody wearing a mask. As I was leaving the facility, I saw one man spraying down the trays that are used on the conveyor belt when the guards are scanning visitor's items.

6. While I was in those facilities, I conducted legal visits with my clients. Through those meetings, I learned the following:

   a. My clients told me that there were announcements at various points of the day asking people to clean. However, there was no enforcement of the cleaning and it was mainly expected that residents would be cleaning. I learned that one of my clients was still programming because only outside programming had stopped. And because programming was a requirement to stay in the unit, he had to

participate. I also learned that residents had been given a bar of soap the week of March 16, but that it was not a big bar, and for those people who did not have money to buy soap for the shower or to wash their clothes, it would not last long. My clients confirmed that they were not told that they would be getting any more soap once it was finished. In addition, hand sanitizer in the units had been primarily reserved for use by staff alone. Clients were also concerned about cleaning supplies. One mentioned that it had been several days since anything in the unit was properly cleaned because they had not gotten a refill of their cleaning supplies. He was starting to think about using shampoo to clean the showers because he did not have any disinfectant.

One of my clients lived in a unit where people from his unit were escorted out by staff in masks because of possible exposure to the U.S. Marshal. He said that those people had been living in the unit and interacting with others, and that no one had spoken to the rest of them about their interactions with the people that were quarantined. Another client said that staff do not clean common areas in the unit, it is up to the residents to clean their cells and common areas.

One of my clients said that his unit did have cleaning supplies. He said he was trying to clean regularly but there were other guys in his unit that were not taking it seriously and were not cleaning or washing their hands regularly.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 29th day of March 2020, in Washington, D.C.

Kavya Naini
Staff Attorney
Public Defender Service for DC
633 Indiana Ave. NW

Washington, DC

EXHIBIT 15

DECLARATION OF IESHAAH MURPHY
SUPERVISING ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is Ieshaah Murphy. I make these statements based upon my personal knowledge.

2. I am a supervising attorney in the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since February 19, 2017. Prior to working as a supervising attorney, I was a staff attorney in the Trial Division at PDS. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a supervising trial attorney at PDS is to represent people in criminal proceedings in the District of Columbia Superior Court and to supervise the practice of PDS's trial attorneys.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. Since March 1, 2020, I have visited CDF two times.

5. While I was in those facilities, I observed the following:

    a. On March 5, I visited CDF. I observed no changes to the normal protocol of entering the facility. I entered the front door, placed my bag, which included a laptop and client files, onto the conveyor belt to be searched, and I was patted down. None of the corrections officers were wearing gloves, masks, or any other protective gear. Another attorney entered the facilty just after I did. He was also searched. The two corrections officers who searched my bag and patted me down did not wash their hands before also doing the same things to the other attorney. In the visiting hall, the corrections officer was not wearing gloves or a mask. I never saw anyone attempt to clean or wipe down the visiting hall area.

    b. On March 18, I visited CDF. I observed a slight change in protocol to enter the building. Before entering, staff checked my temperature with a forehead thermometer and provided me with a questionnaire. The questionnaire asked me if I had any lower respiratory symptoms (cough, shortness of breath) or fever, if I had come into close contact with someone diagnosed with or suspected of having COVID-19, or if I had recently traveled to an area with known local spread of COVID-19. I answered "No" to all questions. No one asked any follow-up

questions. My temperature was 98.2 degress. Upon entering the jail, the procedure for getting searched and getting an ID remain unchanged. None of the corrections officers were wearing gloves, masks, or any other protective gear. The corrections officer who search my bag did not wash his hands prior. The corrections officer behind the glass partition, responsible for giving me an ID and entering into the computer which clients I came to visit, was coughing. He did not cover his mouth and coughed all over the keyboard and the paperwork I had filled out to see my clients. He returned my ID and the paperwork to me. The corrections officers would not let me take a container of Lysol up to the visiting hall with me. They allowed me to take disinfectant wipes and hand sanitizer. The proctocol in the visiting hall was the same as any other visit. The corrections officer administering the legal visit was not wearng gloves or a mask. Upon noticing me giving one client hand sanitizer, she told me that was not allowed. During the two hours I was there, I did not notice any attempts by staff to clean the area.

6. While I was in those facilities, I conducted legal visits with my clients. Through those meetings, I learned the following:

a. There are multiple residents on various units who are sick and coughing.
b. One client had a cell mate who was currently sick (coughing, sore throat).
c. The process for getting seen at the infirmary still takes 2-3 days, at best.
d. The staff is not cleaning common areas regularly (not even once a day).
e. They are not provided with products to clean their cells.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the **27th** day of March 2020, in Washington, D.C.

Ieshaah Murphy
Supervising Attorney
Public Defender Service for DC
633 Indiana Ave. NW

Washington, DC

EXHIBIT 16

DECLARATION OF **SYLVIA SMITH**
STAFF ATTORNEY AT THE PUBLIC DEFENDER SERVICE

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

1. My name is **Sylvia Smith** I make these statements based upon my personal knowledge.

2. I am a staff attorney in the Trial Division at the Public Defender Service for the District of Columbia (hereinafter "PDS") and have served in this role since October 5, 2015. PDS is a federally funded, independent organization dedicated to representing indigent adults and children accused of crimes in the District of Columbia. My principal responsibility as a trial attorney at PDS is to represent people in criminal proceedings in the District of Columbia Superior Court.

3. As part of my duties as an attorney at PDS, I regularly conduct legal visits with clients in the custody of the District of Columbia's Department of Corrections, both at the Central Detention Facility ("CDF") and at the Correctional Treatment Facility ("CTF").

4. On **March 29, 2020,** I visited CDF. While I was in CDF, I observed the following:

   a. When I entered CDF, there were three correction officers ("COs") with gloves and masks on. Besides these three women, during the course of my visit, I did not see any other COs with masks on, and only saw one other CO wearing gloves. That is, between the seven COs I personally interacted with, and one CO that I observed, none were wearing masks, and only one was wearing gloves.
   b. When I entered into the screening area, there were two COs, one operating the metal detection conveyor belt, the other CO was operating the x-ray machine and the hand-wand metal-detector. Neither CO was wearing masks or gloves.
   c. Another CO entered behind me with a pizza in her hand. The same CO with the pizza ran the x-ray machine for me.
   d. At the time I headed up to the 2nd floor for my visit, the CO with the pizza was trying to find some plastic to wrap it in.
   e. When I got to the 2nd floor, there was a female CO in the area where our clients are called down to visitation. That CO did not have a mask nor did she have gloves on. She was eating sunflower seeds and spitting them into a paper or Styrofoam cup. As she was entering my information and calling for my client, I asked about whether or not the area had been washed down. She told me that she thinks the visitation area is cleaned once a day, though she hadn't seen them do it that day, and did not know if they wiped down the phones.

f. I saw a cleaning cart in the visitation area. On the cart was a bag full of rags in it. There was also a bottle with a "Windex" brand label on it. I didn't see other cleaning supplies on the cart and it was just stationed there without anyone around.
g. After meeting with my client, I asked a CO if I could leave my client with a mask as I had heard that some residents had masks. The CO said I could not and that masks were considered contraband.
h. I was at the facility for 2 hours and did not hear any announcements over the intercom. I am certain there were no announcements while I was in the facility.

5. While I was at CDF I conducted meeting(s) with my client(s), through which I learned the following:

a. There are approximately 180 people on the unit.
b. Residents are getting updates about people testing positive at CDF and CTF not through staff, but through reading the news.
c. Residents are not being provided with laundry detergent, and have not been offered detergent for free.
d. Residents worried about getting infected through the food have had to rely solely on food through commissary.
e. No one is cleaning residents' cells, and they have not been offered cleaning supplies to clean their cells.
f. The COs are not wearing masks and most do not wear gloves.
g. The staff at the facility do not appear to be cleaning common areas regularly, or even daily. The cleaning supplies are limited and appear to be watered down. Residents on "detail" are responsible for cleaning, not DOC staff.
h. The phones on the units are being used frequently, and not being wiped down between calls.
i. More people are exhibiting symptoms. When they report these symptoms, staff tell them to put in a request for medical. It takes 2 to 3 days to get seen by medical.

6. While I was at CTF on March 29, 2020, I learned the following from the CO who was operating the metal detection conveyer belt:

- Three people were in "safe cell" at CDF because they had been exhibiting symptoms and awaiting testing;
- 25 staff members were on administrative leave from CTF after one of the residents tested positive for Covid-19.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the **29th** day of March 2020, in Washington, D.C.

Sylvia Smith
Staff Attorney
Public Defender Service for DC
633 Indiana Ave. NW

Washington, DC