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:

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

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

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.

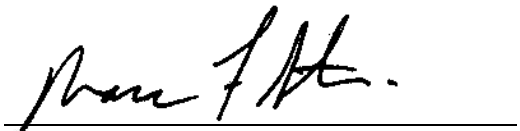
i. Inmates should be permitted access to cleaning supplies so they may clean their individual cells. This will both keep cells cleaner, and also stem panic amongst the incarcerated population.

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