UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.*, *Plaintiffs-Petitioners,* v. QUINCY BOOTH, *et al.*, *Defendants-Respondents*.	No. 1:20-cv-00849 (CKK)

PLAINTIFFS' MEMORANDUM IN SUPPORT
OF THEIR AMENDED MOTION FOR PRELIMINARY INJUNCTION

PRELIMINARY STATEMENT

On March 30, 2020, when Plaintiffs filed for a preliminary injunction and a temporary restraining order, there were five positive COVID-19 cases among residents in Department of Corrections' ("DOC") care. Despite Defendants' assurances that "DOC has taken and continues to take extensive measures to ensure that the District's incarcerated population remains safe and secure amid this pandemic," Dkt. No. 25 at 2, the facts on the ground tell a different story. Today, there are 180 confirmed positive COVID-19 cases in DOC facilities — more than a twenty-five fold increase. The rate of infection in DOC facilities is over thirteen times greater than the rate of infection in the District of Columbia. One DOC resident died due to COVID-19, and another is on life support. Five DOC residents are in the hospital.

This dire situation need not have been the outcome. Just across the Potomac River, the Arlington County Detention Center (a high-traffic jail facility with around 500 residents) has recorded zero COVID-19 cases. In Arlington, the chief prosecutor, together with the county sheriff and the public defender, decreased the jail population by nearly a third, ensuring the space and

staffing levels to implement social distancing.[1] By contrast, the DOC resident population has been reduced by just one sixth (or half as much as Arlington's) since this lawsuit was filed.

Rather than acting swiftly and decisively to prevent, and then to contain, a COVID-19 outbreak, Defendants moved slowly in responding to the global pandemic. As this Court concluded in issuing a temporary restraining order on April 19, 2020, DOC "fail[ed] to take comprehensive, timely, and proper steps to stem the spread of the virus." Dkt. No. 51 ("TRO Op.") at 22. In so concluding, the Court expressed significant doubts over whether DOC "policies are being fully implemented," noting that "access to cleaning supplies varied," that social distancing was not being enforced in part due to understaffing, and that "COVID-19 symptoms such as coughs and fevers" were not quickly attended to by medical staff. *Id.* at 17-20. The Court issued a temporary restraining order requiring Defendants immediately to remedy the unconstitutional conditions in their facilities. *See* Dkt. No. 50 ("TRO Order").

Although nearly a month has passed since this Court's order, many of the dangerous conditions that the Court ordered improved remain substantially unchanged. *Amici* Grace Lopes and Mark Jordan provided the Court with an oral report detailing just how little progress has been made. *See* Dkt. No. 69 ("*Amici* Oral Report").

The Court's April 19th TRO	*Amici*'s May 11th Report
Sick call responses: "Correctional officers and other staff who are in contact with inmates should ensure that the medical staff are promptly informed about inmates who present with symptoms of COVID-19 and medical staff should respond to the housing unit on an expedited basis." TRO Order at 1.	*Amici* reported a "lack of unimpeded access to [sick-call] forms," that officers "were unable to consistently produce the [sick-call] forms readily," and that due to "significant correctional officer staffing shortages," residents have greatly reduced opportunities "to submit sick-call request forms to medical staff." *Amici* Oral Report at 16-17.

[1] ARLNow.com, *Some Arlington Inmates Freed Amid Coronavirus Concerns*, May 7, 2020, 3:45 p.m., https://www.arlnow.com/2020/05/07/some-arlington-inmates-freed-amid-continued-coronavirus-fears/

The Court's April 19th TRO	*Amici*'s May 11th Report
Social distancing: "Defendants shall ensure appropriate and consistent implementation of social distancing policies by addressing limitations in current staffing levels, supervisory oversight of line staff, and provide enhanced education related to the importance of social distancing." TRO Order at 2.	*Amici* observed that social distancing "certainly is not prevalent, certainly not during our site visits," and cited "staffing limitations," which "undercut the ability to staff to enforce [social distancing]." *Amici* Oral Report at 43.
Sanitation: "[P]roper cleaning supplies that have been sanitized regularly shall be immediately provided to each unit, and a schedule for cleaning common areas and cells shall be established and enforced." TRO Order at 2.	*Amici* reported that sanitation is "clearly especially deficient at the jail," that residents are given "four or five paper towels," that availability of cleaning supplies remains variable from housing unit to housing unit, and that residents "continue to rely upon the ripped towels and the ripped T-shirts" to clean their cells. *Amici* Oral Report at 41.
Conditions on isolation units: "[D]efendants shall take immediate steps to provide consistent and reliable access to legal calls, personal telephone calls, daily showers, and clean clothing and clean linens to all inmates on isolation status." TRO Order at 2.	*Amici*'s report noted that due in part to "staffing limitations," some residents on isolation units "hadn't been allowed to shower within the past couple of days," that some jail residents on one corner of the isolation unit did not have reliable access to a phone, and that residents are locked in their cells for days on end. *Amici* Oral Report at 30, 34, 36.
Access to legal calls: "[D]efendants shall ensure that all inmates . . . have access to confidential, unmonitored legal calls of a duration sufficient to discuss legal matters." TRO Order at 3.	*Amici* reported that "legal calls that are scheduled [by an attorney] are being conducted in the offices of case managers with the case manager present" and that other residents are only allowed to use the phone "at 1:00, 2:00, and 3:00 a.m." *Amici* Oral Report at 33-34.

In sum, Defendants have responded to the Court's Order in the same way they did to this global pandemic: slowly and insufficiently. The results of Defendants' action and inaction are seen starkly in the data, which show that infections continue to climb in facilities that still house around 1,325 residents.[2]

[2] When the Court issued its TRO on April 19, 2020, there were around 1400 residents in DOC facilities.

In light of the imminent threat to the health of the proposed class of DOC residents and Defendants' lackluster performance both before and after the issuance of the TRO, greater relief is necessary to protect the health and safety of DOC residents. Accordingly, Plaintiffs urge the Court to join other federal courts around the country by implementing a process to safely transition a portion of DOC residents to community supervision. Faced with comparably less severe outbreaks in Ohio, California, Massachusetts, and Connecticut, federal judges have established procedures to ensure that vulnerable incarcerated people are carefully transferred out of unsafe correctional institutions and safely into supervised home confinement. *See Martinez-Brooks v. Easter*, No. 20-cv-569 (MPS), 2020 WL 2405350 (D. Conn. May 12, 2020); *Wilson v. Williams*, — F. Supp. 3d —, No. 20-cv-794 (JSG), 2020 WL 1940882 (N.D. Ohio Apr. 22, 2020), *aff'd*, *Wilson v. Williams*, No. 20-3447 (6th Cir. May 4, 2020); *Rivas v. Jennings*, — F. Supp. 3d —, No. 20-cv-2731 (VC), 2020 WL 2059848 (N.D. Cal. Apr. 29, 2020); *Savino v. Souza*, — F. Supp. 3d —, No. 20-cv-10617 (WGY), 2020 WL 1703844 (D. Mass. Apr. 8, 2020).

In accord with those other federal courts, this Court should adopt Plaintiffs' proposed preliminary injunction. Plaintiffs ask the Court not only to extend and expand its relief concerning conditions Plaintiffs face, but also to appoint an expert to assist the Court in carefully identifying and granting tailored petitions for *habeas corpus* that would permit a portion of DOC residents to be freed from their dangerous confinement and supervised instead in the community. This Court has the authority to improve the health and safety of proposed class members by using the writ of *habeas corpus* to transition supervision of some DOC residents to the community, or by using the legal tool known as "enlargement" to do so. Because COVID-19 presents a severe risk to the health and safety of the proposed class and because Defendants continue to act with deliberate

indifference to that risk in a manner that has led to a tragically high rate of infection, the Court should begin that process now.

FACTUAL BACKGROUND

As the Court knows, and as Defendants do not dispute, COVID-19 has caused a worldwide global pandemic and poses a serious risk of harm. At the time this case was filed, on March 30, 2020, the World Health Organization ("WHO") estimated that there were 638,146 confirmed cases, 30,039 confirmed deaths, and 203 countries, areas, or territories affected. Dkt. No. 1 ("Compl."), at ¶ 20. The Centers for Disease Control and Prevention ("CDC") estimated that as of March 30, 2020, there were 122,653 confirmed cases and 2,112 confirmed deaths in the United States. *Id.* ¶ 21. Plaintiffs predicted in their initial filing that, due to the highly contagious nature of COVID-19, data and statistical modeling show that absent intervention, cases of COVID-19 will continue to grow exponentially. *Id.* ¶ 23

That prediction was unfortunately correct. As of May 15, 2020, the WHO estimates that there are 4,347,935 confirmed cases, 297,241 confirmed deaths, and 216 countries, areas, or territories affected.[3] The CDC estimates that as of May 15, 2020, there are 1,384,930 confirmed cases and 83,947 confirmed deaths in the United States, with cases and deaths in all 50 states and the District of Columbia.[4]

People in all age brackets are at risk of serious illness and death from COVID-19. Reviewing data collected by the CDC, Dr. Marc Stern — an expert on correctional health care and a board-certified internist — explains:

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[3] *See* WORLD HEALTH ORG., *Coronavirus disease (COVID-19) Pandemic* (last visited May 15, 2020, 5:00 PM), https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

[4] *See* CTRS. DISEASE CONTROL & PREVENTION, *Cases in U.S.* (last visited May 15, 2020, 5:00 PM), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

> 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.

See Dkt. No. 1-1 ("Stern Decl.") at ¶ 14. Nearly 40 percent of people requiring hospitalization due to COVID-19 were between the ages of 20 and 54. *Id.*

For people who contract COVID-19, the symptoms can be extremely severe. Dr. Meyer writes that "[s]erious illness occurs in up to 16% of cases, including death." Dkt. No. 5-2, Ex. 1 ("First Meyer Decl."), at ¶ 23. COVID-19 can cause intense pain, and recent research suggests that, in addition to the short-term risk of death posed by COVID-19, contracting the virus can lead to other serious long-term medical conditions, including cardiovascular disease. Compl. ¶ 27. One respiratory physician explained that the lungs "become filled with inflammatory material" and "are unable to get enough oxygen to the bloodstream." *Id.* ¶ 25.

The available data from the CDC to date shows that, in total, 20.7 to 31.4 percent of people who tested positive for COVID-19 require hospitalization; 4.9 to 11.5 percent require admission to the ICU; and 1.8 to 3.4 percent die. Compl. ¶ 29. By way of comparison, the WHO estimates that the COVID-19 mortality rate is between three and four percent, while the mortality rate of seasonal influenza is well below 0.1 percent. *Id.* ¶ 30. Unlike the flu, however, there is no vaccine or cure for COVID-19. *Id.* ¶ 32.

ARGUMENT

A. Plaintiffs are likely to succeed on the merits.

The Court already found, in granting a temporary restraining order, that Plaintiffs are likely to prevail on the merits of their constitutional claims. Developments since the TRO was entered confirm that conclusion. As the number of DOC residents and staff who have tested positive for

COVID-19 continues to rise, and additional evidence sheds light on the unsanitary and unsafe conditions in Defendants' facilities, it is all the more clear that Plaintiffs are likely to succeed on the merits of their Fifth and Eighth Amendment claims.

1. Plaintiffs and proposed class members are likely to prevail on the merits of their constitutional claims.

Plaintiffs raise Fifth Amendment due process claims regarding pretrial detainees and Eighth Amendment claims regarding post-conviction detainees. To prevail under the Eighth Amendment, Plaintiffs must show that (1) prison conditions pose "an unreasonable risk of serious damage" to a prisoner's health (an objective test) and (2) prison officials acted with deliberate indifference to the risk posed (a subjective test). *Helling v. McKinney*, 509 U.S. 25, 33-35 (1993). As this Court explained, a post-conviction Plaintiff "must show that the jail conditions exposed him to an unreasonable risk of serious damage to his health and that Defendants acted with deliberate indifference in posing such a risk." TRO Op. at 12.

To prevail under the Fifth Amendment, this Court has recognized, pretrial Plaintiffs "do not need to show deliberate indifference in order to state a due process claim for inadequate conditions of confinement." *Id.* at 11 (applying *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015)). A pretrial Plaintiff need only show that "Defendants knew or should have known that the jail conditions posed an excessive risk to their health." *Id.* at 12.

a. The Court correctly found that Plaintiffs were likely to prevail on the merits.

In granting the TRO, the Court found that Plaintiffs were likely to prevail on the merits of their constitutional claims. First, the Court found that Plaintiffs were likely to show that "they have been exposed to an unreasonable risk of damage to their health." *Id.* at 12. COVID-19 infection rates in DOC custody and the expert declaration of Dr. Jaimie Meyer both supported the

conclusion that Plaintiffs face an elevated risk of contracting COVID-19. *Id.* at 13. The Court also found that Plaintiffs cannot practice social distancing — "one of the most important risk-reduction policies" — in DOC facilities. *Id.* at 14. Citing *amici*'s first inspection report, the Court recognized that the failure to enforce social distancing was due, "at least in part, to an understaffing of correctional officers and their supervisors." *Id.* at 14-15. In light of the statistical evidence, Plaintiffs' expert evidence, the declarations of DOC inmates and staff, and the *amici* report, the Court concluded that Plaintiffs likely "will be able to show that they have been exposed to an unreasonable risk of damage to their health." *Id.* at 15. That finding alone was sufficient to establish likelihood of success on the Fifth Amendment claim. *Id.*

The Court also found a likelihood of success on Plaintiffs' Eighth Amendment claim. As Defendants were aware of the health threat posed by COVID-19, the central question before the Court was whether "Defendants have recklessly disregarded the risk to Plaintiffs' health." *Id.* at 16. The Court found that they had, citing a wealth of evidence casting doubt on whether precautionary measures contained in DOC policies were being implemented. *See id.* at 17-22. The Court relied on *amici*'s findings that "access to cleaning supplies varied from unit to unit," that many residents relied on "rags that they made by tearing facility issued towels or t-shirts," and that "cleanliness of common spaces [was] inconsistent among housing units." *Id.* at 17-18. The Court took note of DOC's failures to implement contact tracing and poor conditions on isolation units that discouraged residents from voluntarily self-reporting COVID-19 symptoms. *Id.* at 19-20. Finally, the Court's conclusion regarding Defendants' deliberate indifference was also supported by uncontested allegations (supported by independent audits) of the poor ventilation of DOC facilities, the lack of prompt access to medical attention, and the lack of access to confidential legal calls. *Id.* at 20-22. In sum, the Court concluded that "Defendants are aware of the risk that

COVID-19 poses to Plaintiffs' health and have disregarded those risks by failing to take comprehensive, timely, and proper steps to stem the spread of the virus." *Id.* at 22.

b. Even after this Court's Order, Defendants continue to violate Plaintiffs' constitutional rights.

The TRO, entered on April 19, directed the DOC to make several changes to the implementation of policy and procedure to rectify the unconstitutional conditions identified by the Court. Nearly a month later, however, it is clear from the statistical evidence, from *amici*'s follow-up report, from Plaintiffs' declarations, from evidence presented in Superior Court, and from information from DOC staff members, that conditions in DOC facilities do not satisfy constitutional standards or this Court's order. Many of the problems identified by the Court in its April 19, 2020 Order, including access to medical care, enforcement of social distancing, understaffing, and sanitation remain seriously deficient and are arguably worse than before the Court's Order.

Expert Jaimie Meyer agrees. Having reviewed *amici*'s oral report from May 11, 2020, as well as *amici*'s written report from April 18, 2020 and declarations from DOC residents, Dr. Meyer "reaffirm[s] that people living and working in DC DOC facilities remain at risk of serious harm due to COVID-19 infection." Ex. 1, Supp. Meyer Decl. ¶ 3. Dr. Meyer identifies "major and pervasive system-level deficits" that, as described below, put Plaintiffs' and proposed class members' lives at risk. *Id.*

i. Medical care

First, inconsistent access to medical care continues to pose a risk of serious harm to all DOC residents. The Court recognized in April that residents who "have requested medical aid for COVID-19 symptoms report long waits for medical care, testing, or separation from the general population." TRO Op. at 20. Accordingly, the Court required that the "process associated with

sick call requests on the non-quarantine units is expedited and reflects appropriate sensitivity to the wide variety of symptoms associated with COVID-19 disease." TRO Order at 1.

In spite of the Court's order, *amici* found in their follow-up investigation that medical access on non-quarantine units is plagued by a host of problems. To request medical care, residents must submit a sick-call request form, and those forms are maintained by housing unit correctional staff. *Amici* Oral Report at 16. Residents can get a form only by requesting one from a correctional officer. *Id.*

This system suffers from several systemic flaws that result in the ineffective provision of medical care. To begin, while the system relies on residents being let out of their cell to obtain a sick call request slip from a housing staff member, *amici* have reported that "two to three days can elapse between an inmate's release for their hour out-of-cell time." *Id.* at 17. Further, staff training on this system is minimal: When *amici* inspectors themselves asked correctional officers for a form, "officers were unable to consistently produce the forms" and "[i]n one case, an officer upon request gave us the wrong form." *Id.*

Even when a resident is able to obtain and submit a sick call slip, additional days can elapse before a medical staff person follows up on the request for help. In a third of slips analyzed by *amici*, it took three or more days after a resident requested help for medical staff to respond. *Id.* at 19. One resident was made to wait over a week after submitting a request for medical help before he was seen. *Id.* Of particular concern, *amici* documented this pattern of delay for COVID-19-related symptoms, including coughing, shortness of breath, loss of taste, and fever; two-thirds of those requests were not responded to until over two days after they were submitted. *Id.* at 20. Two residents who requested care for COVID-19 related symptoms were not seen until "four [and five] days after the request was submitted," and one subsequently tested positive. *Id.* There is no

way to know how many residents were infected with COVID-19 in the four days while that resident awaited constitutionally-mandated care.

Each of *amici*'s concerns about the sick call process are echoed in the declarations of DOC residents. Brian Thomas was admitted to the Central Detention Facility ("CDF") on April 27th, and since that date, "there have been 4-5 days that [he is] not allowed out of [his] cell." Ex. 2, Thomas Decl. ¶ 16; *see also* Ex. 3, Jenkins Decl. ¶ 10 ("I would go several days [between April 13 and May 1] without being allowed out of my cell for my one hour of recreation time."). Even when residents are allowed out of their cell, obtaining a sick call form can be impossible. "Last week they ran out of sick slips on Northwest-2," so no residents of that entire housing unit were able to use the sick call system. Ex. 4, Perry Decl. ¶ 8; *see also* Ex. 30, Knight Decl. ¶ 5 ("Sick call slips and Inmate Grievance Procedure forms were not . . . available on my unit between the dates of April 23, 2020 and May 12, 2020."). The problem is not limited to the CDF; the C2B block at the Correctional Treatment Facility ("CTF"), which houses residents over 50 years old, "had no sick call slips or inmate request slips available" for "the entire week of May 4, 2020." Ex. 5, Stankavage Decl. ¶ 15. Even when residents are let out of their cells, and even when there are sick call slips available, residents face another hurdle to accessing medical care, because staff do not reliably collect the sick call slips that are submitted. On one unit at CTF, "nobody picked up sick call slips that inmates submitted" between March 26 and April 24. *See* Ex. 6, Jaggers Decl. ¶ 13. In sum, residents face obstacles both in obtaining sick call slips and in submitting them, and even when residents overcome those systemic obstacles, they face significant delays in actually obtaining care.

This broken system has surely led to, and will continue to lead to, increased spread of the virus within DOC facilities. LeDauntae Perry's experience is representative. Mr. Perry began

exhibiting symptoms of COVID-19 in early April 2020; he put in a sick call request and was given an inhaler and antibiotics for what a doctor described as a "sinus infection." Ex. 4, Perry Decl. ¶ 4. His symptoms did not improve, and he requested "to see a doctor three times by submitting a sick slip." *Id.* ¶ 7. Although he put the slips in the right box, he "didn't see correctional officers or anyone else empty the sick slip boxes," and no medical staff responded to his requests. *Id.* When another resident on his housing unit tested positive, his unit became a "quarantine unit," and nurses came to check residents' temperatures. *Id.* ¶ 9. For weeks, Mr. Perry "repeatedly tried to get medical attention by asking corrections officers and the nurses who took [his] temperature for help." *Id.* ¶ 13. "I was asking every day for help. There were no sick slips for me to put in a request for medical attention." *Id.* Finally, on May 4 —after weeks of symptoms — Mr. Perry was tested for COVID-19 and his results came back positive on May 7. *Id.* ¶¶ 14, 17. During the weeks Mr. Perry begged daily for help, he shared a cell with another resident. *Id.* ¶ 16.

Mr. Perry's experience closely parallels that of Romiel Hightower, who was housed on a different housing unit than Mr. Perry. Mr. Hightower's cellmate tested positive on April 10, and Mr. Hightower requested a test that day but was denied. Ex. 7, Hightower Decl. ¶ 4. Shortly after his cellmate tested positive, Mr. Hightower began exhibiting symptoms of COVID-19 and put in "three medical requests and a grievance but was never taken for a test." *Id.* ¶ 5. He asked "every medical staff who came by and all the guards for a COVID test, [but] no one gave me one." *Id.* Remarkably, and in violation of CDC guidelines and DOC policy, Defendants returned Mr. Hightower's cellmate to his cell. It was only after a Superior Court judge ordered DOC to test Mr. Hightower (remarking that returning Mr. Hightower's positive cellmate to his cell is "not compliant with the CDC" guidelines) that Mr. Hightower was tested. *See* Ex. 8, Hightower Transcript at 26. His test came back positive. Ex. 7, Hightower Decl. ¶ 7.

Residents who are on quarantine units — that is, residents who are presumed to have been exposed to COVID-19 — fare little better. Residents on those units have their temperatures checked daily, but otherwise must rely on the sick call system to report medical issues; residents are *not* tested or offered treatment during the temperature check. For instance, Eric Cooper was having "trouble breathing" and was "coughing a lot," but despite putting in "multiple sick call requests," the only medical staff he saw was for his temperature check. Ex. 10, Cooper Decl. ¶ 8. "That person only checked my temperature but did not do anything else to help me." *Id.*; *see also* Ex. 4, Perry Decl. ¶ 9 ("Nurses come around our unit twice a day to check every inmate's temperature. I would tell the nurses that I feel sick. The nurses would say my temperature is fine and they didn't help me get seen by a doctor."). Another resident "was complaining for days" that he was feeling ill before he was given a test. Ex. 31, Rezeine Transcript at 21. That resident was later found sweating profusely in his cell and required emergency transportation to the hospital. *Id.* at 20.

Dr. Meyer explains the critical, and potentially fatal, flaw in this system. It is "highly problematic" to use "fever [as] the sole trigger for testing," because "people infected with COVID-19 may exhibit a wide range of symptoms which, according to the CDC include: cough, shortness of breath," and other symptoms. Ex. 1, Supp. Meyer Decl. ¶ 5; *see also* Ex. 9, K. Johnson Decl. ¶ 5 (reporting that medical staff refused to "test anyone for COVID-19 who didn't have a temperature over 100 degrees"). In other words, as Dr. Meyer explains, by not testing residents who present with symptoms other than fever, the DOC is keeping many infected residents on housing units where they can easily spread the virus to others.

ii. Enforcement of social distancing

Second, the DOC's failure to enforce social distancing continues to contribute to the rapid spread of the virus in Defendants' facilities. The Court explained in granting the TRO that "one of the most important risk-reduction policies which has not been adequately addressed by Defendants is social distancing." TRO Op. at 13. Social distancing is a "crucial part of containing the spread of COVID-19," as evinced by both expert reports and the dramatic transformation of our society. *Id.*

Since the Court's April 19th Order, the DOC has made little progress towards fully implementing social distancing. Although *amici* recognized that there is "increased evidence of social distancing," *amici* concluded that social distancing "is not prevalent" and "certainly [was] not during [their] site visits." *Amici* Oral Report at 42. As they observed with their initial inspection report, *amici* noted that "staffing limitations . . . undercut the ability of staff to enforce [social distancing] when there are an insufficient number of staff on the housing units." *Id.* at 43.

Reports from DOC residents confirm *amici*'s evaluation. Brian Thomas entered the DOC on April 27, and since he has been at the CDF, "nobody told [him] to social distance [him]self from other people. Nobody has told [him] to stay six feet away from other people." Ex. 2, Thomas Decl. ¶ 17. Tony Horne, who is housed on a different unit, explains that on his unit, "more than 5 people are being let out of their cells at a time. Sometimes more than 10 people are let out of their cells at one time." Ex. 11, Horne Decl. ¶ 9. Officers do not enforce "when people are supposed to be allowed out of their cells," resulting in residents who "are out for multiple hours at a time." *Id.* ¶ 10.

Video footage from DOC facilities also confirm *amici*'s evaluation. Footage from CDF shows around ten residents are seen out of their cells at a given times; residents are seen clustering

closely together near telephones (which are not spaced six feet apart); and residents are seen interacting with DOC staff members in close groups. *See* Ex. 32, Photos.

Conditions in DOC facilities also force residents into violating basic social distancing rules. On May 12, 2020, DOC staff crammed a dozen "residents from various units" into an elevator at CTF to take the residents to the medical unit. Ex. 5, Stankavage Decl. ¶ 3. When they arrived at the medical unit, approximately 15 to 20 residents were waiting in a small room to be seen by medical staff. *Id.* ¶ 6. The next day, on May 13, 2020, at least 10 residents were waiting in that same room. *Id.* ¶ 9. Whether by dint of facility design or lack of enforcement, DOC residents are forced to violate social distancing rules that are fundamental to curbing the spread of the virus.

Compounding the risk associated with DOC's failures regarding social distancing is DOC's evident difficulty complying with CDC guidelines regarding quarantining and isolating residents who have tested positive. In addition to erroneously returning a resident who tested positive to Mr. Hightower's cell, as discussed above, DOC has also failed to ensure that residents who could be positive are isolated from other residents. For instance, people who are tested for COVID-19 (who, per DOC policy, have exhibited symptoms of COVID-19) are supposed to be isolated until their test results are available. However, on the Northeast 1 unit at CDF, correctional officers have on multiple occasions let those residents awaiting test results out of their cells at the same time as residents who were not symptomatic. Ex. 12, D. Johnson Decl. ¶ 14. In fact, one resident of the Northeast 2 unit himself explains that he was tested for COVID-19 on April 16, and while awaiting the result of the test, the next day (in violation of DOC policy) was "allowed out of [his] cell even though [he] was supposed to be on quarantine." Ex. 33, Swint Decl. ¶ 11; *see also* Ex. 34, Banks Decl. ¶¶ 11-12 (recounting that around May 5, "[w]hile awaiting the results of his COVID-19, [an] individual remained on the unit like everyone else and I saw this individual

participate in recreation."). Other times, correctional officers let residents awaiting test results out of their cells and then failed to clean any of the common areas or showers after those residents used them. Ex. 12, D. Johnson Decl. ¶ 15.

This problem is not isolated to Northeast 1. Anthony Robertson, housed on Northwest 2, was tested for COVID-19 on April 20 and was moved to a single cell, but he was let out for recreation "with everyone else" while awaiting the results of his (positive) COVID-19 test. Ex. 13, Robertson Decl. ¶ 6. Nor is the problem limited to CDF; on the C2B block at the CTF — the block for people age 50 and older — eight to ten people have been let out at a time, and residents sit next to each other or stand together near the microwave, and staff members do not attempt to enforce or inform residents about social distancing. *Id.* ¶ 6. On the D2B block at CTF, "five or six people" crowd into the TV room, but staff do "not say anything or attempt to enforce social distancing." Ex. 14, Ingraham Decl. ¶ 43.

In a particularly concerning case, DOC staff reported encountering a resident on Northwest 1 who had tested positive for COVID-19 the previous day, and through some administrative error, had not been moved to the isolation unit until the next day, when correctional officers encountered that resident "laying on his bunk sweating profusely." *See* Ex. 15 ("DOC Docs."), at 1. The resident was immediately transported to the hospital by ambulance. *See id.* In other words, this symptomatic and positive resident remained on his general population housing unit for nearly an entire day because he was not taken to the isolation unit. This problem is not an isolated occurrence, as another DOC resident reported that he tested positive for COVID-19 but was not moved to the isolation unit until the following day. Ex. 13, Robertson Decl. ¶ 7. When he told a doctor that he had tested positive and needed to be transferred to the isolation unit, the doctor responded that he "couldn't be positive because [he] would have been moved already." *Id.*

Further, despite DOC's assurances that residents in isolation are returned to the general population if their COVID-19 symptoms are decreasing, the DOC has released residents from isolation who are clearly still symptomatic. For instance, Anthony Robertson was told his "time [was] up" on the isolation unit and that he would be moved back to the general population, even though he had "coughed up blood that morning." Ex. 13, Robertson Decl. ¶ 18. Another resident on the isolation unit "was still experiencing symptoms of COVID-19" when he was told that the DOC was "going to send [him] back to the general population because they needed the cell for other inmates who had tested positive." Ex. 11, Horne Decl. ¶ 4.

The dangerous combination of DOC's failure to enforce social distancing and its errors regarding quarantine and isolation — specifically, failing to isolate residents who have tested positive and should not be returned to the general population, and failing to separate residents who are symptomatic and/or awaiting test results from non-symptomatic residents — has resulted in, and will continue to result in, the rapid spread of the virus throughout DOC's facilities. "Given that COVID-19 is a highly contagious virus spread by droplets within close contact, the disease will continue to spread in facilities where social distancing is not enabled." Ex. 1, Supp. Meyer Decl. ¶ 8.

iii. Sanitation

Amici and the Court agreed that there "is a critical need for the defendants to strengthen the environmental health and safety program at both the CDF and the CTF." TRO Order at 2. The need to improve sanitation in DOC facilities was so great that *amici* and the Court recommended that DOC "immediately retain a registered sanitarian to oversee the environmental health and safety programs at both facilities and provide training so that cleaning tools and products are used properly." *Id.* at 2.

No sanitarian has been retained, and the sanitation program has not improved. In April, residents used "tattered and soiled rags that they made by tearing facility issued towels or t-shirts." *Id.* at 18 (quotation marks omitted). Today, residents "continue to rely upon the ripped towels and the ripped T-shirts" for cleaning. *Amici* Oral Report at 41. *Amici* emphasized that this problem was "[a]bout the same" as previously reported. *Id.* at 44. In April, *amici* reported that "access to cleaning supplies varied from unit to unit." TRO Op. at 17. Today, *amici* report that the availability of cleaning supplies is "not uniform from housing unit to housing unit." *Amici* Oral Report at 41. *Amici* concluded that appropriate sanitation is a "continuing issue at both facilities" and "clearly especially deficient at the [CDF]." *Id.*

Residents' reports confirm that sanitation is clearly deficient. The DOC opened the North 2 housing unit at CDF as an isolation unit for the increasing number of CDF residents who test positive for COVID-19. That unit "had not been used to house inmates for years," and when COVID-19-positive residents were moved to the unit, it was "noticeably filthy," with "feces stains on the walls." Ex. 16, Burl Decl. ¶ 6; *see also* Ex. 17, Ex. 17, Quarles Decl. ¶ 6 ("The floor is extremely dirty. There is trash on the floor that inmates toss onto the tier through the food slot in their doors."). The showers on multiple housing units are dirty. *See, e.g.*, Ex. 35, A. Jackson Decl. ¶ 4 ("I saw there was blood and mold throughout the shower area."); Ex. 13, Robertson Decl. ¶ 15; Ex. 2, Thomas Decl. ¶ 15. Multiple housing units lack cleaning supplies. *See, e.g.*, Ex. 14, Ingraham Decl. ¶ 47 ("On April 27, our unit [D2B] ran out of cleaning supplies."); Ex. 16, Burl Decl. ¶ 8 ("I have not been provided any cleaning supplies to clean myx cell on N2."); Ex. 12, D. Johnson ¶ 5 ("During the period from April 22, 2020 to May 8, 2020 I did not have access to any chemicals to clean my cell."); Ex. 18, Toran Decl. ¶ 9 ("I am not provided supplies to clean sinks

or toilets."); Ex. 17, Quarles Decl. ¶ 17 ("I have received no cleaning solution since my transfer to the medical unit on March 11, 2020.").

The conditions for residents who are confined to safe cells[5] are even more concerning. Those residents are supplied with no running water whatsoever: "Feces and other bodily waste remain in the toilet until the Correctional Officers come in to flush it manually," which can take several hours. Ex. 20, Doe Decl. ¶ 6.[6] Residents in a safe cell are "not allowed out of [their] cell," are left in their cells with lights on full brightness for 24 hours a day, are allowed to shower roughly once a week, and lack any access to any supplies to clean their cell with. *Id.* ¶¶ 3, 4, 16.

Residents lack access to effective cleaning supplies. Residents are cleaning with "Oasis Pro Laundry Fresh Room Refresher," *see* Ex. 20, Warren Decl. ¶ 7, a product that Dr. Meyer explains does "not have activity against and is not approved for disinfection for COVID-19. Ex. 1, Supp. Meyer Decl. ¶ 11. Incredibly, residents are using that product — which is more akin to a scented room spray than a hygienic product — to clean and decontaminate cells of residents who tested positive for COVID-19. *See* Ex. 20, Warren Decl. ¶ 21 ("When I cleaned the contaminated cells, I was only provided with the cleaner I always use ("Oasis Pro Laundry Fresh Room Refresher")).

When residents do have access to cleaning supplies, they still are not informed about what kind of cleaning agents should be used and how to use them. Dkt. No. 49-1, ("*Amici* Initial Report"), at 30 ("It was evident that knowledge regarding the appropriate use of the different cleaning and sanitizing agents was generally at a very low level."); *accord* Ex. 14, Ingraham Decl. ¶ 44 ("Since April 19, my unit has not received any instructions on which cleaning chemicals to

[5] Safe cells house residents who are placed on suicide watch.

[6] For fear of retaliation, this declarant did not want to supply his real name or cell number, but would consider doing so upon request.

use on which surfaces."); K. Johnson Decl. ¶ 18 ("Since April 19, no verbal presentations or town hall meetings have occurred addressing COVID-19."). Nor are officers — whether due to understaffing or other reasons — supervising cleaning. While detail residents are supposed to clean common areas twice daily, "detail inmates would actually clean the common areas between 2-3 times a week, as opposed to twice a day." Ex. 35, A. Jackson Decl. ¶ 8.

The poor sanitation at the jail contributes in myriad ways to the spread of the virus. Without proper cleaning products, the virus lingers on surfaces, allowing it to spread rapidly in confined environments like the D.C. jail. Ex. 1, Supp. Meyer Decl. ¶ 11. "Cleaning and disinfecting practices can mitigate this risk of disease transmission but remains inadequate in the DC DOC." *Id.* By failing to retain a sanitarian immediately or hire professional cleaners to clean the secure side of the jail, and by failing to provide adequate and appropriate cleaning supplies and instruction, Defendants have increased the risk that residents will contract COVID-19.

iv. Punitive conditions on isolation units

This Court recognized that "punitive conditions for [residents] in isolation are not acceptable," not just because they are unconstitutional themselves, but also because they "make it more likely that inmates will hide their symptoms to avoid the potential for isolation and continue to infect others in the general population." TRO Op. at 21-22. The Court, therefore, ordered Defendants to "provide consistent and reliable access to legal calls, personal telephone calls, daily showers, and clean clothing and clean linens to all inmates on isolation status." TRO Order at 2.

But conditions on the isolation unit at CDF are still punitive, discouraging residents from self-disclosing COVID-19 symptoms for fear of being sent to the unit. Reports from that unit are disturbing, to say the least. The unit features "feces stains on the walls" of the common areas and in cells. Ex. 16, Burl Decl. ¶ 6; *see also* Ex. 13, Robertson Decl. ¶ 9 ("[W]hen I got to my isolation

cell on N2, it had not been cleaned and was still dirty from the previous person."). There is no hot water in the sinks, *see* Ex. 7, Hightower Decl. ¶ 9, and food on the unit is "often served hours after regular mealtimes," Ex. 16, Burl Decl. ¶ 7, or not at all, *see* Ex. 13, Robertson Decl. ¶ 12 (reporting that residents on the isolation unit sometimes missed meals altogether). As the *amici* report, residents in isolation do not have consistent access to showers, with some going days without access. *Amici* Oral Report at 34; *accord* Ex. 9, K. Johnson Decl. ¶ 10 ("I went six days [on the isolation unit at CTF] without being permitted to shower."); Ex. 7, Hightower Decl. ¶ 9 ("I had many fewer opportunities to shower [on the isolation unit at the jail], only once every three or four days after lots of complaining."); Ex. 13, Robertson Decl. ¶ 10 ("Between April 23rd and April 28th [on the isolation unit at CDF], I was not able to shower."). Access to the phone on the isolation units is also sporadic. *See* Ex. 7, Hightower Decl. ¶ 9 ("I . . . couldn't use the phones every other day or third day [on the isolation unit at the jail]."); *Amici* Oral Report at 30 (explaining that the rolling phone cart for residents on the isolation unit "were not available to inmates on one segment of the housing unit").

Poor sanitation and lack of access to cleaning supplies also deters some residents from identifying symptoms for fear of being sent to the isolation unit. One resident who spent 14 days on an isolation unit reports that "[d]uring the 14 days in [isolation], [he] did not receive any soap" or "clean clothes." Ex. 33, Swint Decl. ¶¶ 18-19. Nor are residents in isolation allowed to use the mail. *Id.* ¶ 22.

Defendants are also not disinfecting materials that pass between isolation units and general population units, fueling the spread of the virus in the facility. Kenard Johnson, a 54-year-old resident at CTF, tested positive for COVID-19 on April 12, 2020, and was instructed to take his "sheets, mattress, and clothes with [him]" from his housing unit into the isolation unit. Ex. 9, K.

Johnson Decl. ¶ 10. A week later, Mr. Johnson was returned to his same housing unit, and he "took [the] same sheets, mattress, and clothing with [him] from isolation to [his housing unit]," even though they "had still not been washed since [he] had tested positive for COVID-19." *Id.* ¶ 12. Weeks later, he is still using the same sheets since he tested positive. *Id.*

These conditions not only spread the virus themselves, they also discourage residents from reporting symptoms for fear of transfer to a punitive housing unit. Without improved conditions in the housing units for residents who test positive, some residents will avoid seeking help when they need it, putting not only themselves but also their cellmates and their entire housing unit at risk. In spite of this Court's April 19 Order, DOC has not taken the necessary steps to improve conditions on isolation units.

v. Legal call access

The Court ordered Defendants to "ensure that all inmates . . . have access to confidential, unmonitored legal calls of a duration sufficient to discuss legal matters." TRO Order at 3. As *amici* and residents report, that has not happened.

Residents have two options to speak to their lawyer: they can call their attorney from a phone on their housing unit, or their attorney can prearrange a legal call that is provided from a housing correctional officer's phone. Neither mechanism complies with the Court's order.[7]

First, before residents can make a call from the housing unit phone, they have to be let out of their cells. But as *amici* observed, residents are frequently locked in their cells for days at a time without any ability to use the housing unit phone. *Amici* Oral Report at 17 ("[I]nmates do not receive an hour out of their cells daily."); *see also, e.g.*, Ex. 3, Jenkins Decl. ¶ 10 ("While I was

[7] *Amici* report that some residents on isolation status have access to a rolling cart that does permit those residents to make an unmonitored legal call from their cell. *See Amici* Oral Report at 29-30.

on South 2 [between April 13 and May 1], I would go several days without being allowed out of my cell."); Ex. 34, Banks Decl. ¶ 5 (resident declaring on May 13 that "this week, I received one hour of recreation on May 10, 2020. I have not had another day of recreation this week yet."). Even when residents are let out of their cells, as *amici* report, they are often let out in the middle of the night when a legal call (or any call at all) is not feasible. *See Amici* Oral Report at 33; *see, e.g.*, Ex. 10, Cooper Decl. ¶ 13 ("Sometimes I am not let out for my hour of recreation time. Sometimes when they do let me out it is done at 3:00 in the morning so I cannot call my family or attorney."); Ex. 22, Phillip Decl. ¶ 5 ("When we are let out of our cells for an hour it is often in the middle of the night."). On top of that, calls from the housing unit phone are not confidential and are overheard by other jail residents and staff on the housing unit. *See* Ex. 10, Cooper Decl. ¶ 20 ("If I am able to make a call from the unit phone, it is not a private, confidential call. Other inmates on the unit and the guards can all hear my half of the conversation.").

The second mechanism — calls initiated by attorneys and placed in the case managers' offices — also do not comply with the Court's order, because they are not confidential. *Amici* confirm that calls "are being conducted in the offices of case managers with the case manager present." *Amici* Oral Report at 33; *see also, e.g.*, Ex. 9, K. Johnson Decl. ¶ 16 ("On April 27, 2020, I had a legal call in the case manager's office. The case manager was sitting right there during the legal call and could hear the conversation."). Access to these calls is also spotty, because, as the Court noted in its order, "[t]elephone calls in confidential settings are generally organized by DOC case management staff; however, most of those staff are either on quarantine or working remotely." TRO Op. at 22.

Simply put, Defendants are not complying with the Court's Order of April 19 requiring Defendants to "ensure that all inmates . . . have access to confidential, unmonitored legal calls of a duration sufficient to discuss legal matters," TRO Order at 3.

vi. Understaffing

Underlying nearly all of the above deficiencies — in enforcing social distancing, in providing medical care, in scheduling legal calls, in sanitation — is the chronic and severe understaffing of DOC facilities. *Amici*'s initial report revealed that understaffing across DOC posts was a significant hindrance to the effective implementation of policies and procedures to contain and treat COVID-19. *Amici* reported that "[t]he failure to enforce social distancing requirements is a supervision deficit . . . [that] appears at least in part to be attributable to significant understaffing of correctional officers and their supervisors at both facilities." *Amici* Initial Report at 20. The implementation of the "urgent care system" also depends on "the availability of escort staff [and] willingness of correctional officers to facilitate calls to medical staff while they perform other duties on the unit." *Amici* Initial Report at 10. The Court agreed, explaining that "[u]nderstaffing during a crisis situation such as the COVID-19 pandemic makes it difficult to enact and enforce the necessary precautionary measures," TRO Op. at 15, and ordering Defendants to "address[] limitations in current staffing levels [and] supervisory oversight of line staff," TRO Order at 2.

In spite of the Court's Order, understaffing persists. *Amici* observed, consistent with staff and managers' reports, "that [DOC is] currently staffing lower than the levels that they normally staff at because they do not have sufficient staff." *Amici* Oral Report at 23. Housing units that "normally have five or even six correctional officers . . . have three or four correctional officers" staffing the entire housing unit. *Id.* As noted above, in addition to affecting the enforcement of

social distancing, these "significant correctional officer staffing shortages" also pose a barrier to accessing medical care, as residents rely on housing unit correctional officers to pass out and collect sick call slips. *See id.*at 17. Dr. Meyer explains how chronic understaffing can be deadly for DOC residents. "Even the most comprehensive protocols and policies that are informed by science are totally meaningless if not implemented, enforced, and continuously monitored. Implementation will be challenging if not impossible in DC DOC, which is strained by severe understaffing." Ex. 1, Supp. Meyer Decl. ¶ 12.

Reports from DOC staff members themselves reveal just how dire the staffing situation is. On May 3, 2020, one housing unit at CDF had *just one officer* working on the housing unit. *See* Ex. 15, DOC Docs. at 10. Staff members report working unconscionably long shifts — over 24 hours — during which they cannot possibly complete all of their job responsibilities. *See id.* at 6 (reporting that two officers were on duty "for 25 hours" and requesting relief "as soon as possible because we are very tired and exhausted"); *id.* at 4-5 (listing six correctional officers who worked over 24-hour shifts on April 26); *see also id.* at 8 (officer reporting that he had worked over a 16-hour shift on a housing unit without a single break). On May 4, an officer worked a 22-hour shift without relief, collapsed on the floor of the housing unit, and was rushed to the hospital. *Id.* at 13.

The chronic understaffing in DOC facilities, which would be a crisis in any context, creates particularly dangerous conditions for DOC residents now. Residents who are positive for COVID-19 rely on frequent checks from correctional officers to ensure that their symptoms do not rapidly escalate — a crucial function, as the CDC advises that "some patients . . . rapidly deteriorate one week after illness onset."[8] Nevertheless, residents report a critical lack of staffing on units housing

[8] CTRS. FOR DISEASE CONTROL & PREVENTION, *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)* (2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

positive residents: "On May 2, 2020 I was having difficulty breathing. I tried to get the attention of a correction officer for multiple hours. No one walked the unit and no one came to check on me." Ex. 11, Horne Decl. ¶ 3(m).[9]

Residents who have medical conditions other than COVID-19 also face severe health risks because of understaffing. Residents are routinely told that medical issues that are not directly related to COVID-19 cannot be addressed during the pandemic. One resident's "tonsils started hurting in April," with the "pain as a 4 on a scale of 1-10." Ex. 23, Randolph Decl. ¶ 8. Medical staff informed him that his tonsils needed to be removed, but they could not perform the operation "because of COVID-19." *Id.* ¶ 8. Now, weeks later, the pain is a "10," Mr. Randolph "cannot sleep because of the pain," and it "hurts to speak." *Id.* "I am almost in tears right now because of how much it hurts to speak." *Id.* Other chronic conditions, such as kidney disease, have been ignored while medical resources are stretched too thin. *See* Ex. 24, Miller Decl. ¶¶ 3-4 (a resident with "sharp pains near [his] kidneys" was removed from the list of residents who needed to see medical staff because "there were too many people" on the list); *see also* Ex. 36, Howard Decl. ¶ 13 ("[M]edical told me I needed teeth pulled but that they would not be able to pull my teeth until after COVID-19 was over."). One man who had an MRI related to a diabetic condition on March 20 was completely unable to see his physician for a month following the MRI. Ex. 6, Jaggers Decl. ¶ 14.

Dr. Meyer explains that neglecting conditions other than COVID-19 actually increases the risk of death or serious illness when residents contract COVID-19. Not only does understaffing

[9] This problem is compounded by correctional officers' fear of contracting the virus: "Some correctional officers refuse to come near me and other inmates who have tested positive for COVID-19. A female correctional officer ordered me and other inmates to stay away from her and stated, 'stay away, y'all got that shit' in a dehumanizing fashion." Ex. 16, Burl Decl. ¶ 10.

"result in undue negative health outcomes related to chronic health conditions, but also increased risk of complicated COVID-19 infections for people living with underlying health conditions like diabetes, chronic lung disease, heart disease, and kidney disease." Ex. 1, Supp. Meyer Decl. ¶ 13.

Understaffing may also contribute to disciplinary issues between residents and staff. As *amici* report, and DOC officers confirm, officers are tired and forced to work overtime — factors that contribute to disturbances in the facility. *Amici* Oral Report at 37. Disturbances, in turn, can impede access to medical care. *See id.* at 25 (noting times when "an incident . . . precluded the [medical] provider from entering the unit"). These incidents also result in the use of mace against residents, which contributes to violent coughing. DOC officers used mace to resolve "an argument with a CO over toilet paper," Ex. 13, Robertson Decl. ¶ 16; when they perceived a resident as talking on the phone too long, Ex. 25, Barksdale Decl. ¶ 7; and when they perceived a shower as taking too long, Ex. 26, Lucas Decl. ¶ 6. The use of mace on quarantine units, where some residents have been exposed to COVID-19, is commonplace. *See, e.g.*, Ex. 27, Moseley Decl. ¶ 9 ("On April 27, 2020, corrections officers used mace on an inmate in the quarantine unit who was also positive for COVID-19. On April 30, the day I was released, eight people got maced, including myself."); Ex. 28, P. Johnson Decl. ¶ 8 ("On or about May 1, 2020, a person was maced on my unit. I could smell the mace for days. It had me coughing and makes my nose and throat scratchy."). The use of mace on isolation units, where residents are positive for COVID-19 and already facing respiratory challenges, is also concerning. *See* Ex. 11, Horne Decl. ¶ 3(n) ("On April 30, 2020, correctional officers sprayed mace in the [isolation] Unit, which made it even harder to breathe."); Ex. 33, Swint Decl. ¶ 27 (officers used mace on resident of isolation unit who "asked a correctional officer for tissues").

The consistent use of mace as a disciplinary tool is contributing to the spread of COVID-19 among residents and staff. Dr. Meyer explains that mace "may actually facilitate disease transmission" because "inhaled irritants disrupt the mucous membranes of the nose, throat, and upper respiratory system that can increase risk of COVID-19 infection if exposure occurs. The irritants also cause people to cough, thereby increasing potential disease transmission." Ex. 1, Supp. Meyer Decl. ¶ 10.

The continued understaffing in DOC puts residents at serious risk. Residents who may have COVID-19 cannot access medical care unless a housing unit officer is available to let them out of their cells, provide them a sick call form, collect that form, and transmit it to the medical staff. Residents who are confirmed positive rely on correctional officers to regularly observe them for the rapid onset of symptoms requiring emergency treatment. Without an appropriate number of officers in DOC facilities, residents continue to be at grave risk of serious injury or death.

vii. Structural problems in the facilities

Several problems identified by Plaintiffs were beyond *amici*'s charge to investigate but nevertheless persist. These structural features of DOC facilities were identified by Dr. Meyer, and cited by the Court, as contributing to the "rapid spread" of COVID-19 in Defendants' facilities. Specifically, Dr. Meyer identified the lack of "negative pressure rooms" for the treatment of infected persons to ensure that the virus is not transmitted "through droplets to others" and the lack of sufficient ventilation, which "promotes highly efficient spread of diseases through droplets." Dkt. No. 5-2 ("First Meyer Decl."), at ¶ 28(c). In this Court's opinion granting a temporary restraining order, the Court explained that "the quarantine unit is not properly sealed off from the general population," and expressed particular concern that the "ventilation conditions described in the District of Columbia's Auditor's report . . . will increase the rate of the spread of the virus."

TRO Op. at 21 (quoting First Meyer Decl. ¶ 28(c)). There is no indication that the DOC has addressed the significant ventilation challenges that promote the spread of the virus in the D.C. jail. Accordingly, Dr. Meyer "reaffirm[s] [that] the deficiencies identified in [her] earlier declaration regarding poor ventilation and insufficient medical facilities to control the spread of COVID-19" continue to pose risks of serious injury to DOC residents. Ex. 1, Supp. Meyer Decl. ¶ 3.

B. Plaintiffs and proposed class members face irreparable harm.

This Court has already held that "Plaintiffs' risk of contracting COVID-19 and the resulting complications, including the possibility of death, is the prototypical irreparable harm." TRO Op. at 23. The Court so concluded because Plaintiffs demonstrated that they are "at a significantly higher risk of infection with COVID-19 as compared to the population to the community" and "at a significantly higher risk of harm if they do become infected." *Id.* at 24. "Given the gravity of Plaintiffs' asserted injury, as well as the permanence of death, the Court finds that Plaintiffs have satisfied the requirement of facing irreparable harm unless injunctive relief is granted." *Id.*

Plaintiffs and proposed class members continue to be at risk of irreparable harm. Weeks after the Court's Order, DOC residents are nearly fourteen times more likely to contract COVID-19 than other District of Columbia residents.[10] And as *amici*'s report and declarations from DOC residents make clear, access to medical care in DOC facilities remains troublingly inconsistent.

[10] The government's data of May 15, 2020, reported 6,871 positive COVID-19 tests in the District, and 180 positive COVID-19 tests among DOC residents. *See* District of Columbia, Coronavirus Data (last accessed May 15, 2020), https://coronavirus.dc.gov/page/coronavirus-data. As of May 15, 2020, there were around 1,325 people in DOC custody, and the most recent Census Bureau population estimate for the District of Columbia was 705,749, see U.S. Census Bureau, QuickFacts - District of Columbia (last accessed May 15, 2020), https://www.census.gov/quickfacts/DC. Therefore, the rate of infection in the District of Columbia was 0.97 percent, while the rate of infection in the DOC was 13.58 percent.

See, e.g., *Amici* Oral Report at 18-19 (reporting that 12 percent of sick call requests from the CTF were collected over two weeks after they were submitted); Ex. 4, Perry Decl. ¶ 8 (reporting that a housing unit "ran out of sick slips" for a week). This factor continues to support injunctive relief.

C. The balance of hardships and the public interest weigh in Plaintiffs' favor.

This Court previously held that "the public interest weighs in favor of granting injunctive relief." TRO Op. at 24. As the Court explained, there could be "no harm to the Government when a court prevents unlawful practices," *id.* at 25, like those Plaintiffs were likely to succeed in showing. The Court also credited the public interest in safeguarding public health by reducing the risk of infection to DOC residents, and found that the requested relief "does not impose an undue burden on Defendants." *Id.*

Here again, the balance of hardships and the public interest continue to favor Plaintiffs. Because Plaintiffs remain likely to prevail on the merits, the balance of hardships and the public interest in preventing unconstitutional harm weigh in favor of granting injunctive relief. Moreover, as Dr. Stern explains, downsizing the population of the jail will "help to 'flatten the curve' overall — both within the jail setting and without." Stern Decl. ¶ 14. That is because, given the churn of people — residents, staff, visitors — through Defendants' facilities, the outbreak of COVID-19 in the jail will be impossible to confine to DOC facilities. Compounding the problem, Dr. Stern explains, is that "vulnerable populations are at the highest risk of severe complications from COVID-19, and . . . when they develop severe complications they will be transported to community hospitals — thereby using scarce community resources (ER beds, general hospital beds, ICU beds)." *Id.* ¶ 13. Accordingly, these two factors remain in Plaintiffs' favor.

D. The Court should join other federal courts and expand the requested relief to safely transition a portion of DOC residents into community supervision.

To avert the horrific consequences of the unmitigated spread of COVID-19, federal courts around the country have granted class-wide relief, through the use of the writ of *habeas corpus*, to ensure the health and safety of incarcerated people. That relief has taken the form of a court-established "process by which inmates would be evaluated promptly for transfer to home confinement," *Martinez-Brooks*, 2020 WL 2405350, at *2 n.1; *see also Wilson*, 2020 WL 1940882, at *10-11 (same); or an outright order of release of vulnerable residents, *see Thakker v. Doll*, No. 20-cv-480 (JEJ), 2020 WL 2025384, at *12 (M.D. Pa. Apr. 27, 2020). A federal court in California directed a facility to provide it with the "names, ages, any health vulnerabilities, and any criminal information" regarding each confined person, so that the Court, "likely with the assistance of several Magistrate Judges," could "implement a system for considering individual bail applications" over a two-week period, *Rivas*, 2020 WL 2059848, at *3; that court is currently considering those applications and granting, deferring, and denying release on an aggregate basis. *See, e.g.*, Bail Order No. 4, Dkt. No. 115, *Rivas*, 20-cv-2731 (JC) (N.D. Cal. May 7, 2020) (denying one bail request without prejudice, deferring three bail requests, and granting two bail requests with particular conditions). The *Rivas* court modeled its procedure on one adopted by the District of Massachusetts, which "relied on its inherent authority expeditiously to review bail applications for all of the detainees in the class, one by one, and released almost a third of them to house arrest under strict conditions." *Savino v. Souza*, No. 20-cv-10617 (WGY), 2020 WL 2404923, at *1 (D. Mass. May 12, 2020).

These diverse federal courts have recognized that where plaintiffs are likely to succeed on the merits of their claim that they "face a grave risk of serious illness or death due to COVID-19," and where they are likely to succeed in showing that "prison officials knew of and disregarded an

excessive risk to inmate health or safety," urgent and decisive action is needed. *Martinez-Brooks*, 2020 WL 2405350, at *31 (cleaned up). Each court established processes for the transition of incarcerated people into safer community settings, doing so in even less dire circumstances than those here. For instance, in *Martinez-Brooks*, the Court used its *habeas* authority to establish a structured release mechanism after 69 out of around 1,000 residents tested positive, *see* 2020 WL 2405350, at *4 — about half the rate of positive tests in Defendants' facilities. In *Wilson*, the Court relied on its *habeas* power to do the same after 59 out of around 2,500 residents tested positive. *See* 2020 WL 1940882, at *2. And in *Thakker*, where 40 residents, out of around 250, had confirmed cases (a rate closer to the rate of infection in DOC facilities), the Court granted outright release on a class-wide basis. *See* 2020 WL 2025384, at *8.

The spreading pandemic at the D.C. Jail calls urgently for the kind of relief that these courts have ordered. As described by *amici* and confirmed by DOC residents and staff, Defendants either will not, or cannot, comply with the Court's temporary restraining order. Chronic understaffing undermines the implementation of the Court's clear directives to "ensure appropriate and consistent implementation of social distancing policies," to "ensure that the triage process associated with sick call requests on the non-quarantine units is expedited," and to "ensure that all inmates . . . have access to confidential, unmonitored legal calls," to name just a subset of areas described above where Defendants have fallen short. TRO Order at 2-3. Having demonstrated that DOC cannot implement Court-ordered reforms over a timespan of four weeks, while the number of positive cases in their facilities rises rapidly, Defendants cannot be entrusted with the health and safety of its residents. Greater action is necessary.

That greater action should include reducing the population of DOC residents. Plaintiffs' experts and other federal courts agree that reducing the confined population is the most important

step to ensure the health and safety of DOC residents and the community. As Dr. Stern explained, downsizing the population of the jail will "help to 'flatten the curve' overall — both within the jail setting and without." Stern Decl. ¶ 14. "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." *Id.* ¶ 13. After specifically reviewing the particular outbreak in, and conditions at, DOC facilities, Dr. Stern was "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." *Id.* ¶ 11. Dr. Meyer agrees that "[r]educing 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." Meyer Decl. ¶ 34. From a "public health perspective," Dr. Meyer is "strongly of the opinion that individuals who are already in those facilities should be evaluated for release." *Id.* at ¶ 35; *see also Basank v. Decker*, No. 20-cv-2518 (AT), 2020 WL 1481503, at *6 (S.D.N.Y. March 26, 2020) ("[P]ublic health and safety are served best by rapidly decreasing the number of individuals detained in confined, unsafe conditions.").

Having reviewed *amici*'s findings, the Court's Order, and the record, Dr. Meyer is even more firmly convinced that release is necessary to improve the conditions in DOC facilities:

> Reduction in the size of the prison population is a public health strategy that supports all of the above infection prevention and control efforts. When people inside the facility have the physical space to socially distance and the inmate population is small enough for the staff to enforce social distancing and proper sanitation, there is reduced disease transmission. A reduced inmate population also results in the greater availability of adequate medical attention. Finally, it improves safety because appropriate supervision is assured.

Ex. 1, Supp. Meyer Decl. ¶ 14. Through the writ of *habeas corpus*, the Court has the authority to ensure residents' safety and to implement the clear recommendations of public health officials.

i. The Court can, and should, grant release as a remedy for unconstitutional conditions of confinement.

This Court's power to order relief for constitutional violations using the writ of *habeas corpus* is both substantial and flexible. "Habeas is at its core a remedy for unlawful executive detention." *Munaf v. Geren*, 553 U.S. 674, 693 (2008). It exists to allow prisoners to challenge "the fact or duration of [their] confinement," and, as provided in both the U.S. Constitution and federal law, empowers federal courts to rectify wrongful confinement. *Wilkinson v. Dotson*, 544 U.S. 74, 78 (2005); *see* 28 U.S.C. §§ 2241, 2243. The Supreme Court has made clear that *habeas corpus* is "above all, an adaptable remedy." *Boumediene v. Bush*, 553 U.S. 723, 779 (2008). The writ "is not now and never has been a static, narrow, formalistic remedy; its scope has grown to achieve its grand purpose — the protection of individuals against erosion of their right to be free from wrongful restraints upon their liberty." *Jones v. Cunningham*, 371 U.S. 236, 243 (1963).

Consistent with the Supreme Court's pronouncements on the flexibility and breadth of the *habeas* remedy, the D.C. Circuit has explicitly held that release is a proper remedy for conditions of confinement claims. In *Aamer v. Obama*, 742 F.3d 1023 (D.C. Cir. 2014), the Court held that Circuit "precedent establishes that one in custody may challenge the conditions of his confinement in a petition for *habeas corpus*." *Id.* at 1032. The *Aamer* Court went on to explain that as a remedy for a *habeas* petition challenging conditions of confinement, "a court may simply order the prisoner released unless the unlawful conditions are rectified, leaving it up to the government whether to respond by transferring the petitioner to a place where the unlawful conditions are absent or by eliminating the unlawful conditions in the petitioner's current place of confinement." *Id.* at 1035; *see also id.* at 1036 ("Where the specific detention abridges federally protected

interests — by placing petitioner in the wrong prison, denying him treatment, imposing cruel and unusual punishment, impeding his access to the courts, and so on — it is an unlawful detention *and habeas lies to release the petitioner therefrom*.").

Applying *Aamer* and other circuit cases holding the same, "many courts have found that insufficient jail action in light of the virus can serve as a basis for release." *Cristian R. v. Decker*, No. 19-cv-20861 (SDW), 2020 WL 2029336, at *2 (D.N.J. Apr. 28, 2020) (collecting cases). Thus, the Court can — and should — exercise its *habeas* authority to release DOC residents who can be safely supervised outside of the dangerous D.C. jail.

ii. The Court can also order release without granting habeas petitions at this juncture by temporarily enlarging Plaintiffs-Petitioners' custody.

Even if the Court is not prepared to grant writs of *habeas corpus* at this stage, the Court can still effectuate release by temporarily "enlarging" Plaintiffs' custody. District courts have authority, when *habeas* petitions are pending, to "enlarge" the custody of petitioners. Enlargement is a provisional remedy that modifies custody by expanding the site in which it takes place. Enlargement is not release; the person remains in custody, even as the place of custody is changed, or enlarged, from a particular prison to a hospital, halfway house, a person's home, or another setting.

The D.C. Circuit (and others) have recognized the inherent authority of district courts to enlarge the custody of *habeas* petitioners during the pendency of a *habeas* proceeding. *Baker v. Sard*, 420 F.2d 1342 (D.C. Cir. 1969), held that "[w]hen an action pending in a United States court seeks release from what is claimed to be illegal detention, the court's jurisdiction to order release as a final disposition of the action includes an inherent power to grant relief pendente lite, to grant bail or release, pending determination of the merits." *Id.* at 1343; *see also United States v. Kelly*, 790 F.2d 130, 139 (D.C. Cir. 1986) (recognizing in a habeas proceeding that a district court can

order interim bail or release before a final ruling on the merits); *accord Woodcock v. Donnelly*, 470 F.2d 93, 94 (1st Cir. 1972) (per curiam).

This Court has applied a two-prong test in determining whether to grant enlargement while a *habeas* petition is pending. Plaintiffs must show "that (1) the [*habeas*] petition is based on a substantial claim of law, and (2) the motion for bail is based on exceptional circumstances deserving of special treatment." *Meskel v. United States*, No. 04-cr-53 (RMU), 2005 WL 1903375, at *2 (D.D.C. July 13, 2005). Plaintiffs meet both requirements.

First, the petitions here are based on substantial claims of law. As this Court has already held, Plaintiffs are likely to succeed in showing Fifth and Eighth Amendment violations. TRO Op. at 9. And these violations are of the most serious kind: that Defendants are deliberately indifferent to the substantial risk of death or serious harm that Plaintiffs face in light of a global pandemic. It is not surprising, then, that other courts that have granted enlargement have recognized that deliberate indifference to COVID-19 is a substantial claim of law. *Hernandez v. Decker*, No. 20-cv-1589 (JPO), 2020 WL 1547459, at *3 (S.D.N.Y. Mar. 31, 2020); *see also Coronel v. Decker*, — F. Supp. 3d —, No. 20-cv-2472 (AJN), 2020 WL 1487274, at *9 (S.D.N.Y. Mar. 27, 2020) (same); *Savino*, 2020 WL 1703844, at *8 (same); *Wilson*, 2020 WL 1940882, at *4 (same); *Clark v. Hoffner*, No. 16-cv-11959 (VAR), 2020 WL 1703870, at *4 (E.D. Mich. Apr. 8, 2020) (same).

As to the second prong of the enlargement inquiry, there can be no doubt that COVID-19 presents exceptional circumstances warranting special treatment. Serious threats to health are the quintessential exceptional circumstances justifying enlargement. *See, e.g., Lucas v. Hadden*, 790 F.2d 365, 367 (3d Cir. 1986) (explaining that risk to a habeas petitioner's health is an "extraordinary circumstance that may justify a grant of bail prior to the disposition of the habeas

petition"). Even the United States has conceded, in other cases, that "health complications" are the type of extraordinary circumstances warranting bail prior to a final determination in a *habeas* proceeding. *Kiadii v. Decker*, 423 F. Supp. 3d 18, 21 (S.D.N.Y. 2018).

The myriad federal courts that have implemented procedures to effectuate release have relied on enlargement to do so. The Court in *Wilson* explained that it had "inherent authority to grant enlargement to a defendant pending a ruling on the merits of that defendant's habeas petition." 2020 WL 1940882, at *4. Because of the "exceptional circumstances at [FCI] Elkton"—a rate of infection that is less severe than that at the D.C. Jail — "and the Petitioners' substantial claims, that are likely to succeed at the merits stage," the Court held that enlargement was the necessary and proper remedy. *Id.* So too in *Rivas* did the Court rely on the "extraordinary" nature of the COVID-19 pandemic to exercise its "authority to release detainees on bail while their *habeas* cases are pending." 2020 WL 2059848, at *3.

Plaintiffs here face even more dire circumstances than the facilities in which courts have exercised inherent authority to enlarge plaintiffs' custody. *See supra* at 29. Without swift relief from this Court, Plaintiffs will continue to face unconstitutional risk to their health and well-being.

iii. The PLRA does not bar release as a remedy.

The Prison Litigation Reform Act ("PLRA") does not preclude the relief requested here. By its terms, the PLRA excludes from its requirements all "*habeas corpus* proceedings challenging the fact or duration of confinement in prison." 18 U.S.C. § 3826(g)(2). Plaintiffs' suit here challenges the fact of Plaintiffs' confinement in the D.C. Jail; it is that fact of confinement in a facility where a pandemic is spreading that poses a significant risk of death or serious injury for Plaintiffs and proposed class members. As the Sixth Circuit explained, in holding that the PLRA did not bar *habeas* relief in analogous circumstances, "Petitioners' proper invocation of § 2241

also forecloses any argument that the PLRA applies given its express exclusion of '*habeas corpus* proceedings challenging the fact or duration of confinement in prison' from its ambit." Order at 3, *Wilson v. Williams*, No. 20-3447 (6th Cir. May 4, 2020) (quoting 18 U.S.C. § 3626(g)(2)); *see also Martinez-Brooks*, 2020 WL 2405350, at *16 -17 (rejecting the application of the PLRA to a class action seeking *habeas* relief under § 2241).

Nor does the PLRA regulate enlargement at all. As relevant here, the PLRA regulates only "prisoner release order[s]." 18 U.S.C. § 3626(a)(3). Enlarging Plaintiffs' custody is plainly not a "release order," because Plaintiffs would still remain in custody, albeit custody of a different form. *See Wilson*, 2020 WL 1940882, at *10 (holding PLRA does not prevent enlargement because it is not release). This comports with the general rule that a transfer from one form of custody to another does not comprise a "prisoner release order" as defined by the PLRA. *See, e.g.*, *Reaves v. Dep't of Correction*, 404 F. Supp. 3d 520, 522 (D. Mass. 2019).

iv. Appointing an expert is the best way to release residents consistent with public health and public safety.

This Court need not embark on a process of assessing individuals' fitness for release or enlargement alone. In *Wilson* and *Martinez-Brooks*, courts established a process to assess fitness for release that involved input from corrections professionals to "evaluate inmates with COVID-19 risk factors for home confinement and other forms of release that is . . . clearly focused on the critical issues of inmate and public safety." *Martinez-Brooks*, 2020 WL 2405350, at *1. Plaintiffs ask the Court to appoint an expert under Federal Rule of Evidence 706 or as an *amicus curiae* who can assist the Court in creating such a process.

Plaintiffs have asked one potential expert — Vincent Schiraldi — to provide the Court with a more detailed understanding of the role that this expert could play. Mr. Schiraldi is the former Director of the District of Columbia's Department of Youth Rehabilitation Services and the former

Commissioner of New York City's Department of Probation. Ex. 29, Schiraldi Decl. ¶¶ 1-2. He explains that the Court's expert would

> work with relevant agencies to create and implement release policies . . . in order to reduce the population so that there is (a) more room to allow for greater separation of inmates in the jail and, when necessary, medical separation and (b) fewer inmates to allow the thinning complement of correctional officers and other staff to adequately implement COVID-19 related policies, as well as secure and provide health care and programming for the reduced population.

Id. ¶ 14. Mr. Schiraldi proposes "[u]tilizing the [Pretrial Services Agency]'s risk assessments" to determine the level of supervision appropriate for released residents. *Id.* ¶ 18. The expert would also, in partnership with the relevant agencies, "oversee the implementation of these release mechanisms, monitor outcomes, [and] report results to the Court on a regular basis." *Id.* ¶ 25.

iv. At a minimum, the Court should maintain the requirements of the TRO and make some of its recommended measures from the prior order mandatory.

Whatever the Court orders regarding reducing the population confined in DOC facilities, it should require that Defendants improve conditions at its facilities — and do so immediately. To achieve this result, Plaintiffs ask that the Court to convert the TRO into a preliminary injunction after modifying it to require that Defendants take concrete steps to address the ongoing deficiencies that *amici* identified in the May 11 hearing.

Converting the TRO into a preliminary injunction is necessary because the risks that the TRO sought to address remain and have even worsened in the weeks since the TRO issued. It is still the case that "individuals placed in [CDF and CTF] are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at significantly higher risk of harm if they do become infected." TRO Op. at 13 (quoting First Meyer Decl. ¶ 33; alteration in original); *see* Ex. 1, Supp. Meyer Decl. ¶ 3. It also remains the case that Plaintiffs "cannot take the same precautions as those who are not detained," TRO Op. at 13; *see*

also Amici Oral Report at 43 ("[T]here still isn't a prevalence of social distancing" at the CTF and CDF). These facts led the Court to issue the TRO and their persistence justifies extending it.[11]

Other conditions motivating the TRO remain unaddressed as well. For example, while the Court ordered Defendants to ensure that "medical staff are promptly informed about inmates who present with symptoms of COVID-19," TRO Order at 1, inmates who complain of those symptoms still wait days for medical attention — if they receive any at all. *See Amici* Oral Report at 20 (in two-thirds of randomly sampled sick calls involving COVID-19 conditions at the CDF, inmates were seen a minimum "of two days after the request was submitted"); Ex. 3, Jenkins Decl. ¶ 7 (stating that, despite concerns of having COVID-19 symptoms, resident placed three sick calls and did not receive treatment). The Court also ordered Defendants to allow inmates to "have access to confidential, unmonitored calls," "immediately" provide inmates "proper cleaning supplies," and "take immediate steps to provide . . . daily showers . . . to all inmates on isolation status." TRO Order at 2-3. However, nearly a month after the order, many inmates still cannot call their lawyers in private, *Amici* Oral Report at 32, do not have sufficient cleaning supplies to clean their cells, *id.* at 41, and go days without showering, *id.* at 34; Ex. 2, Thomas Decl. ¶ 16. The need for these reforms has only increased with time, *see* Ex. 1, Supp. Meyer Decl. ¶ 3, and the Court should demand that Defendants make them.

The Court also should go further. Defendants' track record justifies a "more comprehensive order to insure against the risk of inadequate compliance." *Hutto v. Finney*, 437 U.S. 678, 687

[11] Even if Defendants had successfully eliminated these risks—which they have not—the court would retain power to grant injunctive relief. Its authority to do so "survives discontinuance of illegal conduct, and because the purpose is to prevent further violations, injunctive relief is appropriate when there is a cognizable danger of recurrent violation." *U.S. Dep't of Justice v. Daniel Chapter One*, 89 F. Supp. 3d 132 (D.D.C. 2015) (quoting *United States v. W.T. Grant Co.*, 345 U.S. 629 (1953)), *aff'd*, 650 F. App'x 20 (D.C. Cir. 2016).

(1978). So too do the observations of *amici* and the professional opinion of Dr. Meyer, which demonstrate that crucial safeguards remain unimplemented. *See, e.g.*, *Amici* Oral Report at 16-21 (discussing delays in obtaining medical attention); Ex. 1, Supp. Meyer Decl. ¶ 3. For example, whereas the TRO recommended that Defendants "retain a registered sanitarian to oversee the[ir] environmental health and safety programs," TRO Order at 2, the preliminary injunction should *require* Defendants to do so. To Plaintiffs' knowledge, Defendants have not hired such an expert; perhaps as a result, inmates continue to lack cleaning supplies and fresh linens. Ex. 2, Thomas Decl. ¶ 16; Ex. 3, Jenkins Decl. ¶ 16. Accordingly, the preliminary injunction should require Defendants to take the step that the TRO suggested and retain a sanitarian.

The Order should also add specificity to the TRO's mandates. For instance, in order to ensure access to confidential legal calls, the Court should require that Defendants provide every inmate with a cell phone. The Court has asked Defendants to address the confidential legal call issue since the very first hearing in this matter more than six weeks ago. Dkt. No. 18 at 35. Ordering cell phones for inmates — an idea the Court proposed, Dkt. No. 33 at 54 — would address the legal-call issue by allowing inmates to contact their attorneys from their cells. Defendants expressed openness to this idea at the most recent hearing, stating that they had begun "looking at" cell phones. *Amici* Oral Report at 46. The preliminary injunction should require they provide them.

Regarding medical care, the Court should mandate that Defendants create a 24-hour medical hotline that inmates can contact using the tablets that Defendants currently possess or cell phones to be provided. The existing system for requesting medical attention simply does not work. And the delays it causes not only prolong the time inmates suffer without medical attention but

also increase the risk that individuals who have contracted the virus will spread it. A direct line between inmates and the medical unit would mark a significant advance in addressing these issues.

Finally, the Order should include specific timelines and safeguards to ensure compliance. Specifically, within five days of the Court's order, Defendants should be required to purchase the cell phones, establish the medical hotline, and provide a status update on its plan for implementing the other actions covered in the order. The Court should further direct the parties to confer within 10 days of the order to develop an information-sharing arrangement that allows Plaintiffs to take discovery and confirm Defendants' ongoing adherence to the Court's commands.

"To incarcerate, society takes from prisoners the means to provide for their own needs. Prisoners are dependent on the State for food, clothing, and necessary medical care. . . . Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care." *Brown v. Plata*, 563 U.S. 493, 510-11 (2011). Since this crisis began, Defendants have had the responsibility to take appropriate precautions to protect the Plaintiffs in their care. For nearly a month, that constitutional duty has taken concrete form in this Court's TRO. Yet conditions at the D.C. Jail remain dire, and the number of residents and staff who have tested positive for COVID-19 cases continue to rise. In the face of Defendants' unwillingness or inability to meet their constitutional requirements, this Court should impose requirements commensurate with the seriousness of the crisis and the risks to Plaintiffs' lives.

CONCLUSION

The Court should grant Plaintiffs' Motion for a Preliminary Injunction.

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Washington, D.C.

Respectfully submitted,

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