

EXHIBIT 1

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.
2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. In 2017-2018, I volunteered to run monthly AIDS awareness programming at Danbury FCI and FSL federal prisons for women in Danbury, Connecticut. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.
3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.
4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.
5. I am being paid \$200 per hour for my time reviewing materials and preparing this report.

6. I have not testified as an expert at trial or by deposition in the past four years.
7. I have been asked by the Public Defender Service for the District of Columbia to review and comment on materials in connection with a case to be filed on behalf of certain incarcerated individuals who are at an increased risk of contracting and developing complications from exposure to COVID-19. I was specifically asked to comment on jail conditions during and preparedness for the COVID-19 pandemic.
8. In addition to my knowledge, training, education, and experience in the field of prison healthcare and infectious diseases, and the resources relied upon by experts in infectious diseases and prison health, I also reviewed specifically the Centers for Disease Control and Prevention (CDC) guidance on management of COVID-19 in correctional facilities (available at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>), the Bureau of Prisons (BOP) modified operations plan (available at https://www.bop.gov/coronavirus/covid19_status.jsp), the National Commission on Correctional Health Care (NCCHC) materials on COVID-19 (available at <https://www.ncchc.org/COVID-Resources>), and the World Health Organization interim guidance on Preparedness, prevention and control of COVID-19 in prisons and other places of detention (available at http://www.euro.who.int/_data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1).

II. Heightened Risk of Epidemics in Jails and Prisons

9. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.
10. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.
11. Reduced prevention opportunities. Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through

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

12. Disciplinary segregation or solitary confinement facilities is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff. Because incarcerated people may perceive quarantine as punitive, or as a living arrangement that allows fewer privileges than their regular housing, incarcerated people may be deterred from self-reporting symptoms to medical staff. As a result, they may remain in congregate settings while infected, potentially transmitting infections to others.
13. Reduced prevention opportunities. During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.
14. Reduced prevention opportunities. During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.
15. Increased susceptibility. People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.¹ This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.
16. Jails and prisons are often poorly equipped to diagnose and manage infectious disease

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

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

17. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.
18. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.
19. Health safety. As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.
20. Safety and security. As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.
21. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.² Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in

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

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

III. Profile of COVID-19 as an Infectious Disease⁴

22. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to nor developed protective responses against this virus. A vaccine is currently in development but will likely not be available for at least another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for use in clinical trials. People in prison and jail will likely have even less access to these novel health strategies as they become available.
23. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.⁵ Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.⁶ Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially

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

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

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

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

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

24. The care of people who are infected with COVID-19 depends on how seriously they are ill.⁷ People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.
25. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.
26. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place. Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

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

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

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

- ii. Report resulting from a non-profit agency inspection of the DC jails:
 - Washington Lawyers' Committee for Civil Rights and Urban Affairs, "D.C. Prisoners: Conditions of Confinement in the District of Columbia" (published June 11, 2015)
- iii. Declarations from those living and working within the DC jails:
 - CTF inmates Keon Jackson and Eric Smith
 - CDF inmates D'Angelo Phillips and Edward Banks
 - Public Defender Service staff who entered the jail facilities to meet with clients and who have conducted phone interviews with clients regarding conditions within the jails:
 - Division Chief Jonathan Anderson;
 - Supervising Attorney Joseph Wong;
 - Supervising Attorney Ieshaah Murphy;
 - Staff Attorney Daniel Pond;
 - Staff Attorney Rachel Cicurel;
 - Staff Attorney Ronald Resetarits;
 - Staff Attorney Kavya Naini;
 - Investigative Intern Eileen Johnson;
 - Investigative Intern Katherine Kuenzle;
 - Investigative Intern Samuel Cyphers;
 - March 25, 2020 Fraternal Order of Police Department of Corrections Labor Committee Letter to Quincy L. Booth

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

a. General Prevention Practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


29. The above examples illustrate that the D.C. DOC remains unprepared to address the current COVID-19 pandemic. As the CDC acknowledges, even a prison operating precisely under its guidelines would be a far more dangerous environment than the community, given the mayor’s directive to remain at home and business and school closures in place.
30. D.C. DOC’s inability to adequately contain and treat COVID-19 is especially concerning for higher risk individuals, such as older adults and people with chronic illnesses such as diabetes, liver disease, pregnancy, heart disease, and lung disease. People with these particular characteristics are most susceptible to becoming seriously ill or even dying should they become infected with COVID-19.
31. There is true urgency to act on these facts now. Data from the US during other infectious disease outbreaks (e.g. influenza) and data from other countries during COVID-19 show that when prison systems are unprepared for pandemics, people in prison experience much higher rates of morbidity and mortality than even affected communities. Such crises within prisons endanger communities as a whole by increasing the overall number of cases and increasing pressure on hospitals. There is no current approved vaccine or antiviral medication treatment for COVID-19 so public health preparedness is the only tool we have.
32. Inadequate screening and testing procedures in facilities, including failing to test inmates who have demonstrated symptoms of COVID-19, increase the widespread COVID-19 transmission.

V. Conclusion and Recommendations

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

34. Reducing the size of the population in jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large.
35. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in DC jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.
36. This is especially important for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 65. Nonetheless, it remains the case, given the conditions in the DC jails, that everyone in the CDF and CTF is right now at serious risk of contracting COVID-19 and, if that occurs, of dying from it.
37. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for rapid and severe COVID-19 spread in these facilities is a matter of hours not days. Once a case of COVID-19 is identified in a facility, it is only a matter of time until there is a widespread outbreak. In the past several days, first one, then two, and now four, inmates in D.C. DOC custody have tested positive for COVID-19 with many inmates reportedly in quarantine. More cases are sure to follow because of under-resourced, under-staffed, or minimally implemented infection prevention and control measures.

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



Dr. Jaimie Meyer

March 29, 2020
Wilton, Connecticut