IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

STEPHANIE GASCA, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 17-cv-04149
	)	
ANNE PRECYTHE, et al.,	)	
	)	
Defendants.	)	

SUGGESTIONS IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION
FOR RELIEF PURSUANT TO ALL WRITS ACT

In light of the unprecedented and deadly threat presented by the COVID-19 pandemic, Plaintiffs respectfully ask that this Court exercise its power under the All Writs Act, 28 U.S.C. § 1651, to enter a writ of mandamus or, alternatively, an injunctive order: (1) temporarily enjoining all parole revocation proceedings; (2) directing Defendants to withdraw or cancel all pending parole warrants and parole board holds; and (3) commanding Defendants to release the following individuals on parole supervision:

(a) all class members with conditions or characteristics which, according to the CDC, categorize them as high-risk for severe illness from COVID-19;

(b) all class members held in custody and still awaiting a parole revocation decision;

(c) all class members whose parole has been revoked on the basis of technical violations;

(d) all class members whose parole was revoked and who have less than one year left before their release date; and

(e) all class members whose parole was revoked on the basis of a laws violation based on conduct which did not result in a criminal conviction.

This relief is warranted and urgently necessary to protect and preserve the integrity of these proceedings, the safety and wellbeing of the Plaintiff class, and the health of the public at large.

Given the emergency nature of this motion, Plaintiffs respectfully request an expedited briefing schedule and telephonic hearing.

Factual Background

1. The COVID-19 pandemic

We are living in the midst of an unprecedented, world-wide health emergency caused by the rapid spread of the deadly coronavirus, COVID-19. There is no vaccine for this novel virus and there is no cure for COVID-19.[1]

On March 11, 2020, the World Health Organization officially classified COVID-19 as a pandemic.[2] Governor Parsons declared a State of Emergency on March 13, 2020.[3] COVID-19 is highly transmissible. The Centers for Disease Control and Prevention ("CDC") advise that the virus passes through coughing and by contact with surfaces.[4] The virus can live on surfaces for up to two to three days and in the air for up to three hours.[5] Carriers can transmit the virus to others even before they show symptoms themselves.[6]

The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that.[7] The effects of COVID-19 are very serious,

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[1] Declaration of Dr. Marc Stern, attached hereto as **Exhibit 1** ("Stern Dec."), ¶ 2.

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

[3] *Governor Parsons Signs Executive Order 20-20 Declaring a State of Emergency in Missouri* (Mar. 13, 2020), *at* https://governor.mo.gov/press-releases/archive/governor-parson-signs-executive-order-20-02-declaring-state-emergency.

[4] *See* "How It Spreads," Center for Disease Control and Prevention (last accessed Mar. 25, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html.

[5] *Coronavirus Resource Center*, Harvard Health Publishing, Harvard Medical School (Mar. 25, 2020), *at* https://www.health.harvard.edu/diseases-and-conditions/coronavirus-resource-center.

[6] *See* "How It Spreads," Center for Disease Control and Prevention (last accessed Mar. 25, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html.

[7] Stern Dec. at ¶ 4.

especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as—but not limited to—weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.[8] Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. [9] The overall case fatality rate has been estimated to range from 0.3 to 3.5%.[10]

The number of known COVID-19 infections increases daily and exponentially. As of March 25, 2020, the new strain of coronavirus which causes COVID-19 has infected over 459,800 people, leading to at least 20,846 deaths worldwide.[11] As of the filing of this motion, 372 Missourians have been infected with COVID-19 and eight have died.[12] In neighboring Illinois, there are now 1,875 cases and 21 have died.[13]

The Missouri Capitol and state government office buildings have closed to the public starting Tuesday, March 24, and will remain closed until April 6.[14] Governor Parsons has issued an executive order prohibiting social gatherings of more than 10 people in a single place, in line with CDC guidance.[15] St. Louis City, St. Louis County, and Kansas City officials have issued

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[8] *Id*. at ¶ 5; *see also* Coronavirus Disease 2019 (COVID-19): People Who are at Higher risk, CDC, *at* https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/people-at-higher-risk.html (last accessed March 24, 2020).

[9] Stern Dec. at ¶ 6.

[10] Declaration of Chris Beyrer, MD, MPH, attached hereto as **Exhibit 2** ("Beyrer Dec."), at ¶ 5.

[11] *Coronavirus Map: Tracking the Spread of the Outbreak*, The New York Times (Mar. 25, 2020), *at* https://nyti.ms/2U4kmud (updating regularly).

[12] *Coronavirus in the U.S.: Latest Map and Case Count*, The New York Times (Mar. 25, 2020), *at* https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (updating regularly).

[13] *Id*.

[14] *Live Updates: Coronavirus In The St. Louis Region*, St. Louis Public Radio (Mar. 25, 2020), *at* https://news.stlpublicradio.org/post/live-updates-coronavirus-st-louis-region.

[15] *Missouri Gov. Parson to ban gatherings over 10 people, won't order businesses closed*, The Kansas City Star (Mar. 20, 2020), *at* https://www.kansascity.com/news/coronavirus/article241377326.html; Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission, Center

"shelter-in-place" orders that mandate everyone stay in their homes, with limited exceptions.[16] Schools across the state are closed; in St. Louis City and County, public schools are closed through April 22, 2020.[17]

On March 23, Missouri Department of Corrections ("MDOC") confirmed the first positive COVID-19 case among inmates in its custody.[18] He had shown symptoms since at least March 4, and been hospitalized since March 19.[19]

Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure.[20]

2. Conditions of confinement and the spread of coronavirus

The recommendations by the CDC and guidance from Missouri's Governor are not available to class members detained in county jails or MDOC custody.[21] Prisons and jails are congregate environments in which inmates are confined in close proximity to other inmates and the staff around them.[22] As noted by correctional public health expert Dr. Marc Stern: "In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread.

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for Disease Control and Prevention, 3 (Mar. 12, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf.

[16] *Live Updates: Coronavirus In The St. Louis Region*, St. Louis Public Radio (Mar. 25, 2020), *at* https://news.stlpublicradio.org/post/live-updates-coronavirus-st-louis-region; *see, e.g.,* St. Louis County Department of Public Health 2019 Novel Coronavirus Stay at Home Order, *available at* https://stlouisco.com/portals/8/docs/document%20library/CountyExecutive/Executive%20Orders/Stay%20at%20Home%20Order.pdf (last accessed Mar. 25, 2020).

[17] *See* n14, *supra*.

[18] *See Missouri Department of Corrections Offender Tests Positive for COVID-19* (Mar. 23, 2020), *at* https://content.govdelivery.com/accounts/MODOC/bulletins/282c94f.

[19] *Id.*

[20] Stern Dec. at ¶ 6.

[21] *See* Stern Dec. at ¶ 8; Beyrer Dec. at ¶ 13.

[22] Stern Dec. at ¶ 7; *see also* Beyrer Dec. at ¶¶ 13-14.

This therefore presents an increased danger for the spread of COVID-19 if and when it is introduced into the facility."[23] Many of those incarcerated suffer from underlying health conditions, including, among many others, asthma, diabetes and hypertension, that place them at elevated risk for contracting serious COVID-19.[24] And prisons and jails are notoriously unsanitary. Rick Raemisch, the former head of the Colorado prisons department, recently described prisons as "bacteria factories," remarking about the potential impact of the novel coronavirus: "I don't think people understand the gravity of what's going to happen if this runs in a prison, and I believe it's inevitable…You're going to see devastation that's unbelievable."[25]

Moreover, these carceral facilities are not isolated environments. By necessity, members of the free community, including correctional officers, social workers, attorneys, medical personnel and many others, must enter and leave jails and MDOC facilities on a daily basis. The high rate of turnover and population mixing of staff and detainees increases the likelihood of exposure in prisons and jails.[26] If the COVID-19 virus occurs and spreads within a prison or jail, all of these persons are at heightened risk of contracting the virus and, in turn, spreading the virus

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[23] Stern Dec. at ¶ 7.

[24] *See* "Are You at Higher Risk for Severe Illness?" Center for Disease Control & Prevention (last accessed Mar. 19, 2020), https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html; Laura M. Maruschak et al. (2015), *Medical Problems of State and Federal Prisoners and Jail Inmates*, 2011-12. NCJ 248491, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, *at* https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf; *Jails and prisons suspend visitation to keep coronavirus from spreading*, The Washington Post (Mar. 17, 2020), *at* https://www.washingtonpost.com/national/jails-and-prisons-suspend-visitation-to-keep-coronavirus-from-spreading/2020/03/16/0cae4adc-6789-11ea-abef-020f086a3fab_story.html (Josiah D. Rich, a physician and professor of medicine and epidemiology at Brown University who co-founded the Center for Prisoner Health and Human Rights, noting: "But the population you have [in prisons] is not a young, healthy population. It's aging."); Beyrer Dec. at ¶ 16.

[25] David Montgomery, *'Prisons Are Bacteria Factories'; Elderly Most at Risk*, Stateline (Mar. 25, 2020) *at* https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/03/25/prisons-are-bacteria-factories-elderly-most-at-risk?utm_source=The+Appeal&utm_campaign=90a4677194-EMAIL_CAMPAIGN_2018_08_09_04_14_COPY_01&utm_medium=email&utm_term=0_72df992d84-90a4677194-58431187.

[26] Beyrer Dec. at ¶ 15.

to others with whom they come in contact in their homes, neighborhoods, and communities.[27]

In these ways, prisons and jails create the ideal environment for the transmission of contagious disease.[28] For example, outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[29] In China, officials have confirmed the coronavirus spreading at a rapid pace in Chinese prisons, counting 500 cases.[30] Secretary of State Mike Pompeo has called for Iran to release Americans detained there because of the "deeply troubling" "[r]eports that COVID-19 has spread to Iranian prisons," noting that "[t]heir detention amid increasingly deteriorating conditions defies basic human decency."[31] Courts across Iran have granted 54,000 inmates furlough as part of the measures to contain coronavirus across the country.[32] Former secretary of the California Department of Corrections and Rehabilitation called prisons "a tinderbox of potential infection."[33]

This presents health risks to people detained and incarcerated, but also to our communities at large:

> [O]utbreaks of contagious diseases in correctional facilities could lead to the infection of staff, incarcerated people and family members and could negatively impact staffing patterns, rendering

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[27] *See, e.g.,* Declaration of Medical Professionals Concerned about the Risk of the Spread of COVID-19 in the Cook County Jail and the Illinois Department of Corrections, attached hereto as **Exhibit 3**.

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

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

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

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

[32] Claudia Lauer and Colleen Long, *US Prisons, Jails On Alert for Spread of Coronavirus*, The Associated Press (Mar. 7, 2020) *at* https://apnews.com/af98b0a38aaabedbcb059092db356697.

[33] *California Prisons Are a 'Tinderbox of Potential Infection,' Former CDCR Secretary Warns*, KQED (Mar. 23, 2020), *at* https://www.kqed.org/news/11808282/california-prisons-are-a-tinderbox-of-potential-infection-former-cdcr-secretary-warns.

> such facilities more difficult to operate in a safe and healthy manner. Since approximately 11 million people churn through prisons and jails every year, if infectious diseases are spread inside correctional facilities, they have an elevated potential to affect community health.[34]

Dr. Stern notes that the releases of prisoners "supports the broader community because carceral and detention settings… are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a jail or prison slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large."[35]

Now that one prisoner has contracted COVID-19, it is essentially a certainty that it will spread within MDOC, and to surrounding communities. It must be anticipated that this virus will spread rapidly within the prison and that many prisoners will require urgent care. The capacity of Corizon, the health care provider for MDOC, to provide such care is limited and will likely be exceeded, exacerbating the death toll and the risks to all involved.[36]

3. Calls for decarceration to mitigate the spread and impact of COVID-19

In response to the pandemic, several jurisdictions are releasing individuals from prisons and jails. For example, Brooklyn District Attorney Eric Gonzalez, joined by public health experts,

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[34] COVID-19 Statement, EXiT: Executives Transformation Probation & Parole, attached hereto as **Exhibit 4** ("EXiT Statement").

[35] Stern Dec. at ¶ 10.

[36] Dr. Tyler Winkelman, a doctor and researcher at the University of Minnesota focused on health care and criminal justice, said about the potential impact of coronavirus on jail health care systems, "If Covid spreads in a large, thousand-person facility, and within five days you have a thousand people with multiple chronic conditions who just got the virus, that has the potential to really overwhelm a health care system." German Lopez, "A coronavirus outbreak in jails or prisons could turn into a nightmare," *Vox* (Mar. 17, 2020), https://www.vox.com/policy-and-politics/2020/3/17/21181515/coronavirus-covid-19-jails-prisons-mass-incarceration. "One problem is that jails and prisons notoriously do a bad job providing health care to inmates. … [T]hese facilities often deny or delay even basic medical care, causing preventable complications and deaths. In the context of Covid-19, those kinds of delays could mean more time for a sick inmate to infect others." *Id*.

has asked Governor Cuomo to grant emergency clemencies to elderly and sick prisoners.[37] The North Dakota parole board released 56 prisons early as part of a "population mitigation plan" in response to COVID-19.[38] And on March 22, 2020, New Jersey Chief Justice Stuart Rabner signed an order release up to 1,000 inmates from New Jersey jails, citing the "profound risk posed to people in correctional facilities arising from the spread of COVID-19."[39]

In a recent presentation to correctional healthcare workers developed in cooperation with the Centers for Disease Control and Prevention, Dr. Anne Spaulding, a professor of epidemiology and the director of the Emory Center for the Health of Incarcerated Persons, encouraged

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[37] Sarah Lustbader, *Coronavirus: Sentenced to COVID-19*, The Daily Appeal (Mar. 12, 2020) *at* https://theappeal.org/sentenced-to-covid-19/.

[38] *North Dakota paroles 56 prisoners early amid pandemic, including 3 convicted of sexual assault*, The Dickinson Press (March 20, 2020), *at* https://www.thedickinsonpress.com/news/crime-and-courts/5009882-North-Dakota-paroles-56-prisoners-early-amid-pandemic-including-3-convicted-of-sexual-assault.

[39] *See* Consent Order, attached hereto as **Exhibit 5**; *New Jersey to Release Hundreds of Inmates to Slow Coronavirus Spread*, National Review (March 23, 2020), *at* https://www.nationalreview.com/news/new-jersey-to-release-hundreds-of-inmates-to-slow-coronavirus-spread/. For more examples of jurisdictions reducing jail populations to mitigate the COVID-19 crisis, see this Twitter thread compiled by The Justice Collaborative: https://twitter.com/Justice_Collab/status/1240701283972997121 (last accessed March 23, 2020). *See also, e.g., Jails Release Prisoners, Fearing Coronavirus Outbreak,* The Wall Street Journal (Mar. 22, 2020), at https://www.wsj.com/articles/jails-release-prisoners-fearing-coronavirus-outbreak-11584885600*; St. Louis County Justice Center Prepares to Release 100 Inmates Amid Virus Concern*, St. Louis Post-Dispatch (Mar. 24, 2020, at https://www.stltoday.com/news/local/crime-and-courts/st-louis-county-justice-center-prepares-to-release--plus/article_dd8b30f6-c3ea-5229-b7ac-0aa36ee8f14c.html?utm_2-medium=social&utm_source=twitter_stltoday; 1*,000 Inmates Will Be Released From N.J. Jails to Curb Coronavirus Risk*, The New York Times (Mar. 23, 2020), at https://www.nytimes.com/2020/03/23/nyregion/coronavirus-nj-inmates-release.html; NYC Looks to Release 1,000+ Inmates as Tri-State Jails Try to Manage COVID-19 Spread, NBC (Mar. 23, 2020), at https://www.nbcnewyork.com/news/local/jails-in-crisis-tri-state-prisoners-slowly-released-to-manage-covid-19-spread/2339878/; *Ohio Jail to Release Hundreds of Inmates Amid Coronavirus Concerns* (Mar. 16, 2020), at https://www.foxnews.com/us/ohio-jail-releases-hundreds-inmates-coronavirus; Alameda County Releases 250 Inmates Amid Coronavirus Concerns; SF to Release 26 (Mar. 20, 2020), at https://www.sfchronicle.com/crime/article/Alameda-County-releases-250-jail-inmates-amid-15147332.php; *Dozens of Inmates Released From Smith County Jail Over Covid-19 Concerns* (Mar. 23, 2020), at https://www.ktre.com/2020/03/23/dozens-inmates-released-smith-county-jail-over-covid-concerns/; Prisons and Jails are Literally Petri Dishes: Inmates Released, Arrests Relaxed Across Iowa Amid Fears of Coronavirus (Mar. 23, 2020), at https://www.desmoinesregister.com/story/news/crime-and-courts/2020/03/23/coronavirus-iowa-jail-prison-inmates-released-amid-fears-covid-19-virus-polk-county-des-moines/2891117001/.

jurisdictions to consider alternatives to incarceration or detention, such as at-home electronic monitoring, diversionary courts, and community corrections.[40] Dr. Stern, a correctional public health expert, notes that "release from custody is a critically important way to meaningfully mitigate" the risk of serious illness or death to prisoners.[41] He recommends "consideration of release of eligible individuals from jails and prisons, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19."[42] Dr. Beyrer also opines that it is "an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible."[43]

These professional medical opinions are echoed by various community supervision executives who recently published a statement on the importance of using best practices during the COVID-19 pandemic.[44] Those community supervision professionals, including the National Association of Probation Executives, recommend immediately suspending incarceration for technical violations.[45] That same recommendation was made by the REFORM alliance in their Safer Plan Policy[46] and in a set of recommendations promulgated by a team of experts at Amend at UCSF.[47] And just today, United Nations High Commissioner for Human Rights Michelle

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[40] Dr. Anne Spaulding, Coronavirus COVID-19 and the Correctional Facility for the Correctional Healthcare Worker (Mar. 9, 2020) *at* https://www.ncchc.org/filebin/news/COVID_for_CF._HCW_3.9.20.pdf.

[41] Stern Dec. at ¶ 9.

[42] Stern Dec. at ¶ 11.

[43] Beyrer Dec. at ¶17.

[44] *See* EXiT Statement.

[45] EXiT Statement at 3.

[46] *The Safer Plan: Preventing the Spread of Communicable Disease in the Criminal Justice System*, *available at* https://medium.com/@reformalliance/the-safer-plan-preventing-the-spread-of-communicable-disease-in-the-criminal-justice-system-e9572b8babea.

[47] *COVID-19 in Correctional Settings: Immediate Population Reduction Recommendations*, Amend at UCSF (Mar. 24, 2020), attached hereto as **Exhibit 6**.

Bachelet called for a reduction in prison and jail populations to prevent the further spread of COVID-19.[48]

4. The Missouri parole revocation system endangers class members and heightens the public health risk

Members of the Plaintiff class are processed in and out of these facilities on a regular basis. Every year, over 6,000 class members are processed for alleged parole violations.[49] Of those, at least 90% have their parole revoked and are sent back to prison.[50] Between February 27, 2019 and November 7, 2019, defendants conducted over 1,900 parole revocation hearings—or approximately 237 per month.[51] According to MDOC's own report, 4,869 people were returned to prison on technical violations[52] in fiscal year 2019.[53]

Even those who do not have their parole revoked after this process, but instead are continued on parole or receive "delayed action" spend weeks or months detained or incarcerated.[54]

Each of these individuals—all members of the instant Plaintiff class—are processed through a revocation system this Court has already deemed unconstitutional.[55]

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[48] *Urgent action needed to prevent COVID-19 "rampaging through places of detention" – Bachelet* (Mar. 25, 2020), *at* https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25745&LangID=E.

[49] ECF No. 130 at 2.

[50] *Id*.

[51] *See* Defendants' Nov. 7, 2019 Response to Interrogatory No. 21, attached hereto as **Exhibit 7**.

[52] A "laws violation" is an encounter with law enforcement, including but not limited to an arrest or filing of new charges. A "technical violation" is any violation other than a laws violation. *See* MDOC Rules and Regulations Governing the Conditions of Probation, Parole, and Conditional Release (Sept. 23, 2019), *at* https://doc.mo.gov/sites/doc/files/media/pdf/2019/09/Rules_and_Regulations_Governing_the_Conditions_of_Probation_Parole_and_Conditional_Release_White-book.pdf.

[53] Table 5.1, Profile of the Institutional and Supervised Offender Population (June 30, 2019), *at* https://doc.mo.gov/sites/doc/files/media/pdf/2020/03/Offender_Profile_2019_1.pdf.

[54] *See* n52, supra; *see also* ECF No. 130 at 2; Mar. 4, 2020 Deposition of James Weston, attached hereto as **Exhibit 8**, at 18:21-21:19 (discussing class members being held in limbo on "board hold status"), 51:15-20 (giving example of class member being on "board hold status" for three weeks).

[55] ECF No. 146.

Legal Standard

Under the All Writs Act, federal courts "may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law." 28 U.S.C. § 1651; *see Bank of America, N.A. v. UMB Financial Services, Inc.*, 618 F.3d 906, 914-15 (8th Cir. 2010) (Under the All Writs Act, "the district court has the inherent ability to protect its own jurisdiction over the dispute pending before it," including by issuing an injunction); *In re Y & A Group Sec. Litig.*, 38 F.3d 380, 382–83 (8th Cir. 1894) ("The All Writs Act makes plain that each federal court is the sole arbiter of how to protect its own judgments: federal courts 'may issue all writs necessary ... in aid of their respective jurisdictions....' 28 U.S.C. § 1651(a).")). This power is not limited to parties before the court in the underlying litigation. On the contrary, "the power conferred by the [All Writs Act] extends, under appropriate circumstances, to persons who, *though not parties to the original action* . . . are in a position to frustrate the implementation of a court order or the proper administration of justice, . . . and encompasses even those who have not taken any affirmative action to hinder justice." *United States v. New York Tel. Co*., 434 U.S. 159, 174 (1977) (emphasis added); *see also United States v. Yielding*, 657 F.3d 722, 728 (8th Cir. 2011).

A writ of mandamus may be issued in extraordinary circumstances where "(1) the petitioner can establish a clear and indisputable right to the relief sought, (2) the defendant has a nondiscretionary duty to honor that right, and (3) the petitioner has no other adequate remedy." *Zhu v. Chertoff*, 525 F. Supp. 2d 1098, 1099–1100 (W.D. Mo. 2007); *quoting Castillo v. Ridge*, 445 F.3d 1057, 1060-61 (8th Cir. 2006).

Courts can also issue injunctive orders under the All Writs Act. While entitlement to a preliminary injunction under the All Writs Act requires consideration of the same factors as a preliminary injunction under FED. R. CIV. P. 65, an All Writs Act injunction "need not rigidly comply with Rule 65's proscriptions so long as the injunction is 'specific and definite enough to apprise those within its scope of the conduct that is being proscribed.'" *Yielding*, 657 F.3d at 727 (quoting *In re Baldwin–United Corp*., 770 F.2d 328, 338 (2d Cir.1985)).

Argument

The All Writs Act and the inherent powers of the federal courts provide this Court with ample authority to enter protective orders against actions that threaten the orderly and proper progression of a case. This Court already ruled, in February of 2019, that Missouri's parole revocation system is unconstitutional. Since then, thousands of parolees have continued to process through the system as the parties litigate the remedy in this case. In the meantime, class members have continued to suffer constitutional violations and unconstitutional incarceration. Now that class members' incarceration is also a threat to their life, and to public health at large, the Court must act.

Exposing the Plaintiff class to the indisputable risk of harm from COVID-19—and contributing to the rapid spread of the virus within Missouri prisons and jails—would severely interfere with the fair and orderly adjudication of this case. A writ of mandamus or, alternatively, an injunctive order, is warranted to ensure the proper administration of justice in this case. Absent such an order, Defendants will continue to process hundreds of Missouri residents through an unconstitutional parole revocation process, exposing them, other inmates, and prison and jail staff, and the community at large, to the novel coronavirus, and further contributing to the rapid spread of the deadly virus.

To protect the Plaintiff class from the known, very serious risk of COVID-19, and to serve the public interest in slowing the spread of COVID-19, Plaintiffs ask that the Court order Defendants to halt all parole revocation proceedings, except to withdraw or cancel any pending parole warrants and parole board holds, and to release on parole supervision (either continuing their parole or "delaying action"): (a) all class members with conditions or characteristics which, according to the CDC, categorize them as high-risk for severe illness from COVID-19; (b) all persons held in custody and still awaiting a parole revocation decision; (c) all class members whose parole has been revoked on the basis of technical violations; (d) all class members whose parole was revoked and who have less than one year left before their release date; and (e) all class members whose parole was revoked on the basis of a laws violation based on conduct which did not result in a criminal conviction.

Defendants can release these five categories of class members without risk to the community. By "delaying action" for those who have not yet received a revocation decision, the Court would not be prohibiting Defendants from doing their job. Once the pandemic was under control, Defendants could choose to return someone from that group for revocation. Those who have had their parole revoked on the basis of a technical violation—such as failing to report a new residence, or not maintaining employment—do not pose a risk to the safety and security of our communities. Nor do those revoked on the basis of a laws violation for conduct that did not result in a conviction. In the face of an unprecedented pandemic, there is insufficient justification to order these individuals to remain in prison. And those who had their parole revoked but are less than one year from their release date should be released because, by nature of their out date, they have been deemed ready to be released back into the community. Finally, releasing prisoners who are at high risk of serious illness or death should they contract the COVID-19 virus is in line with the professional recommendation of Plaintiffs' correctional public health expert, Dr. Stern.[56]

Such relief is warranted, whether styled as a writ of mandamus or injunctive order. Indeed, the traditional equitable factors weight in favor of injunctive relief here. *See Canady v. Allstate Ins. Co.*, 282 F.3d 1005, 1020 (8th Cir. 2002) (citing *Dataphase Sys. v. C.L. Sys.*, 640 F.2d 109,

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[56] *See* Stern Dec. at ¶ 11.

113 (8th Cir.1981)). *First*, Plaintiffs have already demonstrated a likelihood of success on the merits, having successfully secured summary judgment in their favor. *Second*, absent an order from the Court, class members will continue to have their parole revoked, in violation of *Gagnon* and *Morrissey*, and be sent back to Missouri prisons where they stand to have their Eighth Amendment rights violated for being exposed to a substantial risk of serious harm or death from COVID-19.

To fail to act would amplify the rate at which COVID-19 is spreading in our jails, prisons, and communities. To fail to act could result in the death of class members. These circumstances present a clear threat of irreparable harm. *Third*, the relief sought herein is in the public interest—not only because it preserves the integrity of these proceedings and protects the health of class members, but also because it protects public health.[57] *Lastly*, the relief can be granted without posing a risk to the community or a burden on Defendants—indeed, it would ease any burden they currently face in attempting to operate a revocation system in the midst of an unprecedented pandemic. It would also ease the burden that is inevitably about to land on the MDOC health care system.

The relief requested here is especially important in light of this Court's recent order further postponing the evidentiary hearing that precedes a final judgment and potential court-ordered reforms to Defendants' parole revocation process. *See* March 23, 2020 Notice of Hearing Cancellation. Given the health risks, the Court made the wise choice to delay the hearing. Still, this means the Plaintiff class will have to wait longer to obtain relief from a process which was deemed unconstitutional over one year ago. In the interim, additional parolees will be unconstitutionally revoked. Permitting these cogs to continue to turn not only endangers class

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[57] *See* Stern Dec. at ¶¶ 6-11.

members' due process rights, it endangers their lives.

A parole revocation should not be a death sentence, but that is precisely what is at stake here. It is of crucial importance to the administration of justice that this Court require Defendants to act to stop parole revocations and release certain class members.

WHEREFORE, for the foregoing reasons, Plaintiffs respectfully request that the Court grant this motion, enter a writ of mandamus or injunctive order as further described above, and grant such further relief as is just and appropriate under the circumstances. Plaintiffs also ask for an expedited briefing schedule and expedited telephonic hearing on the motion in light of its emergency nature.

Dated: March 25, 2020

Respectfully submitted,

RODERICK AND SOLANGE MACARTHUR
JUSTICE CENTER

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CERTIFICATE OF SERVICE

I hereby certify that on the 25th day of March, 2020, a true and correct copy of the foregoing was electronically filed using the Court's online case filing system, which will send notice to all counsel of record.

By: /s/ Amy E. Breihan
One of Plaintiffs' Attorneys

EXHIBIT 1

DECLARATION OF DR. MARC STERN

I, Marc Stern, declare as follows:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I also have considerable familiarity with the immigration detention system. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I have also served as a consultant to Human Rights Watch in their preparation of two reports on health-related conditions of confinement in ICE detention facilities. In those capacities, I have visited and examined more than 20 ICE detention facilities and reviewed hundreds of records, including medical records and detention death reviews of individuals in ICE detention. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease and has reached pandemic status. Over 406,900people around the world have received confirmed diagnoses of COVID-19 as of March 24, 2020, including 52,215 people in the United States. At least 18,293 people have died globally as a result of COVID-19 as of March 24, 2020, including 675 in the United States, and 6 in the State of Missouri alone. These numbers will increase, perhaps exponentially.

3. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. The only way to control the virus is to use preventive strategies, including social distancing.

4. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that.

5. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

6. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure.

7. Jails and prisons are congregate environments, i.e. places where people live and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread. This therefore presents an increased danger for the spread of COVID-19 if and when it is introduced into the facility. To the extent that detainees or prisoners are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching

objects used by others, the risks of spread are greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in another congregate environment: nursing homes and cruise ships.

8. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in jails and prisons, placing people at risk, especially when the number of inmates is high.

9. For prisoners who are at high risk of serious illness or death should they contract the COVID-19 virus, release from custody is a critically important way to meaningfully mitigate that risk. Additionally, the release of detainees and prisoners who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of prisoners in a facility. Combined, this has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of corrections staff such that they can continue to ensure the safety of inmates.

10. The release of prisoners, especially those with increased health-related vulnerability, also supports the broader community because carceral and detention settings, regardless of the level of government authorities that oversee them, are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a jail or prison slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large.

11. As a correctional public health expert, I recommend urgent consideration of release of eligible individuals from jails and prisons, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19.

12. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court. One of the most worrisome changes would be confirmation of a case of COVID-19 within the jail or prison, either among staff or inmates. In the event of this occurring, and eligible inmates are being quarantined or isolated due to possible exposure to the virus, I recommend that the inmate(s) be tested for the virus if testing is available. Armed with the results of that test if it is available, or in the absence of other instructions from the health authority of the municipality to which they will be returning or the Missouri State public health authority, those who can easily return to a home without exposure to the public, should be released to that home for continued quarantine or isolation for the appropriate time period. All others can be released to appropriate housing as directed or arranged in coordination with the relevant health authority.

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

Executed this 24th day in March, 2020 in Tumwater, Washington.

Dr. Marc Stern

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

March, 2020

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SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

OLYMPIA BUPRENORPHINE CLINIC, OLYMPIA, WASHINGTON 2019 - PRESENT

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

OLYMPIA FREE CLINIC, OLYMPIA, WASHINGTON 2017 - PRESENT

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

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

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

WASHINGTON STATE DEPARTMENT OF CORRECTIONS 2002 – 2008

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

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

- As the first incumbent ever in this position, ushered the health services division from an operation of 12 staff in headquarters, providing only consultative services to the Department, to an operation with direct authority and responsibility for all departmental health care staff and budget. As part of new organizational structure, created and filled statewide positions of Directors of Nursing, Medicine, Dental, Behavioral Health, Mental Health, Psychiatry, Pharmacy, Operations, and Utilization Management.

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

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

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

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

Regional Medical Director, New York Region, 2000 – 2001

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

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

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

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

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

Acting Facility Medical Director, 1998 – 1999

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

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

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

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

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

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

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

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

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

Staff Physician, 1988 – 1990

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

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

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

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

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

FACULTY APPOINTMENTS

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

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

OTHER PROFESSIONAL ACTIVITIES

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

1972 – 1975 Chief of Service or Assistant Chief of Operations, 5 Quad Volunteer Ambulance Service, University at Albany.

1972 – 1975 Emergency Medical Technician Instructor and Course Coordinator, New York State Department of Health, Bureau of Emergency Medical Services

REVIEWER/EDITOR

2019 – present Criminal Justice Review (reviewer)

2015 – present PLOS ONE (reviewer)

2015 – present Founding Editorial Board Member and Reviewer, Journal for Evidence-based Practice in Correctional Health, Center for Correctional Health Networks, University of Connecticut

2011 – present American Journal of Public Health (reviewer)

2010 – present International Advisory Board Member and Reviewer, International Journal of Prison Health

2010 – present Langeloth Foundation (grant reviewer)

2001 – present Reviewer and Editorial Board Member (2009 – present), Journal of Correctional Health Care

2001 – 2004 Journal of General Internal Medicine (reviewer)

1996 Abstract Committee, Health Services Research Subcommittee, Annual Meeting, Society of General Internal Medicine (reviewer)

1990 – 1992 Medical Care (reviewer)

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

2019 – present Washington Association of Sheriffs and Police Chiefs

2005 – 2016 American Correctional Association/Washington Correctional Association

2004 – 2006 American College of Correctional Physicians (Member, Board of Directors, Chair Education Committee)

2000 – present American College of Correctional Physicians

RECOGNITION

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

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

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

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

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

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

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

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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EXPERT TESTIMONY

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EXHIBIT 2

Declaration for Persons in Detention and Detention Staff
COVID-19

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

I, Chris Beyrer, declare as follows:

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

The nature of COVID-19

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

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

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

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

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

The risks of COVID-19 in detention facilities

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

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

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

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

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

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

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

Executed this 16th day of March, 2020.

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Professor Chris Beyrer[1]

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

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EXHIBIT 3

Declaration of Medical Professionals Concerned about the Risk of the Spread of COVID-19 in the Cook County Jail and Illinois Department of Corrections

Dr. Michael Puisis, Dr. Robert Cohen, Dr. John Raba, Dr. Sergio Rodriguez, and Dr. Ron Shansky

1. Dr. Michael Puisis is an internist who has worked in correctional medicine for 35 years. He was the Medical Director of the Cook County Jail from 1991 to 1996 and Chief Operating Officer for the medical program at the Cook County Jail from 2009 to 2012. He has worked as a Monitor or Expert for Federal Courts on multiple cases and as a Correctional Medical Expert for the Department of Justice on multiple cases. He has also participated in revisions of national standards for medical care for the National Commission on Correctional Health Care and for the American Public Health Association. Additionally, he participated in revision of tuberculosis standards for the Centers for Disease Control and Prevention (CDC).
2. Dr. Robert Cohen is an internist. He has worked as a physician, administrator, and expert in the care of prisoners and persons with HIV infection for more than thirty years. He was Director of the Montefiore Rikers Island Health Services from 1981 to 1986. In 1986, he was Vice President for Medical Operations of the New York City Health and Hospitals Corporation. In 1989, he was appointed Director of the AIDS Center of St. Vincent's Hospital. He represented the American Public Health Association (APHA) on the Board of the National Commission for Correctional Health Care for 17 years. He has served as a Federal Court Monitor overseeing efforts to improve medical care for prisoners in Florida, Ohio, New York State, and Michigan. He has been appointed to oversee the care of all prisoners living with AIDS in Connecticut, and also serves on the nine member New York City Board of Corrections.
3. Dr. Raba is an internist who was the Medical Director of the Cook County Jail from 1980 to 1991. He was the Medical Director of the Fantus Health Center of the Cook County Health and Hospital System from 1992 to 2003. He was the Co-Medical Director of Ambulatory and Community Health Network for the Cook County Bureau of Health Services from 1998 to 2003. He has monitored multiple jail and prison systems for

Federal Courts. He has also provided consultations for many jail systems in the United States.

4. Dr. Sergio Rodriguez is a practicing internist. He was Medical Director of the Cook County Jail from 2005 to 2008. He was Medical Director of the Fantus Health Center of the Cook County Health and Hospital System until 2015.

5. Dr. Ronald Shansky is an internist who has worked in correctional medicine for 45 years. He was the Medical Director of the Illinois Department of Corrections from 1982 to 1992 and from 1998 to 1999. He was a Court Appointed Receiver of two correctional medical programs. He has been appointed by U.S. Courts as Medical Expert or Monitor in ten separate Court cases and has been a Court appointed Special Master in two cases. He has been a consultant to the Department of Justice involving correctional medical care. He also participated in revision of national standards for medical care for the American Public Health Association and of standards for the National Commission on Correctional Health Care.

6. Coronavirus disease of 2019 (COVID-19) is a pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.

7. The number of cases of COVID-19 in the United States are rising rapidly. As of March 19, 2020, cases in the United States have been doubling almost every day and a half. Cases in Illinois total 288 as of March 19, 2020. There were 170 cases on March 18, 2020, indicating that the doubling rate was slightly over 1 day, which suggests a significantly expanding infection rate.

8. UpToDate[1] reports an overall case mortality rate from the disease of 2.3%.

9. Medical care for COVID-19 focuses on prevention, which emphasizes social distancing, handwashing, and respiratory hygiene. Currently, severe disease is treated only with supportive care including respiratory isolation, oxygen, and mechanical ventilation as a last resort. In cities with widespread disease, hospitals are anticipating a lack of ventilation

[1] UpToDate is an online widely used medical reference in hospitals, health organizations and by private physicians.

equipment to handle the expected cases. Cook County Health and Hospital System has suspended scheduled appointments for outpatient care. Chicago may experience a similar lack of ventilation equipment, but we will not know for a week or two if that will occur, and if it occurs there will be little time to adjust to the situation.

10. COVID-19 is transmitted by infected people when they cough. Droplets of respiratory secretions infected with the virus can survive as an aerosol for up to three hours[2]. Droplets can be directly transmitted by inhalation to other individuals in close proximity. Droplets can land on surfaces and be picked up by the hands of another person who can then become infected by contacting a mucous membrane (eyes, mouth, or nose) with their hand. Infected droplets can remain viable on surfaces for variable lengths of time, ranging from up to 3 hours on copper, 24 hours on cardboard, and 2-3 days on plastic and stainless steel.[3]

11. There is no evidence that asymptomatic persons can transmit COVID-19. A recent study of a cruise ship[4] demonstrated that about 17% of persons infected with COVID-19 had no symptoms. However, infected individuals become symptomatic in a range of 2.5 to 11.5 days with 97.5% of infected individuals becoming symptomatic within 11.5 days. The total incubation period is thought to extend up to 14 days. Thus, persons coming into jails or prisons can be asymptomatic at intake screening only to become symptomatic later during incarceration. For that reason a correctional intake screening test for COVID-19 is reasonable in our opinion. Screening inmates daily for cough, shortness of breath, or fever daily would be a logistically daunting task that would not be fully effective in these institutions. Because testing kits are not currently available in the volume necessary to screen all inmates, and because the range of symptom acquisition ranges from 2 to 11 days,

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[2] National Institute of Health, available at [https://www.nih.gov/news-events/news-releases/new-coronavirus-stable-hours-surfaces.](https://www.nih.gov/news-events/news-releases/new-coronavirus-stable-hours-surfaces)

[3] *Id*.

[4] Kenji Mizumoto, Kayaya Katsushi, Alexander Zarebski, Gerardo Chowll; *Estimating the asymptomatic proportion of coronavirus disease 2019 (COVID-19) cases on board the Diamond Princess cruise ship, Yokohama, Japan, 2020*, EUROSURVEILLANCE (Mar. 12, 2020), https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.10.2000180.

symptom screening at booking alone will not identify all persons who will become ill.

12. Supply of testing material for COVID-19 is limited. The CDC reports as of March 19, 2020 that CDC and public health laboratories have performed only 37,824 tests for COVID-19 nationwide. The CDC's current recommendation for testing for COVID-19 is that physicians should use their judgment to determine if a patient has signs or symptoms of the disease and whether the person should be tested. They include priorities for testing as hospitalized patients, symptomatic older adults especially with co-morbid conditions, and any person who has had close contact with a known case of COVID-19. These guidelines are apparently based on the limitation of testing material. There are numerous examples in the press of physicians being unable to order tests and people who have symptoms being unable to obtain testing.

13. Medical personnel are hampered by the inability to readily access testing. Testing resources are so scarce that, nationwide, rationing of this test is occurring even for persons who are symptomatic.

14. An individual's immune system is the primary defense against this infection. As a result, people over 65 years of age and persons with impaired immunity have a higher probability of death if they are infected. It is important to note that the older a person is, the higher likelihood of death; this is thought to be due to impaired immunity with aging. Persons with severe mental illness in jails and prisons are also, in our opinion, at increased risk of acquiring and transmitting infection because they may be unable to communicate symptoms appropriately.

15. Jails and prisons are long known to be a breeding ground for infectious respiratory illnesses. Tuberculosis is a bacteria which is significantly less transmissible than COVID-19 yet has been responsible for numerous outbreaks of illness in prisons and jails over the years. For this reason, the CDC still recommends screening for this condition in jails and prisons.

16. At a time when the President's task force on COVID-19 recommends limiting gatherings to no more than 10 persons, the County of Cook is forcing 5,500 people to live in congregate living conditions at the Cook County Jail with an influx of approximately 100 to 150 new inmates a day. These inmates intermingle and it is not possible to attain the President's

aim of limiting gatherings of less than 10 individuals. This is contrary to the President's recommendation and contrary to current public health recommendations. This is likely to result in spread of disease.

17. Jails and prisons promote the spread of respiratory illnesses because large groups of strangers are forced suddenly into crowded congregate housing arrangements. This situation is complicated by the fact that custody and other personnel who care for detainees live in the community and can carry the virus into the Jail with them.

18. The current CDC recommendations for social distancing and frequent handwashing measures, which are the only measures available to protect against infection, are not possible in the correctional environment. Furthermore, repeated sanitation of horizontal surfaces in inmate living units and throughout a jail is not typically done and would be an overwhelming task. Jails in this regard are similar to cruise ships and nursing homes where COVID-19 is known to have easily spread. Jails also recirculate air which contributes to spread of airborne infectious disease.

19. A large number of employees are required to work in jails and prisons. These individuals have frequent contact with inmates, often requiring breaking the recommended CDC guidelines for social distancing. Frequent handwashing is not easily available for inmates or staff. Their risk is considerable. Tuberculosis outbreaks in jails and prisons have often resulted in custody employees becoming infected. These employees return to the community and can and will transmit the infection to others in their family and community. In this sense, jails act as incubators of respiratory infectious disease. COVID-19 would have a rapid and dramatic spread within the correctional environment and if this occurs, the outbreak would inevitably result in spread to the community.

20. <u>It is our opinion that steps should be taken to release any inmate who is a low risk to the community</u>. The risk of promoting the spread of the infection to the inmate population, and thereby to the community, needs to be weighed against the reason for not releasing the inmate from incarceration. Release measures should prioritize inmates over 65, inmates with immune disorders, inmates with significant cardiac or pulmonary conditions, or inmates with cognitive disorders. We say this

because of the unlikelihood of effective screening and protective housing for all inmates.

21. It is our opinion that at this time, if and when COVID-19 testing becomes widely and readily available, all inmates coming into a jail or prison should be tested for COVID-19 prior to congregate housing. This is our expert opinion because inmates will be forced to live with one another with the uncertain risk that one of them is infected. Inmates cannot engage in social distancing. In our experience, spread of contagious respiratory disease can be prevented by screening. Also, intake symptom screening alone will not identify all inmates who may have disease but are not yet symptomatic.

22. It is our opinion that all persons with any symptom consistent with COVID-19 or with fever be placed in respiratory isolation and tested for COVID-19.

23. It is our opinion that all inmates over 65, all persons with severe mental illness, all persons with immune disorders or with serious cardiac or pulmonary disease, and all persons with any cognitive disorder should have a daily symptom and temperature screening. Any positive symptom or temperature should require respiratory isolation and testing for COVID-19.

24. It is our opinion that all inmates coming into the jail on any day be housed in separate housing (quarantined).[5] Pending release from quarantine, all individuals in such housing should have a symptom and temperature screening daily. The CDC recommends a 14 day isolation and this should be considered.

25. It is our opinion that convicted inmates in the Cook County Jail who are not screened and tested should not be transferred to the Illinois Department of Corrections. If such inmates are properly quarantined for 14 days prior to transfer and present without symptoms, this transfer would be acceptable.

26. We did not address the personal protection equipment of health care and custody personnel and presume that this is being done at the facility.

[5] 97.5 % of infected individuals become symptomatic by day 11.5 as reported in UpToDate.

Lack of this equipment places both inmates and staff at high risk of infection and transmission.

Executed this 20th day in March, 2020 in Chicago, Illinois

/s/ Dr. Michael Puisis______
Dr. Michael Puisis

/s/ Dr. Robert Cohen___
Dr. Robert Cohen

/s/ Dr. Jack Raba_____
Dr. Jack Raba

/s/ Dr. Ron Shansky___
Dr. Ron Shansky

/s/ Dr. Sergio Rodriguez_
Dr. Sergio Rodriguez

EXHIBIT 4

EXiT: EXECUTIVES
TRANSFORMING
PROBATION & PAROLE

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Statement from community supervision executives on the importance of using best practices during the COVID-19 crisis

In this time of national concern over the spread of COVID-19, the undersigned probation and parole executives and associations offer the following guidance and recommendations to (1) utilize social distancing to reduce the unnecessary and inadvertent spread of the coronavirus through community supervision, while (2) continuing to support persons under supervision and assure public safety.

People under correctional control are especially medically vulnerable. They disproportionately suffer from heart conditions, tuberculosis, HIV and diabetes, among other medical vulnerabilities. Further, outbreaks of contagious diseases in correctional facilities could lead to the infection of staff, incarcerated people and family members and could negatively impact staffing patterns, rendering such facilities more difficult to operate in a safe and healthy manner. Since approximately 11 million people churn through prisons and jails every year, if infectious diseases are spread inside correctional facilities, they have an elevated potential to affect community health. Finally, the millions of people visiting probation and parole offices are similarly medically vulnerable, putting our staff and one another at heightened risk of becoming infected.

With 4.5 million people on probation and parole nationally, there are more people under supervision than is necessary from a public safety standpoint. Too many people are placed under supervision who pose little public safety risk and are supervised for excessive supervision periods beyond what is indicated by best practices. This stretches probation and parole resources; hampers our ability to assist and supervise those most in need; and ultimately contributes to the revocation and incarceration of people for technical, non-criminal violations, like missing appointments and substance use.

This would be concerning under any circumstances. But it is especially problematic with the current COVID-19 emergency. As such, the undersigned probation and parole executives and associations offer the following guidance and recommendations for elected and appointed officials that comport with best practices and will help reduce the impact of community supervision on the spread of the coronavirus. Many of these recommendations can and should be enacted quickly before there is any inadvertent contagion:

1. **Immediately limit office visits for people on parole and probation.** In order to avoid unnecessary travel and congregating in waiting rooms where the virus may spread, probation and parole departments should forgo reporting altogether for those who pose lower risk and/or have people under supervision report via telephone, on-line or by postcards. Research on, and experience with, computerized reporting has found that lower-risk individuals in particular perform well on computerized reporting.

2. **Suspend or severely limit technical violations for the duration of the coronavirus crisis.** Research has not found an association between technical violations and favorable public safety or rehabilitative outcomes. Further, probation and parole revocations for technical violations are a significant contributor to jail and prison churn. Incarceration for technical violations should be immediately suspended or drastically curtailed legislatively or administratively to reduce the possibility of unnecessarily carrying the virus into correctional facilities or from such facilities into the community. Given the limited research support for reincarceration for technical violations, the

public safety and rehabilitation outcomes of reducing violations should then be carefully evaluated before technical violations are reinstated to pre-crisis levels.

3. **Reduce intake onto probation and parole to only those who absolutely need to be under supervision.** We urge courts and paroling authorities to limit placing people under supervision to only those who need, and can benefit from, community supervision. Courts and paroling authorities should release people from supervision as soon as possible who are low risk or who have shown through their performance on probation or parole that they no longer need to be under supervision. Persons currently on probation or parole for more than two years who are in compliance should be considered for immediate discharge from supervision.

4. **Reduce the terms of probation and parole to only as long as necessary to achieve the goals of supervision.** Most reoffending occurs in the first 18-24 months of supervision, suggesting that probation and parole terms longer than that engender costs with diminishing benefits. Legislatures, courts and paroling authorities should limit supervision terms to 18-24 months and allow people to further earn time off for compliance with conditions.

The above two recommendations would focus probation and parole resources on those who can truly benefit from community supervision, while limiting the travel, office visits and incarceration that increase COVID-19 exposure of persons under supervision.

5. **Train staff to provide clear, accurate and understandable information to probation and parole clients.** Supervision staff should inform their clients of proper precautions, recommended by public health officials, against virus spread such as staying home when sick, covering coughs and sneezes, frequently washing hands with soap and water and cleaning frequently touched surfaces.

Community supervision executives

Tyler Bouma, Executive Director, Marion County (IN) Community Corrections

Linda Brady, Probation Officers Professional Association of Indiana (POPAI) Past-president

Corinne Briscoe, Director, Macoupin/Greene/Scott Probation District, Illinois

Barbara Broderick, EXiT Co-Chair; and former Chief Probation Officer, Maricopa County (AZ) Adult Probation

William Burrell, Corrections Management Consultant; and former Chief, Adult

Probation Services, New Jersey State Court System

Michael Cimino, Chief Probation Officer, Maricopa County (AZ) Adult Probation

Edward J. Dolan, Commissioner, Massachusetts Probation Service

Adolfo Gonzales, Chief Probation Officer, San Diego County, CA

Kele Griffone, Division Director, Salt Lake County Criminal Justice Services

Billie Grobe, Associate, Justice System Partners; and former Chief Probation Officer, Yavapai County, AZ

Norris Henderson, EXiT Steering Committee Member; and Executive Director, Voice of the Experienced (VOTE)

Gary Hinzman, Past President, American Probation and Parole Association (APPA), and former Director of the Sixth District Department of Correctional Services, Iowa

Marcus Hodges, Associate Director, Washington DC Court Services and Offender Supervision Agency (CSOSA)

Martin F. Horn, Distinguished Lecturer, John Jay College of Criminal Justice, former Commissioner, New York City Department of Probation, and former Executive Director, New York State Division of Parole

Michael Jacobson, Executive Director, CUNY Institute for State and Local Governance; and former Commissioner, New York City Corrections and Department of Probation

David Johnson, Director, Division of Adult Parole, Colorado Department of Corrections

Sally Kreamer, Deputy Director, Iowa Department of Corrections

Steven Lessard, Chief Probation Officer, Gila County, AZ

Brian Lovins, Principal, Justice System Partners; and former Assistant Director, Harris County (TX) Community Supervision and Corrections Department

Scott MacDonald, Justice Consultant, Justsolve Inc., and former Chief Probation Officer, Santa Cruz County, California

Joseph M. Mancini, Director of Operations, SEAT Center, Associate Commissioner, Office of Community Partnerships, New York State Office of Children and Family Services, and former Director of Probation, Schenectady

County, NY

Terri McDonald, former Chief Probation Officer, Los Angeles County, CA

Rod McKone, Chief Adult Probation Officer, Pinal County, AZ

David Muhammad, Executive Director, National Institute for Criminal Justice Reform (NICJR); and former Chief Probation Officer, Alameda County, CA

Mario Paparozzi, Professor, Department of Sociology and Criminal Justice, University of North Carolina at Pembroke; and former Chairman, New Jersey State Parole Board

Francine Perretta, Executive Director, Association of Women Executives in Correction (AWEC), former Deputy Probation Commissioner, Westchester County, New York, and former Director of Probation, St. Lawrence County, New York

Veronica Perry, Chief Probation Officer, Medina County, OH

Susan Rice, Chief Probation Officer, Miami County (IN) Probation

Gary A. Roberge, Executive Director, Connecticut Judicial Branch, Court Support Services Division

Vincent N. Schiraldi, EXiT Co-Chair; Co-Director, Columbia Justice Lab; and former Commissioner, New York City Department of Probation

Curtis Shanklin, Minnesota Deputy Commissioner of Corrections and Community Services Division

Beth Skinner, Director, Iowa Department of Corrections

Wendy Still, Chief Probation Officer, Alameda County, CA

Scott Taylor, Consultant, JustUs; and former Director, Multnomah County (OR) Department of Community Justice

Ray Wahl, Consultant, JustUs; and former Deputy State Court Administrator, Utah State Courts

Kathy Waters, Director, Adult Probation Services, Arizona Supreme Court

Community supervision associations

National Association of Probation Executives (NAPE)

To add your name as a signatory to this statement, please email Clarice Robinson at cr2992@columbia.edu.

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EXHIBIT 5

SUPREME COURT OF NEW JERSEY
DOCKET NO. 084230

FILED
MAR 22 2020
Heather J. Baker
CLERK

In the Matter of the Request to Commute or Suspend County Jail Sentences	CRIMINAL ACTION CONSENT ORDER

This matter having come before the Court on the request for relief by the Office of the Public Defender (see attached letter dated March 19, 2020), seeking the Court's consideration of a proposed Order to Show Cause (see attached) designed to commute or suspend county jail sentences currently being served by county jail inmates either as a condition of probation for an indictable offense or because of a municipal court conviction; and

The Court, on its own motion, having relaxed the Rules of Court to permit the filing of the request for relief directly with the Supreme Court, based on the dangers posed by Coronavirus disease 19 ("COVID-19"), and the statewide impact of the nature of the request in light of the Public Health Emergency and State of Emergency declared by the Governor. *See* Executive Order No. 103 (2020) (Mar. 9, 2020); and

The Office of the Attorney General, the County Prosecutors Association, the Office of the Public Defender, the American Civil Liberties Union of New Jersey having engaged in mediation before the Honorable Philip S. Carchman, P.J.A.D. (ret.); and

The parties having reviewed certifications from healthcare professionals regarding the profound risk posed to people in correctional facilities arising from the spread of COVID-19; and

The parties agreeing that the reduction of county jail populations, under appropriate conditions, is in the public interest to mitigate risks imposed by COVID-19; and

It being agreed to by all parties as evidenced by the attached duly executed consent form;

IT IS HEREBY ORDERED, that

A. No later than 6:00 a.m. on Tuesday, March 24, 2020, except as provided in paragraph C, any inmate currently serving a county jail sentence (1) as a condition of probation, or (2) as a result of a municipal court conviction, shall be ordered released. The Court's order of release shall include, at a minimum, the name of each inmate to be released, the inmate's State Bureau of Identification (SBI) number, and the county jail where the inmate is being detained, as well as any standard or specific conditions of release. Jails shall process the release of inmates as efficiently as possible, understanding that neither immediate nor simultaneous release is feasible.

1. For inmates serving a county jail sentence as a condition of probation, the custodial portion of the sentence shall either be served at the conclusion of the probationary portion of the sentence or converted into a "time served" condition, at the discretion of the sentencing judge, after input from counsel.
2. For inmates serving a county jail sentence as a result of a municipal court conviction, the custodial portion of the sentence shall be suspended until further order of this Court upon the rescission of the Public Health Emergency declared Executive Order No. 103, or deemed satisfied, at the discretion of the sentencing judge, after input from counsel.

B. No later than noon on Thursday, March 26, 2020, except as provided in paragraph C, any inmate serving a county jail sentence for any reason other than those described in paragraph A shall be ordered released. These sentences include, but are not limited to (1) a resentencing following a finding of a violation of probation in any Superior Court or municipal court, and (2) a county jail sentence not tethered to a probationary sentence for a fourth-degree crime, disorderly persons offense, or petty disorderly persons offense in Superior Court. The custodial portion of the sentence shall be suspended until further order of this Court upon the rescission of the Public Health Emergency declared Executive Order No. 103, or deemed satisfied, at the discretion of the sentencing judge, after input from counsel. Jails shall process the release of inmates as efficiently as possible, understanding that neither immediate nor simultaneous release is feasible.

C. Where the County Prosecutor or Attorney General objects to the release of an inmate described in Paragraph A, they shall file a written objection no later than 5:00 p.m. on Monday, March 23, 2020. Where the County Prosecutor or Attorney General objects to the release of an inmate described in Paragraph B, they shall file a written objection no later than 8:00 a.m. on Thursday, March 26, 2020.

1. The objection shall delay the order of release of the inmate and shall explain why the release of the inmate would pose a significant risk to the safety of the inmate or the public.
2. Written objections shall be filed by email to the Supreme Court Emergent Matter inbox with a copy to the Office of the Public Defender.

3. The Office of the Public Defender shall provide provisional representation to all inmates against whom an objection has been lodged under this Paragraph.
4. The Office of the Public Defender shall, no later than 5:00 p.m. on Tuesday, March 24, 2020, provide responses to any objections to release associated with inmates described in Paragraph A, as it deems appropriate. The Office of the Public Defender shall, no later than 5:00 p.m. on Thursday, March 26, 2020, provide responses to any objections to release associated with inmates described in Paragraph B, as it deems appropriate.
5. The Court shall appoint judge(s) or Special Master(s) to address the cases in which an objection to release has been raised.
    a. On or before Wednesday, March 25, 2020, the judge(s) or Special Master(s) will begin considering disputed cases arising from Paragraph A; on or before Friday, March 27, 2020, the judge(s) or Special Master(s) will consider disputed cases arising from Paragraph B.
        i. The judge(s) or Special Master(s) shall conduct summary proceedings, which shall be determined on the papers. In the event the judge(s) or Special

Master(s) conduct a hearing of any sort, inmates' presence shall be waived.

ii. Release shall be presumed, unless the presumption is overcome by a finding by a preponderance of the evidence that the release of the inmate would pose a significant risk to the safety of the inmate or the public.

iii. At any point, the Prosecutor may withdraw its objection by providing notice to the judge(s) or Special Master(s) with a copy to the Office of the Public Defender. In that case, inmates shall be released subjected to the provisions of Paragraphs D-I.

iv. If the judge(s) or Special Master(s) determine by a preponderance of the evidence that the risk to the safety of the inmate or the public can be effectively managed, the judge(s) or Special Master(s) shall order the inmate's immediate release, subject to the provisions of paragraphs D-I.

1. The Order of the judge(s) or Special Master(s) may be appealed on an emergent basis, in a summary manner to the Appellate Division.
2. Should a release Order be appealed, the release Order shall be stayed pending expedited review by the Appellate Division.
3. The record on appeal shall consist of the objection and response filed pursuant to this Paragraph.

v. If the judge(s) or Special Master(s) determine by a preponderance of the evidence that risks to the safety of the inmate or the public cannot be effectively managed, the judge(s) or Special Master(s) shall order the inmate to serve the balance of the original sentence.

1. The Order of the judge(s) or Special Master(s) may be appealed on an emergent basis, in a summary manner to the Appellate Division.

2. Should an Order requiring an inmate to serve the balance of his sentence be appealed, the Appellate Division shall conduct expedited review.
3. The record on appeal shall consist of the objection and response filed pursuant to this Paragraph.

b. The judge(s) or Special Master(s) should endeavor to address all objections no later than Friday, March 27, 2020.

D. Any warrants associated with an inmate subject to release under this order, other than those associated with first-degree or second-degree crimes, shall be suspended. Warrants suspended under this Order shall remain suspended until ten days after the rescission of the Public Health Emergency associated with COVID-19. *See* Executive Order No. 103 (2020) (Mar. 9, 2020).

E. In the following circumstances, the county jail shall not release an inmate subject to release pursuant to Paragraphs A, B, or C(5)(a)(iii) or (iv), absent additional instructions from the judge(s) or Special Master(s):

1. For any inmate who has tested positive for COVID-19 or has been identified by the county jail as presumptively positive for COVID-19, the county jail shall immediately notify the parties and the County Health Department of the inmate's medical condition, and shall not release the inmate without further instructions from the judge(s) or Special Master(s). In such cases, the parties shall immediately confer with the judge(s) or Special Master(s) to determine a plan for isolating the inmate and ensuring the inmate's medical treatment and/or mandatory self-quarantine.
2. For any inmate who notifies the county jail that he or she does not wish, based on safety, health, or housing concerns, to be released from detention pursuant to this Consent Order, the county jail shall immediately notify the parties of the inmate's wishes, and shall not release the inmate without further instructions from the judge(s) or Special Master(s). In such cases, the parties shall immediately confer with the judge(s) or Special Master(s) to determine whether to release the inmate over the inmate's objection.

F. Where an inmate is released pursuant to Paragraphs A, B, or C(5)(a)(iii) or (iv), conditions, other than in-person reporting, originally imposed by the trial court shall remain in full force and effect. County jails shall inform all inmates, prior to their release, of their continuing obligation to abide by conditions of probation designed to promote public safety. Specifically:

1. No-contact orders shall remain in force.
2. Driver's license suspensions remain in force.
3. Obligations to report to probation officers in-person shall be converted to telephone or video reporting until further order of this Court.
4. All inmates being released from county jails shall comply with any Federal, State, and local laws, directives, orders, rules, and regulations regarding conduct during the declared emergency. Among other obligations, inmates being released from county jails shall comply with Executive Order No. 107 (2020) (Mar. 21, 2020), which limits travel from people's homes and mandates "social distancing," as well as any additional Executive Orders issued by the Governor during the Public Health Emergency associated with COVID-19.

5. All inmates being released from county jails are encouraged to self-quarantine for a period of fourteen (14) days.
6. Unless otherwise ordered by the judge(s) or Special Master(s), any inmate being released from a county jail who appears to be symptomatic for COVID-19 is ordered to self-quarantine for a period of fourteen (14) days and follow all applicable New Jersey Department of Health protocols for testing, treatment, and quarantine or isolation.

G. County Prosecutors and other law enforcement agencies shall, to the extent practicable, provide notice to victims of the accelerated release of inmates.

1. In cases involving domestic violence, notification shall be made. N.J.S.A. 2C:25-26.1. Law enforcement shall contact the victim using the information provided on the "Victim Notification Form." Attorney General Law Enforcement Directive No. 2005-5.
    a. Where the information provided on the "Victim Notification Form" does not allow for victim contact, the Prosecutor shall notify the Attorney General.

b. If the Attorney General, or his designee, is convinced that law enforcement has exhausted all reasonable efforts to contact the victim, he may relax the obligations under N.J.S.A. 2C:25-26.1.

2. In other cases with a known victim, law enforcement shall make all reasonable efforts to notify victims of the inmate's accelerated release.

3. To the extent permitted by law, the Attorney General agrees to relax limitations on benefits under the Violent Crimes Compensation Act (N.J.S.A. 52:4B-1, *et seq*.) to better provide victims who encounter the need for safety, health, financial, mental health or legal assistance from the State Victims of Crime Compensation Office.

H. The Office of the Public Defender agrees to provide the jails information to be distributed to each inmate prior to release that includes:

1. Information about the social distancing practices and stay-at-home guidelines set forth by Executive Order No. 107, as well as other sanitary and hygiene practices that limit the spread of COVID-19;

2. Information about the terms and conditions of release pursuant to this consent Order;
3. Guidance about how to contact the Office of the Public Defender with any questions about how to obtain services from social service organizations, including mental health and drug treatment services or any other questions pertinent to release under this consent Order.

I. Any inmate released pursuant to this Order shall receive a copy of this Order, as well as a copy of any other Order that orders their release from county jail, prior to their release.

J. Relief pursuant to this Order is limited to the temporary suspension of custodial jail sentences; any further relief requires an application to the sentencing court.

3/22/2020 9:50 p.m. /s/Stuart Rabner
Date Chief Justice Stuart Rabner, for the Court

The undersigned hereby consents to the form and entry of the foregoing Order.

3/22/2020 /s/Gurbir S. Grewal
Date Office of the Attorney General

3/22/2020 /s/Angelo J. Onofri
Date County Prosecutors Association of New Jersey

3/22/2020 /s/Joseph E. Krakora
Date Office of the Public Defender

3/22/2020 /s/Alexander Shalom
Date American Civil Liberties Union of New Jersey

EXHIBIT 6

March 24, 2020
brie.williams@ucsf.edu
http://amend.us

Brie Williams, MD, MS
Professor of Medicine
UCSF Division of Geriatrics
Director, Amend at UCSF

COVID-19 in Correctional Settings: Immediate Population Reduction Recommendations

Amend at UCSF is a health-focused correctional culture change program led by a team of experts from medicine (including geriatrics, infectious disease, and family medicine), public health, and correctional health and policy. As we confront a rapidly worsening COVID-19 epidemic, **reducing population density inside correctional facilities is an urgent first-line public health measure.** Failure to reduce populations smartly and safely will significantly increase the likelihood of disease transmission in these uniquely vulnerable settings.[1] <u>This document provides recommended immediate **first steps** towards purposeful and public health-oriented population reduction at Departments of Corrections with the goal of optimizing the health and safety of patients and staff</u>.

The Public Health Rationale for Population Reduction.

1. **Medical vulnerability**. Correctional populations are enriched with medically vulnerable patients (people of older age or with chronic medical conditions) who have the highest risk of serious illness when infected with COVID-19. This risk is compounded by limited space and few private rooms with solid doors, **making effective social distancing and compliance with "shelter-in-place" guidance virtually impossible in U.S. jails and prisons, most of which are operating at or above capacity.** In a growing number of U.S. jurisdictions, social distancing and/or "shelter-in-place" directives are the community standard healthcare recommendations. In the context of a highly transmissible infectious disease like COVID-19, it can be argued that correctional systems have a constitutional obligation to provide these same public health protections to their residents.
2. **Prisons are not isolated from local communities.** Hundreds of thousands of correctional officers and correctional healthcare workers enter these facilities every day, returning to their families and their communities at the end of each shift. The risk of transmission between correctional settings and surrounding communities is particularly elevated because COVID-19 is highly transmissible, including by asymptomatic carriers. **Decreasing population density inside U.S. jails and prisons will reduce COVID-19 transmission risk inside these facilities *and* in local communities.**
3. **Jails and prisons have far less medical treatment capacity than community hospitals**. Correctional healthcare systems are designed to treat relatively mild types of respiratory problems for a limited number of people. This means that **a surge in incarcerated people with serious respiratory illness is likely to impose an unmanageable burden on community hospitals**, particularly in rural areas where many U.S. prisons are located.

The Immediate Public Health Goal of Population Reduction.

The immediate public health goals of population reduction are to enable social distancing and to free up beds in every correctional facility so that *medical* isolation and quarantine wings can be created for patients diagnosed or awaiting laboratory results for COVID-19 infection. As population reduction results in increased bed space, medical isolation and quarantine units should be developed using as little population movement within the facility as possible since every new contact carries with it the potential to transmit the infection.

[1] For more on the unique challenges to slowing the spread of coronavirus faced by U.S. correctional systems, see Amend's guidance on COVID-19 in *Correctional Settings: Unique Challenges and Proposed Responses* at http://amend.us/covid.

March 24, 2020
brie.williams@ucsf.edu
http://amend.us

Brie Williams, MD, MS
Professor of Medicine
UCSF Division of Geriatrics
Director, Amend at UCSF

Immediate Steps to Take to Reduce Risk of COVID-19 Spread in Departments of Corrections.

1. **Close Intake immediately.** Since it will be impossible to adequately assess recent exposures for most new admissions, any newly admitted residents should immediately enter quarantine. However, if prison intake units continue to function at their usual pace, the need to quarantine new admissions would impose considerable and *avoidable* strain on valuable resources (including areas to use for quarantine). Thus, all new admissions into U.S. prisons should be immediately suspended until medical leadership has developed an effective containment strategy for the facility, and no transmissions have been recorded for 14 days. All new admissions into U.S. jails should be similarly suspended except in cases of a serious, credible threat to public safety.

2. **Decrease population density using a purposeful strategy focusing on the following high medical risk populations:**
   - **Persons 50 years of age or older within 2 years of a parole or release date.** Accelerate release for all those in age brackets known to be disproportionately vulnerable to serious illness following COVID-19 diagnosis who are scheduled to return to the community, have a home to go to and are eligible for Medicaid or VA health benefits.[2] Increase discharge/reentry planning staff to support housing, health insurance enrollment, and medical care planning for this group.
   - **People of any age who have already completed compassionate release or medical parole request paperwork and have a housing and medical plan in place.** Prioritizing seriously ill incarcerated patients for immediate release will free up medical beds in prisons, lower the likelihood of COVID-19 mortality among the population, and allow correctional healthcare staff to focus attention on COVID-19 patients. In some states, Governors can take immediate action for these patients using commutation or reprieve (temporary sentence suspension) powers.
   - **All who have been successful at pardon or parole hearings but remain incarcerated pending completion of administrative processes** (e.g. approval of housing plans already positively assessed by a parole board). Individuals of all ages who meet this criterion should be released to impove outcomes for those who remain incarcerated. Particular priority should be given to those with a chronic health condition (e.g. diabetes) that increases the risk of serious illness from COVID-19.

3. **Document the medical / public health rationale for each release** to ensure decision-making is well supported by relevant medical guidance, responsive to the urgent call to action necessitated by the rapidly worsening COVID-19 pandemic, and transparent. A template for documenting essential medical / public health release information is provided in an Appendix to this document.

While undertaking medically-informed, decisive action to decrease prison populations may seem to some like an overreaction to the COVID-19 crisis, it is a critical public health intervention that will save the lives of incarcerated people, correctional staff, and people living in surrounding communities.

[2] Older age, stable housing, and access to health care are all associated with a low likelihood of recidivism. This accelerated release proposal aims to reduce the likelihood of COVID-19 exposure for correctional staff and lower the public health risks associated with a surge of patients in needs of critical care seeking urgent transfer from prisons to community hospitals.

EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI CENTRAL DIVISION

STEPHANIE GASCA, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 2:17–cv–04149–SRB
	)	
ANNE PRECYTHE, *et al.*,	)	
	)	
Defendants.	)	

DEFENDANTS ANSWERS AND OBJECTIONS TO PLAINTIFFS' THIRD SET OF INTERROGATORIES TO DEFENDANTS

Defendants respond to Plaintiff's Third Set of Interrogatories to Defendants as follows:

INTERROGATORIES

General Objections: Defendants object to the definitions and instructions set out after the interrogatories in that they extend the duties of a party beyond those required by the rules of civil procedure.

Defendants object to the direction in the heading to the Third Set of Interrogatories that the Defendants answer the interrogatories separately in that the information requested will be the same regardless of which defendant answers.

13. Identify all persons who prepared, supplied information for, or in any way assisted with the preparation of the answers to these Interrogatories or Plaintiffs' Fourth Set of Requests for Production to the Board Defendants,

served contemporaneously herewith. For each person, identify the following:

A. Full name;

B. Current address and telephone number;

C. Current occupation;

D. Relationship to you;

E. Designate the Interrogatory and/or Request for which he or she provided information; and

F. A description of the information or materials provided.

ANSWER: Besides counsel, the following individuals have assisted with the preparation of Defendants' responses to the Third Set of Interrogatories and the Fourth Set of requests for Production:

Stacey Ross, Office Manager, Office of Professional Standards, Missouri Department of Corrections

David Oldfield, Research Manager, Missouri Department of Corrections

Pam Rogers, Secretary of the Parole Board, Missouri Department of Corrections

Steven Mueller, Parole Board Operations Manager, Missouri Department of Corrections

Todd Schwent, Assistant Division Director, Division of Probation & Parole, Missouri Department of Corrections

14. For the time period of February 27, 2019 to present date, please provide the names and MDOC numbers of each parolee revoked, and specific the type of parole violation(s) alleged.

ANSWER: See response to Fourth Set of Requests for Production No. 6.

15. For the time period of February 27, 2019 to present date, please provide the names and MDOC numbers of each parolee who received a Field Violation Report and received a continuance rather than revocation. For each parolee who received a continuance, please specify type of parole violation(s) alleged.

ANSWER: Responsive document provided: DEFs 172600-172693.

16. For the time period of February 27, 2019 to present date, identify each individual who had a preliminary revocation hearing and set forth: (a) the date and location of the hearing; (b) how long the Class Member was detained or incarcerated prior to the hearing; (c) the name and contact information for the hearing officer; (d) whether any witnesses were present in person or via telephone at the hearing; and (e) the outcome of the hearing.

ANSWER: With regard to parts (d) and (e), Defendants object because the producing this information is not proportional to the needs of the case and the burden and expense of the proposed discovery outweighs its likely benefit. Defendants do not maintain information regarding witnesses at preliminary hearings or of the outcome of preliminary hearings in an electronically searchable form. Collection of this information would require reviewing each parole file to determine whether witnesses were called and the outcome of the preliminary hearings.

Subject to this objection, and without waiving it, Defendants provide a partially responsive document: DEFs 172600-172693.

17. For the time period of February 27, 2019 to present date, identify each individual who had a revocation hearing and set forth: (a) the date and location of the hearing; (b) how long the Class Member was detained or incarcerated prior to the hearing; (c) the name and contact information for the hearing officer; (d) whether any witnesses were present in person or via telephone at the hearing; and (e) the outcome of the hearing.

ANSWER: Objection. Producing this information is not proportional to the needs of the case and the burden and expense of the proposed discovery outweighs its likely benefit. Defendants do not maintain all the information requested in an electronically searchable form. Collection of the information not in electronically searchable form would require reviewing each parole file to determine that information.

Subject to this objection, and without waiving it, Defendants will supplement this response with the information that is electronically searchable.

18. For the time period of February 27, 2019 to present date, identify each individual who was screened for counsel for his or her preliminary and/or final revocation hearing, as well as the outcome of such screening, and any specific reasons why counsel was appointed or found to not be necessary.

ANSWER: Objection. The Interrogatory is not proportional to the needs of the case and the burden and expense of the proposed discovery outweighs its likely benefit. Defendants maintain their completed Counsel Eligibility Screening Instruments, and notes related thereto, in individual parole files. Producing these records would require reviewing each parole file.

19. For the time period of February 27, 2019 to present date, identify each individual who was found to need counsel for his or her preliminary and/or final revocation hearing when screened and explain what steps, if any, were taken to ensure that individual was represented by counsel.

ANSWER: Objection. The Interrogatory is not proportional to the needs of the case and the burden and expense of the proposed discovery outweighs its likely benefit. Defendants maintain their completed Counsel Eligibility Screening Instruments, and notes related thereto, in individual parole files. Producing these records would require reviewing each parole file.

20. For the time period of February 27, 2019 to present date, please provide the names and MDOC numbers of each parolee for whom the Defendants lifted the parole hold and released from MDOC custody pending a final revocation hearing.

ANSWER: Objection. The interrogatory is vague in that the phrases "lifted the parole hold", "released from MDOC custody", and "pending a final revocation hearing" are not clear.

21. Since February 27, 2019, how many final parole revocation hearings occurred at each MDOC facility where parole revocation proceedings take place after the parolee had been in custody more than 45, 60, 90, 120, and 365 days?

ANSWER:

DAYS INCARCERATED UNTIL HEARING

LESS THAN 45	1,290
45-59	247
60-89	216
90-119	75
120-364	76
365+	3
TOTAL	1,907

22. Please set forth, since February 27, 2019, (a) how many parolees were subject to the Parole Revocation Process; and, of those parolees, how many: (b) signed a waiver of preliminary hearing; (c) had a preliminary hearing; (d) presented witness testimony at a preliminary hearing; (e) were represented by appointed counsel at a preliminary hearing; (f) were represented by privately-retained counsel at a preliminary hearing; (g) signed a waiver of final hearing; (h) had a final hearing; (i) presented witness testimony at a final hearing; (j) were represented by appointed counsel at a final hearing; and (k) were represented by privately-retained counsel at a final hearing.

ANSWER: Objection. Producing this information is not proportional to the needs of the case and the burden and expense of the proposed discovery outweighs its likely benefit. Defendants do not maintain all the information requested in an electronically searchable form. Collection of the information not in electronically searchable form would require reviewing each parole file to determine that information.

Subject to this objection, and without waiving it, Defendants will supplement this response with the information that is electronically searchable.

Total Number of Parolees subject to Parole Revocation process:	
ii. Total who signed a waiver of preliminary hearing:	
iii. Total who had a preliminary hearing:	
iv. Total who presented witness testimony at a preliminary hearing:	
v. Total represented by appointed counsel at a preliminary hearing:	
vi. Total represented by privately-retained counsel at a preliminary hearing:	
vii. Total who signed a waiver of final hearing:	
viii. Total who had a final hearing:	
ix. Total who presented witness testimony at a final hearing:	
x. Total represented by appointed counsel at a preliminary hearing:	
xi. Total represented by privately-retained counsel at a preliminary hearing:	

VERIFICATION

I, Jennifer Zamkus, hereby solemnly swears under penalty of perjury that the information given in answer to the above interrogatories is true and correct to the best of my knowledge and belief as provided by staff.

Jennifer Zamkus
Jennifer Zamkus

STATE OF MISSOURI)
) ss
COUNTY OF Callaway)

Subscribed and sworn to before me this 7 day of November, 2019.

Deborah L. Vance
Notary Public

My commission expires 12-5-2020.

DEBORAH L. VANCE
Notary Public - Notary Seal
STATE OF MISSOURI
County of Callaway
My Commission Expires 12/5/2020
Commission # 12624108

Respectfully submitted,

ERIC S. SCHMITT
Attorney General

Michael Pritchett
Assistant Attorney General
Missouri Bar No. 33848
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ATTORNEYS FOR DEFENDANTS DUSENBERG, FITZWATER, JONES, MCSWAIN, PRECYTHE, RUCKER, WELLS, AND ZAMKUS

CERTIFICATE OF SERVICE

I hereby certify that on this 7th day of November, 2019, foregoing was mailed by United States Postal Service to the following:

Sheila A Bedi
Locke E. Bowman
Roderick and Solange MacArthur Justice Center
375 East Chicago Avenue
Chicago, IL 60611

Amy E. Breihan
Megan G. Crane
3115 South Grand Blvd.
Suite 300
St. Louis, MO 63118

Michael Pritchett
Assistant Attorney General

EXHIBIT 8

PohlmanUSA®
Court Reporting and Litigation Services

James Weston

March 4, 2020

Stephanie Gasca, et al.

vs.

Anne Precythe, et al.

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI

STEPHANIE GASCA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	Case No. 17-cv-04149
	)	
ANNE PRECYTHE, ET AL.,	)	
	)	
Defendants.	)	

VIDEOTAPED DEPOSITION OF JAMES WESTON
TAKEN ON BEHALF OF THE PLAINTIFFS
MARCH 4, 2020

Stacey L. Preusser, IL-CSR, MO-CCR

INDEX OF EXAMINATION

INDEX OF EXHIBITS

(Exhibits are attached to transcript.)

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI

STEPHANIE GASCA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	Case No. 17-cv-04149
	)	
ANNE PRECYTHE, ET AL.,	)	
	)	
Defendants.	)	

VIDEOTAPED DEPOSITION OF JAMES WESTON, produced, sworn, and examined on behalf of Plaintiffs, MARCH 4, 2019, between the hours of 10:08 in the forenoon and 2:55 in the afternoon of that day, at Roderick and Solange MacArthur Justice Center, 3115 South Grand Boulevard, Suite 300, St. Louis, MO 63118, before Stacey L. Preusser, MO-CCR, IL-CSR.

A P P E A R A N C E S

The Plaintiffs, Stephanie Gasca, et al., represented by Megan Crane of Roderick & Solange MacArthur Justice Center, 3115 S. Grand Suite 300, St. Louis, MO 63118

The Defendants, Anne Precythe, et al, represented by Matthew Kimminau of Missouri Attorney General, PO Box 899, Jefferson City, MO 65102

The Defendants, Anne Precythe, et al., represented by Michael Pritchett of Missouri Attorney General, PO Box 899, Jefferson City, MO 65102

IT IS HEREBY STIPULATED AND AGREED by and between counsel for the Plaintiffs and counsel for the Defendants, that this deposition may be taken in shorthand by Stacey L. Preusser, a Certified Shorthand Reporter and Certified Court Reporter, and afterwards transcribed into typewriting, and the signature of the witness is reserved by agreement of counsel and the witness.

* * * * * * * * * * * *

THE VIDEOGRAPHER: We are on the record. This is the videotaped deposition of James Weston. Today's date is March 4th, 2020, and the time is 10:08 a.m.

This is the case of Stephanie Gasca, et al versus Anne Precythe, et al. Case number 17-CV-04149 pending in the United States District Court for the Western District of Missouri.

This deposition is being held at 3115 South Grand Avenue, Suite 300, St. Louis, Missouri 63118.

My name is Matthew Schnorf, videographer. And the court reporter is Stacey Preusser. We are both with PohlmanUSA Court Reporting.

Counselors, will you please state your

waiting on or I'm waiting to be told how to proceed by the parole board or something like that.

Well, the whole time that the first guy is still waiting, I'm continuing to get more guys and more guys and more guys. So it's kind of like an accordion. You know, might be 30 or it might be 50, you know, depending on --

And it really depends on the time of year also. Like right before Christmas, our caseloads increase dramatically because many of the county jails want to try and empty out their facility. And so if -- if there's any chance that any offender could possibly be brought to the prison, they want to do that so they could have more space in their facility over, you know, just usually a long weekend. That's my understanding. That's why we have the big dumps at certain times of the year.

Q. I understand that you're saying it fluctuates and there's kind of no way to put a number on it.

I guess could you explain how long a parolee is assigned to you, like at what point in the process that would start and at what point that would end in which you're no longer responsible for them?

A. Okay. So the way that we're trying to best

process the offenders, if an offender is in the field and is in jail, the board has -- and there have been violations, and the field officer has recommended revocation or maybe not, but anyway, if there's a warrant issued and has not been canceled yet and the detaining agency, the county sheriff's department does not want to hold them anymore and if we don't know what the board wants to do with the offender's status yet, so the field officer may have been recommending revocation, but the parole board is still reviewing information, they don't know what they want to do with the offender's status, that sheriff or that -- that county might bring them to our facility. And we still don't know what -- what's to be done with the supervision because we haven't been told what -- what to do with the parole -- by the parole board yet.

If that offender is delivered to our facility, it's called board hold status. Okay. So he's mine if his number ends in four, five or six.

And so what that means is -- basically is the board is telling us hold on to this guy because we don't know what we want to do yet; we're waiting on some piece of information to be -- an additional field officer's report or a police officer -- a police report or something -- something altogether different.

And so day one, that -- that offender is assigned to me. And I look at it to see if everything is -- is ready for the board to tell us what to do.

And until they tell us what to do -- like until they see that report for recommending revocation and then it's my understanding they just look at the totality of the circumstances, and then they'll tell us either they want the supervision continued or placed in delayed action.

If it's either one of those, then I meet with the offender and make sure the home plan and make sure that it's approvable by the field office wherever that home plan is at. And once it is approved, then we release them to that district, going to that home plan.

But if the board wants -- tells us to, yes, go ahead and process this offender's supervision for revocation, that's whenever I turn it over to one of the other officers in the office.

We have three board hold officers. I'm one of them. We have two officers that deal primarily with the parole violators.

So once the -- and whenever I say that, I mean once we receive the board's decision to process the supervision for revocation, that's whenever I turn

it over to one of the parole violator officers.

And what they try to do is whenever an offender is in board hold status, they try to get them upstated -- updated one way or the other within two weeks, but that doesn't always happen.

And myself and my supervisor, you know, on a couple of cases, it'll have taken a longer period of time than what we feel like, you know, hey, what's going on. It looks like everything is done. This guy should be ready to go one way or the other.

Any time we've communicated with central office is what's the hold up, have you guys -- are you waiting on something, is there anything I can do to get this case going. They never tell us. They just say, you know, it's still being processed. And so we just sit and wait until we're told what to do, and then we do it as soon as possible.

Q. And so who is it in central office that you're contacting in those circumstances?

A. The parole analyst.

Q. And --

A. Usually. Every now and then it might be someone else. I -- I might've actually reached out to a board member once or twice, but I can't even say that I've definitely done that. And for what reason,

is the reason?

A. Yeah, at meetings just that -- like I said because the terminology wasn't -- they didn't -- certain lawyers didn't like the terminology and didn't like the timeframes, and --

So like before it was an offender -- for an offender to be processed as a parole violator, it was worded should be processed in a reasonable amount of time. And it was just -- 30 days isn't a reasonable amount of time. That was discussed. That was never listed anywhere.

And it was also 30 days from the date that the offender was ordered to be processed as a parole violator from the parole board.

Okay. So if you came into the institution January 1st and you were on board hold status for three weeks, then third week of January the board says process as a parole violator. That's whenever the 30 days starts. And it's 30 business days, so it even extends it out farther.

Well, now we're locked into 30 days. And it doesn't say anything about board hold, differentiate between board hold or from the time they were ordered to be processed as a parole violator.

Like my three guys that went off to federal

go through the spiel about the Notice of Rights. So now that --

A. I try to still.

Q. Okay. But it's usually quicker now?

A. Well, it's whenever the offender stops me.

Q. So it's still your practice to start reading the form to them until they stop you?

A. Yeah.

Q. Okay.

A. I mean, that's what we were told to do.

MS. CRANE: Okay. Okay.

MR. KIMMINAU: I don't have anything further.

THE COURT REPORTER: Signature?

THE VIDEOGRAPHER: This concludes our deposition. Going off the record at 2:55 p.m.

MR. KIMMINAU: Waive presentment but not signature.

(Whereupon signature was reserved, and the deponent was excused.)

(The exhibits were retained by the court reporter.)

COMES NOW THE WITNESS, JAMES WESTON, and having read the foregoing transcript of the deposition taken on the 4 day of MARCH, 2020 acknowledges by signature hereto that it is a true and accurate transcript of the testimony given on the date hereinabove mentioned.

____
[JAMES WESTON]

Subscribed to before me this _________ day of _________________________, 2020.

____
[Notary Public]

My commission expires: ______________________.

(JAMES WESTON Videotaped Deposition)
STEPHANIE GASCA, ET AL. vs. ANNE PRECYTHE, ET AL.
Reporter: Stacey L. Preusser, MO-CCR, IL-CSR
Date Taken: MARCH 4, 2020.

REPORTER CERTIFICATE

I, Stacey L. Preusser, MO-CCR, IL-CSR, do hereby certify that there came before me at Roderick and Solange MacArthur Justice Center, 3115 South Grand Boulevard, Suite 300, St. Louis, MO 63118,

JAMES WESTON,

who was by me first duly sworn; that the witness was carefully examined, that said examination was reported by myself, translated and proofread using computer-aided transcription, and the above transcript of proceedings is a true and accurate transcript of my notes as taken at the time of the examination of this witness.

I further certify that I am neither attorney nor counsel for nor related nor employed by any of the parties to the action in which this examination is taken; further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in this action.

Dated this 11th day of MARCH, 2020.

Stacey L. Preusser

STACEY L. PREUSSER, MO-CCR, IL-CSR