

EXHIBIT A

Declaration of Dr. Georges C. Benjamin

I, Georges C. Benjamin, M.D, declare and state as follows:

1. I am the Executive Director of the American Public Health Association (APHA). I have served in that role since December, 2002. The APHA has more than 25,000 individual public health professional members and our mission is to: “Improve the health of the public and achieve equity in health status.”

2. I am a graduate of the Illinois Institute of Technology and the University of Illinois College of Medicine. I am licensed to practice medicine in Maryland and the District of Columbia. I am board-certified in internal medicine and a Master of the American College of Physicians, a fellow of the National Academy of Public Administration, a fellow emeritus of the American College of Emergency Physicians, an elected member of the National Academy of Medicine (Formally the Institute of Medicine) of the National Academies of Sciences, Engineering and Medicine, a honorary fellow of the Faculty of Public Health and an honorary fellow of the Royal Society of Public Health.

3. I served as the Secretary of the Maryland Department of Health and Mental Hygiene. I became Secretary of Health in Maryland in April 1999, following four years as its Deputy Secretary for Public Health Services. I served as Secretary of the Department until December of 2002.

4. Following graduation from medical school, I began my career at the Madigan Army Medical Center in Tacoma, Washington in 1981, serving there until I was transferred to the Walter Reed Army Medical Center in Washington, D.C. in 1983. Following my discharge from the United States Army in 1987, I was appointed as Chair of the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital, serving in that post until December of 1990. From January 1990 to the fall of 1991 I was the Acting Commissioner for Public Health for the District of Columbia, and the Director of the Emergency Ambulance Bureau in the District of Columbia Fire Department. I returned to serve as the Director of the Emergency Ambulance Bureau from 1994 to 1995.

5. I started my medical practice in the United States Army, where, from 1981 to 1983 I managed a 72,000-patient per year ambulatory care service as chief of the Acute Illness Clinic at the Madigan Army Medical Center and was an attending physician within the Department of Emergency Medicine in Tacoma, Washington. From 1983 to 1987 I served as chief of emergency medicine at the Walter Reed Army Medical Center.

6. In April 2016, I was appointed by President Obama to the National Infrastructure Advisory Council. In that role, I help advise the President on how best to assure the security of the nation's critical infrastructure.

7. I have extensive experience working on issues related to vulnerable populations including people who are incarcerated.

Coronavirus Epidemic

8. On March 11, 2020, the World Health Organization declared that the rapidly spreading outbreak of COVID-19, a respiratory illness caused by a novel coronavirus, is a pandemic, announcing that the virus is both highly contagious and deadly.¹ To date, the virus is known to spread from person-to-person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.² The CDC also warns of “community spread” where the virus spreads easily and sustainably within a community where the source of the infection is unknown.³ Experts are still learning how it spreads.

9. The incubation period (between infection and the development of symptoms) for COVID-19 is typically five days, but can be as short as two days. Some infected persons never experience symptoms. There is evidence that transmission can occur before the development of symptoms or from persons who are infected and never develop symptoms.

10. As of April 4, 2020, novel coronavirus has infected more than 1,139,207 people, leading to more than 60,874 deaths worldwide.⁴ In the United States, there are at least 278,537 confirmed cases and there have been at least 9,920 deaths.⁵ There are confirmed coronavirus cases in every state, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

11. The first COVID-19 cases in Maryland were reported on March 5.⁶ The virus has been spreading rapidly. There have been at least 3,125 COVID-19 confirmed cases in Maryland and 53 deaths as of April 2, 2020.⁷

12. The COVID-19 virus has made its way into the Maryland correctional system. As of April 3, the Maryland Department of Public Safety and Correctional Services reported at least three prisoners, eight staff and two Division of Probation and Parole employees have been

¹ World Health Organization, Media Briefing on March 11, 2020: <https://www.who.int/dg/speeches/detail/whodirector-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>.

² Centers for Disease Control and Prevention, Coronavirus Disease 2019: *How it Spreads*, <https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html>

³ *Id.*

⁴ Johns Hopkins University Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering, <https://coronavirus.jhu.edu/map.html>.

⁵ *Id.*

⁶ Ovetta Wiggins and Jenna Portnoy, *Coronavirus in Maryland: three Montgomery County residents contracted the virus*, *The Washington Post* (5 March 2020).

⁷ See Maryland Dep’t of Health Coronavirus Disease 2019, <http://coronavirus.maryland.gov> (last accessed April 4, 2020).

confirmed infected.⁸ These infections are geographically dispersed in Jessup, Baltimore, and Hagerstown and led to quarantines in correctional facilities.⁹ First responders throughout the State have confirmed infections.¹⁰ This does not capture the full extent of cases, as there have been reported cases at County detention centers, including Prince George’s County.¹¹

13. There is currently no vaccine or cure for COVID-19. The Centers for Disease Control and Prevention have emphasized the need to prevent further transmission of the virus. To prevent new infections, the Centers for Disease Control and Prevention strongly recommend the following actions: physical distancing by keeping at least 6 feet of space between people, avoiding group settings, thorough and frequent handwashing, and cleaning surfaces with EPA approved disinfectants.¹² The President’s *Coronavirus Guidelines for America*, to slow the spread of the coronavirus, warns that social gatherings in groups of more than 10 people should be avoided.¹³

14. On March 23, 2020, the CDC issued “Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.” This Guidance was drafted with the recognition that people who are incarcerated live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.¹⁴ These measures emphasize the importance of physical distancing, medical isolation of symptomatic and infected individuals, rigorous screening, and significantly enhanced hygienic practices, and are the minimum measures necessary to limit transmission to incarcerated persons, staff and the public.

15. The CDC recommends that social or physical distancing strategies be implemented to increase the physical space between incarcerated persons, “ideally 6 feet between all individuals, regardless of the presence of symptoms.”

⁸ *BREAKING: COVID-19 in MD Prisons; 17 People Test Positive*, Fox 45 News (April 3, 2020); <https://foxbaltimore.com/news/coronavirus/breaking-covid-19-in-md-prisons-17-people-test-positive>.

⁹ *Id.*

¹⁰ *Coronavirus Latest: Anne Arundel County Police Officer Test Positive for COVID-19*, WJZ Channel 13, CBS Baltimore (April 2, 2020): <https://baltimore.cbslocal.com/2020/04/02/coronavirus-latest-anne-arundel-county-police-officer/>; *Coronavirus Cases: 2 Baltimore Sheriff’s Deputies Test Positive for COVID-19* WJZ Channel 13, CBS Baltimore (April 2, 2020): <https://baltimore.cbslocal.com/2020/04/02/coronavirus-cases-2-baltimore-sheriffs-deputies-test-positive-for-covid-19/>.

¹¹ [Keith L. Alexander](#), Dan Morse and Spencer S. Hsu, *As inmates in D.C., Maryland and Virginia test positive for the coronavirus, jail officials scramble to reduce the risk*, Washington Post (Apr. 1, 2020).

¹² *How to Protect Yourself*, Centers for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html>. See also *Coronavirus, Social Distancing, and Self-Quarantine*, Johns Hopkins Medicine, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-social-distancing-andself-quarantine>.

¹³ *The President’s Coronavirus Guidelines for America*, https://www.whitehouse.gov/wpcontent/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf.

¹⁴ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

16. The CDC specifically recommends enforcing space between people in common areas; reassigning bunks to provide more space between people “ideally 6 feet or more in all directions”; staggering meals and time in recreational spaces; limiting the size of group activities; and rearranging seating in the dining hall so that there is more space between individuals.

17. To mitigate the spread of Covid-19 in correctional setting, the CDC recommends that facilities clean and disinfect surfaces and objects that are frequently touched several times per day; ensure there is sufficient stocks of hygiene supplies, cleaning supplies, and medical supplies; provide a no-cost supply of soap, running water, disposable towels, tissues and no-touch trash receptacles for disposal to people in custody sufficient to allow for frequent hand washing; and consider relaxing restrictions on allowing alcohol-based hand sanitizer where security concerns allow.

18. The CDC recommends rigorous screening protocols. The CDC specifically recommends pre-intake screening and temperature checks for all new entrants in the prison, medical isolation of all symptomatic individuals, and quarantine of individuals who have had contact with a known COVID-19 case, and screening all correctional staff and others who enter a facility.¹⁵

19. In addition, the CDC recommends that correctional officials restrict transfers of people in custody to and from facilities unless necessary or to prevent overcrowding; communicate clearly and frequently with people in custody about changes to their daily routine and how they can help mitigate the spread of the virus; and conduct verbal screening and temperature checks for all staff, newly admitted incarcerated persons, and visitors.¹⁶

Certain Identifiable Populations Are Far More Vulnerable To COVID-19 Than The Population At Large Is.

20. The Centers for Disease Control have identified two groups of people at higher risk of contracting and succumbing to COVID-19: adults over 60 years old and people with chronic medical conditions.¹⁷

¹⁵ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

¹⁶ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

¹⁷ *If You Are at Higher Risk*, Centers for Disease Control and Prevention, <https://tinyurl.com/vtbebcz>; *see also Report of the WHO-China Joint Mission on Coronavirus Disease (COVID-19)*, <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> at 12.

21. Many people in custody have chronic illnesses and some are serving long sentences and have grown older while incarcerated. While everyone is vulnerable to serious illness or death if they contract COVID-19, people with medical conditions or who are older are at greater risk.

22. COVID-19 is more dangerous to persons in these high-risk groups than to the general population. Older people who contract COVID-19 are more likely to die than people under the age of 60. In a February 29th WHO-China Joint Mission Report, the preliminary mortality rate analyses showed that individuals age 60-69 had an overall 3.6% mortality rate and those 70-79 years old had an 8% mortality rate.¹⁸ It has been found that older people diagnosed with COVID-19 are more likely to be very sick and require hospitalization to survive because the acute symptoms include respiratory distress, cardiac injury, arrhythmia, septic shock, liver dysfunction, kidney injury and multi-organ failure. Access to a mechanical ventilator is often required, as is the ability to be intubated quickly.

23. People with chronic medical conditions (no matter their age) are also at significantly greater risk from COVID-19 because their already-weakened systems are less able to fight the virus. These chronic medical conditions include lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy. Those with pre-existing medical conditions have a higher probability of death if infected. The WHO-China Joint Mission Report provides that the mortality rate for those with cardiovascular disease was 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.¹⁹

Correctional Settings Increase the Risk of Transmission

24. In correctional settings, CDC recommended social or physical distancing, sanitation, medical isolation and quarantining measures are nearly impossible.²⁰

25. Correctional settings increase the risk of contracting an infectious disease, like COVID-19, due to the high numbers of people living in close quarters, the large number of individuals with chronic, often untreated, illnesses, minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and no possibility of staying at a distance from others.

26. More than 38% of people in correctional custody nationally have a chronic illness.²¹

¹⁸ *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart*, <https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/> (data analysis based on WHOChina Joint Mission Report, *supra*).

¹⁹ *Report of the WHO-China Joint Mission on Coronavirus Disease (COVID-19)*, <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> at 12.

²⁰ *See We Are Not a Hospital: A Prison Braces for the Coronavirus*, New York Times, March 18, 2020, <https://www.nytimes.com/2020/03/17/us/coronavirus-prisons-jails.html>.

27. Correctional facilities house large groups of people together. They sleep and eat in close proximity to one another and have no ability to socially distance. This means there are more people who are susceptible to getting infected all congregated together in a context in which fighting the spread of an infection is nearly impossible.

28. 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.²²

Reducing Population Size at Specific Correctional Facilities Is a Crucial Public Health Measure

29. Under the conditions in most prisons and jails, it will not be possible to prevent the spread of COVID-19. Congregate settings allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing or touching surfaces touched by an infected person. When people live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater.²³

30. An outbreak in prison could have a devastating impact on public health far beyond the prison walls. Staff who enter and leave the facility could transmit the virus to the broader community and demands for intensive care beds and ventilators could overwhelm local hospitals and health care providers. It is essential at this time that all steps are taken to reduce infection and to “flatten the curve” to ensure that our health care system does not collapse.

31. Given that the only viable public health strategy available in the United States currently is prevention of spread of COVID-19, reducing the size of the population in detention centers, jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large.

²² *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) at <https://bit.ly/2TNcNZY>.

²³ *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control (March 23, 2020); <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html> (“Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.”); *Preparedness, prevention and control of COVID-19 in prisons and other places of detention Interim guidance*, World Health Organization (March 15, 2020); https://www.ncchc.org/filebin/news/WHO_Preparedness-prevention-and-control-of-COVID-19-in-prisons_002.pdf; (“The very fact of being deprived of liberty generally implies that people in prisons and other places of detention live in close proximity with one another, which is likely to result in a heightened risk of person-to-person and droplet transmission of pathogens like COVID-19. In addition to demographic characteristics, people in prisons typically have a greater underlying burden of disease and worse health conditions than the general population, and frequently face greater exposure to risks such as smoking, poor hygiene and weak immune defence due to stress, poor nutrition, or prevalence of coexisting diseases, such as bloodborne viruses, tuberculosis and drug use disorders.”)

I declare under penalty of perjury declare and pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge.

Dated: Gaithersburg, Maryland
April 5, 2020

A handwritten signature in black ink, appearing to read "Georges C. Benjamin". The signature is written in a cursive style with a large, looped initial "G".

Georges C. Benjamin, M.D.

EXHIBIT B

Declaration of Dr. Joshua M. Sharfstein

I, Joshua M. Sharfstein, M.D, declare and state as follows:

1. I am a Professor of the Practice in Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health.

2. I am offering this declaration on my own behalf and not on behalf of Johns Hopkins University.

3. Prior to my current position, I served as Secretary of the Maryland Department of Health and Mental Hygiene (including during the Ebola pandemic in 2014), the Acting Commissioner and then the Principal Deputy Commissioner of the U.S. Food and Drug Administration (including during the H1N1 Flu pandemic of 2009), and Commissioner of Health for the City of Baltimore. I have been elected as a member of the National Institute of Medicine and the National Academy of Public Administration. My complete curriculum vitae is attached as Exhibit A.

4. My areas of teaching and research include public health crisis and response, healthcare payment, and the opioid epidemic. I teach a class entitled “Crisis and Response in Public Health Policy and Practice” and am the author of *Public Health Crisis Survival Guide: Leadership and Management in Trying Times*, from Oxford University Press.

5. I am closely following the COVID-19 pandemic. I have written articles about the pandemic in the *Journal of the American Medical Association*, *USA Today*, and the *New York Times*.

6. I write this declaration to explain why the novel coronavirus and its associated disease, COVID-19, are public health emergencies requiring aggressive measures to protect the public health and, for my purposes, the health of every member of our community. A critical component of a comprehensive approach is addressing the populations of incarcerated persons in jails, prisons, and detention centers. A thoughtful and comprehensive approach to this challenge is urgently needed.

7. I am familiar with the State of Maryland’s response to date to COVID-19 since the first cases were reported in Montgomery County on March 3.

8. As part of its overall response to COVID-19, the State of Maryland should adopt a strategy to address its prisons, jails, and detention centers.

The Coronavirus Epidemic and the Strain on the Health Care System

9. COVID-19 is a serious disease and has reached pandemic status. At least 1,093,000 people around the world have received confirmed diagnoses of COVID-19 as of April 4, 2020, including over 277,000 people in the United States, and over 3,000 in Maryland. At least 58,000 people have died globally as a result of COVID-19 as of April 4, 2020, including more

than 6,500 people in the United States, and 53 in Maryland. These numbers have been growing rapidly, and will likely continue to increase in the coming days.

10. COVID-19 is a disease caused by the novel zoonotic coronavirus SARS-CoV2. There is no vaccine to prevent COVID-19, and there is no cure for COVID-19. There is no pre-existing immunity to the virus in the world's population. Currently, the only way to control the spread of the virus is isolation of cases, quarantine of contacts, and preventive measures including hygiene and social distancing.

11. The progression of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as a few days after exposure and their condition can seriously deteriorate in as little as five days.

12. The effects of COVID-19 are potentially very serious for all people. COVID-19 has infected and killed children, young adults, adults, and the elderly. COVID-19 is currently estimated to kill 3 to 35 people per thousand infected (.5 to 3.5%), making it more lethal than the seasonal flu.

13. Particularly vulnerable people include individuals aged 50 years and older as well as those of any age with underlying health problems such as weakened immune systems (including due to cancer treatment), chronic lung disease, asthma, serious heart conditions, diabetes, renal failure, and liver disease. Pregnancy is also of concern for serious COVID-19 infection.

14. Vulnerable populations who do not die may have prolonged serious illness for the most part requiring expensive hospital care, including ventilators that are in very short supply, and an entire team of providers. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from neurological damage and loss of respiratory capacity.

15. The projected numbers of COVID-19 cases will result in a significant strain on healthcare providers nationally. Many hospitals already operate near full capacity and do not have the ability to rapidly expand to account for the expected surge in COVID-19 patients.

16. The experiences of other countries including China, Italy, and Spain show that around 20% of COVID-19 cases require hospitalization, 5% of cases require the Intensive Care Unit (ICU), and around 2.5% require very intensive help, with items such as ventilators or extracorporeal oxygenation.

17. As the examples of Italy and Spain indicate, and as the U.S. example of New York does is at risk for demonstrating as well, a surge in patients can exhaust the capacity of the health care system to care for them. This crisis would result not only in COVID-19 patients not receiving necessary care, but also in effects such as staff, bed, and supply shortages to treating individuals throughout the healthcare system.

18. If the healthcare system becomes overwhelmed, the fatality rate of COVID-19 is certain to rise. Moreover, the mortality rate for many other patients with life-threatening illness is certain to rise as well.

Transmission of COVID-19 in Congregate Facilities Such as Jails

19. SARS-CoV2 is thought to spread mainly from person-to-person between people who are in close contact with one another (within about six feet) and through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs; the droplets may also persist in the air for a number of hours. It may be possible for a person to contract COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or eyes.

20. People in congregate environments, which are places where people live, eat, and sleep in close proximity, face increased danger of contracting COVID-19, as already evidenced by the rapid spread of the virus in cruise ships, nursing homes, and jails and prisons.

21. In particular, detention facilities have significant risk of infectious spread because of the design of the facilities. People live closely together. Toilets, sinks, and showers are shared. Food preparation and food service is communal. These characteristics and others facilitate the spread of COVID-19.

22. The experience of other pandemic sites shows how COVID-19 spreads rapidly in congregate settings such as jails and prisons. For example, in Wuhan, China – where COVID-19 originated – over half of all reported cases were incarcerated persons. These are some other examples where COVID is spreading quickly in detention centers:

- The detention center at Rikers Island in New York City reported its first case of COVID-19 on March 17, 2020; by March 24, Rikers reported 52 confirmed COVID-19 cases,¹ and by April 1, there were 231 cases among incarcerated persons and 223 among staff members.²
- The number of detainees who tested positive in Illinois' Cook County Jail rose from two to 210 between March 23 and April 4.³

¹ Julia Craven, *Rikers Island Has 52 Confirmed COVID-19 Cases*, Slate (Mar. 25, 2020), <https://slate.com/news-and-politics/2020/03/coronavirus-is-spreading-on-rikers-island.html>.

² Catherine Kim, *Why people are being released from jails and prisons during the pandemic*, Vox (Apr. 3, 2020), <https://www.vox.com/2020/4/3/21200832/jail-prison-early-release-coronavirus-covid-19-incarcerated>.

³ NBC Chicago, *Cook County Jail Now Reports 210 Inmates Have Tested Positive for COVID-19* (Apr. 4, 2020), <https://www.nbcchicago.com/news/coronavirus/cook-county-jail-now-reports-210-inmates-have-tested-positive-for-covid-19/2250366/>.

- Michigan reported its first case of COVID-19 at a correctional facility on March 23; by March 27, the case count had climbed to at least 24 inmates, one parolee, and three Michigan Department of Corrections employees.⁴ By March 31, Michigan prisons had 78 positive tests,⁵ and as of April 5, there were 206 COVID-19 cases across nine Michigan prisons.⁶ Parnall Correctional Facility in Jackson County, Michigan, reported 90 of those cases, surpassing the total number of cases (81) than the rest of Jackson County.⁷
- The Massachusetts Treatment Center in Bridgewater reported its first case on March 21.⁸ As of April 3, 23 incarcerated persons and 7 staff members (6 Department of Corrections employees and one medical provider) at MTC had tested positive, including 2 deaths.⁹

23. Because many jails and prisons lack the necessary medical resources to care for COVID-19 cases, an outbreak of COVID-19 within a detention center would increase the number of individuals who need to be treated by the community healthcare system. This would exacerbate the strain on the healthcare infrastructure I noted above.

Recommendations from the Centers for Disease Control and Prevention

24. On March 23, CDC issued guidance on correctional and detention facilities. The CDC specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons “ideally 6 feet between all individuals, regardless of the presence of symptoms.” CDC recommends “increased space between individuals in cells, as well as in lines and waiting areas such as intake... stagger time in recreation spaces ...restrict

⁴ Ted Roelofs, *Coronavirus cases surge in Michigan’s crowded prisons*, Bridge Magazine (Mar. 27, 2020), <https://www.bridgemi.com/michigan-government/coronavirus-cases-surge-michigans-crowded-prisons>.

⁵ Timothy Williams, et al., *‘Jails Are Petri Dishes’: Inmates Freed as the Virus Spreads Behind Bars*, New York Times (Mar. 31, 2020), <https://www.nytimes.com/2020/03/30/us/coronavirus-prisons-jails.html>.

⁶ Paul Egan & Angie Jackson, *Why coronavirus is running rampant in Michigan prisons*, Detroit Free Press (Apr. 5, 2020), <https://www.freep.com/story/news/local/michigan/2020/04/05/coronavirus-spreading-fast-michigan-prisons/2938733001/>.

⁷ *Id.*

⁸ Jackson Cote, *Coronavirus and prisons: Inmate serving life sentence tests positive for COVID-19 at Massachusetts Treatment Center in Bridgewater*, Mass Live (Mar. 21, 2020), <https://www.masslive.com/coronavirus/2020/03/coronavirus-and-prisons-inmate-serving-life-sentence-tests-positive-for-covid-19-at-massachusetts-treatment-center-in-bridgewater.html>.

⁹ Steph Solis, *Coronavirus: 2nd inmate at Massachusetts Treatment Center dies after testing positive for COVID-19*, Mass Live (Apr. 3, 2020), <https://www.masslive.com/coronavirus/2020/04/coronavirus-2nd-inmate-at-massachusetts-treatment-center-dies-after-testing-positive-for-covid-19.html>.

recreation space usage to a single housing unit per space... stagger meals... rearrange seating in the dining hall so that there is more space between individuals...provide meals inside housing units or cells... limit the size of group activities... and reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.”

25. Following the CDC recommendations will protect not only people in detention, but also will protect the staff at county and state correctional facilities.

Examples of Approaches Taken By Other Jurisdictions

26. Reduction of jail and prison populations will increase the ability of correctional facilities to implement CDC recommendations within the prison. Increased implementation of social distancing will reduce the risk of spread of COVID-19 among incarcerated persons and the staff who work at detention centers.

27. In light of these risks, courts and local officials across the country have taken steps to reduce their jail and prison populations. These are some examples:

- On March 22, the Supreme Court of New Jersey ordered the release of *all* prisoners serving county jail sentences.¹⁰
- On April 3, the Pennsylvania Supreme Court ordered the chief judge of all counties to “immediately” engage in a review of the “current capabilities of their county correctional institutions . . . to address the spread of COVID-19,” “to ensure that the county correctional institutions in their districts address the threat of COVID-19,” as necessary “to identify individuals of incarcerated persons for potential release” and “to undertake efforts to limit the introduction of new inmates into the county prison system.”¹¹
- On April 3, the Massachusetts Supreme Court ruled that pre-trial detainees not charged with certain violent offenses, as well as incarcerated individuals held on technical probation and parole violations, is entitled to a rebuttable presumption of release.¹²
- On March 22, the Chief Justice of Kentucky Supreme Court told state judges to release jail inmates “as quickly as we can,” noting that “jails are susceptible to worse-case scenarios due to the close proximity of people and the number of pre-existing

¹⁰ *In the Matter of the Request to Commute or Suspend County Jail Sentences*, No. 082430 (N.J. March 22, 2020), <https://www.njcourts.gov/notices/2020/n200323a.pdf?c=9cs>. The order provided a mechanism for prosecutors, within 24-to-48 hour, object to the release of specific prisoners who “would pose a significant risk to the safety of the inmate or the public,” with such objections to be considered by judges or special masters appointed by the Supreme Court.

¹¹ *In re: The Petition of the Pennsylvania Prison Society et al.*, No. 70 MM 2020 (Apr. 3, 2020).

¹² *Order, Committee for Public Counsel Servs. et al. v. Chief Justice of the Trial Court, et al.*, No. SJC-12926 (Apr. 3, 2020), available at <https://www.mass.gov/files/documents/2020/04/03/12926.pdf>.

conditions,” and that courts have the responsibility “to work with jailers and other county officials to safely release as many defendants as we can as quickly as we can.”¹³

- On March 20, the Chief Justice of the California Supreme Court issued guidance encouraging the state’s superior courts to, *inter alia*, (a) “lower bail amounts significantly”; (b) “consider a defendant’s existing health conditions, and conditions existing at the anticipated place of confinement, in setting conditions of custody”; and (c) “identify detainees with less than 60 days in custody to permit early release.”¹⁴
- On March 26, the Chief Justice of the Michigan Supreme Court, together with the Michigan Sheriff Association, issued a joint statement urging judges to (a) “reduce and suspend jail sentences for people who do not pose a public safety risk”; (b) “release far more people on their own recognizance while they await their day in court”; and (c) “use probation and treatment programs as jail alternatives.”¹⁵
- On March 19, the Chief Justice of the Ohio Supreme Court urged “judges to use their discretion and release people held in jail and incarcerated individuals who are in a high-risk category for being infected with the virus.”¹⁶
- On March 20, the Chief Justice of the Montana Supreme Court wrote to all judges in the state asking each judge to “review your jail rosters and release, without bond, as many prisoners as you are able, especially those being held for non-violent offenses.”¹⁷

¹³ Kyle C. Barry, *Some Supreme Courts Are Helping Shrink Jails to Stop Outbreaks. Others Are Lagging Behind*, The Appeal (Mar. 25, 2020), <https://theappeal.org/politicalreport/some-supreme-courts-are-helping-shrink-jails-coronavirus/>; John Cheves, *Chief Justice Pleads for Kentucky Inmate Release Ahead of COVID-19 but Progress Slow*, Lexington Herald Leader (Mar. 23, 2020), <https://www.kentucky.com/news/coronavirus/article241428266.html>.

¹⁴ Advisory from California Chief Justice Tani Cantil-Sakauye to Presiding Judges and Court Executive Officers of the California Courts (Mar. 20, 2020), <https://newsroom.courts.ca.gov/news/california-chief-justice-issues-second-advisory-on-emergency-relief-measures>.

¹⁵ Joint Statement of Chief Justice Bridget M. McCormack, Mich. Sup. Ct. and Sheriff Matt Saxton, Exec. Dir., Mich. Sheriff Ass’n (Mar. 26, 2020), [https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20\(003\).pdf](https://courts.michigan.gov/News-Events/press_releases/Documents/CJ%20and%20MSA%20Joint%20Statement%20draft%202%20(003).pdf).

¹⁶ Press Conference, Ohio Chief Justice Maureen O'Connor and Gov. Mike DeWine (Mar. 19, 2020); see also WLWT5, *Release Ohio Jail Inmates Vulnerable to Coronavirus, Chief Justice Urges* (Mar. 19, 2020), <https://www.wlwt.com/article/release-ohio-jail-inmates-vulnerable-to-coronavirus-chief-justice-urges/31788560>.

¹⁷ Letter from Mike McGrath, Chief Justice of Montana Supreme Court, to Montana Courts of Limited Jurisdiction Judges (Mar. 20, 2020), <https://courts.mt.gov/Portals/189/virus/Ltr%20to%20COLJ%20Judges%20re%20COVID-19%20032020.pdf?ver=2020-03-20-115517-333>.

- On March 16, the Chief Justice of the South Carolina Supreme Court ordered that everyone held in jail on bond in a non-capital case be released, unless there exists an “unreasonable danger” or “extreme flight risk.”¹⁸
- On March 20, the Washington Supreme Court directed that all trial courts in the state prioritize hearings that could result in the release of a defendant in custody, providing that courts “shall hear motions for pretrial release on an expedited basis” and that any person fitting within the CDC’s definition of vulnerable populations would be presumed to have demonstrated a “material change in circumstances” justifying reconsideration of previously ordered bail conditions.¹⁹
- On March 17, the Chief Judge of Maine’s trial courts, with the approval of the chief justice of the Maine Supreme Court, vacated all outstanding warrants for unpaid fines, restitution, fees, and failures to appear.²⁰ The order resulted in the vacatur of more than 12,000 warrants.²¹

28. Similarly, local authorities have acted to sharply reduce prison populations:

- Cuyahoga County, Ohio, which encompasses Cleveland, has decreased its prison population by more than 30 percent, releasing approximately 600 out of a total of 1,900 incarcerated people.²²
- The Los Angeles County Sheriff authorized the release of 1,700 prisoners, reducing the county jail population by 10 percent.²³

¹⁸ Memorandum from Donald W. Beatty, Chief Justice of South Carolina Supreme Court, to Magistrates, Municipal Judges, and Summary Court Staff (Mar. 16, 2020), <https://www.sccourts.org/whatsnew/displayWhatsNew.cfm?indexId=2461>.

¹⁹ *In the Matter of Statewide Response by Washington State Courts to the COVID-19 Public Health Emergency*, No. 25700-B-607 (Wash. Mar. 20, 2020), <http://www.courts.wa.gov/content/publicUpload/Supreme%20Court%20Orders/Supreme%20Court%20Emergency%20Order%20re%20CV19%20031820.pdf>.

²⁰ See Emergency Order Vacating Warrants for Unpaid Fines, Unpaid Restitution, Unpaid Court-Appointed Counsel Fees, and Other Criminal Fees (Mar. 17, 2020), <https://www.courts.maine.gov/covid19/emergency-order-vacating-warrants-fines-fees.pdf>.

²¹ Judy Harrison, *Maine courts vacate warrants for unpaid fines and fees*, Bangor Daily News (Mar. 17, 2020), <https://bangordailynews.com/2020/03/16/news/state/maine-courts-vacate-warrants-for-unpaid-fines-and-fees/>.

²² Scott Noll & Camryn Justice, *Cuyahoga County Jail releases hundreds of low-level offenders to prepare for coronavirus pandemic* (March 20, 2020), <https://www.news5cleveland.com/news/local-news/oh-cuyahoga/cuyahoga-county-jail-releases-hundreds-of-low-level-offenders-to-prepare-for-coronavirus-pandemic>.

²³ *L.A. County releases 1,700 inmates to lessen jail population due to COVID-19 crisis* (Mar. 25, 2020), <https://www.foxla.com/news/l-a-county-releases-1700-inmates-to-lessen-jail-population-due-to-covid-19-crisis>.

- Officials in two other California counties, Alameda County and Santa Clara County, released more than 300 prisoners from each jurisdiction's respective jails.²⁴
- In Colorado, the Jefferson County Sheriff's Office announced it would release all prisoners who had served more than half their sentence,²⁵ and Larimer County temporarily released all 142 people sentenced to its work release program.²⁶
- In Allegheny County, Pennsylvania, as of April 2, 701 people held in the county jail were approved for release by the courts and physically discharged from custody.²⁷
- In Travis County, Texas, judges have begun to release more people from local jails on personal bonds (about 50% more often than usual), focusing on preventing people with health issues who are charged with non-violent offenses from going into the jail system.²⁸
- A court order in Spokane, Washington authorized the release of people being held pretrial and some people serving sentences for "low-level" misdemeanor offenses.²⁹
- In Hillsborough County, Florida, over 160 people were released following authorization via administrative order for people accused of ordinance violations, misdemeanors, traffic offenses, and third degree felonies.

²⁴ Robert Salonga, *Bay Area courts, authorities ramp up release of inmates to stem COVID-19 risks in jails*, The Mercury News (Mar. 19, 2020), <https://www.mercurynews.com/2020/03/19/bay-area-courts-authorities-ramp-up-release-of-inmates-to-stem-covid-19-risks-in-jails/>.

²⁵ Elise Schmelzer, *Uneven response to coronavirus in Colorado courts leads to confusion, differing outcomes for defendants*, The Denver Post (Mar. 21, 2020), https://www.denverpost.com/2020/03/21/colorado-courts-coronavirus-judges/?fbclid=IwAR0Da1qjZsSU48THOo-Hi24ibgCW_ed1nMVfmRJ1BaZNFJJsVo1BJO0lsk.

²⁶ Carina Julig, *Larimer County inmate in community corrections program tests positive for coronavirus*, The Denver Post (Mar. 22, 2020), https://www.denverpost.com/2020/03/22/coronavirus-larimer-county-inmate/?fbclid=IwAR0_M2BhVxD42BjlfTh_bYVwSfg6nH68cwLArtGt7GPpl58FqpE4g_Bnfgo.

²⁷ WTAE Pittsburgh, *701 inmates released from Allegheny County Jail due to coronavirus concerns* (Apr. 2, 2020), <https://www.wtae.com/article/inmates-released-from-allegheny-county-jail-due-to-coronavirus-concerns/31953103#>.

²⁸ See Ryan Autullo, *Travis County judges releasing inmates to limit coronavirus spread*, Statesman (Mar. 16, 2020), <https://www.statesman.com/news/20200316/travis-county-judges-releasing-inmates-to-limit-coronavirus-spread?fbclid=IwAR3VKawwn3bwSLSO9jXBxXNRuaWd1DRLsCBFc-ZkPNIINWW8xnzLPvZYNO4>.

²⁹ See Chad Sokol, *Dozens released from Spokane County custody following Municipal Court emergency order*, The Spokesman-Review (Mar. 17, 2020), <https://www.spokesman.com/stories/2020/mar/17/dozens-released-from-spokane-county-custody-follow/>.

- More than 85 people (almost 7% of the jail's population) have been released from the Greenville County Detention Center in Greenville, South Carolina, following a state order from the Supreme Court Chief Justice Donald Beatty urging South Carolina judicial circuits to avoid issuing bench warrants and start releasing people charged with non-violent offenses.³⁰
- In Salt Lake County, Utah, the District Attorney reported that the county jail plans to release at least 90 people this week and to conduct another set of releases of up to 100 more people in the next week.³¹
- In New Orleans, Louisiana, the District Court judges have issued orders calling for the immediate release of people held in the New Orleans jail awaiting trial for misdemeanors, arrested for failure to appear at probation status hearing, detained in contempt of court, or detained for failing a drug test while on bond.³²

Maryland Actions to Date

29. To reduce COVID-19, Maryland's Department of Corrections has suspended prison visits. However, the Department's website does not include information related to the release of prisoners or how the Department intends to meet, or is meeting, the CDC recommendations.

30. As far as I am aware, the state has not made recommendations to County-run Jails on the release of people in detention. As a result, there is no consistent standard or approach to the release of people in detention or to the implementation of CDC recommendations.

Recommendations

31. Maryland's response to the coronavirus requires urgent attention to jails and prisons, based on the guidance put forward by the CDC.

32. In light of the risks presented by COVID-19 to incarcerated persons and detention center staff, as well as the burden an outbreak of COVID-19 within a jail or prison could have on

³⁰ See Daniel J. Gross, *Dozens of inmates released from Greenville jail amid growing COVID-19 concerns*, Greenville News (Mar. 20, 2020), <https://www.greenvilleonline.com/story/news/local/south-carolina/2020/03/20/dozens-released-greenville-south-carolina-jail-due-covid-19-fears/2883854001/>.

³¹ See Jessica Miller, *Hundreds of Utah inmates will soon be released in response to coronavirus*, The Salt Lake Tribune (Mar. 21, 2020), https://www.sltrib.com/news/2020/03/21/hundreds-utah-inmates/?fbclid=IwAR3r8BcHeEkoAOcyP3pmBu9XWkEj4MMsDC_LUH4YZn2QGd18hALk4vM9X1c.

³² WDSU, *Orleans Criminal Court judges order release of certain inmates amid coronavirus crisis* (Mar. 26, 2020), <https://www.wdsu.com/article/orleans-criminal-court-judges-order-release-of-certain-inmates-amid-coronavirus-crisis/31943462#>.

the community health care system, Maryland should adopt a plan to discharge incarcerated persons who can safely be released.

33. The more such individuals who can be released from detention, the more likely jails and prisons will be able to successfully implement measures recommended by the CDC to prevent and slow the spread of COVID-19.

34. Maryland leaders should regularly disclose the number of cases of COVID-19 in people in detention and correctional staff and transparently explain the steps being taken in jails and prisons to implement the CDC recommendations, including progress towards full implementation.

35. Release of incarcerated persons has a public safety component and a public health component. Steps to address the public health component include providing education to people who are being released about COVID-19, providing basic supplies for hygiene upon release, and providing access to safe accommodations and food. For people presumed exposed to COVID-19 but not showing symptoms, individuals should be referred to public health agencies for quarantine and monitoring.

36. Conditions related to and understanding of the novel coronavirus and COVID-19 are changing rapidly, and this declaration is drafted under intense time pressures in an evolving, public health crisis. Information contained herein may rapidly change from the date I sign this. I offer this declaration because it is critical to national public health that public health recommendations are followed.

In accordance with Rule 1-304 of the Maryland Rules, I solemnly affirm under the penalties of perjury that the contents of the foregoing declaration are true to the best of my knowledge, information, and belief.

Dated: Baltimore, Maryland
April 5, 2020



Joshua M. Sharfstein, M.D.

EXHIBIT C

Declaration of Stuart O. Simms, Esq.

Declaration of Stuart O. Simms, Esq.

I, Stuart O. Simms, Esq., declare and state as follows:

1. I am an attorney licensed to practice in the State of Maryland and am currently a partner with the law firm Brown, Goldstein & Levy in Baltimore. I graduated with a bachelor's degree from Dartmouth College in 1972, and earned my law degree from Harvard Law School in 1975.
2. Prior to entering private practice, I served as the Secretary of Maryland's Department of Public Safety and Correctional Services (DPSCS) from June 1997 through January 2003. In that capacity, I oversaw all state correctional facilities and detention centers housing more than 20,000 incarcerated individuals. I also oversaw the state parole and probation systems.
3. From February 1995 through May 1997, I served as the Secretary of Maryland's Department of Juvenile Services.
4. From November 1987 through February 1995, I served two consecutive four-year terms as the elected State's Attorney for Baltimore City, the top prosecutor representing the City of Baltimore. Prior to being elected State's Attorney, I served as a Deputy State's Attorney for Baltimore City from 1983 through 1987.
5. From 1978 through 1982, I served as an Assistant United States Attorney for the District of Maryland in Baltimore.
6. Through my many experiences in government at the state, local, and federal levels, including as the Secretary of DPSCS and the State's Attorney for Baltimore City, I am familiar with all of the correctional facilities and detention centers operated by the State of Maryland, and certain facilities maintained by municipalities, including the Baltimore City Central Booking facility.
7. I am familiar with the measures recommended by the Centers for Disease Control and Prevention (CDC) in its "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities."¹ These measures include implementing social distancing within correctional facilities and medical isolation and quarantine of certain classes of incarcerated persons, including new entrants and symptomatic individuals. Upon review of the CDC's guidance, I understand those terms to be defined as follows:
 - a. Social distancing — The practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease

¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

(ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic).²

- b. Quarantine — The practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms.” If symptoms develop during the quarantine period (ideally 14 days), the individual should be placed under medical isolation. The CDC’s guidance recommends that each quarantined individual should be quarantined in a single cell with solid walls and a solid door that closes.³
 - c. Medical Isolation — Confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission.⁴
8. Based on my knowledge of, and familiarity with, Maryland’s correctional and detention facilities, it would be extremely difficult, if not impossible, for such facilities to implement social distancing, quarantining, or medical isolation in accordance with the CDC’s recommendations given the population density and architectural layout at each facility. The DPSCS has announced it is undertaking certain measures like suspending visits, modified movement, staff temperature checks, procuring additional materials, and having Maryland Corrections Enterprises produce masks and hand sanitizer. While laudable, these changes do not appreciably change population density. This puts incarcerated persons and staff who work in these facilities at risk.
 9. For that reason, absent measures aimed at reducing the population of incarcerated individuals at each facility, COVID-19 is likely to spread far more rapidly throughout Maryland’s correctional and detention facilities than it would through the community at large.
 10. Accordingly, to reduce the risk of transmission of COVID-19 in Maryland’s correctional and detention facilities, the DPSCS and local authorities that operate detention centers should be required to:
 - a. Use their authority to release as many people from their custody as possible, at least on a temporary basis. Such releases should, be consistent with public safety, focus on non-violent offenders, people being held pre-trial, people incarcerated for technical violations of probation or parole, as well as inmates who are high risk of serious injury or death due to COVID-19, including individuals with serious chronic medical conditions and individuals who are 50 years or older. For example, steps could be taken to expedite the release of those non-violent parolees who are eligible for parole over the next 6 months; and similarly expedite parole of those over 65.

² *Id.*

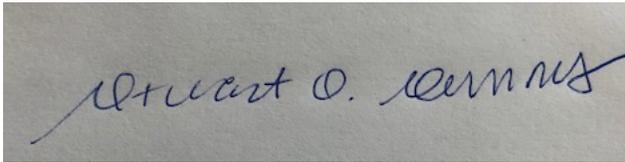
³ *Id.*

⁴ *Id.*

- b. Work with court administrators and public health officials to identify for immediate release people in detention who are at high risk of being affected by coronavirus, including people who are 50 years and older, those who are pregnant, and those with serious chronic medical conditions.
 - c. Partner with community providers to connect people leaving custody with medical care, housing, and other essential services.
11. By releasing inmates who are: (1) nonviolent; (2) elderly (and, therefore, low risk); (3) medically-impaired (and, therefore, at greater risk); and (4) arrested only for technical violations of probation or parole, Maryland prisons and jails both can avoid unnecessary deaths in custody and can enable greater resources and “distancing” for remaining incarcerated population.

In accordance with Rule 1-304 of the Maryland Rules, I solemnly affirm under the penalties of perjury that the contents of the foregoing declaration are true to the best of my knowledge, information, and belief.

Executed this 6h day of April, 2020.

A photograph of a handwritten signature in blue ink on a light-colored surface. The signature is written in a cursive style and reads "Stuart O. Simms".

Stuart O. Simms

EXHIBIT D

Declaration of Dr. Chris Beyrer

Declaration of 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 current semester, I am teaching the epidemiology course on emerging infections at Hopkins. 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. Over the course of my career, I have at various times studied and published on the spread of infectious diseases within prisons. A copy of my curriculum vitae is attached as Exhibit A.
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.
3. Maryland was one of the first states to report COVID-19 cases, reporting its first case on March 3, 2020.¹ On March 5, 2020, Governor Hogan declared a State of Emergency because of the threat to public health presented by the COVID-19 pandemic.² On March 16, 2020, the Governor announced an executive order that included an order of social distancing for all Maryland residents.³ On March 30, 2020, the Governor issued a “shelter in place” order to all Maryland residents.⁴ On April 3, 2020, the Governor stated, “We now have widespread, community transmission. This virus is everywhere and it is a threat to nearly everyone.”⁵
4. As of April 5, 2020, Maryland has confirmed and reported 3,609 cases of coronavirus statewide, with 936 hospitalizations and 67 deaths resulting from the virus.⁶ These numbers have soared exponentially since the first 3 confirmed cases in Maryland on March 3, 2020, and the number of cases is doubling approximately every four days.
5. According to the latest analysis from Institute of Health Metrics and Evaluation, Maryland will not hit its peak count of daily COVID-19 deaths until April 28, 2020.⁷ On this date alone, Maryland is projected to have 53 COVID-19 related deaths (more than our total

¹ <https://www.wbalTV.com/article/timeline-coronavirus-in-maryland/31394971>

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ <https://www.baltimoresun.com/coronavirus/bs-md-hogan-friday-updates-20200403-zrsvgdh335hnhn43frusflccxy-story.html>

⁶ <https://coronavirus.maryland.gov>

⁷ <https://covid19.healthdata.org/projections>

count today OR compared to the 67 deaths reported as of today).⁸ Maryland is projected to have a shortage of hospital beds available for coronavirus patients by April 18, 2020.⁹

6. As of April 5, 2020, Maryland has confirmed and reported 17 cases of coronavirus in its prisons in 8 different facilities.¹⁰ This number includes 4 corrections officers, 10 contract workers, and 3 inmates. The predominance of cases among officers and civilian staff was also seen at the start of the Wuhan prison outbreaks and on Rikers Island in New York. There was a total of 3 reported cases statewide less than a week ago on March 30. On March 31, an anonymous corrections officer at Jessup Correctional Institution stated, "My fear is that it's already spread through the prison, and it's just going to continue to spread like wildfire. And it's going to be a disaster."¹¹

The nature of COVID-19

7. 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 the initial cases were associated with a wet seafood market in Wuhan City.
8. On January 7, 2020, the virus was isolated and identified. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus which caused the 2002-2003 SARS epidemic.
9. On March 11, 2020, the World Health Organization (WHO) announced that the outbreak of COVID-19 is a pandemic.¹² On March 13, President Trump declared a national emergency.¹³
10. As of April 5, 2020, the CDC has confirmed 304,826 cases of coronavirus in the United States.¹⁴ The CDC projects that over 200 million people in the United States could be infected with COVID-19 over the course of the pandemic without effective public health intervention, with as many as 200,000 to 1.7 million projected deaths under a worst case scenario.¹⁵
11. COVID-19 is a serious disease. There is no vaccine or known cure. The overall case fatality rate has been estimated to range from 0.3 to 3.5% in most countries, but over 7.0% in Italy. This is 5-35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. Overall, some 20% of cases will have more severe disease requiring medical intervention and support.
12. Once contracted, COVID-19 can cause severe damage to lung tissue, including a permanent loss of respiratory capacity, and it can damage tissues in other vital organs, such as the heart, central nervous system, and liver.¹⁶

⁸ *Id.*

⁹ *Id.*

¹⁰ <https://foxbaltimore.com/news/coronavirus/breaking-covid-19-in-md-prisons-17-people-test-positive>

¹¹ <https://baltimore.cbslocal.com/2020/03/31/correctional-officer-fears-more-coronavirus-cases-in-maryland-prisons/>

¹² <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>

¹³ <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>

¹⁴ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html#2019coronavirus-summary>

¹⁵ <https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html>

¹⁶ Centers for Disease Control, *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*, <https://cutt.ly/etRPVRI>

13. The case fatality rate can be significantly higher 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.
14. 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 in parts of China.
15. COVID-19 can severely damage lung tissue, which requires an extensive period of rehabilitation, and in some cases, cause permanent loss of breathing capacity. COVID-19 may also target the heart, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can reduce the heart's ability to pump.
16. People over the age of fifty face a greater risk of serious illness or death from COVID-19. According to the World Health Organization February 29, 2020 preliminary report, individuals age 50-59 had an overall mortality rate of 1.3%; 60-69-year-olds had an overall 3.6% mortality rate, and those 70-79 years old had an 8% mortality rate.¹⁷
17. People of any age who suffer from certain underlying medical conditions, including lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, and asthma, also have an elevated risk. The World Health Organization February 29, 2020 report estimated that the mortality rate for those with cardiovascular disease was 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.
18. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than [209] countries and all populated continents, heavily affected countries include Italy, Spain, Iran, South Korea, and the US, now the world's most affected country. As of April 5, 2020, there have been 1,252,265 confirmed human cases globally, 68,413 known deaths, and some 258,000 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.
19. COVID-19 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection. This means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.
20. The U.S. CDC estimates that the reproduction rate of the virus (referred to as 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 influenza pandemic of 1918, (which killed between 17 and 50 million people worldwide) is thought to have higher

¹⁷*Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart*, <https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/> (data analysis based on WHO China Joint Mission Report, *supra*).

infectivity. This again, is likely a function of all human populations not having pre-existing immunity and currently being highly susceptible.

21. The attack rate, the proportion of people exposed who contract the disease, is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations, including in closed settings such as nursing homes, ships, and detention facilities. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days. It is important to note that infected people can be contagious during the incubation period, even before they manifest any symptoms.
22. The best way to slow and prevent spread of the virus is through “social distancing.” Social distancing involves avoiding human contact, and staying at least six feet away from other people. Even vigilant efforts to improve personal hygiene will not be enough to slow the spread of COVID-19. Consequently, every American institution—from schools¹⁸ to places¹⁹ of worship, from businesses²⁰ to legislatures²¹—have either dramatically reduced the number of people in close quarters, or closed entirely.

The risks of COVID-19 in detention facilities

23. People in congregate environments, which are places where people live, eat, and sleep in close proximity, face increased danger of contracting COVID-19, as already evidenced by the rapid spread of the virus in cruise ships and nursing homes. On April 4, 2020, Maryland reported the presence of COVID-19 in 60 of its nursing homes.²² This includes more than 90 cases among residents and staff at Pleasant View Nursing Home.²³
24. Detention centers are congregate environments. 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.
25. 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.
26. There are a number of features of detention facilities that 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

¹⁸ <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-schools.html>

¹⁹ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/guidance-community-faith-organizations.html>

²⁰ <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html>

²¹ <https://cutt.ly/4tRPQne.a>

²² <https://www.baltimoresun.com/coronavirus/bs-md-hogan-friday-updates-20200403-zrsvgdh335hnhn43frusflccxy-story.html>

²³ <https://www.baltimoresun.com/coronavirus/bs-md-coronavirus-cluster-response-20200401-vbdynzsd5zaebdrsokao2gxthu-story.html>

limits on hygiene and personal protective equipment such as masks and gloves in some facilities. In addition to these factors, I understand:

- a. It is virtually impossible for people who are confined in prisons, jails, and detention centers to engage in the necessary social distancing required to mitigate the risk of transmission, particularly at typical population levels that involve dorm, pod and double-cell housing.
 - b. Hot water, soap, and paper towels are often in limited supply. Limits on soap (copays are common) and hand sanitizer, since it can contain alcohol, are also risks for spread.
 - c. Incarcerated people, rather than professional cleaners, are responsible for cleaning the facilities and often are not given appropriate supplies.
 - d. Correctional facilities frequently have insufficient medical care for the population even outside times of crisis.
27. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. Reported outbreaks of COVID-19 in multiple detention facilities in China are associated with introduction into facilities by staff. Similarly, for the outbreak at Riker's Island in New York City, majority of early cases were among prison staff, not inmates. The early evidence from Maryland also suggests it is following this trend -- the initial reports from the Department of Public Safety and Correctional Services indicate that five times as many staff have been infected as incarcerated persons.²⁴
28. The evidence concerning COVID-19 indicates that once it enters a detention center, it spreads significantly faster inside the detention center than outside. During the peak of the outbreak in Wuhan, China —the province where COVID-19 originated—over half of all reported COVID-19 cases were incarcerated people. In the United States, this is demonstrated by dramatic outbreaks in the Cook County jail,²⁵ and Rikers Island in New York City, where the transmission rate for COVID-19 is estimated to be the highest in the world.²⁶ Based on the evidence I have seen, I estimate the reproduction rate of the virus in prisons The U.S. CDC estimates that the reproduction rate of the virus (R_0) in jails to be 4-5, meaning that each newly infected person is estimated to infect on average 4 or 5 additional persons.
29. 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 and aging and chronically ill populations who may be vulnerable to more severe illnesses after infection, and to death from COVID-19 disease.

The risks of community spread from detention facilities

30. The history of severe epidemics indicates that once an epidemic is in a prison, it is likely to spread back into the community.
31. For example, severe epidemics of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of Tuberculosis in multiple states

²⁴ Kyle Parsons, *Md. Dept. of Public Safety and Correctional Services Reports 17 COVID-19 Cases*, WBOC (Apr. 3, 2020).

²⁵ Sam Kelly, *134 inmates at Cook County Jail confirmed positive for COVID-19*, CHICAGO SUN-TIMES (Mar. 30, 2020). <https://cutt.ly/6tYTqi5>.

²⁶ LEGAL AID SOCIETY, *Analysis of COVID-19 Infection Rate in NYC Jails* (last visited March 30, 2020, 11:00 AM), <https://cutt.ly/RtYTbWd>

in that region. This is the case for several reasons. First, correctional officers and other staff go back to their communities every day. Because individuals can be infected with and spread COVID-19 without or before they manifest symptoms, screening may not detect when a staff member has become infected. In other words, the possibility of asymptomatic transmission means that monitoring fever of staff or detainees is inadequate for identifying all who may be infected and preventing transmission. While I understand that the DPSCS has stated it is conducting temperature checks and administering a screening questionnaire, I do not believe such screening is sufficient to prevent spread of COVID-19 back into the community since it is now known that asymptomatic persons with normal temperatures can be infected with COVID-19 and infectious for others.

32. Second, detention facilities typically lack the necessary medical facilities to isolate or treat persons infected with COVID-19. As discussed above, COVID-19 can cause serious medical conditions, including Acute Respiratory Distress Syndrome (ARDS), other types of severe lung tissue damage, diminished breathing capacity, and heart conditions including myocarditis. These are serious medical conditions that require hospitalization. To the extent incarcerated persons develop any of these conditions, they will need to be hospitalized, placing a toll on community hospitals. As stated above, Maryland is already projected to have a shortage of hospital beds available for coronavirus patients by April 18, 2020.
33. Given these factors, it is a near certainty that a COVID-19 outbreak cannot and will not be contained within a prison's walls. Rather, it will reemerge back into the community. This in turn will undermine the efforts Maryland has made to date to reduce spread of the virus.

Conclusion and Recommendations

34. Given the experience in China as well as the literature on infectious diseases in jail, additional outbreaks of COVID-19 among the U.S. jail and prison populations are highly 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.
35. Despite the significant restrictions Governor Hogan has ordered, state and local correctional officials have not provided assurances that correctional facilities in Maryland have implemented or can implement key recommendation to prevent spread of COVID-19 in correctional facilities, or from correctional facilities to the community. In particular, these officials have not indicated that Maryland correctional facilities have implemented or plan to implement the measures necessary to achieve social distancing, screening, medical isolation or quarantine, or enhanced hygienic practices that has been deemed essential to prevent the spread of coronavirus.
36. 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 public health emergency to reduce the number of persons in detention as quickly as possible.

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

Executed this 5h day of April, 2020.

Chris Bey

Professor Chris Beyrer

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EXHIBIT E

Declaration of Dr. Jonathan L. Golob

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. I am also a member of the Physicians for Human Rights. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.
2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of April 2, 2020, there are over 800,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 45,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States in regions like New York, New Jersey, Louisiana, Michigan and Illinois.
3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.
4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound

deconditioning, loss of digits, neurologic damage, and loss of respiratory capacity that can be expected from such a severe illness.

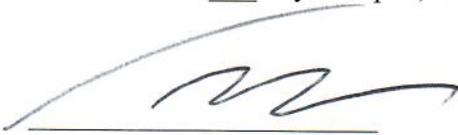
5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.
6. The incubation period (between infection and the development of symptoms) for COVID-19 is typically 5 days, but can vary from as short as two days to an infected individual never developing symptoms. There is evidence that transmission can occur before the development of infection and from infected individuals who never develop symptoms. Thus, only with aggressive testing for SARS-COV-2 can a lack of positive tests establish a lack of risk for COVID-19.
7. When a community or institution lacks a comprehensive and rigorous testing regime, a lack of proven cases of COVID-19 is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.
8. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.
9. COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

10. There is no cure and vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.
11. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.
12. In early March, the highest known person-to-person transmission rates for COVID-19 were in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. More recently, the highest transmission rates have been recorded in the Rikers Island jail complex in New York City, which is over seven times the rate of transmission compared to the spread in New York City. To illustrate, the number of confirmed cases among inmates soared from one to nearly 200 in the matter of 12 days.
13. This is consistent with the spread of previous viruses in congregate settings. During the H1N1 influenza (“Swine Flu”) epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers such as prisons and jails, particularly when residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff. With new individuals and staff coming into the detention centers who may be asymptomatic or not yet presenting symptoms, the risk of infection rises even with symptom screening measures.
14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as a prison, or jail, or an immigration detention center, with limited access to

adequate hygiene facilities, limited ability to physically distance themselves from others, and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 3 day in April, 2020 in Ann Arbor, Michigan.

A handwritten signature in black ink, appearing to read 'J. Golob', is written over a horizontal line.

Dr. Jonathan Louis Golob

EXHIBIT F

Declaration of Dr. Robert B. Greifinger

Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities*, a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.¹
2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with immigration detention centers, having toured and evaluated the medical care in approximately 20 immigration detention centers, out of the several hundred correctional facilities I have visited during my career. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

COVID-19

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of March 31, 2020, according to the World Health Organization, more than 750,890 people have been diagnosed with COVID-19 around the world and 36,405 have died. In the United States, about 140,640 people have been diagnosed and 2,398 people have died thus far.² These numbers are likely an underestimate, due to the lack of availability of testing.
4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.
5. People in the high-risk category for COVID-19, i.e., adults over 50 years old or those with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

¹ Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. *Journal of Correctional Health Care OnlineFirst*, published on May 12, 2010 as doi:10.1177/1078345810367593.

² World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report-71, Mar. 31, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200331-sitrep-71-covid-19.pdf?sfvrsn=4360e92b_4.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.
7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.
8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy.

The Risks of COVID-19 in Immigration Detention

9. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.
10. Immigration detention facilities are enclosed environments, much like the cruise ships and nursing homes that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the “social distancing” needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.
11. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.

ICE Has Failed to Adequately Respond to COVID-19 at Worcester County Detention Center and Howard County Detention Center

12. I have reviewed a declaration by Capt. Jennifer Moon filed on March 30, 2020 (“Moon Declaration,”) and a declaration filed by Kevin J. Brown filed on March 30, 2020 (“Brown Declaration”).
13. In my opinion, the Moon declaration presented in this case is of limited utility in evaluating the effectiveness of ICE’s COVID-19 response at the Worcester County

Detention Center and Howard County Detention Center as it is vague and not provided by anyone who has a direct role in managing the facilities or the health of detainees. As Captain Moon writes, the ICE Health Service Corps (IHSC) provides “oversight” and “monitor[s]” the medical care at these sites, but IHSC does not provide care or have a management, supervision, implementation or enforcement role at the facilities. Her declaration states that ICE “follow[s] guidance issued by the Centers for Disease Control” without referring to any particular guidance. Moon asserts that there are zero confirmed cases of COVID-19, but does not elaborate on whether anyone has been tested or on whether and how much testing is available at these two facilities.

14. There are increasingly reports of COVID-19 infections in correctional and detention sites around the country. Once COVID-19 is introduced into these facilities, it spreads like wildfire.
15. Two weeks ago, the jail at Rikers Island in New York City had not had a single confirmed COVID-19 case. Rikers now has a rate of infection that is far higher than the infection rates of the most infected regions of the world.³ By March 30, 2020, 167 inmates, 114 correction staff and 20 health workers at Rikers tested positive for COVID-19; two correction staff members have died and multiple inmates have been hospitalized. The Chief Medical Officer of Rikers has described a “public health disaster unfolding before our eyes.” In his view, following CDC guidelines has not been enough to stem the crisis: “infections in our jails are growing quickly despite these efforts.”⁴
16. Jails and detention centers are congregate environments where the risk of infection and infectious spread are extraordinarily high. Like the explosive growth at Rikers, the Cook County Jail went from two confirmed COVID-19 cases on March 23 to 134 cases in a matter of one week.⁵ In one facility for which I work for the federal court as a medical monitor, there have been 15 test-positive staff members, and six test- positive health care staff, several test-positive inmates and multiple other tests pending results.
17. From the evidence I have reviewed, it is my opinion that ICE has failed to adequately comprehend and respond to the COVID-19 pandemic for those detained in ICE custody, including at Worcester and Howard County Detention Centers.
18. Most significantly, ICE fails to appreciate the importance of releasing detainees to limit the risk for the individuals released, for those who remain detained, and for the general public. Because of the risks inherent in detention centers, and the

³ Jan Ransom, *We’re Left for Dead: Fears of Virus Catastrophe at Rikers Jail*, NY Times, Mar. 30, 2020.

⁴ Ross MacDonald (@RossMacDonaldMD), Twitter (Aug. 30, 2020, 8:03 PM), <https://twitter.com/rossmacdonaldmd/status/1244822686280437765?s=12> (“I can assure you we were following the CDC guidelines before they were issued. We could have written them ourselves. . . [I]nfections in our jails are growing despite these efforts.”).

⁵ Sam Kelley, *134 Inmates at Cook County Jail Confirmed Positive for COVID-19*, Chicago Sun Times, Mar. 30, 2020.

unparalleled importance of social distancing, release is the most important means of mitigating the spread of COVID-19 in ICE detention centers. This would be true even if the conditions inside the facility were impeccable.

19. Detention centers are extraordinarily high-risk environments for the transmission of infectious diseases. Thus, the “capacity” of a facility is not an appropriate marker for the facility’s ability to house people safely during the COVID-19 pandemic. This is because the facility’s capacity does not take into account the need for social distancing in mitigating the COVID-19 pandemic. Social distancing of six feet, as recommended by the CDC, will be impossible in all ICE facilities without significant downsizing. This is especially true in light of the common practice of facility lockdowns. The Moon Declaration does not acknowledge, let alone explain, how ICE is addressing the need for all detainees and staff to practice social distancing.
20. Beyond ICE’s fatal disregard for the need to release people to enable social distancing, the Moon Declaration reflects a misapprehension of the COVID-19 pandemic. In particular, it misses the mark in analyzing whether an individual has “possible exposure” to COVID-19. In considering whether a detainee has “possible exposure,” ICE focuses on “close contact” with “laboratory-confirmed COVID-19” cases and potential foreign travel, instead of on community spread. This results in a dramatic undercounting of who may be exposed to COVID-19. This has ripple effects and results in severely inadequate mitigation measures. The failure to appropriately consider the current sources of COVID-19 exposure is evident in the policy concerning screening, monitoring, quarantine and isolation.
21. Given the severe lack of testing capacity nationwide, determining possible exposure by considering whether an individual has had contact with a *confirmed* case undercounts risk. Many more people have been infected with COVID-19 than have been confirmed. Further, “close” contact is not required for infectious spread. Part of what is so pernicious about the disease is that it spreads through droplets that can remain on surfaces for days, spreading between people who have never even met. The focus on recent travel ignores the reality of community transmission in much of the United States. At this point, nearly everyone who is not practicing social distancing might be in contact with someone who has the virus.
22. Monitoring active symptoms, including fever, is important. To limit the spread of the virus, however, ICE policy must also recognize the significance of the spread of COVID-19 from *asymptomatic* individuals. An individual can present without a fever or respiratory problems and still be infected and infectious. The Moon Declaration only considers the risk of asymptomatic infection when an individual has “known exposure to a person with confirmed COVID-19.” Yet there are many more COVID-19 cases than are confirmed.
23. There is apparently no automatic isolation or quarantining of new arrivals. According to the

Moon Declaration, ICE quarantines individuals only if they have “known exposure to a person with confirmed COVID-19” or if they are symptomatic new arrivals. This is not enough. Nearly every person who newly arrives at the detention facility will have had close contact to someone with COVID-19. Thus, appropriate guidelines would quarantine and monitor all new arrivals.

24. The Moon Declaration provides no clarity about when medical personnel at Worcester and Howard County Detention Centers test detainees or staff, or how many tests they have available. The Moon Declaration provides only that IHSC is following CDC guidance, and that symptomatic detainees will be tested and isolated if positive. Yet from the declarations of Plaintiffs, I understand that detainees with symptoms, including medically vulnerable detainees, are reporting that they are not being tested. This raises concerns about their care, about the credibility of the assertions in the Moon Declaration, and about ICE’s adherence to CDC guidance.
25. Staff, vendors and other non-detained personnel are especially important vectors in this outbreak. Since they go back and forth between the outside world, detention centers will be hit by COVID-19 when the rest of the community is, staff and their families included. Despite this, the Moon Declaration provides only general references to “screening all staff and vendors when they enter the facilities including body temperatures.” This is not enough to guard against staff or vendors introducing COVID-19 into these facilities, particularly as staff may be infected but asymptomatic.
26. In addition to general CDC guidance, the CDC has established particular guidance for congregate facilities in light of their heightened risks and unique characteristics.⁶ ICE’s COVID-19 guidance also does not follow relevant CDC guidance. The CDC Guidance for Correctional and Detention Facilities recognizes the need to pay particular attention to “higher-risk individuals” and “make all possible accommodations to reduce [their risk of] exposure.” The Moon Declarations do not meaningfully address this. To protect high-risk individuals, ICE would need to include an improved intake process, cohorted housing areas for high-risk individuals, increased infection control measures, and increased medical surveillance, including daily checks for signs and symptoms.
27. ICE does not do daily monitoring for fever and respiratory symptoms of “all” individuals

⁶ See, *i.e.*, CDC, Interim Guidance on Management of Coronavirus 2019 (COVID-19) in Correctional and Detention Facilities, Mar. 23, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>; CDC, Long-Term Care Facilities, Nursing Homes, Mar. 21, 2020, at <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>. In considering mitigation measures for infectious diseases, detention centers are much like nursing homes or other long-term care centers because they are confined spaces where people are in close quarters for an extended period of time.

despite the CDC recommendation. ICE also fails to ensure access to necessary items to limit exposure, such as hand sanitizer and masks for symptomatic individuals.

28. The isolation and quarantine procedures outlined in the Moon Declaration and Brown Declaration do not comply with best practice. The CDC identifies “cohorting” as a suboptimal practice of group quarantining. Where cohorting can be an effective mitigation strategy in the absence of sufficient space for medical isolation, it requires adequate space for appropriate groupings. For instance, confirmed cases should not be in the same cohort as suspected cases or case contacts; those who had contact with an infected person ten days ago should not be in the same cohort as someone who had contact with an infected person two days ago. Yet this is likely impossible based upon the staffing and space constraints inherent in ICE detention. The detention facility’s medical unit simply cannot handle the volume of patients that would need this level of monitoring. There needs to be significantly more facilities and staffing to meet these needs, but, the Moon Declaration does not mention any to accommodate such a level.
29. The ICE response envisions using isolation rooms to monitor individuals with COVID-19 symptoms. However, the Brown and Moon Declarations make clear that there are no negative pressure isolation rooms and four observation cells in their medical unit at Worcester; no information is provided regarding Howard. Based on the experience of detention and other congregate facilities, and the trajectory of this virus, as soon as there are infections at the detention facility, if there are not already, there will be many more than 1-4 people with COVID-19 in the detention center at a time. Moon also states that the two facilities have “identified housing units for the quarantine of patients who are suspected of or test positive for COVID-19 infection” but does not say whether these two distinct populations are housed separately and does not say anything about the two facilities’ capacity for this separate housing relative to their current or overall capacities. Symptomatic patients should live separately from those who are asymptomatic or at risk but who do not have confirmed cases, but in my experience, the structure of detention centers makes this nearly impossible.
30. Isolation is not a proper solution for people without symptoms or confirmed disease. Detainees who are isolated are monitored less frequently. If they develop COVID-19 symptoms, or their symptoms escalate, they may not be able to get the medical attention they desperately need in a timely fashion. It also makes it more likely that these detained people will attempt suicide or self-harm, giving rise to more medical problems in the midst of a pandemic. Isolation also increases the amount of physical contact between staff and detained people—in the form of increased handcuffing, escorting individuals to and from the showers, and increased use of force due to the increased psychological stress of isolation.

Plaintiffs Are at Risk for Serious Illness and Death from COVID-19

31. I have reviewed the factual claims of Plaintiffs’ medical conditions made in Plaintiffs’ complaint. On the basis of the claims presented, I conclude that plaintiffs in this lawsuit

present with personal health characteristics that put them at high risk for complications from COVID-19 should they be exposed to the virus in detention.

- a. Upon information and belief, Mr. Mauricio Coreas has been diagnosed with diabetes. As a result, he is at higher risk for complications from COVID-19 due to these medical conditions. According to the CDC and the American Diabetes Association, those with diabetes are at a higher risk for COVID-19 complications, but also to deadly conditions resulting from the viral infection itself overwhelming the body, such as diabetic ketoacidosis.
 - b. Upon information and belief, Angel Guzman Cedillo suffers from hypertension. As a result, he is at higher risk for complications from COVID-19. Early research has shown that those with a diagnosis of hypertension have more severe symptoms and are more likely to die from COVID-19.
32. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time. Release also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.
33. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.
34. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from detention by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with local or state public health authorities.

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

Executed this 31st day in March, 2020 in New York City, New York.



Robert B. Greifinger, M.D.

EXHIBIT G

Joint Declaration of
Johns Hopkins University Physicians

Declaration

We, the undersigned physicians and medical students of Johns Hopkins, declare as follows:

1. The signatories of this document include medical students, practicing physicians, and experts in public health and healthcare in the carceral system.
2. COVID-19, the clinical condition caused by the SARS-CoV-2 virus, is a highly infectious and deadly disease spread via respiratory droplets. The virus can be efficiently transmitted by people who are asymptomatic, and can survive on hard surfaces such as stainless steel or plastic for up to 72 hours.¹
3. In order to avoid transmission, the Centers for Disease Control and Prevention (CDC) recommends maintaining a distance of at least 6 feet from others, disinfecting surfaces frequently, and washing hands often.² As of April 3, the CDC also recommends wearing non-medical, cloth face masks for all people in public settings where social distancing measures are difficult to maintain.³ Many states have issued stay-at-home orders and prohibited gatherings of greater than 10 people,⁴ and symptomatic individuals are asked to self-quarantine.
4. The close quarters of most U.S. correctional facilities make such essential disease-prevention measures as social distancing and contact tracing (identifying and closely monitoring those who have been in contact with infected individuals) difficult at best. Soap and hand sanitizers are often not readily available in jails and prisons.⁵ For those who inevitably become sick, the resources needed for testing, isolation, and treatment are sorely lacking.
5. Furthermore, these institutions are not closed; people are constantly entering and leaving the environment (e.g. custody officers, health care workers, newly incarcerated people, and contract workers). This flux results in a high risk environment.
6. As health professionals and trainees, we are concerned about the potential of COVID-19 to disproportionately affect the health of individuals experiencing incarceration, as well as the staff working in correctional facilities. We therefore urge you to protect them before it is too late.

Populations vulnerable to COVID-19

7. Risk for severe infection increases with a variety of comorbidities such as diabetes, hypertension, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and chronic liver disease. Comorbidities increase the risk of severe disease course, ICU admission, invasive ventilation and death.⁶⁻¹⁰ Pregnant people are also an at-risk population for COVID-19, as they are more susceptible to severe illness and death from respiratory infections.¹¹
8. Incarcerated people are highly affected by these comorbidities. Nationally, they were found to have higher rates of hypertension than the general population.¹²⁻¹³ In investigating chronic conditions such as hypertension, asthma, diabetes, ischemic heart disease, COPD, and cerebrovascular disease, it has been shown that two thirds of those incarcerated over 55 have at least one comorbid condition.¹⁴ Additional studies show that 40% of all incarcerated persons have at least one chronic illness.¹³ Consequently, incarcerated populations should be especially considered in infection control measures to limit the impact of the COVID-19 pandemic.

9. It is estimated that up to a quarter of the US prison population has been infected with tuberculosis,³² with a rate of active TB infection that is 6-10 times higher than the general population.³³ Flu outbreaks are regular occurrences in jails and prisons across the United States.^{34,35} With a mortality rate 10 times greater than the seasonal flu and a higher R_0 (the average number of individuals who can contract the disease from a single infected person) than Ebola, an outbreak of COVID-19 in detention facilities would be devastating.

The state of healthcare for incarcerated individuals

10. Despite the fact that incarcerated populations are actually the only group in the US that is constitutionally guaranteed healthcare (Supreme Court case *Estelle v Gamble*, 1974), reports show that incarcerated individuals in Maryland have frequently been denied access to basic, lifesaving medical treatment. In 2015, a motion filed in the U.S. District Court of Maryland found evidence of seven possibly preventable deaths due to lack of basic medical care. One person with a heart condition was not provided his medications. Another died after the nurse at the jail infirmary did not notify the physician that an incarcerated person required hospital care.¹⁵ These cases suggest that the current carceral healthcare system is not equipped to provide adequate care for incarcerated persons who contract COVID-19.
11. Corizon, the company that the Department of Public Safety and Correctional Services has contracted to provide healthcare to incarcerated persons in Maryland since 2019, has been sued over 1000 times across the U.S. for allegations of “neglect, malpractice, and, in dozens of cases, wrongful injury or death.”¹⁶ In 2015, Corizon lost its contract with Rikers Island jail complex in New York after the company hired healthcare workers with behavioral concerns and records of kidnapping and murder.¹⁷ Under Corizon’s care, an incarcerated individual with diabetes at Rikers was left without food, water, or the insulin he needed for 6 days, while uniformed officers and healthcare providers made 57 visits to his cell without providing him assistance.¹⁸ This does not inspire confidence that the current carceral healthcare system under Corizon will be responsive to the health needs of incarcerated persons if they contract COVID-19.

Current state of COVID-19 in Maryland prisons

12. According to local media reports, 17 positive cases of COVID-19 have been identified within Maryland prisons as of April 4, including 3 incarcerated individuals and 14 staff members.¹⁹ Reports from correctional staff and advocacy organizations indicate that social distancing guidelines, such as remaining 6 feet away from others and avoiding groups of 10 or more people, are not consistently being observed in Maryland prisons. Furthermore, while the Maryland Department of Public Safety and Correctional Services (DPSCS) has implemented screening protocols (checking for fevers and respiratory symptoms), these protocols only capture symptomatic individuals. Research has demonstrated that COVID-19 can be transmitted prior to the onset of symptoms.²⁰⁻²⁵ Thus, reducing disease entry into correctional facilities is essentially impossible; instead, disease spread within must be contained.

13. Controlling the spread of COVID-19 is incredibly difficult in any setting, but many experts believe that the prison environment presents a particular challenge. A representative from the DPSCS stated that “total social distancing is impossible in a prison setting.”²⁶ This sentiment is supported by a letter from over 200 faculty from Johns Hopkins, which states “it may be extremely difficult, however, to achieve and sustain prevention of transmission in these closed settings and given the design feature of these facilities.”^{5,27} Many organizations and experts concur that carceral settings are poorly suited for the containment of disease.
14. In combination with well-documented, pre-existing concerns regarding healthcare quality in Maryland state prisons, the danger of viral spread in this setting is extremely concerning.

What we are calling for

15. On March 25, 2020, nearly two hundred members of the Johns Hopkins University faculty and staff penned a letter to Maryland Governor Larry Hogan outlining their demands for ensuring the health and safety of incarcerated Marylanders during the COVID-19 pandemic. In this same vein, we urge you to take the following necessary steps:
 - Implement guidelines from the CDC²⁸ and the National Commission on Correctional Health Care²⁹ for COVID-19 in correctional settings, and maintain transparency by requiring all facilities to make their guidelines publically available.
 - Ensure transparency in guideline implementation; have facilities publicly publish their COVID-19 response plans or mandate reporting to a state agency, on the levels of both healthcare for individuals and general sanitation
 - Ensure adequate access to personal protective equipment for institutions of incarceration
 - Ensure that soap, access to frequent handwashing, and hand sanitizer are readily available free of charge to all incarcerated individuals
 - Lower the barriers to care and encourage incarcerated individuals experiencing COVID-19 symptoms to seek care by waiving all co-pays during the pandemic. Provide COVID-19 tests for all sick incarcerated individuals and correctional facility employees, as well as their close contacts.
 - Screen all staff and incarcerated individuals daily for symptoms via a temperature check; screen on arrival and departure for staff
 - Enforce pre-trial detention only for cases of legitimate security concern and not for an inability to pay bail or other associated fines or parole violations
 - Prioritize release for incarcerated individuals over 60 years old, those who are pregnant, and those with chronic conditions such as heart disease, lung disease, or diabetes, or who are otherwise immunocompromised
 - Invest additional resources in re-entry in order to ensure that released individuals have access to safe shelter where they are able to adhere to CDC guidelines, including social distancing, handwashing, and masking
 - Implement social-distancing precautions for incarcerated individuals and correctional facility employees without relying on the use of solitary confinement, which has long been shown to have serious adverse effects on many incarcerated individuals³⁰ and increase the potential for prisoner abuse.³¹

The March 25 letter from Johns Hopkins faculty highlights the ways in which the COVID-19 global pandemic illuminates the interconnectedness of all human beings. Now, more than ever, we must protect the health of some of the most vulnerable members of our society and, in doing so, advance the fight against COVID-19.

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

Executed this 6th day of April, 2020.



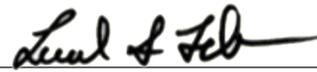
Carolyn Beth Sufrin, A.M., M.D., Ph.D.



Julius Ho, M.D., M.P.H.



Jordan Halley Nahas-Vigon, M.D.



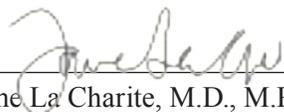
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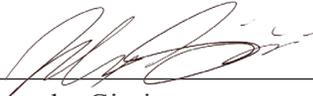
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EXHIBIT H

Declaration of Erica J. Suter, Esq.

Declaration of Erica J. Suter, Esq.

I, Erica J. Suter, hereby declare, based on personal knowledge, and under penalty of perjury, as follows:

1. My name is Erica J. Suter. I have been a licensed attorney for 17 years. I am a solo practitioner and a member of the Executive Committee of the Maryland Criminal Defense Attorney's Association (MCDAA).
2. The MCDAA is an incorporated association representing experienced trial and appellate lawyers who are members of the Maryland Bar and who devote a substantial part of their practices to criminal defense. MCDAA devotes much of its energy to identifying, and attempting to avoid or correct, problems in the criminal justice system. MCDAA members have been working with clients and colleagues in seeking to prevent and address the coronavirus pandemic in Maryland's prisons and jails.
3. In my capacity as an officer of MCDAA, I asked our members to share their experiences litigating for the release of their clients in light of COVID-19. This information is shared with their permission. Paragraph 2 is my client's story. Paragraph 5 was conveyed to me directly by an inmate:
4. Last week, I filed an emergency motion for release for a client in Baltimore City who is in residential drug treatment pursuant to an 8-507 order. I have been advised that it will take 7-10 days to get a hearing on my Motion. The State has not yet stated its position on the Motion. The client is not bail eligible. My client was serving a sentence for possession with intent to distribute. I have been advised that there are approximately 75 men at this treatment facility with five or six men sharing a bedroom. My client has been in treatment for 90 days and been fully compliant with the requirements of the program. My client suffers from asthma and was taken to the emergency room last week for an asthma attack. The Center for Disease Control and the World Health Organization advise that an asthma diagnosis elevates the risk that one will become seriously, potentially lethally ill, if one contracts COVID-19. It is impossible to practice social distancing in this setting. The residents share a kitchen and bathrooms. My client is terrified of contracting COVID-19.
5. I spoke with an inmate today at a prerelease facility. He advised that it is impossible to practice social distancing at the facility. He is in "open housing," with approximately 50 men and their bunks in an open room. The bunks are not six feet apart. Men were provided two bars of soap last week and have not received any additional cleaning supplies since. When it is time for meals, all the men in the unit line up, shoulder-to-shoulder, to pick up their tray and return to the housing unit. The inmate requested that his name not be used because he was concerned that he would face negative consequences for reporting this information.
6. In Frederick County, criminal defense attorney Michelle Martz advises that in Frederick County Detention Center, a client informed her that he is in a "pod" with 10 people. He

shares a cell with another person within the pod and their bunks are less than six feet apart. They share a sink and a toilet. One cell in the pod does not have a working toilet, so the men in that cell must share toilets with men in another cell. Not all sinks have hot water. At times, including, April 1, 2020, no sinks in the pod had hot water. They are not provided with any cleaning supplies. The phones are not disinfected between calls.

7. Ms. Martz filed an Emergency Motion for Reconsideration of Sentence on behalf of a 73-year-old client who suffered a massive stroke in 2013, has high blood pressure, and other related medical conditions who is currently serving a sentence in Frederick County Detention Center. The State opposed relief and quoted Frederick County Sheriff Chuck Jenkins, whose agency runs the Frederick County Adult Detention Center, and has publically stated that the detention center has taken appropriate measures to prevent the spread of COVID-19 and that inmates are safer in jail than if they were released. The Court denied the motion.
8. Ms. Martz filed an Emergency Motion for Bond Review on behalf of a client charged with felony possession of a controlled dangerous substance and possession of long arm weapons. Ms. Martz noted in her motion that her client had no prior convictions and that possession of a long arm weapon is quite common in rural Frederick County and not particularly associated with criminal activity. The client was willing to post bond and would consent to any reasonable condition of pretrial release including, but not limited to GPS monitoring. The State opposed and quoted Sheriff Jenkins' assertion that inmates were safer in the facility than if they were released. The Court denied relief.

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

Dated: 4/5/2020


Erica J. Suter

EXHIBIT I

Declaration of Leslie Schell

DECLARATION OF LESLIE SCHELL

I, Leslie Schell, being over the age of eighteen and of sound mind, do hereby declare the following:

1. I worked in correctional facilities for two and a half years.
2. I worked as the Health Services Administrator at the Baltimore City Detention Center (BCBIC, MDC, WDC, JI, Juvenile) and at the Maryland Correctional Institution-Jessup (MCI-J), providing operational management and oversight of delivery of health care services for incarcerated individuals through Wexford Health Sources, the primary health care provider for the Maryland Department of Public Safety and Correctional Services until 2018. My duties included operational management of medical, pharmacy, and ADA population.
3. The health care services that I observed and learned about were seriously inadequate and not consistent with community standards of care. For example:
 - a. Health care staff shortages were a pervasive problem.
 - b. Health care staff credentials were often not current for the duties they were assigned.
 - c. Nurses did not practice appropriate nursing protocol. Often weights were not included in "vital signs" thereby compromising accurate and appropriate assessment and monitoring of care for serious conditions.
 - d. Follow-up for medical concerns of incarcerated individuals frequently did not occur or did not occur in a timely way.
 - e. Preventable deaths occurred due to lack of proper care and coordination between corrections staff and health care workers.
 - f. Corrections officers are short-staffed and overworked and do not always make required rounds to check on and observe conditions of people in cells, leading to neglect of medical care needed by some persons.
 - g. Ordered medical consultations were sometimes denied by corporate which frequently frustrated the professional staff who felt these consultations were pertinent to good medical care and follow up. This caused health problems to exacerbate.
 - h. Medication renewals often were not timely refilled or provided. Keep on Person medications were left in bins, not getting distributed to the inmates. These medications were frequently discarded after becoming out of date having never been used. Detainees were frequently transferred without their

medication. Daily meds were frequently delayed many days until they were re-ordered, received, signed in and re-stocked by the receiving facility.

- i. Sick call requests of individuals were not processed timely or according to policies.
 - j. Individuals with disabilities were not properly accommodated, for instance inadequate care to prevent bed or pressure sores for persons in wheelchairs. They were not housed on ADA assigned units which made transfer for personal care unavailable and impossible.
 - k. Examples of lax care include individuals not getting proper care for a broken arm, not having sutures removed, cases of sepsis, masks, tubing and proper water not being ordered for CPap (continuous positive airway pressure) users, forcing patients to use old, dirty material.
 - l. Prisoners are housed and receive meals in dorms housing up to several hundred people in close proximity.
 - m. At MCI-J, prisoners receive their meals in a community food hall.
4. Maryland's prison population includes a significant number of individuals with respiratory conditions including chronic lung disease or moderate to severe asthma; people with heart disease or other heart conditions; people who are immunocompromised as a result of cancer, HIV/AIDS, or any other condition or related to treatment for a medical condition; people with chronic liver or kidney disease or renal failure(including hepatitis and dialysis patients); people with diabetes, epilepsy, hypertension, blood disorders (including sickle cell disease), inherited metabolic disorders and people who have had or are at risk of stroke, all of who are especially vulnerable to COVID-19.
 5. It is impossible to achieve social distancing standards in prison settings that exist in Maryland.
 6. At least in all of the facilities in Baltimore and Jessup, when prisoners in the Maryland prisons are brought to medical clinics for care, they are housed in "bullpens" with typically up to 40 people who are sitting and standing shoulder to shoulder in direct contact.
 7. At least in all of the facilities in Baltimore and Jessup, when prisoners are brought for medical calls, they are brought by units. Typically up to 50-60 prisoners stand shoulder to shoulder, shaking hands and doing other body to body contact while waiting to get to the window to receive their medications.
 8. For all of these reasons, infectious diseases, particularly airborne diseases such as COVID-19, are likely to spread rapidly between individuals in correctional facilities.
 9. Prison health units I observed are not equipped with sufficient emergency medical equipment, such as oxygen tanks, nasal cannula, and oxygen face masks, to respond to an outbreak of patients with respiratory distress. Staff were not properly trained to respond to emergency medical calls.

10. Each day, hundreds of staff must come and go from prison facilities, potentially carrying with them the novel coronavirus for days, even weeks, without ever showing symptoms. These settings pose a particular risk of spreading the virus, with catastrophic consequences not just to the prisoners and staff, but also to their communities and the hospitals that serve them.
11. Previous healthcare colleagues have expressed concern over the inadequate handling of precautions as it relates to the current Corona outbreak. They have advised me that 20 healthcare providers/workers are out with active cases of Corona, which is extremely worrying.

I, Leslie Schell, hereby affirm under the penalties of perjury that the above information is accurate based upon my best information and belief.



Signature

4/5/2020

Date

EXHIBIT J

Declaration of Gina Elleby

DECLARATION OF Gina Elleby

I, Gina Elleby, make the following declaration based on my personal knowledge and declare, under the penalty of perjury, that the following is true and correct.

1. My name is Gina Elleby. I am a graduate of the Howard University School of Law, employed as the Intake and Investigations Manager within the Legal Department at the American Civil Liberties Union of Maryland. In this capacity, I oversee all requests for legal assistance submitted to the organization, as well as investigations undertaken by staff to determine the best course of action in addressing these requests.
2. Over the course of years, I have communicated with countless prisoners, detainees, and their families in the course of my employment about conditions of confinement and access to adequate healthcare in Maryland's prison and jail facilities.
3. During March and April of 2020, many requests and inquiries have come to me at the ACLU concerning response in Maryland to the coronavirus, particularly from family members, staff, and people incarcerated in Maryland's prisons and jails, including Baltimore County Detention Center, Prince George's County Detention Center, Baltimore City Correctional Center, and Eastern Correctional Institution – Annex.
4. BALTIMORE COUNTY DETENTION CENTER
 - a) Prospective clients at the Baltimore County Detention Center have described their concerns of exposure to COVID-19 at the jail as of April 2, 2020.
 - b) Staff daily release over 30 detainees in a tier from their cells into a day room for recreational time for durations of at least 30 minutes, during which time the detainees are locked out of their individual cells even after governments established orders restricting public gatherings to 10 or less people.
 - c) Guards have regular contact with and distribute food to the detainees without protective equipment, such as gloves and masks, and detainees do not have consistent access to cleaning supplies to keep their spaces sanitized.
 - d) Many people in detention, including one client with a medical condition which compromises his immune system, are experiencing symptoms – such as sneezing and runny noses – which may indicate COVID-19 infection, but no one in detention is being tested for the virus, receiving treatment, or being separated from others without symptoms.
 - e) People in detention continue to be housed together, reportedly in groups of three to a single cell in some cases.
 - f) When new intakes are brought to the facility, they may be housed with the existing population within 36 hours although in the larger community outside Maryland detention centers, potentially exposed people are asked to self-isolate for up to 14 days.
 - g) All clients expressed fear for their health and safety.

5. PRINCE GEORGE'S COUNTY DETENTION CENTER

- a) Prospective clients and their families have described their concerns of exposure to COVID-19 at the jail as recently as April 5, 2020.
- b) One person held pretrial cleans the medical unit, including the bathrooms, where quarantined detainees are housed without protective equipment. This detainee also cleans other areas within the jail without protective equipment, potentially exposing himself and other healthy detainees to infection.
- c) While cleaning the medical unit, this person overheard medical staff confirm at least nine cases of COVID-19 inside the jail and witnessed at least six detainees transferred to different housing. Recently, this detainee has noticed that nearly every person on their unit now has flu-like symptoms. This person believes that an outbreak has already started in the jail. The detention center has only publicly acknowledged three detainees tested positive for the virus, and one correctional officer as of April 3, 2020¹.
- d) This same person suffered a broken nose last month. This person can no longer breathe through their nose as a result of the injury and has not received any medical treatment even after making requests. This person is worried that this injury would make a COVID-19 infection even worse.
- e) Another person shares a small cell with a cellmate where social distancing, as recommended by public health officials, is impossible. They worry about their inability to avoid contracting the virus if the other is exposed. The jail simply recommends that detainees in “in double cells ... sleep in opposite directions on their bunk beds so their heads are farther apart.”²
- f) People held at the jail received little education about preventing the spread of the virus aside from more frequent hand-washing but have no access to soap or alcohol-based hand sanitizer.
- g) People are released for meals and recreation in smaller groups – reduced from 50 people to 25 – which makes the jail’s recommendation that prisoners eat in groups of two impossible to observe.³
- h) Those held in the facility are not given any protective equipment, such as masks or gloves.
- i) People in the jail experience regular delays in medical care, typically waiting 2-3 weeks for service after submitting a formal request.
- j) When describing the high risk of COVID-19 infection in the jail in an interview with the *Washington Post*, the director of the county Department of Corrections Mary Lou McDonough compared jails to “cruise ships” as hotspots of viral spread.⁴ A family

¹ <https://www.wusa9.com/article/news/health/coronavirus/coronavirus-prince-georges-county-jail-inmates-officer/65-b4e2051e-7b29-41e7-96f3-eb2a9473e038>, last accessed: 2020.04.04

² https://www.washingtonpost.com/local/public-safety/as-inmates-in-dc-maryland-and-virginia-test-positive-for-the-coronavirus-jail-officials-scramble-to-reduce-the-risk/2020/04/01/b0d9cfd8-7363-11ea-85cb-8670579b863d_story.html, last accessed: 2020.04.04

³ *Id.*

⁴ *Supra*, n. 2

member of a person at the jail told legal intake staff, “This [heightened risk of exposure to the virus] is a life sentence without being tried or sentenced.”

6. BALTIMORE CITY CORRECTIONAL CENTER

- a) Clients have explained that social distancing is impossible for two people sharing a cell at Baltimore City Correctional Center at recent population levels.
- b) They also characterized the facility as generally chaotic and poorly maintained even prior to the pandemic.
- c) Worse still, many people held at BCCC must share essentials in recreational spaces, such as microwaves, coffee pots, restrooms, and phones. Without access to disinfecting products, such as wipes and alcohol-based sanitizer, and regular cleaning, these shared items may be points of transmission between detainees.

7. EASTERN CORRECTIONAL INSTITUTION – ANNEX

- a) Prospective clients and their families have described concerns about exposure to COVID-19 at the prison as recently as April 4, 2020.
- b) A person imprisoned in the Annex building on Eastern Correctional Institution campus witnessed several prison employees exhibiting flu-like symptoms. These employees have not returned to work, but people in the prison were not told whether they were tested or are suspected of exposure to the virus.
- c) A person in the prison believes another prisoner died last week. People inside the prison suspect COVID-19 caused the person’s death, but the administration did not inform anyone about the circumstances of death. The person also observed media seeking access to the facility after the death, and the prison denying access.
- d) People in the Annex are no longer permitted to eat meals together or enjoy recreational time in the weight-lifting area. However, people are still released in groups of 10 to the kitchen to grab meals to eat in their cells. Five to six kitchen employees may come into contact with meals during preparation. Social distancing remains impossible for the people in the facility.
- e) Recently, the facility distributed two bars of soap per person for hand washing. The supply does not appear to be unlimited, and people are unsure whether more will be provided.
- f) The Dorchester building at the Annex houses 70 men in bunks that are about one foot apart. Based on reports, no steps have been taken to depopulate individuals from this dorm.
- g) Other housing units hold men in pods that typically have four bunks, two on each side. Two bunks in a pair are separated by about 18 inches while the two pairs of bunks are four feet across from each other. Two people in a bunk pair are in arm’s reach.
- h) If a person reports symptoms of illness, medical staff will screen the person for fever. If the person has a fever, everyone in their pod will be placed on 3-day bunk restriction, during which time they are all monitored for fevers. If the temperatures come down, the restriction is lifted for the pod.

- i) The contractors from Keefe Commissary Network are still delivering commissary items, so people with money gifted by family or earned by work assignment may purchase better quality soap. Individuals are only permitted to order two bars at a time, and indigent people do not have the ability to purchase goods. As of April 5, 2020, the Department has acknowledged 17 positive COVID-19 tests, eight of which are contractual employees.⁵
- j) A client has overheard nurses considering refusing to report to work if the virus is identified at ECI although there do not currently appear to be noticeable staffing reduction at this time, and the virus has not yet been identified at ECI.
- k) On April 2, 2020 around 11:37 AM, a family member of someone in the Annex called the Department of Public Safety and Correctional Services' "COVID-19 hotline" (410-769-6419) with concerns about the well-being of the people in the facility. A representative of the Department acknowledged that imprisoned people cannot effectively practice social distancing in these facilities despite attempts to isolate the sick.
- l) None of the detainees or prisoners I have spoken with have been tested for COVID-19.

I declare, under penalty of perjury, the foregoing is true and correct, to the best of my knowledge and belief.

Dated: 4.5.2020



Gina Elleby

⁵ <https://foxbaltimore.com/news/coronavirus/breaking-covid-19-in-md-prisons-17-people-test-positive>, last accessed: 4.5.2020

EXHIBIT K

Declaration of Martina Hazelton

DECLARATION of Martina Hazelton

I, Martina C. Hazelton, make the following declaration based on my personal knowledge and declare under the penalty of perjury that the following is true and correct.

1. My name is Martina C. Hazelton. I am a federal employee. My husband is housed in the Maryland Division of Correction.
2. I founded and facilitate the Lifer Family Support Network (FSN), which is an organization made up of people who gather regularly to share information and advocate for the safety and humanity of our loved ones serving sentencing inside Maryland's prisons and jails. The FSN includes parents, children, relatives, and "adoptive/chosen" family for those inside who have lost all of their family during their incarceration. We also include members who have recently returned from incarceration and their families are the primary mechanism for reentry.
3. The FSN members and I correspond with officials within the Department of Public Safety and Correctional Services, Maryland Parole Commission, General Assembly of Maryland, and other decision-makers regarding the rights and experiences of people held in prisons and jails. For obvious reasons, we pay close attention to what prison and jail officials are doing, as they have complete control over our loved ones. Whether or not it is possible for our loved ones to obtain release at this time, they do not deserve nor were they sentenced to a death sentence because public officials did not care about them enough to act.
4. Members of the FSN remain in constant contact with our loved ones inside and are deeply concerned about the condition of the facilities, decisions of prison administrators, and close proximity which all increase the transmissibility of COVID-19. Through our lived experience, we are aware of the overwhelming barriers to containing highly infectious illnesses, like COVID-19, and this is increasingly more difficult in prisons and jails.
5. Even absent any kind of pandemic, there is a significant disconnect between the written policies and understanding of prison administrators and the actual practices and experiences. For example, there is a complete lack of education and practical application of handwashing, sanitizing etc. There is also major variation across different facilities in terms of how they operate. Across the board, there have been longstanding staffing shortages and problems with medical care. Sanitation is always a concern. Some of our loved ones have been so disgusted by the lack of sanitation that they cannot stand to eat food prepared in the prison kitchens and rely on food obtained through commissary. The food trays received often have roaches and standing water that makes the food completely inedible.
6. In the weeks since COVID-19 was announced, FSN members and others in our networks have exchanged information about what is or is not happening in various facilities and our concerns.
7. I am terrified for the safety of my husband and many others who are confined in prison and jails, which are ill-prepared for the inevitable introduction of the virus to

their facilities. Based on years of visiting prisons in Maryland communicating on a regular basis with my husband, I do not think Maryland's prisons are capable of implementing the required social distancing and hygiene needed, nor providing minimally adequate medical care, without major changes.

8. I am especially worried about what will happen as the virus spreads and staffing is further reduced as correctional officers and other administrative and contract staff start being turned away due to illness or quarantine.
9. For example, my husband currently lives in Building 1 at Western Correctional Institution. My understanding is that there is a nurse at WCI who was displaying symptoms and who tested positive. She worked on the 4 am shift distributing medicine. I am told that 14 officers were sent home and all the people who came in contact with her are being confined to their cells. They are locked in with their cellmates, even if their cellmates were not directly exposed by this nurse.
10. My understanding is that Building 1 is where WCI houses those who are geriatric and physically or medically challenged, so many of the people in his building have conditions that make them more vulnerable to COVID-19. My husband has Stage 2 hypertension, which makes him vulnerable to serious illness if he contracts COVID-19.
11. Everybody in his building is double-celled except those who are on the first floor. On that bottom tier, people are single-celled for some reason usually relating to a medical issue or disability, for example because they are wheelchair bound. But even though they are single-celled they all come out to the same common dayroom and share showers and phones. Moreover, in order for those people to obtain medication, they have to leave the building. For those who are in wheelchairs, they are assigned someone on that same tier who is able to push their wheelchair to take them to get their medication. There has been no change in this practice.
12. No matter what part of the building they are in, people share the same common dayrooms, showers, and phones. They have modified some of the movement, and increased some cleaning but it is not enough. My husband is a sanitation worker. He cleans after each shift comes out on his tier, but there is a lot of common contact within each shift. For example, there are four phones, all right next to each other. Phones are the lifeline right now. Based on his description it would be impossible to social distance. He is cleaning more frequently but if he is not the first person on the phone after everyone touches it doesn't matter—he has been exposed.
13. For meals, correctional staff are bringing trays to the people in the building. They are the ones most likely to be bringing in COVID-19, so this does not make sense. Some people have refused trays rather than be exposed.
14. Other FSN members have shared similar concerns about their loved ones. Several members have loved ones in the DOC who are over 50 and/or who have serious medical conditions that make them more vulnerable to COVID-19.

15. For example, one of our members has a loved one at Maryland Correctional Institution in Jessup, where there have been confirmed cases of COVID-19. Her loved one is 64 years old. He has high blood pressure and has previously been diagnosed with Hepatitis C. They report there is not social distancing nor adequate hygiene.
16. Another FSN member whose loved one recently was exonerated has expressed concern about the elderly and medically vulnerable prisoners who remain in the prison. She was aware of several individuals who had served many decades of incarceration who were now in their 80s. There are many people who are very vulnerable whose safety could be improved if they are single-celled, but this cannot happen if there are not some reductions in the population.
17. To keep the men and women in our state prisons and jails safe, it is critical that the state do everything in its authority to keep the people in its custody out of harm's way and drastically reduce the population to protect the safety of those who must remain.
18. FSN members are acutely concerned about those who are at greater risk of death if they contract COVID-19, due to age and other medical conditions.
19. FSN members have been able to obtain bits and pieces of information, and we understand that the DOC is trying, but there is a major difference between how things are presented and how they operate in practice. For example, one of the people in our network shared the below exchange based on a call made on March 30 to the DOC Family Hotline which is supposed to answer our questions:

I asked:

If an inmate tests positive what is the protocol?

"14 days quarantined"

At what point will they receive hospital care?

"I don't know"

What is being done differently with staff to stop the spread?

"Temperature checks at the beginning of shifts"

Nothing else?

"I don't know"

Is locking down 23:1 as is currently in some facilities DPSCS's answer to this crisis?

"I don't know"

Are sick tickets or medical requests being handled differently to accelerate the inmate being seen?

"I don't know... I would hope so"

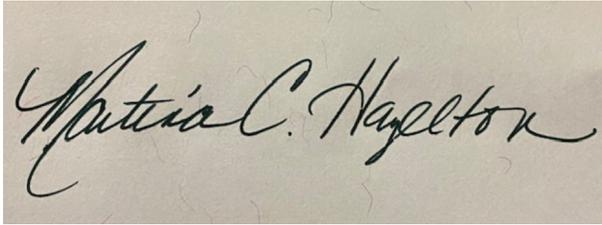
Will family be notified if an inmate is sent to the hospital?

"Yes"

Will DPSCS continue to update the website with ongoing information?

"I Don't know"

She finally just said "They did not provide me with a lot of information"



Martina C. Hazelton

Martina C. Hazelton
April 5, 2020

EXHIBIT L

Declaration of Earl Young

DECLARATION OF Earl Young

I, Earl Young, being over the age of eighteen and of sound mind, do hereby declare the following:

1. My name is Earl Young, and I am a member of the Lifer Family Support Network.
2. I was incarcerated for 34 years, until 2019. During my incarceration I lived in a number of DOC-operated facilities, including Jessup Correctional Institution, Eastern Correctional Institution, and the Baltimore City Correctional Center, among others. I speak regularly with people who are still inside.
3. I am concerned about the health of those who remain inside. I know several people who are still inside who are at risk because of their age or other illnesses. I know from living in the same facilities as them and from what people inside are reporting to me that they are not able to be six feet apart or to overcome all the barriers to protect against the spread of COVID-19.
4. One of the people I know who is at JCI is 70 years old and the Maryland Parole Commission has previously determined, on at least three occasions, he can safely be released back to his home. He has been incarcerated for decades and is someone on the chronic care caseload. He has high blood pressure and other medical issues that require him to take 10-12 pills daily. Due to his needs he has more nursing contact, but no special housing because the medical tier is too small to accommodate everyone who needs it. They prioritize the cases like those who have limited mobility and those who are mentally incapable to be in double celling.
5. Another person at JCI is now more than 80 years old. He has numerous medical issues and is on the medical tier (A building) at JCI. The Maryland Parole Commission has previously determined that he could safely be released.
6. A third person at JCI is over 70 years old with many underlying, chronic medical issues, which caused his confinement to a wheelchair in the past and have left him seriously debilitated. All three of these people would be greatly harmed if they were exposed to COVID-19.
7. There are numerous barriers to social distancing in Maryland prisons. There are many common areas like showers, phones and common equipment in recreational areas. In order to help keep them clean, people would need alcohol-based sanitizer or wipes. People are also typically locked out of their cells during recreation time, but there isn't enough space in a dayroom for everyone to distance six feet apart.
8. I have seen and heard descriptions of the extra soap the facilities are distributing. The soap are tiny bars which are typically provided to indigent people who cannot purchase soap. The bars are so small that no soap remains after just a few uses. Further, hand washing outside of a cell – during rec time, for example – means operating handles and buttons which make keeping clean hands impossible.

9. As a former maintenance worker in these facilities, I am also concerned about the poor condition and maintenance of the ventilation systems which are important to contain the virus traveling between rooms and cells. The frequent and necessary contact between people and others preparing and distributing food, guards, medical staff, and others makes passing along the infection very easy.
10. I do not believe administrators will be able to contain the virus if it is introduced to their facilities.

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

Dated: 4.5.2020

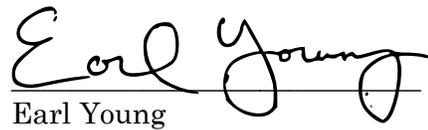

Earl Young

EXHIBIT M

Declaration of Lorie Friend

DECLARATION OF LORIE FRIEND

I, Lorie Friend, make this declaration based on my personal knowledge and declare under the penalty of perjury that the following is true and correct.

1. My name is Lorie Friend, and I live in Garrett County, Maryland. I am a registered nurse, with 25 years in the profession. My experience includes work in the Obstetrics Department, the Medical/Surgical Unit, and currently, the Outpatient Surgical Department at Garrett Regional Medical Center (GRMC).
2. Ours is a rural community with only a small hospital. GRMC is a 55-bed hospital that is not nearly equipped to handle the situation if coronavirus were to sweep through our community. At GRMC we have just three ventilators in our Intensive Care Unit, and four for use in our operating room. Staff at the hospital have been told that the community can expect a spike in COVID-19 cases and hospital admissions around April 23, and some preparation is taking place, at least with respect to personal protective equipment and clearance of bed space, although that is limited.
3. As a nurse confronting the coronavirus pandemic, I understand too well its frightening implications if we do not abide by the recommendations of public health professionals. Isolation and social distancing are critical for everyone, according to the guidelines of the Centers for Disease Control and Prevention. For people in prisons and jails, however, these measures are not possible.
4. My 28-year-old son, Christopher Friend, is incarcerated at the Garrett County Detention Center, serving a four-month sentence on a non-violent misdemeanor charge. He began serving this sentence on March 11. Prior to detention, he was in school full-time at Garrett Community College.
5. Christopher is 28-years-old, and suffers from an anxiety disorder, with periodic heart palpitations, for which he manages with the anti-anxiety medication, Citalopram. I don't think he is getting any medication nor any other medical treatment or monitoring for his anxiety. One day, he was extremely anxious, so he tried talking to an officer. The officer told him not to get his hopes up because they weren't going to risk letting people out. One morning, he had a fever of 103 degrees, which went down to 99 by afternoon, but was enough to frighten Christopher and the others in his cell. Because of his condition, his fear of exposure to the coronavirus is overwhelming.

Conditions at the Garrett County Detention Center

6. The Garrett County jail, like many jails, is overcrowded and unsanitary. As of late March, there were no hand sanitizing stations, adequate soaps, gloves, masks, or other personal protective equipment. They still don't have any antibacterial soaps or personal protective equipment. Prisoners and staff cannot practice social distancing by staying six feet apart. The employees at the jail come and go to the facility every day, returning to their families and communities, where any of them could come in contact with someone who is infected with the virus. The

transmission process of this virus is unlike anything medical professionals have seen and is exceptionally hazardous. Not only could they pass this to their families, but to the people living at the jail as well. This would become a catastrophic event for our community, for my son and my family.

7. In March (last month), plans were underway to close the Garrett County jail for renovations, including upgrades to the ventilation system. While I don't know the seriousness of the conditions requiring repair and renovations, it was serious enough that the plan included moving all detainees to other facilities and to home detention. In any case, conditions at the jail were already possibly hazardous to the health and safety of prisoners and staff.
8. One measure the jail has said it is putting in place to address the pandemic is that no one will be allowed out of the jail to attend “specialty” medical appointments. Jail administrators have represented to me and my son that any COVID-19 infections at the jail will be “handled” by facility staff. This is absurd. The virus is novel, and not even the best medical experts in the world can “handle” it. The only medication generally provided at the jail is Tylenol.
9. Because detainees’ temperatures are taken daily, jail officials say detainees are safest inside. But I don’t see how that is true with staff coming and going every day, and nobody able to practice social distancing as recommended by health professionals. Christopher lives in a cell with six others, with no window. All six of them share one toilet and one sink above the toilet to wash hands and get drinking water from. They spend most of their time in the cell, and are no longer allowed to walk outside. It is all completely inconsistent with what Governor Hogan has directed for those of us living outside jail facilities.
10. The Garrett County jail houses prisoners prior to trial or serving sentences for a maximum of 18 months. Given these short-term sentences, most crimes at issue are less serious, and most detainees, like Christopher, pose no real public safety threat. They could be released to home detention with monitoring, and this would keep everyone safer.
11. If and when he is released, he will live with me, where he has his own bedroom with a private bathroom.
12. As a mother and a nurse, I am extremely concerned about Christopher’s well-being while incarcerated during this pandemic. I have been making inquiries and extensive efforts to secure his release, but thus far have had no success. I have written to the Garrett County State’s Attorney, the Judge, and sheriff’s department officials. So many letters, but it seems like no one is listening and no one cares. It is for this reason that I am turning in desperation to this Court, asking the Court to use its authority as Maryland’s highest court overseeing the justice system to help me save Christopher by releasing him from detention.
13. While Christopher is my son and primary objective right now, I am deeply concerned about everyone else in the jail, who are living in conditions that make it impossible to keep the virus from spreading quickly within the jail and then into our community. The possibility of an outbreak at the jail, spreading to families of staff and people detained, is a doomsday scenario because our local hospital and other hospitals in our region do not have the space nor equipment

to handle an outbreak. But, it's a doomsday scenario that has a high likelihood of happening if we don't act now before COVID-19 gets into the jail.

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

Date: April 5, 2020

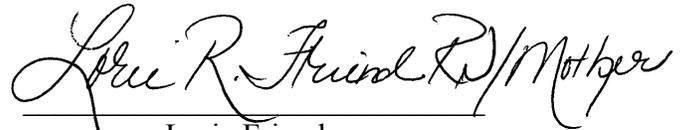

Lorie Friend

EXHIBIT N

Declaration of Julie Magers

I, Julie Magers, declare based on personal knowledge and under the penalty of perjury, as follows:

1. I am over the age of 18 years, and competent to give testimony.

I am the wife of Michael Patrick Mehaffie. Michael is currently incarcerated at Roxbury Correctional Institution (RCI) in Hagerstown, MD. His DOC number is 442415. Michael has served one quarter of his 20-year sentence for a non-violent commercial burglary (2nd degree). He has a clean institutional record.

2. Michael suffers from chronic illnesses and permanent disabilities. This includes progressive multiple sclerosis and heart disease. He is also prediabetic; and hearing, sight and mobility impaired (he must walk with a rolling walker).

3. Michael's loved ones are extremely worried about his well-being, safety and his life during this COVID-19 pandemic. Michael is already vulnerable because of his serious medical conditions and disabilities, but in this crisis situation, it renders him even more vulnerable.

4. During his incarceration, Michael has experienced a serious decline in his health and has been rendered permanently disabled. We believe this is due, at least in part, to the lack of adequate healthcare afforded to him by the Maryland Department of Public Safety and Correctional Services (DPSCS) contractors, who currently administer the medical care for all Maryland correctional facilities. This problem seems even more acute now, because correctional staff recently informed him that until further notice, chronic care patients will not be seen for their regular appointments and that no one will be transferred out for medical care unless it is a 911 emergency.

5. As Michael is already medically compromised due to his health conditions and has already experienced medical care neglect, we are very concerned his health will be further compromised should he contract the COVID-19 virus. Michael's multiple sclerosis since being incarcerated has rapidly progressed and he experiences serious relapses causing respiratory issues, an inability to walk/move, and loss of consciousness. Should Michael contract the virus, health professionals have stated that his symptoms would be exacerbated by the virus and he has a high risk of complications including inability to breathe, severe cognitive dysfunction and increased inability to move rendering him unable to function.

6. According to our Johns Hopkins Board-certified Neurologist, Dr. Emily Harrington, the minimum standard of care for someone experiencing a relapse is immediate transfer to a hospital, steroid treatment and monitoring. Just recently, on March 3, 2020, Michael experienced a relapse in his cell causing him to lose consciousness and fall to the floor. He regained consciousness on his own several hours later while lying on the floor. He requested medical attention, however he was not seen for several days even after he reported what happened. Instead of receiving care for this episode, he was sent back to his tier by the medical

contractor. This has been a common experience for him and this was just one of many incidents. Should he contract the coronavirus, he is at a high risk for further relapses which could result in more severe complications. This would require a standard of care and monitoring that the current medical contractor has never previously provided, and is not equipped to provide.

7. Michael is further at risk because he is also prediabetic and has heart disease. According to the CDC, the National MS Society and public health experts nationwide, these conditions further increase his risks of serious complications if he is exposed to the coronavirus. Given past healthcare neglect he has experienced while incarcerated, this is of enormous concern to me.

8. The DPSCS has claimed to have implemented implemented certain protocols during the pandemic, including increased sanitation, access to soap, personal protective equipment (PPE) , and medical care. But it is Michael's experience that these measures are NOT being taken at RCI. Michael has not been given access to sanitation supplies. There has been no increased sanitation on his tier. He is not allowed personal protective equipment to protect himself, has only been given two bars of soap, on one occasion. Meanwhile, he has been forced to be in close proximity to others, including those who are experiencing signs of illness. He is forced to take medication from medical staff who are not wearing PPE. In every day routine, the correctional staff do NOT wear any PPE. He must eat food served by individuals who also do not wear PPE and who have not been cleared by a healthcare professional to be negative for COVID-19.

9. Even with if the limited protocols were being implemented as claimed, social distancing is not possible in the setting where Michael is held. There are too many individuals incarcerated to accomplish this. Typically, there are more than 30 individuals forced to stand back to back in line for medication, over 20 in the waiting area for the medical department, entire tiers and buildings lining up to get food or commissary. Similarly, at least 20-30 are together for recreation, even with staggered recreation. Under these circumstances, it is not possible for social distancing to occur per CDC guidelines.

10. Overall, it is our belief that RCI is unable to follow the recommended guidelines for someone who is chronically ill and at-risk. Michael and other at-risk individuals incarcerated there are not given the opportunity to protect themselves. Because of this, I am extremely worried for his safety. Michael was sentenced for a non-violent property crime and sentenced to a term of years, but now, due to this pandemic, he could endure unnecessary pain and suffering or even lose his life if action is not taken.

11. Michael Mehaffie has a solid home plan and family support that can adequately take care of him and make sure he is able to follow all requirements of release and community supervision. He is a strong candidate for a safe release and in the current state of his incarceration and medical vulnerability, he is at serious risk if not released.

Declaration of Lauren Young, Esq., Disability Rights Maryland

I, Lauren Young, Esq., being over the age of eighteen and of sound mind, do hereby declare the following:

1. I am a Maryland attorney and Director of Litigation at Disability Rights Maryland.
2. Disability Rights Maryland is the state's federally mandated Protection and Advocacy agency. Congress established Protection and Advocacy agencies to protect the rights of persons with disabilities and authorized such agencies to monitor and inspect facilities that house persons with disabilities, including prisons.
3. I have worked at Disability Rights Maryland for over twenty years and have prior experience investigating conditions in jails and institutions, including drafting Health Care Standards for Juvenile Detention facilities in West Virginia.
4. Over the past three years I have visited six large prison facilities, several multiple times, meeting staff and administrators, interviewing incarcerated individuals and reviewing records. Tours have included segregation units and general population units, infirmaries and special needs units, special observation housing units, indoor and outdoor recreation areas, medical and case management areas, and social work or counseling offices. Thousands of pages of records have been reviewed.
5. In meeting and reviewing records of incarcerated individuals and persons with disabilities I observed individuals with diabetes, hepatitis, respiratory issues, especially asthma, lung, heart and kidney disease, people who are immune compromised, those who have had or are at high risk for stroke, people with epilepsy, cancer, serious mental illness and other conditions that place them at substantial risk of serious illness and death from the novel coronavirus. Several studies note a higher mortality rate among COVID 19 infected individuals with such underlying conditions.
6. People with disabilities are more likely to have multiple health conditions and secondary health conditions than are those without disabilities. Multiple studies demonstrate that people with disabilities are disproportionately represented in our prisons and jails.
7. Due to congregate living and shared space, the vulnerabilities of a large portion of the prison population, poor infection control capacity and inadequate staffing, our prisons are not equipped to provide preventive or responsive medical care to the threat presented by COVID-19, leaving individuals at substantial risk of very serious harm. While these concerns are true for prisons generally, they reflect what I have observed in Maryland facilities. For example:
 - There is insufficient onsite medical isolation and quarantine space to adequately care for individuals and to operate infection control practices if significant numbers of persons are infected or have had contact with persons who are infected or symptomatic for the virus.

- Some facilities have cells with prison bars and do not provide enclosed cells with solid walls and solid doors that can fully close to prevent contagion.
- There is insufficient capacity for single celling if there is a significant outbreak.
- Separate bathroom facilities are not available.
- Some prison infirmaries use congregate housing with multiple individuals in an assigned room and living in extremely close contact, where social distancing rules cannot apply and where toilets and showers are shared.
- Sanitary conditions are compromised as toilets, showers, and phones are shared, as are common areas and cells.
- Some housing areas have extremely poor ventilation, antithetical to prevention of and protection from the virus.
- There are numerous common area surfaces with which individual staff and incarcerated individuals come in contact, including multiple metal surfaces where the coronavirus has the reported ability to maintain for prolonged periods of time. The virus is known to spread from person to person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.
- Many incarcerated persons with disabilities require close supervision or direct contact with correctional officers to go to showers or use a telephone or to engage in any recreational or out of cell time, including attending health care appointments.
- Social distancing is not possible.
- A primary response of our prisons to COVID-19 has been to increase isolation and segregation, which is especially harmful to the health of persons with serious mental illness and those with serious health care conditions who need additional support to maintain mental and physical health. Volunteer led programs and visitations have been suspended. While additional telephone time has reportedly been offered to individuals, not all individuals can effectively use this resource.
- Correctional and other prison staff, including health care professionals, support staff, and administrators travel in and out of the facilities; staffing for correctional officers is based on three shifts per day, exposing facilities to contagion.
- Correctional staff vacancies have been at seventeen percent and higher before the current pandemic, and health care staff vacancies have also been a recurrent issue prior to this immediate crisis. Staffing issues are fundamental to providing adequate care at all

times, and made more critical during the current crisis as additional responsibilities for monitoring care, delivering meals, staggering movements for smaller groups of persons, responding to heightened concerns of incarcerated persons related to their health needs, and facility cleaning and screening are placed on staff.

- Correctional staff are required to accompany incarcerated individuals during their stay at local hospitals, thus presenting increased pressures on an already deficit staffed system if infected incarcerated individuals require hospitalization.
 - Staff for our prisons have already been limited due to the coronavirus.
8. Correctional facilities and departments across the country are reducing prison populations to protect lives and develop adequate space for needed isolation and quarantine. However, Maryland has not announced any such plans.
 9. To effectively prevent the continued spread of the COVID19 infection in prison communities, the state must take urgent steps to release, increase use of parole proceedings, apply or reinstate good time credits to permit release, use medical parole, transfer to home detention and discharge persons who can be adequately and safely released and particularly those who are elderly and have disabilities that make them medically vulnerable to contagion or deteriorating health conditions.
 10. For vulnerable populations, the symptoms of COVID-19, particularly shortness of breath, can be severe, and complications can manifest at an alarming pace, creating an urgent need to immediately develop plans for protecting at risk individuals including developing transfers of such persons from the prison environment. The only way to prevent complications and the enormous risk to medically vulnerable people is to prevent them from becoming infected.
 11. Reducing prison populations helps to protect everyone, including those remaining in prisons, as facilities may be better able to apply prevention and treatment protocols with a more manageable census.
 12. Statements in this declaration do not suggest that Maryland has made no effort to address COVID 19 in our prisons. I have been informed by the Department of Public Safety and Correctional Services that there are efforts to address this crisis within the facilities with additional cleaning, changes to protocols, waiving medical co-pays, implementing staff screening, increasing telephone use and other emergency actions that are in development. However, the challenges in the prisons remain severe and individuals remain at severe risk.

I hereby affirm, under the penalties of perjury, that the above statements are true based upon my best personal knowledge and belief.

Lauren Young

Director of Litigation

April 5, 2020

Disability Rights Maryland
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Laura Young

EXHIBIT P

Memorandum Opinion, *Coreas v. Bounds*, No. 8:20-cv-0780-TDC,
2020 WL 1663133, at *2 (D. Md. Apr. 3, 2020)

**UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND**

MAURICIO COREAS and
ANGEL GUZMAN CEDILLO,

Petitioners,

v.

DONNA BOUNDS,
*in her official capacity as Warden,
Worcester County Detention Center,*
JACK KAVANAUGH,
*in his official capacity as Director,
Howard County Detention Center,*
JANEAN OHIN,
*in her official capacity as
Acting Baltimore Field Office Director,
U.S. Immigration and Customs Enforcement,*
MATTHEW T. ALBENCE,
*in his official capacity as Deputy Director
and Senior Official performing the duties of
the Director of the U.S. Immigration
and Customs Enforcement,*
and
IMMIGRATION AND CUSTOMS
ENFORCEMENT,

Respondents.

Civil Action No. TDC-20-0780

MEMORANDUM OPINION

Petitioners Mauricio Coreas and Angel Guzman Cedillo (“Guzman Cedillo”), currently in immigration detention, have filed this action pursuant to 28 U.S.C. § 2241 against Respondents Donna Bounds, Warden of the Worcester County Detention Center in Snow Hill, Maryland; Jack Kavanaugh, Director of the Howard County Detention Center in Jessup, Maryland; Janean Ohin, the Acting Baltimore Field Office Director for United States Immigration and Customs

Enforcement (“ICE”); Matthew T. Albence, Deputy Director and Senior Official performing the duties of the Director of ICE; and ICE. Pending before the Court is Petitioners’ Motion for a Temporary Restraining Order (“TRO”), seeking their immediate release in response to the COVID-19 pandemic. The Motion is fully briefed, and the Court held a video hearing on the Motion on April 2, 2020. For the reasons set forth below, the Motion will be DENIED WITHOUT PREJUDICE.

BACKGROUND

I. The COVID-19 Pandemic

The virus identified as SARS-CoV-2, commonly referred to as the novel coronavirus (“the Coronavirus”), has caused a global pandemic of the condition known as COVID-19. As of April 3, 2020, there were 932,166 confirmed cases and 46,764 deaths worldwide. *Coronavirus Disease (COVID-19) Pandemic*, World Health Org., <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>. As of April 2, 2020, there were 213,144 confirmed cases and 4,513 deaths in the United States. *Cases in U.S.*, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>. The Centers for Disease Control and Prevention (“CDC”) has projected that, without effective public health intervention, about 200 million people in the United States may contract the disease, and, under some projections, as many as 1.5 million people in the United States may die from the disease. Another organization’s projection puts the potential number of American fatalities at 2.2 million. Moreover, some evidence suggests that, even when not fatal, COVID-19 results in long-term, serious illnesses, which may include severe damage to internal organs, in about 16 percent of cases.

COVID-19 poses special risks for the elderly and those with certain preexisting medical conditions. *Amici Curiae* Public Health and Human Rights Experts Br. at 6-7, ECF No. 32. The

CDC has identified several medical conditions that place an individual at an increased risk of serious COVID-19 complications: “blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological[,] neurologic and neurodevelopmental conditions, and current or recent pregnancy.” Greifinger Decl. ¶ 7, Reply Mot. TRO (“Reply”) Ex. 6, ECF No. 52-6. Of those who have died from COVID-19 in Italy, another country experiencing a high number of COVID-19 cases, about three-fourths had high blood pressure, one-third had diabetes, and one-third had heart disease. According to Dr. Jonathan Louis Golob, an Assistant Professor at the University of Michigan School of Medicine, there is evidence that in the highest risk populations, COVID-19 causes death in about 15 percent of cases. Preliminary data from China has shown that 20 percent of COVID-19 cases involving high-risk categories have resulted in death.

There is no vaccine, antiviral treatment, or cure for COVID-19. The Coronavirus is believed to spread through “droplets” that can be transmitted during close interpersonal contact, though these droplets can also survive on surfaces for days and spread the disease even absent such close contact. *Id.* ¶ 21. There is some evidence that individuals with the Coronavirus can transmit it to others even when they are not yet symptomatic. Public health measures aiming to stop the spread of the virus—most notably the practice of social distancing—have been widespread: “[s]chools, courts, collegiate and professional sports, theater and other congregate settings have been closed,” *id.* ¶ 8, and many states have issued mandatory social distancing polices. The Governor of Maryland issued a stay-at-home order on March 30, 2020. *See* Order of the Governor of the State of Maryland § II, No. 20-03-30-01 (Mar. 30, 2020), <https://governor.maryland.gov/wp-content/uploads/2020/03/Gatherings-FOURTH-AMENDED-3.30.20.pdf>. As of April 2, 2020, 40 states and the District of Columbia had issued stay-at-home or shelter-in-place orders. *See These*

States Have Implemented Stay-at-Home Orders, CNN (Apr. 2, 2020), <https://www.cnn.com/2020/03/23/us/coronavirus-which-states-stay-at-home-order-trnd/index.html>.

Prisons, jails, and detention centers are especially vulnerable to outbreaks of COVID-19. First, even if these facilities suspend in-person visitation, the staff, contractors, and vendors working at the facilities can still introduce the Coronavirus into the facility, a risk that is all the more difficult to contain because asymptomatic individuals can transmit the virus and because these facilities lack the capacity to screen for the virus in asymptomatic individuals. According to Petitioners' expert, Dr. Robert B. Greifinger, an expert on prison and jail health care and the former manager of medical care for the New York State prison system, "[j]ails and detention centers are congregate environments where the risk of infection and infectious spread are extraordinarily high." Greifinger Decl. ¶¶ 1-2, 16. Indeed, there have already been confirmed outbreaks of COVID-19 at several prisons and detention facilities across the United States, including the Rikers Island detention facility in New York City, the Cook County Jail in Chicago, Illinois, and the federal prison in Oakdale, Louisiana, as well as certain New Jersey jails housing ICE detainees. In this region, COVID-19 has been identified in the Clifton T. Perkins Hospital Center, a psychiatric hospital in Jessup, Maryland; and the D.C. Jail in Washington, D.C.

Second, once the Coronavirus is introduced into a detention facility, the nature of these facilities makes the mitigation measures introduced elsewhere in the country difficult or impossible to implement. Detention facilities often lack personal protective equipment that helps prevent the transmission of the virus. Shared facilities, such as bathrooms, dining halls, and telephones, are often not disinfected between uses. Poor ventilation increases the risk of transmission. Detained individuals are often not given the opportunity or tools to wash or sanitize

their hands frequently. And the crowded nature of the facilities can make social distancing recommended by the CDC impossible.

The ICE Health Service Corps, which oversees medical care at ICE detention facilities, has issued new guidelines for addressing the COVID-19 pandemic. *See Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)*, ICE Health Service Corps, Mar. 6, 2020, <https://www.aila.org/infonet/ice-interim-reference-sheet-coronavirus>. The guidelines set out screening procedures that include questioning incoming detainees about travel and potential contact with individuals with COVID-19 and establish some protocols for isolating and monitoring detainees with COVID-19. However, the guidelines do not advise on how and when to test individuals for COVID-19 or to plan for surges once the illness spreads. They also do not include guidance on how to identify detainees at high risk due to health conditions or how to provide special protection for high-risk detainees.

Some courts have granted motions to release high-risk individuals from ICE detention on constitutional grounds. For example, in New York, a federal judge ordered that ten detainees who face a high risk of complications from COVID-19 be released from New Jersey immigration detention facilities in which the Coronavirus was confirmed to be present. *See Basank v. Decker*, 20-cv-2518, 2020 WL 1481503, at *7 (S.D.N.Y. Mar. 26, 2020). Several other federal courts have also ordered ICE detainees released on the grounds that their continued detention under the threat of the Coronavirus violates the Constitution. *See, e.g., Thakker v. Doll*, 20-cv-00480, Doc. No. 47 (E.D. Pa. Mar. 31, 2020); *Castillo v. Barr*, No. 20-cv-0605, 2020 WL 1502864, at *6 (C.D. Cal. Mar. 27, 2020); *Coronel v. Decker*, No. 20-cv-2472, 2020 WL 1487274, at *10 (S.D.N.Y. Mar. 27, 2020). Other courts have declined to release immigration detainees on this basis. *See Sacal-*

Micha v. Longoria, No. 20-cv-0037, 2020 WL 1518861, at *6 (S.D. Tex. Mar. 27, 2020); *Dawson v. Asher*, No. C20-0409JLR-MAT, 2020 WL 1304557, at *1 (W.D. Wash. Mar. 19, 2020).

II. Detention of Petitioners

Petitioners are both detained by ICE in Maryland, and both have underlying medical conditions that place them at increased risk of serious complications or even death from COVID-19. According to Dr. Greifinger, based on reviewing the conditions in their respective facilities, “ICE has failed to adequately comprehend and respond to the COVID-19 pandemic for those detained in ICE custody, including at Worcester and Howard County Detention Centers.” Greifinger Decl. ¶ 17.

A. Mauricio Coreas

Petitioner Mauricio Coreas, a native of El Salvador, is a construction worker who has three daughters in the United States, including one who is a lawful permanent resident as a result of a successful asylum application. Coreas is seeking relief from deportation on asylum grounds and is currently detained by ICE at the Howard County Detention Center (“HCDC”). He is 52 years old and suffers from severe Type 2 diabetes. This medical condition puts him “at high risk for complications from COVID-19 should [he] be exposed to the virus in detention.” *Id.* ¶ 31. Coreas was convicted in 2007 in Virginia state court of burglary, arson, and related crimes, deported after serving his sentence, then convicted in 2016 in this Court of illegal reentry after deportation, 8 U.S.C. § 1326 (2018). In 2020, Coreas was convicted of a violation of supervised release on his illegal reentry conviction and sentenced to time served of approximately seven months of imprisonment. He was taken into ICE custody on January 15, 2020 following completion of that sentence. He is scheduled to have an immigration hearing on April 16, 2020.

At HCDC, low security level detainees are housed in dormitories, large rooms with 32 beds, while higher-level detainees are housed in cells that they share with other detainees. Detainees spend approximately 11 hours per day in communal spaces in which they are placed into close contact with other detainees. As of the filing of this case, these communal spaces, which include dining and restroom facilities, were not disinfected regularly. Detainees come into contact with detainees from other dormitories and parts of HCDC in shared spaces such as the chapel, law library, and medical unit, and with detention staff who regularly move to and from different parts of the facility and in and out of the facility. The medical unit and commissary are shared with individuals who are under pretrial detention in criminal cases. Coreas must visit the shared medical unit twice a day to have his blood sugar level checked. As of March 27, 2020, HCDC had space for approximately 100 immigration detainees and was housing 60 such detainees.

Since March 13, 2020, all programs within HCDC, such as chapel services and group presentations, have been suspended. However, according to Petitioners, certain group activities, such as bible study and recreational games, are ongoing at HCDC. Beginning on March 26, 2020, two days after this lawsuit was initiated, HCDC suspended all visits except for attorney visits through non-contact visiting booths; has begun to take the temperature of everyone entering the facility and is denying access to those with temperatures above 100.4 degrees; has issued cleaning kits to allow detainees to clean their cells and bunks; has begun assigning officers to the same housing posts for 14 days to make contact tracking easier; approved emergency staffing plans for each shift; and developed quarantine procedures. Any new detainees were screened for fever, respiratory illness, travel history, and past contact with persons who had contracted COVID-19. HCDC also now provides disinfectant, hand sanitizer, soap, and masks to housing units. However, Coreas has asserted that detainees are given only one bar of soap every two weeks to use for both

bathing and washing their hands; once that soap runs out, detainees must purchase their own soap, if they have the funds to do so. Soap is often unavailable in the bathrooms. Finally, Coreas has stated that the cleaning procedures in the detention facility have not changed since the beginning of the pandemic.

As of March 27, 2020, Respondents report that HCDC had no confirmed and no suspected cases of COVID-19. However, as acknowledged by Respondents during the hearing on the Motion, HCDC has conducted no tests for COVID-19, has no test kits, and has no plans to conduct testing. Meanwhile, Coreas has observed that “[m]any people are coughing and sneezing” at HCDC. Coreas Decl. ¶ 9, Reply Ex. 2, ECF No. 52-2. In fact, Petitioners identify at least three detainees at HCDC who have been exhibiting symptoms consistent with COVID-19 but who have been neither treated nor tested for the Coronavirus. Moreover, Coreas reports that HCDC has not given detainees any information about the Coronavirus, and that they receive their information instead from the news.

B. Angel Guzman Cedillo

Petitioner Angel Guzman Cedillo, a native of Guatemala, is a construction worker with two sons who live in the United States. As he awaits a hearing at which he will seek relief from deportation based on asylum grounds, Guzman Cedillo is detained at Worcester County Detention Center (“WCDC”). He is 54 years old and has hypertension, prostate problems, and a history of traumatic injuries that have limited his cognitive abilities. As with Coreas, these medical conditions put him “at high risk for complications from COVID-19 should [he] be exposed to the virus in detention.” Greifinger Decl. ¶ 31. In 2010, Guzman Cedillo was convicted of aggravated assault in Georgia, sentenced to six months of imprisonment, and removed to Guatemala. In 2019, he was convicted in this Court of illegal reentry after deportation and sentenced to time served of

approximately eight months of imprisonment. He was taken into ICE custody after completion of his sentence on November 14, 2019. He is scheduled to have an immigration hearing on April 17, 2020.

WCDC generally houses immigration detainees in shared cells with two detainees per cell. At this time, Guzman Cedillo is not currently sharing a cell. As at HCDC, detainees at WCDC spend about half the day in common areas that are not regularly disinfected, come into contact with each other in several shared spaces, and are frequently moved between units by officers. Immigration detainees use the same recreation area as the criminal pretrial detainees, but at different times. Detainees in criminal custody bring meals to those in immigration detention, and the two sets of detainees share one commissary and one barber shop. WCDC's medical facilities are also used by both sets of detainees. Moreover, those in criminal detention clean the facility's common areas. During a shift, WCDC personnel work either in the immigration detainee or the criminal pretrial detainee unit, except for Medical Unit, Processing Area, and Women's Section staff who interact with both categories of detainees. Over time, however, WCDC personnel may rotate units depending on their shift assignment. As of March 27, 2020, WCDC had capacity for over 200 immigration detainees but was housing only 90 such detainees.

Since the emergence of the COVID-19 pandemic and the filing of this lawsuit, WCDC has taken certain steps to address the threat of the Coronavirus. Since March 20, 2020, there have been no ICE detainees transferred into WCDC. Although there are new criminal pretrial detainees entering WCDC, Respondents report that "[t]he facility screens all newly arriving inmates for potential exposure." Brown Decl. ¶ 25, Opp'n Mot. TRO ("Opp'n") Ex. 1, ECF No. 39-1. In-person visits at WCDC have been stopped, save for visits from attorneys, who are screened before entering the building. WCDC also screens and takes the temperatures of all staff who enter the

facility. WCDC “has extra cleaning practices for the facility and housing units, which includes the installation of soap dispensers and hand air dryers in housing unit dayrooms, a common area within the housing unit.” *Id.* ¶ 25. However, the shared showers are not disinfected between uses. Finally, WCDC has identified housing units to be used to quarantine patients who have or are suspected of having COVID-19.

Although Petitioners have alleged that WCDC is under quarantine, Respondents have asserted that such reports related to an ICE administrative facility in Salisbury, Maryland. Rather, Respondents have attested to the fact that as of March 27, 2020, WCDC has had no suspected or confirmed cases of COVID-19. As with HCDC, however, it also has no testing capability and no plans to conduct tests for COVID-19.

DISCUSSION

On March 24, 2020, Petitioners filed their Petition for a Writ of Habeas Corpus and a Complaint for Declaratory and Injunctive Relief, along with a Motion for Temporary Restraining Order seeking their release from ICE detention. In the Motion, they assert that they are likely to succeed on the merits of their claim that their ongoing detention violates their due process rights under the Fifth Amendment to the United States Constitution, and that because of their health conditions that make them especially vulnerable to COVID-19, a TRO or preliminary injunction ordering their immediate release is necessary to avoid irreparable harm.

I. Standing

As a threshold issue, Respondents assert that Petitioners lack standing to assert their claims. One “essential aspect” of the limitations that Article III of the Constitution imposes on federal courts is the requirement “that any person invoking the power of a federal court must demonstrate standing to do so.” *Hollingsworth v. Perry*, 570 U.S. 693, 704 (2013). “To establish Article III

standing, a plaintiff must show (1) an injury in fact, (2) a sufficient causal connection between the injury and the conduct complained of, and (3) a likel[ihood] that the injury will be redressed by a favorable decision.” *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 157-58 (2014) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)). Respondents argue that Petitioners have failed to establish the first and third of these requirements.

A. Injury-in-Fact

Petitioners do not allege that they have already contracted COVID-19, meaning that the injury they seek to redress is a future one. However, an injury can satisfy Article III’s requirements so long as it is “imminent, not conjectural or hypothetical.” *Id.* at 158 (citation omitted). Nevertheless, Respondents claim that Petitioners fail to meet this standard because their alleged injury is “conjectural and not imminent,” as there are no confirmed cases of COVID-19 in their detention facilities. Opp’n at 8.

The Court disagrees. The imminence requirement is met when “the threatened injury is certainly impending, or there is a substantial risk that the harm will occur.” *Susan B. Anthony List*, 573 U.S. at 158. Here, Petitioners, who have the burden to establish standing, *id.*, have offered evidence from a medical expert that “detention centers are congregate environments where the risk of infection and infectious spread are extraordinarily high,” and that Respondents have failed to implement effective measures to decrease the risk of COVID-19 reaching the facility and Petitioners. Greifinger Decl. ¶ 16. The imminence of the injury facing Petitioners is accentuated by the growing number of COVID-19 cases in detention facilities and the widespread havoc the virus can wreak once inside these facilities. As of April 1, 2020, ICE had reported four cases among its detainees and five cases among personnel working at ICE detention facilities. There have also been three reported cases in Maryland prisons, while there have been hundreds of cases

in prisons and jails outside the state. In these circumstances, the Court has no trouble concluding that the injury Petitioners allege is sufficiently imminent to confer standing.

B. Redressability

In addition to showing an injury-in-fact, Petitioners “must show that ‘it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.’” *Sierra Club v. U.S. Dep’t of the Interior*, 899 F.3d 260, 284 (4th Cir. 2018) (quoting *Laidlaw Env’tl. Servs.*, 528 U.S. 167, 181 (2000)). “The burden imposed by this requirement is not onerous.” *Deal v. Mercer Cty. Bd. of Educ.*, 911 F.3d 183, 189 (4th Cir. 2018). “[P]laintiffs need only show that they personally would benefit in a tangible way from the court’s intervention.” *Id.* (citation omitted).

Respondents argue that Petitioners have not met this low burden because they “do not explain how release from HCDC or WCDC—two facilities without a single confirmed case of COVID-19—into the greater Washington, D.C., area will reduce their risk of injury or death.” Opp’n at 9. Even leaving aside the fact that it is impossible to point to any confirmed cases within HCDC or WCDC when Respondents have not conducted any COVID-19 tests at those facilities, this argument strains credulity. Beyond the absurdity of the claim that someone will be safer from a contagious disease while confined in close quarters with dozens of other detainees and staff than while at liberty, Petitioners have provided multiple expert opinions supporting the contrary conclusion, such as that of Dr. Greifinger, who has stated that “[d]etention centers are extraordinarily high-risk environments for the transmission of infectious diseases,” an assertion supported by examples of COVID-19 spreading “like wildfire” in detention facilities around the nation. Greifinger Decl. ¶¶ 14, 19. The Court finds that Petitioners have satisfied the redressability requirement of standing.

II. 28 U.S.C. § 2241

Petitioners seek their release from ICE detention through a petition for a writ of habeas corpus pursuant to 28 U.S.C. § 2241. Under this provision, a district court may grant a writ of habeas corpus if a prisoner “is in custody under or by color of the authority of the United States” or is “in custody in violation of the Constitution or laws or treaties of the United States.” 28 U.S.C. § 2241(c) (2018). Defendants, however, argue that § 2241 is an inappropriate vehicle for raising what it characterizes as a challenge to Petitioners’ conditions of confinement.

In *Preiser v. Rodriguez*, 411 U.S. 475 (1973), the United States Supreme Court, while reaffirming prior decisions allowing inmates to raise challenges to their conditions of confinement as federal civil rights actions, cautioned that “[t]his is not to say that habeas corpus may not also be available to challenge such prison conditions.” *Id.* at 499. Indeed, it expressly noted that in those decisions, the plaintiffs were not, as Petitioners are here, “seeking immediate release or a speedier release from that confinement—the heart of habeas corpus.” *Id.* More recently, the Supreme Court has stated that it has “left open the question whether [prisoners] might be able to challenge their confinement conditions via a petition for a writ of habeas corpus.” *Ziglar v. Abbasi*, 137 S. Ct. 1843, 1862-63 (2017). In the absence of clear guidance, lower courts have split on the extent to which habeas provides a mechanism for asserting challenges to conditions of confinement. *Wilborn v. Mansukhani*, 795 F. App’x 157, 163 (4th Cir. 2019) (listing cases).

The United States Court of Appeals for the Fourth Circuit has not ruled in a published, binding opinion whether § 2241 is available to challenge conditions of confinement. *Id.* at 163-64. Moreover, the Fourth Circuit’s unpublished opinions declining to allow certain claims relating to conditions of confinement to be raised through a habeas petition are clearly distinguishable from the instant Petition. In *Wilborn*, a federal inmate sought to use § 2241 to challenge his housing

assignment within the Bureau of Prisons. *Id.* at 164. In another case, a federal inmate sought to use § 2241 to challenge his failure to receive good conduct credits and a transfer to another facility. *Rodriguez v. Ratledge*, 715 F. App'x 261, 266 (4th Cir. 2017); *see also Braddy v. Wilson*, 580 F. App'x 172 (4th Cir. 2014) (rejecting a federal inmate's use of § 2241 to raise a claim that his conditions of confinement violated the terms of his plea agreement). By contrast, Petitioners are not challenging their placement within their respective detention facilities. Instead, they are seeking release from the facility entirely. *See* Pet. at 30, ECF No. 1 (“Plaintiffs request that this Court . . . [i]ssue a writ of habeas corpus and order Plaintiffs’ immediate release or placement in community-based alternatives to detention.”); Mot. TRO at 25, ECF No. 2-1 (“Plaintiffs respectfully request that this Court . . . order their immediate release from custody.”). Moreover, while the petitioners in the unpublished Fourth Circuit cases were convicted federal prisoners, Petitioners here are civil immigration detainees, who have traditionally had recourse to § 2241 for constitutional challenges to their detention. *See, e.g., Zadvydas v. Davis*, 533 U.S. 678, 687-88 (2001) (holding that § 2241 was a proper vehicle to challenge an immigration detainee’s detention as violating due process due to its length).

In the absence of binding Fourth Circuit authority, this Court concludes, consistent with the positions of several circuits, that a claim by an immigration detainee seeking release because of unconstitutional conditions or treatment is cognizable under § 2241. *See Amer v. Obama*, 742 F.3d 1023, 1038 (D.C. Cir. 2014) (finding that § 2241 is available to challenge a federal detainee’s conditions of confinement); *Jiminian v. Nash*, 245 F.3d 144, 146 (2d Cir. 2001) (same); *Miller v. United States*, 564 F.2d 103, 106 (1st Cir. 1977) (same). First, and most fundamentally, although the grounds on which they seek release relate to their conditions of confinement, Petitioners seek complete release from confinement, which is “the heart of habeas corpus.” *Preiser*, 411 U.S. at

498. Second, for immigration detainees, if § 2241 is unavailable, Petitioners may have no vehicle by which to seek redress for the constitutional violation they allege. *Lee v. Winston*, 717 F.2d 888, 892 (4th Cir. 1983) (stating that 42 U.S.C. § 1983 “cannot be used to seek release from illegal physical confinement”), *aff’d*, 470 U.S. 753 (1985); *cf. In re Jones*, 226 F.3d 328, 333 (4th Cir. 2000) (holding that where 28 U.S.C. § 2255 is “inadequate or ineffective” to test the legality of the detention of a federal prisoner, a prisoner may file a habeas petition pursuant to 28 U.S.C. § 2241). The Court will therefore consider the Petition.

III. TRO

To obtain a TRO or a preliminary injunction, moving parties must establish that (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *see Dewhurst v. Century Aluminum Co.*, 649 F.3d 287, 290 (4th Cir. 2011). A moving party must satisfy each requirement as articulated. *Pashby v. Delia*, 709 F.3d 307, 320-21 (4th Cir. 2013). Because a TRO or a preliminary injunction is “an extraordinary remedy,” it “may only be awarded upon a clear showing that the plaintiff is entitled to such relief.” *Winter*, 555 U.S. at 22.

A. Likelihood of Success on the Merits

In asserting their claims, Petitioners cast themselves as civil detainees held in immigration detention. As an initial matter, the Respondents argue that because they are immigration detainees, Petitioners are entitled to lesser constitutional protections as to their detention conditions than other civil detainees. The Court finds Respondents’ argument on this score unpersuasive. None of the cases cited by Respondents speaks to the situation here. For example, *Reno v. Flores*, 507 U.S. 307 (1993), while reaffirming the broad notion that Congress has plenary power over immigration

matters in rejecting the argument that the Government may not deprive unaccompanied juvenile immigration detainees of their liberty at all, also reaffirmed that aliens are entitled to “due process of law in deportation proceedings.” *Id.* at 305-06. *Mathews v. Diaz*, 426 U.S. 67 (1976), involved a challenge to citizenship requirements for eligibility for certain welfare benefits and thus sheds no light on whether immigration detainees have lesser due process rights than other civil detainees. *Id.* at 80. Where the matter at issue is the conditions of detention, not the right to enter or remain in the United States, the Court rejects Respondents’ suggestion that the due process standards for civil detainees do not apply to individuals in immigration detention.

Civil detainees who challenge the conditions of their confinement are protected by the Due Process Clauses of the Fifth and Fourteenth Amendments. *See Youngberg v. Romeo*, 457 U.S. 307, 315 (1982) (stating, in the context of involuntary civil commitment, that “the right to personal security constitutes a ‘historic liberty interest’ protected substantively by the Due Process Clause” and “that right is not extinguished by lawful confinement” (quoting *Ingraham v. Wright*, 430 U.S. 651, 673 (1977))). These protections are at least as robust as those of the Eighth Amendment because “[i]f it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed—who may not be punished at all—in unsafe conditions.” *Id.* at 315-16. *Cf. Bell v. Wolfish*, 441 U.S. 520, 545 (1979) (holding that pretrial detainees “retain at least those constitutional rights that we have held are enjoyed by convicted prisoners”). Thus, individuals who have been civilly detained or committed “are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.” *Youngberg*, 457 U.S. at 321-22 (addressing persons subjected to involuntary civil commitment for mental health reasons). *Cf. Bell*, 441 U.S. at 536-

37 (holding that pretrial detainees may be held in custody “so long as those conditions and restrictions [of confinement] do not amount to punishment”).

Protections for individuals confined by the state, whether civilly or criminally, include the right to reasonable safety and adequate medical care. *See Youngberg*, 457 U.S. at 315-161; *Raynor v. Pugh*, 817 F.3d 123, 127 (4th Cir. 2016) (holding that prison officials are constitutionally required to maintain “humane conditions of confinement,” including “the provision of adequate medical care” and taking “reasonable measures to guarantee the safety of the inmates”). “The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual’s liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e.g.*, food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.” *DeShaney v. Winnebago Cty. Dep’t of Soc. Servs.*, 489 U.S. 189, 200 (1989).

The Supreme Court has made clear as to reasonable safety that the Eighth Amendment “protects against future harm,” including a “condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year.” *Helling v. McKinney*, 509 U.S. 25, 33 (1993). Under this principle, constitutional violations could arise from “the exposure of inmates to a serious, communicable disease” even if “the complaining inmate shows no serious current symptoms” and “even though the possible infection might not affect all those exposed.” *Id.*; *see Hutto v. Finney*, 437 U.S. 678, 682-83, 687 (1978) (finding no error in the trial court’s conclusion that the conditions of a state prison violated the Eighth Amendment where those conditions included, among other things, daily, random redistribution of mattresses to inmates, some of whom suffered from communicable diseases such as hepatitis and venereal disease); *see*

also *DeGidio v. Pung*, 920 F.2d 525, 526, 533 (8th Cir. 1990) (upholding a district court’s ruling that prison officials’ response to a tuberculosis outbreak, including their screening and control procedures, was inadequate and violated the Eighth Amendment).

1. Health and Safety

Petitioners argue that Respondents have violated their due process rights by failing to protect them from a known threat to their health and safety: the Coronavirus. In the related context of convicted prisoners, the Eighth Amendment requires that prison officials maintain “humane conditions of confinement,” including taking “reasonable measures to guarantee the safety of the inmates.” *Raynor*, 817 F.3d at 127. In order to establish an Eighth Amendment claim arising from a failure to ensure reasonable safety or provide adequate medical care, a convicted prisoner must demonstrate that the actions of prison officials amounted to deliberate indifference to the inmate’s health and safety. *Estelle v. Gamble*, 429 U.S. 97, 106 (1976) (establishing deliberate indifference as the standard for Eighth Amendment inadequate medical care claims); *Helling*, 509 U.S. at 32 (applying the deliberate indifference standard to a claim that a communicable disease threatened inmates’ health and safety). The Fourth Circuit has held that for due process claims by pretrial detainees of inadequate medical treatment, the Eighth Amendment deliberate indifference standard applies. *See, e.g., Hill v. Nicodemus*, 979 F.2d 987, 991-92 (4th Cir. 1992) (“[P]rison officials violate [a] detainee’s rights to due process when they are deliberately indifferent to serious medical needs.”); *see also Young v. City of Mount Rainier*, 238 F.3d 567, 575 (4th Cir. 2001) (“[D]eliberate indifference to the serious medical needs of a pretrial detainee violates the due process clause.”). Since *Hill*, the Supreme Court has called into question the equivalence between the standards applied to claims by pretrial detainees and those applied to claims by post-conviction inmates. In *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015), the Court held that, unlike the standard applied

to post-conviction detainees' excessive force claims under the Eighth Amendment, the standard for pretrial detainees' excessive force claims under the Fourteenth Amendment includes no subjective component. *Id.* at 2472-73. Several circuits have extended this reasoning to hold that the standard for pretrial detainees' claims of inadequate medical care under the Fourteenth Amendment should likewise not include a subjective component. *See, e.g., Miranda v. Cty. of Lake*, 900 F.3d 335, 352 (7th Cir. 2018); *Gordon v. Cty. of Orange*, 888 F.3d 1118, 1124-25 (9th Cir. 2018). In *Gordon*, for example, the court held that a Fourteenth Amendment claim of inadequate medical care is to be evaluated under an "objective deliberate indifference standard" that requires "more than negligence but less than subjective intent—something akin to reckless disregard." *Gordon*, 888 F.3d at 1125 (requiring that a pretrial detainee show that the defendant did not take "reasonable available measures" to address a medical risk even though "a reasonable official in the circumstances would have appreciated the high degree of risk involved," such that the adverse consequences were "obvious"). Although it is sensible, after *Kingsley*, to conclude that a different, less stringent standard should be applied to the claims of pretrial detainees relating to health and safety, this Court remains bound by Fourth Circuit precedent on this issue as stated in *Hill*.

Neither the Supreme Court nor the Fourth Circuit has expressly decided what standard applies to health and safety or inadequate medical care claims raised by individuals in civil detention. In *Heyer v. United States Bureau of Prisons*, 849 F.3d 202 (4th Cir. 2017), the Fourth Circuit stated that in cases involving civilly committed psychiatric patients, inadequate medical care claims would be governed by the professional judgment standard articulated in *Youngberg*, not by the Eighth Amendment deliberate indifference standard. *Id.* at 209 n.6. However, in *Matherly v. Andrews*, 859 F.3d 264 (4th Cir. 2017), in deciding the appropriate standard for civil

detainees' claims of unconstitutionally punitive conditions of confinement, the Fourth Circuit expressly drew on the applicable standard for pretrial detainees because it was "natural to borrow" from that context, and that to do otherwise would result in the "unwieldy outcome" of multiple standards "contingent upon the type of civil detention." *Id.* at 275. Coupling the Fourth Circuit's concern in *Matherly* for a uniformity of standards across varied forms of detention with the clear holding in *Hill* that the deliberate indifference standard applies to pretrial detainee claims of inadequate medical care, the Court concludes that the deliberate indifference standard applies to the Fourteenth Amendment health and safety and inadequate medical care claims asserted here.

Under this standard, a plaintiff must satisfy a two-part inquiry that includes both an objective and a subjective component. *See Raynor*, 817 F.3d at 127. First, a plaintiff must show objectively "a serious deprivation" of rights "in the form of a serious or significant physical or emotional injury," *Danser v. Stansberry*, 772 F.3d 340, 346-47 (4th Cir. 2014), or "a substantial risk of such serious harm resulting from the prisoner's unwilling exposure to the challenged conditions," *Shakka v. Smith*, 71 F.3d 162, 166 (4th Cir. 1995) (quoting *Strickler v. Waters*, 989 F.2d 1375, 1381 (4th Cir. 1993)). Thus, "a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year" may violate the Constitution, even if "the complaining inmate shows no serious current symptoms." *Helling*, 509 U.S. at 33-34; *Webb v. Deboo*, 423 F. App'x 299, 300 (4th Cir. 2011). To establish the subjective component, there must be evidence of deliberate indifference, in that a known excessive risk of harm to the inmate's health or safety was disregarded. *See Wilson v. Seiter*, 501 U.S. 294, 302-03 (1991) (applying the deliberate indifference standard to conditions of confinement claims). "[T]he test is whether the guards know the plaintiff inmate faces a serious danger to his safety and they

could avert the danger easily yet they fail to do so.” *Brown v. N.C. Dep’t of Corr.*, 612 F.3d 720, 723 (4th Cir. 2010) (quoting *Case v. Ahitow*, 301 F.3d 605, 607 (7th Cir. 2002)).

To the extent that Petitioners’ claims are based in part on their underlying medical conditions and the failure to address it, the medical condition at issue must be objectively serious. *Hudson v. McMillian*, 503 U.S. 1, 9 (1992). A medical condition is serious when it is “so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.” *Iko v. Shreve*, 535 F.3d 225, 241 (4th Cir. 2008)) (citation omitted). As for the subjective component, “[a]n official is deliberately indifferent to an inmate’s serious medical needs only when he or she subjectively knows of and disregards an excessive risk to inmate health or safety.” *Jackson v. Lightsey*, 775 F.3d 170, 178 (4th Cir. 2014) (quoting *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)). If the requisite subjective knowledge is established, an official may avoid liability by responding “reasonably to the risk, even if the harm ultimately was not averted.” *See Farmer v. Brennan*, 511 U.S. 825, 844 (1994).

As to the objective prong, the available evidence establishes that COVID-19 is a highly communicable disease that presents a potentially mortal risk, particularly for high-risk individuals such as Petitioners. Although the Government disputes the immediacy of that risk to Petitioners, that argument, as discussed above, *see supra* part I.A, lacks merit because “a remedy for unsafe conditions need not await a tragic event.” *Helling*, 509 U.S. at 33-34 (rejecting the argument that “only deliberate indifference to current serious health problems of inmates is actionable under the Eighth Amendment”). Here, even without direct evidence that individuals within HCDC and WCDC (collectively, “the Detention Facilities”) have contracted the Coronavirus, its spread has been remarkably rapid, including into prisons and detention facilities. Since March 24, 2020, the number of cases in the United States has increased from approximately 54,000 to approximately

250,000. *Cases in U.S.*, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>. There are now approximately 450 cases among detainees and staff at the New York City detention center at Rikers Island. In the past two weeks, it has been reported to have entered immigration detention centers in New Jersey, a federal prison in Louisiana, and the D.C. Jail. It thus presents an imminent risk to health and safety that satisfies the objective prong.

At the same time, as much as Petitioners have sought to paint with broad brush strokes by offering an expert opinion that the nature of immigration detention facilities, including chronic overcrowding, is such that there is a “heightened public health risk” that COVID-19 will spread into such facilities, Greifinger Decl. ¶ 9, the facts relating to the Detention Facilities are of particular importance to the Court’s analysis. At the present time, there are no confirmed cases of COVID-19 among detainees or staff at HCDC or WCDC. Both Detention Facilities have adopted procedures to screen individuals entering the facilities, ended non-attorney visits, and stopped receiving new immigration detainees. At the hearing on the Motion, Respondents reported that the immigration detainee population of HCDC has now been reduced to 38 individuals in a facility with a maximum capacity of 100, and the comparable population of WCDC has been reduced to 86 detainees housed in a facility designed for 200 individuals. These conditions contrast markedly with those at other detention facilities described in the press accounts submitted by Respondents, which include a report of 110 men sleeping in the same room. *Immigrants Jailed by ICE are Sick, Panicking, and Can’t Get Coronavirus Tests* at 3, Reply Ex. 10, ECF No. 52-10. Thus, although there is an objective risk, it is not at the same level as in other facilities.

Turning to the subjective prong, there is no dispute that Respondents were and are subjectively aware of the risk that COVID-19 poses to both healthy and high-risk individuals. The

issue is whether COVID-19 poses an excessive risk that is being disregarded by Respondents. The evidence supports the conclusion that as of the time of the filing of the Petition and the Motion, on March 24, 2020, Respondents were disregarding the risk. Prior to that date, at HCDC, Respondents had reportedly suspended group programs, including chapel services, and had started holding hearings with ICE detainees by telephone. At WCDC, they had stopped ICE transports of detainees in and out of the facility, and they had suspended visits except for attorney visits. Otherwise, as acknowledged at the hearing on the Motion, there is no evidence that they took any other protective measures. It is undisputed that at both facilities, immigration detainees are housed in close quarters. At HCDC, most immigration detainees are housed in dormitory-like facilities that hold up to 32 people, though Coreas and certain other detainees live in two-person cells. At WCDC, immigration detainees are housed in cells that hold up to two people. Guzman Cedillo presently is in such a cell but without a cellmate. During the day, immigration detainees at both facilities spend approximately 11 hours in communal activities and spaces, where they are in close proximity to one another. Nevertheless, as of the filing of the Motion, communal spaces, including restrooms, were not regularly disinfected. It is undisputed that up to that time, detainees were not provided with cleaning materials for their cells or any or adequate soap or hand sanitizer. No systematic social distancing protocols, even within the limitations of a detention facility, were implemented. Further, the limited number of bathrooms available to the detainees were not disinfected after each use. Such facts lead to the inescapable conclusion that, before this lawsuit, HCDC and WCDC were disregarding the known risk of a highly communicable and potentially fatal disease.

Since the filing of this lawsuit, both Detention Facilities have instituted more COVID-19 mitigation efforts. Respondents assert that detainees are now given soap, hand sanitizer, and

cleaning supplies, and they have increased the frequency of cleaning of high use areas in both facilities. According to Respondents, detainees are now advised on the importance of hand washing and told to seek medical assistance if they become ill. Any individuals allowed to come into the Detention Facilities are screened for body temperature, symptoms, and travel histories. The Detention Facilities have identified housing units that could be used to quarantine individuals who are suspected of having COVID-19. Coreas disputes the claims that cleaning frequency at HCDC has increased, and that HCDC is educating the detainee population on the risks of COVID-19 and how to stop the spread of the Coronavirus.

Although steps in the right direction, these measures leave notable gaps. Despite the fact that the Detention Facilities are not currently at full capacity, there continue to be no social distancing protocols at either facility. Even though ICE claims to be following CDC guidance, there is no evidence of any actions to increase the distance among detainees, whether by moving detainees in double cells to single cells to the extent possible, or by requiring detainees to be separated by empty bunks in the dormitory or empty seats in the dining areas. *See Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Ctrs. for Disease Control (Mar. 23, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf> (recommending that correctional and detention facilities stagger meal times, rearrange seating in dining halls to allow more space between individuals, and space out bunks to allow six feet between detainees).

More specifically, the Court finds a major deficiency in the lack of any procedures to address the heightened risk to detainees with certain medical conditions. It is undisputed that Coreas has an objectively serious medical condition, diabetes. Regardless of whether he is

receiving otherwise adequate medical care for that condition, diabetes places Coreas at a significantly higher risk of death or serious harm from COVID-19. For individuals in high risk categories such as Petitioners, the available data shows that the death rate for those with COVID-19 is between 15 percent and 20 percent. While adequate treatment for Coreas's condition would necessarily require separation from, or at least minimization of contact with, other detainees, Respondents have taken no general or specific steps to meet this medical need for distancing, whether by providing Coreas with his own cell and otherwise distancing him from other detainees.

Finally, although the Detention Facilities have instituted screening procedures for entering individuals, they have not conducted any tests for COVID-19, and they have neither the capability nor any plans to do so. This fact not only calls into question the claim that there are no confirmed cases of COVID-19 in either HCDC or WCDC, it also exposes a serious vulnerability, where Petitioners have reported many people coughing and sneezing at HCDC and have identified at least three individuals at HCDC who have symptoms consistent with COVID-19 but have never been tested.

If any detainee or staff member at HCDC or WCDC were known to have COVID-19, the Court would conclude that these identified deficiencies, particularly the absence of *any* steps to address Coreas's obvious medical need for separation from others, would establish knowing disregard of a serious medical need constituting deliberate indifference that would likely violate the Constitution. *See Coronel*, 2020 WL 1487274, at *4-6 (finding deliberate indifference to the medical needs of high-risk detainees for social distancing where the Coronavirus was known to be in a detention facility and “the record demonstrates that ICE has not taken any action to address the particular risks COVID-19 poses to high risk individuals like Petitioners here”); *Basank*, 2020 WL 1481503, at *5 (finding deliberate indifference in the absence of social distancing within the

detention facility and the absence of any “steps to protect high-risk detainees like Petitioners” in facilities where the Coronavirus was present). Where Guzman Cedillo also has an objectively serious medical condition—hypertension—which creates a specific need for distancing from others and which Respondents have taken no steps to address, the Court would reach the same conclusion as to Guzman Cedillo.

At this point, however, where there is no evidence that the Coronavirus is present in either HCDC or WCDC, and Respondents have instituted a screening procedure for those entering the facilities, have suspended non-attorney visits, and have stopped transfers of immigration detainees into the facility, the direct threat to Petitioners remains sufficiently attenuated that the Court will not find that the identified deficiencies have established a likelihood of success on the merits of Petitioners’ claim of deliberate indifference to their health and safety or their serious medical needs. Indeed, in cases in which there were no cases of COVID-19 associated with the detention facility, courts have declined to find a likelihood of constitutional violations and to grant a TRO. *See Sacal-Micha*, 2020 WL 1518861, at *6; *Dawson*, 2020 WL 1304557, at *1. Although at least one federal court has found constitutional violations warranting release of immigration detainees even before the appearance of COVID-19 in a facility, *see Castillo*, 2020 WL 1502864, at *6, the facility at issue in that case, the Adelanto ICE Processing Center in California, is a substantially larger facility with more crowded conditions and a history of health and safety risks. *Id.* at *1-2; *see Office of Inspector Gen., Management Alert: Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California*, U.S. Dep’t of Homeland Sec. at 2 (Sept. 27, 2018), <https://www.oig.dhs.gov/sites/default/files/assets/Mga/2018/oig-18-86-sep18.pdf>. In contrast, the Detention Facilities are substantially below capacity, and Guzman Cedillo already has his own cell. Under the present facts, the Court will not find a likely constitutional violation.

However, the Court recognizes that where HCDC and WCDC are currently unable or unwilling to test for the Coronavirus, there would be no way to determine whether it has entered one of the Detention Facilities. Accordingly, the Court concludes that in the event that the Coronavirus is found in HCDC or WCDC, or if those facilities fail to submit a timely certification that they have obtained COVID-19 tests and will administer a test to any individual at either Detention Facility who exhibits suspected COVID-19 symptoms (“Testing Certification”), the Court would find a likelihood of success on the due process claim based on deliberate indifference to the serious medical needs of Petitioners.

2. Conditions of Confinement

Petitioners separately argue that their detention under the specter of the Coronavirus violates due process because it effectively constitutes impermissible punishment. To establish such a claim, civil detainees must show either that (1) the condition was imposed with the express intent to punish; or (2) it is not reasonably related to a legitimate, nonpunitive governmental objective, such that the intent to punish can be inferred. *Matherly*, 859 F.3d at 275 (considering whether an individual detained in advance of a determination whether he should be civilly committed as a sexually dangerous person was subjected to conditions of confinement that were unconstitutionally punitive). As to the second prong, “due process requires that the conditions and duration of confinement . . . bear some reasonable relation to the purpose for which persons are committed.” *Id.* In assessing whether such a relationship exists, courts consider, as applicable, whether “professional judgment” was exercised in balancing “the legitimate interests of the State and the rights of the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraints.” *Id.*; *Youngberg*, 457 U.S. at 321.

On the first factor, the Court finds no evidence in the record that the conditions of Petitioners' confinement were imposed with the express intent to punish. The Court thus turns to whether the challenged conditions of confinement are reasonably related to a legitimate, nonpunitive governmental objective. *Matherly*, 859 F.3d at 275. Although the Court agrees with Respondents that ordinary detention at HCDC or WCDC would be reasonably related to the legitimate governmental objective of ensuring an immigration detainee's presence at an immigration hearing, the present conditions of confinement are markedly different. At this point, Petitioners are confined in facilities where they are particularly vulnerable to COVID-19 because of the lack of ability to maintain distance from others, and if they contract the Coronavirus they have up to a 20 percent chance of death, greater than the odds of losing a game of Russian roulette. If it were known that there were cases of Coronavirus within the detention facility, the Court would conclude that for high-risk immigration detainees, who are held not for the purpose of answering to criminal charges, but merely to face civil status violations, such conditions imposing a palpable risk of death or serious harm inflict far more serious consequences on them than are justified by the need to hold them for their immigration proceedings. Thus, upon consideration of the governmental interest and the detainee's right to reasonable conditions of safety, such conditions would bear no reasonable relationship "to the purpose for which persons are committed" and would violate due process. *Matherly*, 859 F.3d at 275; *see Thakker v. Doll*, 1:20-cv-00480-JEJ, Doc. No. 47.

At present, however, there are no confirmed cases of COVID-19 in the Detention Facilities. Although in *Thakker*, the court found conditions of confinement at three detention facilities to constitute unconstitutional punishment in light of COVID-19 even though only one of the facilities had a known case of COVID-19, the court relied in part on the fact that the facilities had significant

overcrowding and unsanitary conditions, including the presence of rats. *Thakker*, Doc. No. 47 at 14, 20-21. Here, unlike most immigration detention facilities, HCDC and WCDC are substantially below capacity. Under the specific circumstances before it, the Court does not find that the threat of the Coronavirus in society generally, as opposed to its presence inside a detention facility, inflicts unconstitutional punishment on high-risk detainees. To adopt Petitioners' position would be to hold that the detention of any high-risk immigration detainee during the pandemic is necessarily unconstitutional, a position that the Court is not presently prepared to adopt.

The Court is aware, however, that although there is no direct evidence that the Coronavirus has entered the Detention Facilities, there are individuals at HCDC with symptoms consistent with COVID-19, and neither HCDC nor WCDC has the capability to test anyone for the Coronavirus. Unless Respondents are able to provide the Testing Certification referenced above, the Court would consider the lack of a testing capability to be the equivalent of having positive tests in the detention facility, as there would be no way to know whether high-risk detainees are at direct risk of exposure to the Coronavirus. Thus, while the Court does not presently find a likelihood of success on the merits on this claim, it would so find upon either a showing of evidence that a detainee or staff member at HCDC or WCDC has COVID-19, or upon Respondents' failure to provide the Testing Certification by the stated deadline. Accordingly, while the Court's conclusion on the likelihood of success on the merits precludes issuance of a TRO at the present time, *Pashby*, 709 F.3d at 320-21, it will address the remaining prongs and make findings in the event of a future determination of a likelihood of success on the merits.

B. Irreparable Harm

On the issue of irreparable harm, the Court finds that in the event that Petitioners were able to establish a likelihood of success on the merits on their constitutional claims, they would also be

irreparably harmed. “Generally, irreparable injury is suffered when monetary damages are difficult to ascertain or are inadequate.” *Multi-Channel TV Cable Co. v. Charlottesville Quality Cable Operating Co.*, 551 F.3d 546, 551 (4th Cir. 1994). The Fourth Circuit has held that “the denial of a constitutional right . . . constitutes irreparable harm for purposes of equitable jurisdiction.” *Ross v. Meese*, 818 F.2d 1132, 1135 (4th Cir. 1987); see *Overstreet v. Lexington-Fayette Urban Cty. Gov’t*, 305 F.3d 566, 578 (6th Cir. 2002) (noting that “[c]ourts have also held that a plaintiff can demonstrate that a denial of an injunction will cause irreparable harm if the claim is based upon a violation of the plaintiff’s constitutional rights” and collecting cases). More specifically, Petitioners have introduced uncontroverted evidence that contracting COVID-19 would put them at serious risk of severe medical complications and even death. As discussed above, Petitioners’ medical experts place the risk of death for high-risk individuals at 15 to 20 percent. Moreover, Dr. Greifinger notes that those who do not die from COVID-19 suffer “prolonged serious illness” and that once COVID-19 is introduced into a detention facility, “it spreads like wildfire.” Greifinger Decl. ¶¶ 6, 14. Thus, in the event that a detainee or staff member were found to have COVID-19, or if Respondents fail to submit the Testing Certification such that there would be no way to confirm its presence, there would be a high likelihood of irreparable health consequences that could not be alleviated without release. Respondents’ assertion that “detainees who present symptoms compatible with COVID-19 will be placed in isolation” does not remove the risk that the virus will spread quickly once inside the facility and would specifically threaten high-risk detainees like Petitioners. Moon Decl. ¶ 9. Because Petitioners would face a significant risk of death or serious illness under such circumstances, the Court would find likely irreparable harm. See *Multi-Channel TV Cable Co.*, 22 F.3d at 551.

C. Balance of the Equities and the Public Interest

When a plaintiff seeks preliminary injunctive relief against the Government, the balance of the equities and the public interest factors merge. *See Nken v. Holder*, 556 U.S. 418, 435 (2009) (noting, in the context of a plaintiff’s suit seeking a stay of removal proceedings, that the balance of equities and public interest “factors merge when the Government is the opposing party”); *Roe v. Dep’t of Def.*, 947 F.3d 207, 230 (4th Cir. 2020) (citing *Nken* in the context of a preliminary injunction).

To the extent that the Court were to find a likelihood of success on the merits, it would necessarily find that the detention and treatment of Petitioners would violate due process. Generally, “upholding constitutional rights surely serves the public interest.” *Giovani Carandola, Ltd. v. Bason*, 303 F.3d 507, 521 (4th Cir. 2002). Moreover, the significant risk that the Coronavirus, upon entering HCDC or WCDC, would cause death or serious harm to high-risk detainees like Petitioners, weighs in favor of the requested injunction.

In contrast, however, Respondents express a public interest in the detention of Petitioners grounded both in the general public interest in immigration enforcement, *see Blackie’s House of Beef, Inc. v. Castillo*, 659 F.2d 1211, 1221 (D.C. Cir. 1981), as well as the specific interest in upholding the statutory requirement that these particular detainees are subject to mandatory detention under 8 U.S.C. § 1226(c). As to the general interest, the Court recognizes that it weighs in favor of Respondents, but concludes that it is of markedly less importance than the interest in incarceration of convicted federal or state prisoners, or even the detention of individuals formally charged with federal or state criminal offenses. Thus, the balance of equities in a case involving civil detention tips significantly less favorably toward the Government than in a case involving criminal pretrial detention or post-conviction imprisonment.

As to the specific interest, unlike decisions facing judges relating to individuals who are detained solely because they cannot afford bail, or those relating to immigration detainees who are not subject mandatory detention and for whom there is no specific concern about risk of flight or danger to the community, here, Petitioners both have prior convictions for serious offenses. Coreas was convicted in 2007 of arson and burglary, while Guzman Cedillo was convicted of aggravated assault in 2010. Although these convictions are dated and do not necessarily establish any present risk to the community, it cannot be said that there is no public interest in detention. Furthermore, there is evidence that Coreas would present a risk of non-appearance at his immigration hearing. After he was convicted in this Court in 2015 of illegal reentry after deportation, Coreas was placed on supervised release which required him, if not deported, to report to the United States Probation Office upon release and to not commit any additional crimes. However, when he was released by state authorities after they dismissed charges against him for operating a prostitution business, Coreas did not report to Probation as ordered by this Court, and instead relocated to Iowa, where he was off the radar until he was identified by law enforcement three years later, in 2019, after committing a drug possession crime. Thus, unlike in other cases in which judges have found little or no risk of flight, where Coreas has a demonstrated history of disregarding the orders of this Court specifically, it cannot make such a finding here. Thus, there is a public interest in continued detention in order to have Coreas available for his immigration proceedings.

While Respondents' interests explain why an injunction granting Petitioners' release should not occur prematurely, they do not provide a basis to conclude that upon a finding of a likely constitutional violation, the balance of equities and public interest would not favor release. Although the remedy for unconstitutional conditions of confinement is typically a requirement that the conditions be modified, *Dawson*, 2020 WL 1304557, at *2, neither party has identified any

steps that could be taken that would adequately address any unconstitutional conditions short of release. On balance, the interests of the health and safety of Petitioners would outweigh the public interest in the assurance of the completion of civil proceedings, particularly where ICE would be able to impose conditions of release using “a range of highly effective tools” designed to result in Petitioners’ appearances at their hearings. *See* Lorenzen-Strait Decl. ¶ 15, Mot. TRO Ex. 3, ECF No. 2-5. Thus, upon a finding of a likelihood of success on the merits, this prong would favor issuance of the requested injunction.

CONCLUSION

For the foregoing reasons, the Motion for a Temporary Restraining Order will be DENIED WITHOUT PREJUDICE. Petitioners may renew the Motion, without leave of the Court, in the event of (1) evidence that a detainee or staff member at HCDC or WCDC has COVID-19; (2) the failure of Respondents to file a Testing Certification by **Wednesday, April 8, 2020** that HCDC and WCDC have COVID-19 tests and will administer a test to any individual at HCDC or WCDC with suspected COVID-19 symptoms; (3) the postponement of a Petitioner’s currently scheduled immigration hearing; or (4) other materially changed circumstances. Any renewed Motion will be handled on an extremely expedited basis and may be decided without a hearing. Respondents will be ORDERED to (1) immediately inform the Court and Petitioners of any evidence that a detainee or staff member at HCDC or WCDC has COVID-19; and (2) immediately provide to the Court and Petitioners, upon execution, the above-described Testing Certifications as to both HCDC and WCDC. A separate Order shall issue.

Date: April 3, 2020

/s/ Theodore D. Chuang
THEODORE D. CHUANG
United States District Judge

EXHIBIT Q

Email from Robert L. Green,
Secretary of the Maryland Department
of Public Safety & Correctional Services,
to Hon. Phil Caroom,
Executive Committee Member,
Maryland Alliance for Justice Reform
(Mar. 28, 2020, 2:29 PM)

From: Sonia Kumar [REDACTED]
Subject: Fwd: DPSCS response as to MAJR suggestion for coronavirus protection of DPSCS inmates
Date: March 29, 2020 at 5:25 PM
To: Gina Elleby [REDACTED]

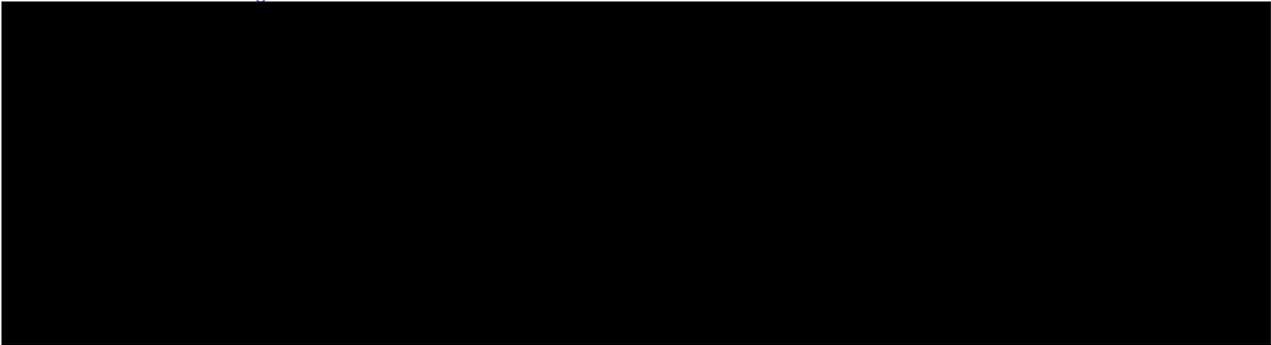


FYI, am going to save updates in one place or something and then circulate to various ppl

Begin forwarded message:

From: Earl young [REDACTED]
Date: March 28, 2020 at 9:22:12 PM EDT
To: Sonia Kumar [REDACTED]
Subject: Fwd: DPSCS response as to MAJR suggestion for coronavirus protection of DPSCS inmates

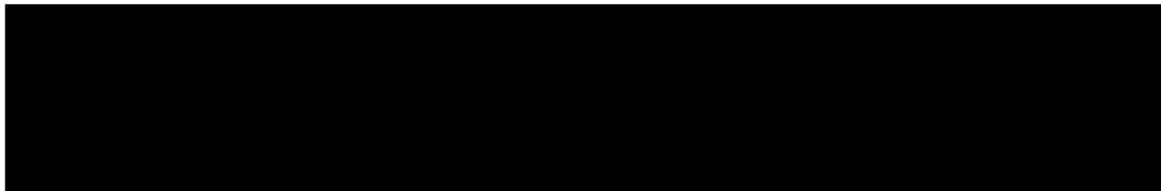
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To all in the struggle - can we support a "HOT LINE", from each facility to support the efforts of Mr. Green and ease the family anxiety! The Family can play an important part in this crisis! Peace

The Struggle Continues!

Begin forwarded message:



Subject: Fwd: DPSCS response as to MAJR suggestion for coronavirus protection of DPSCS inmates

All-
FYI, here is the first response from DPSCS Sec. Rob Green to our series of emails asking for state prison coronavirus plans & releases.

Suggestions for our response?
-Phil

----- Forwarded message -----

From: Robert L. Green -DPSCS- <robertl.green@maryland.gov>
Date: Sat, Mar 28, 2020, 2:29 PM
Subject: Re: Support from Md. Alliance for Justice Reform for coronavirus protection of DPSCS inmates
To: P Caroom <pcaroom@gmail.com>
Cc: Donald Hogan -GOCCP- <donald.hogan@maryland.gov>, Cara Sullivan -GOCCP- <cara.sullivan@maryland.gov>, Sheri D. Smith -DPSCS- <sheri.smith@maryland.gov>, stuart simms <sos@browngold.com>

The facts as presented are not accurate in regards to our systems and operating protocols at this time.

Currently, there are no confirmed cases of COVID-19 in the inmate population. The Department began implementing pro

Currently, there are no confirmed cases of COVID-19 in the inmate population. The Department began implementing pre-pandemic planning weeks ago to include education of staff and review of pandemic plans and review of essential personnel. The Department submitted continuity of operation plans to Maryland Emergency Management Agency (MEMA) and has maintained constant communication with the Department of Health and MEMA. The Department's correctional facilities have run tabletop exercises, drills, and have been continuously reviewing incident command protocols. The Department is monitoring the situation extremely closely and has in place COVID-19 specific operative procedures.

The Department has also made significant modifications to the operations of its correctional facilities, to include: (1) increasing access to hygiene products and frequency of facility sanitation; (2) suspending visitation and volunteer-led programs while leveraging technology to ensure inmates remain connected to loved ones; (3) screening the wellness of staff prior to facility entrance; (4) waiving inmate medical co-pays; and, (5) utilizing social distancing where possible.

(1) Increasing access to hygiene products and frequency of facility sanitation

The Department routinely ensures every incarcerated offender has a sufficient supply of soap, but the Department has ordered a significant shipment to have additional product available. The Department has also significantly increased its sanitation protocol using highly-effective germicidal cleaning agents.

(2) Suspending visitation and volunteer-led programs while leveraging technology to ensure inmates remain connected to loved ones

The Department quickly mitigated the opportunity for introduction of COVID-19 into the prison system by suspending inmate visitation and volunteer-led programs. The Department is also in the process of deploying video visitation with the goal of having a pilot online by March 27, 2020.

(3) Screening the wellness of staff prior to facility entrance;

The Department is using a standardized screening form and checking the temperatures of staff entering its facilities. Any staff member who registers as having a heightened temperature is sent home. Staff who are experiencing illness or other influenza-like symptoms are encouraged to stay home.

(4) Waiving inmate medical co-pays

The Department utilizes a multi-disciplined vendor approach to healthcare delivery within its correctional facilities. To encourage inmates to promptly report any symptoms to a medical treatment provider, the Department has waived its \$2 medical copay.

(5) Utilizing social distancing where possible

The Department has extended the length of recreation for the inmate population and has limited inmate groups to ten where possible. Additionally, the Department has modified meal delivery and instituted a "Grab and Go" dining service to prevent congregation in large groups.

The Department will continue working closely with the Maryland Emergency Management Association, MDH, staff, and external stakeholders to ensure the continued health and well-being of its staff and incarcerated population.

Robert Green



Robert L. Green

Secretary

Department of Public Safety and Correctional Services

300 E. Joppa Road, Suite 1000

Towson, Maryland 21286

Robertl.green@maryland.gov

(410)-339-5032 (O)

On Mar 28, 2020, at 2:12 PM, P Caroom <pcaroom@gmail.com> wrote:

Dear Governor and Sec. Green-

Here is an email from the wife of a state prison inmate (emphasis added):

"[As an inmate's] wife, I am hearing first hand what is actually going on in the prisons especially MCIH. As of now, when a Guard or Supervisor enters the prison, they are given a questionnaire. They are told to answer yes to every question as if they answer no they will

be put on sick call for one week. They are short staffed so they cannot afford not to have them working. They just started taking temperatures but don't stand close enough to the person entering to get an accurate reading.

"Since [one prison] has the only medical equipment for exrays, guys from other prisons are still coming into the institution. There are no ventilators or healthcare people who are equipped to handle this situation. They have designated an area at [the husband's prison] to group any prisoner who may have this virus but they are not equipped to handle this. This information is coming from guards who are scared to be working. This what the public does not see.

"The situation is very serious not just for [my husband] but for everyone serving time in prison. They are a ticking time bomb. I hope that the Governor acts accordingly and lets the elderly and those that have chronic conditions go."

-Phil Caroom
[MAJR exec.com](http://www.majr.com).

On Fri, Mar 20, 2020 at 9:38 AM P Caroom <pcaroom@gmail.com> wrote:

Dear Governor Hogan and Secretary Green:

Attached is a letter from former Md. DPSCS secretary Stuart Simms, as a Md. Alliance for Justice Reform ([MAJR-www.ma4jr.org](http://www.ma4jr.org)) spokesperson, urging active preparations to protect Marylanders in state prisons.

Thanks in advance for its consideration and for your actions to keep all Marylanders as safe as possible from the coronavirus pandemic.

-Phil Caroom
[MAJR exec.com](http://www.majr.com). chair

EXHIBIT R

Declaration of Christopher Duffner

Declaration of Christopher Duffner, Esq.

I, Christopher Duffner, hereby declare, based on personal knowledge, and under penalty of perjury, as follows:

1. My name is Christopher Duffner and I am an Assistant Public Defender in Montgomery County, Maryland. I have been a member of the Maryland Criminal Defense Attorneys' Association since 2018.
2. I filed an emergency motion for release for a client serving a six-month sentence at the Montgomery County Correctional Facility for Driving While Impaired by Alcohol. The sentence began on March 10, 2020, one day before the novel coronavirus was declared a global pandemic by the World Health Organization, and three days before Chief Judge Barbera closed the courts to all but emergency matters.
3. My client is a 40-year-old man with high blood pressure who, according to the epidemiological data from Wuhan, China, faces a six-times-higher than average risk of mortality if he contracts COVID-19. I requested under Md. R. 4-345(e) a modification to suspend the remaining portion of the sentence, or in the alternative, a stay of the sentence under R. 4-348(c) until the pandemic subsides. I highlighted reporting from the *Baltimore Sun* and the *Washington Post* that the coronavirus had entered jails and prisons in our surrounding counties and jurisdictions in Maryland, Washington, D.C., and Virginia.
4. The State opposed my motion and in its response noted, "The defendant has not presented any evidence of a COVID-19 diagnosis." During the hearing, the State argued that the data I cited from the American Heart Association was biased because the AHA is a special interest lobbying organization. They said that high blood pressure is only a risk factor for the elderly.
5. I argued my client was not a public safety risk. Although he had prior convictions for DWI, he had been on release in this case, sober and attending AA with a sponsor, for 13 months between the driving incident and sentencing, without any subsequent offense. Moreover, the State did not even ask for his bond to be revoked after he was convicted at trial. Further, the sentencing judge recommended immediate transfer to our work release program where he had been pre-screened to maintain his existing employment at a car dealership, suggesting he was not viewed as such a public safety risk that he must be separated from society.
6. The acting administrative judge at the hearing denied my motion for the stated reasons that 1) no alcohol education or treatment programs would be accepting participants during this time; and 2) so long as my client's high blood pressure was presumably being treated in the jail, he would not be at higher risk. The judge further noted that COVID-19 has not yet been reported in the Montgomery County jail. His projected release date is now July 11, 2020.

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

Dated: 4/5/20


Christopher Duffner

EXHIBIT S

Declaration of Justin Eisele

DECLARATION OF JUSTIN EISELE

On this April 5, 2020, I, Justin Eisele, of Seddiq Law Firm, do hereby declare on personal information and under the penalty of perjury, as follows:

1. I am a partner at Seddiq Law Firm (“Firm”), which represents primarily criminal defense and immigration clients. I am a member of the Maryland Criminal Defense Attorneys' Association (MCDAA.)

2. Our firm currently represents retained and appointed clients throughout Maryland state and federal criminal courts.

3. We have clients who are incarcerated at the following locations: Western Correctional Institution (Cumberland), Maryland Correctional Training Center (Hagerstown), Montgomery County Detention Center (Rockville), Roxbury Correctional Institution (Hagerstown), Eastern Correctional Institution East (Westover), Charles County Detention Center (La Plata), Montgomery County Correctional Facility (Boyd), and the Prince George’s County Detention Center (Upper Marlboro).

4. I submit this declaration in support of Petitioners.

Educational Background and Professional Experience of Justin Eisele.

5. I have been a practicing criminal defense attorney for 12 years. I began my practice in Arkansas and previously served as the President for the Arkansas Association of Criminal Defense Attorneys.

6. Throughout my practice I have dedicated at least a portion of my practice to indigent defense. I previously handled panel state appointed work in Arkansas, served as a federal public defender in Little Rock for four years, and now I continue to handle indigent cases in both federal and state court in Maryland.

7. I represent people across middle and southern Maryland. I am routinely at local jails and state prisons to visit with clients.

Knowledge About Current Conditions Related to COVID-19.

8. Over the past few weeks I have been filing for emergency detention hearings due to the immediate danger that COVID-19 presents.

9. For example, I have three clients in the Washington, D.C. jail. In a period of just one week, their confirmed cases went from one to 14, a 1,400 percent increase.

10. Detainees at the DC jail, through attorneys at the ACLU and Public Defender Services, have sued the DC jail for their failure to take action, consistent with federal CDC guidelines, that would protect the people living and working in the jail. Notably, the fraternal order of police that represents the staff at the jail have joined in the lawsuit supporting the plaintiffs as a “friend of the court.”

11. The declarations of the staff at the jail are completely consistent with what my three clients there have told me over the phone, about the challenges facing those confronting the coronavirus in the jail.

12. Social distancing is not enforced, the prisoners have no personal protective equipment (PPE), and the jail has refused to properly quarantine

detainees once cases are discovered. There has been a complete disregard for the long incubation period without symptoms that occurs with this infection. These failures have led to the dramatic rise in infections and, from talking to my Maryland clients, these failures are also occurring in the state prison and local jails in Maryland.

13. Through my work, I have heard reports from several clients about the lack of preparedness in Maryland prisons and jails to prevent against spread of the coronavirus inside. Among these client reports are the following:

A. Omar Barnes

Mr. Barnes was, up until Friday, was a prisoner at the Montgomery County Detention Center. On Friday April 3, 2020, he was moved to the Montgomery County Correctional Facility in Boyds, Maryland. He is not sure why this transfer occurred. Mr. Barnes has informed me that neither MCDC staff nor detainees are using social distancing. None of the MCDC detainees have been given PPE. This is despite the fact that Mr. Barnes, while at the Montgomery County Detention Center, was working in the kitchen. Mr. Barnes, trying to be proactive, asked one of the guards (McCauley) for a mask and he was given a mask. After that he was told by another staff member that it looks suspicious that he had one. He eventually was confronted by a Sgt. Sandler about where he had gotten the mask, and he told Sandler McCauley gave it to him. Mr. Barnes is not sure if he was moved to Clarksburg as a retaliatory measure for speaking up about the unsafe contentions at the detention center.

Now at the Clarksburg campus, things are slightly better. They have gloves available now but no masks. Mr. Barnes said it is much more chaotic at the detention center in Rockville and they do not appear to have a plan to follow CDC guidelines.

B. Donald Snyder.

Mr. Snyder is a prisoner at the Maryland Correctional Training Center, who has an exemplary record while incarcerated. He says the prison is over-crowded, and that he does not have free and readily available soap or cleaning supplies. Mr. Snyder is now in Building 2, D Tier of 18800 Roxbury. Some of the cells in his tier are singles, some are doubles. Mr. Snyder in a double which measures approximately 12'X6'. It contains a double bunk and plastic chair. No toilet or sink. None of the cells on his current tier have toilets or sinks, meaning those facilities are communal. There are approximately 66 cells on the tier. Social distancing is not happening. Phones and surfaces are not disinfected between uses. Mr. Snyder and other detainees are sent to meals one tier at a time now instead of all at one time, but the entire tier, which consists of more than 80 prisoners, goes at once. They pick up a tray and bring it back to eat. MCTC has limited recreation hall access to ten prisoners at a time.

Mr. Snyder has heard that there was a woman who worked in the package delivery room who she tested positive for COVID-19. Some correctional officers are now wearing masks, but not all.

C. Donche Barnes.

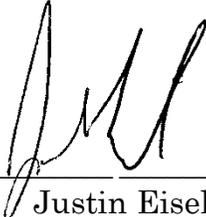
Like Mr. Snyder, Mr. Barnes is also a resident at MCTC. He has articulated the same concerns as Mr. Snyder. There is no personal protective equipment for prisoners. They have to attempt and use makeshift clothing to cover faces. Prisoners have no access to hand sanitizer. They get one bar of soap every week or so, but it is not readily available. Mr. Barnes was on the same tier with the prisoner in package delivery working with the woman who tested positive. That man, for weeks before being quarantined, had been socializing with people around the tier. A lot of the prisoners make bootleg candy and this man was known to do that and distribute it up and until he was quarantined.

D. John Vigna.

Mr. Vigna is an prisoner at the Western Correctional Institution. He says there is no liquid soap or hand sanitizer available, although they do have bars of soap. Mr. Vigna reports that no social distancing at all is occurring at WCI. Mr. Vigna said a night nurse went home sick a few nights ago, which makes people suspect she is infected with COVID-19. Mr. Vigna believes WCI officials may be working to set up an outside area for quarantining, but has not been told where that is or how it will be done.

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

Dated: April 5, 2020


Justin Eisele