IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.*, *

Plaintiffs, *

v. * Civil Action No. ELH-94-2541

LAWRENCE HOGAN, *et al.*, *

Defendants. *

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EMERGENCY MOTION
FOR RELIEF FROM RISK OF INJURY AND DEATH FROM COVID-19

EXPEDITED CONSIDERATION REQUESTED

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Plaintiffs move, on an emergency basis, for an order directing Defendants immediately to take action necessary to protect them from injury and death in light of the COVID-19 pandemic.

A proposed order and supporting memorandum are filed herewith.

Respectfully submitted this 9th day of April, 2020.

/s/
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MEMORANDUM IN SUPPORT OF EMERGENCY MOTION FOR RELIEF FROM RISK OF INJURY AND DEATH FROM COVID-19

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INTRODUCTION

Today's global pandemic of COVID-19, caused by the novel coronavirus, has been characterized as the worst the world has seen since 1918. Several states and countries around the world—including the State of Maryland—have put in place significant restrictions on public gatherings, and many have imposed "shelter-in-place" orders in an attempt to control the spread of the disease. Public health experts, including the Centers for Disease Control and Prevention ("CDC"), have instructed that the *only* effective way to reduce the risk of severe illness or death for vulnerable individuals is social distancing and improved hygiene. Such distancing and hygiene measures are impossible to achieve in crowded detention centers. For this reason, Maryland Attorney General Brian E. Frosh has appealed to Governor Hogan to "act before it's too late to prevent a catastrophic outbreak of COVID-19 in our prisons and jails. Incarcerated populations are densely packed and likely hotbeds for the spread of COVID19." Declaration of David C. Fathi ("Fathi Decl.") Ex. A at 1.

In this class action, the Court in 2016 approved a Settlement Agreement designed to provide persons detained at the Baltimore City Detention Center ("BCDC" or "the Jail") with minimally adequate medical and mental health care, as well as environmental health and safety. Unfortunately, four years later Defendants are far from compliance; indeed, the Court has extended the duration of the medical and mental health provisions until 2022, from their original expiration date of July 2020, in recognition of this fact.

Defendants' failure – documented by the independent medical monitor, Dr. Puisis – to take effective steps to control the inevitable COVID-19 outbreak at the Jail extinguishes any hope that they will be able to comply with the Settlement Agreement. Accordingly, Plaintiffs seek, on an emergency basis, an order that Defendants implement the recommendations of Dr. Puisis and other correctional and public health experts to mitigate the risk of injury and death from this deadly and highly contagious disease.

FACTUAL BACKGROUND

I. The COVID-19 Pandemic Presents Unprecedented Risks to Public Health, and Requires an Unprecedented Response.

The COVID-19 pandemic presents a public health crisis unlike any other seen in our lifetimes. As of April 8, over 395,000 people in the United States have been diagnosed with COVID-19; more than 12,700 have died.[1] No one is immune. In Maryland, as of April 5, there have been 3,609 cases reported statewide, with 936 hospitalizations and 67 deaths. These numbers have soared exponentially since the first three confirmed cases in Maryland on March 3, 2020, and the number of cases is doubling approximately every four days. Declaration of Chris Beyrer, M.D., M.P.H. ("Beyrer Decl."), ¶ 4.

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[1] Centers for Disease Control and Prevention, *Cases in U.S.*, Coronavirus Disease 2019 (COVID-19), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last visited April 9, 2020).

A. COVID-19 is a highly contagious and deadly disease.

As explained in the Declaration of Chris Beyrer, M.D., M.P.H., COVID-19 is a serious disease.[2] This new virus is genetically closely related to the SARS coronavirus that caused an epidemic in 2002-2003. *Id.*, ¶ 8. This new variant of the coronavirus is particularly dangerous; it is associated with a fatality rate that is five to 35 times higher than the rate of death from influenza. About 20 percent of cases of COVID-19 require medical intervention. *Id.*, ¶ 11. Demographic factors among the exposed population affect the rate of fatalities: men have a higher rate of death than women, and the rate of severe disease increases among persons over 50. Fatalities rise to more than five percent of cases for persons with pre-existing medical conditions such as cardiovascular disease, diabetes, and immune compromise. *Id.*, ¶ 13. About 30 percent of patients with more serious disease will progress to Acute Respiratory Distress Syndrome ("ARDS"), which has a mortality rate of 30 percent. *Id.*, ¶ 14.

New information indicates that these effects fall particularly hard on African-Americans. Due to disparate access to health care, resulting in higher incidence of relevant pre-existing medical conditions, as well as disparate health outcomes, Black people are contracting the disease and dying from it at alarmingly higher rates than the population as a whole.[3] These disparities can

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[2] Dr. Beyrer, Professor of Epidemiology, International Health, and Medicine at Johns Hopkins Bloomberg School of Public Health, regularly teaches courses on the epidemiology of infectious diseases. This semester he is teaching a course on emerging infections. He is 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. Beyrer Decl., ¶ 1.

[3] *See, e.g.*, Spencer Overton, *The CDC Must End Its Silence on the Racial Impact of Covid-19*, Washington Post, April 7, 2020, available at https://www.washingtonpost.com/opinions/the-cdc-must-end-its-silence-on-the-racial-impact-of-covid-19/2020/04/07/6d686450-7906-11ea-9bee-c5bf9d2e3288_story.html; Akilah Johnson and Talia Buford, *Early Data Shows African Americans Have Contracted and Died of Coronavirus at an Alarming Rate*, ProPublica, April 3, 2020, available at https://www.propublica.org/article/early-data-shows-african-americans-have-contracted-and-died-of-coronavirus-at-an-alarming-rate.

only be magnified in BCDC where the widely acknowledged disparate impact of the criminal justice system results in disproportionate detention of people of color.[4]

As of April 5, there had been over 1,250,000 cases of COVID-19 worldwide, with more than 68,000 deaths. *Id.* ¶ 18. The virus is fully adapted to human-to-human spread. *Id.* ¶ 19. Because it is a new virus, there is no pre-existing immunity to its spread. The current CDC estimate is that each active case of viral infection will, on average, spread the disease to between 2.4 and 3.8 new victims. *Id.* ¶20. The attack rate given an exposure to the virus is high, estimated as 20 to 30 percent generally, but as high as 80 percent in certain settings, with an incubation period estimated at about fourteen days. *Id.* ¶ 21.

The public health response to COVID-19 has been far-reaching, necessarily touching every aspect of daily life. On March 30, Governor Hogan ordered all Maryland residents to shelter-in-place, in an attempt to flatten the epidemiological curve.[5] Previously, Governor Hogan ordered closed all restaurants, bars, fitness centers, and other areas where people congregate, and prohibited gatherings of 10 or more people.[6] These orders follow the advice of public health experts and recognize that "best practices support limitations on large gatherings and social

[4] Regrettably, neither Maryland nor Baltimore has yet begun to report data on the impact of the pandemic by race, and when they do, the data is likely to be incomplete. *See* Pamela Wood, Luke Broadwater, and Talia Richman, *Maryland Will Start Reporting Info About Race of Coronavirus Patients, Governor Says*, Baltimore Sun, April 7, 2020, available at https://www.baltimoresun.com/coronavirus/bs-md-hogan-tuesday-20200407-jmvtijbmmrb5fmctde4poqta4i-story.html?fbclid=IwAR0CAWZbQBgXkmw2I7A8KTOsa-ZU2sDZRuU5ITIVBJtU20owfmgN9zv0SSU.

[5] Order of the Governor of the State of Maryland, No. 20-03-30-01 (Mar. 30, 2020), https://governor.maryland.gov/wp-content/uploads/2020/03/Gatherings-FOURTH-AMENDED-3.30.20.pdf

[6] Order of the Governor of the State of Maryland, No. 20-03-19-01 (Mar. 19, 2020), https://governor.maryland.gov/wp-content/uploads/2020/03/Amending-Gatherings.pdf

distancing to prevent exposures and transmissions, and reduce the threat to especially vulnerable populations . . . ."[7]

B. Incarcerated people are at particularly high risk of illness and death from COVID-19.

The COVID-19 pandemic poses a particular risk to incarcerated people. The World Health Organization (WHO) has recognized that incarcerated people "are likely to be more vulnerable to the coronavirus disease (COVID-19) outbreak than the general population because of the confined conditions in which they live together for prolonged periods of time." Fathi Decl. Ex. B at 1 (WHO Preparedness, prevention and control of COVID-19 in prisons and other places of detention, Interim guidance ("WHO Guidance")). The Centers for Disease Control and Prevention (CDC) similarly note that because incarcerated people "live, work, eat, study, and recreate within congregate environments," the potential for COVID-19 to spread once introduced to the facility is "heighten[ed]." Fathi Decl. Ex. C at 2 (CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("CDC Guidance")). Further, according to the CDC, incarcerated people "have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages." Fathi Decl. Ex. C at 16.

Dr. Beyrer explains that detention facilities, including jails and prisons, have long been associated with high rates of transmission of communicable diseases that spread through droplets, including tuberculosis, multi-drug-resistant tuberculosis, methicillin-resistant staphylococcus aureus ("MRSA"), and viral hepatitis. Beyrer Decl., ¶ 24. Unfortunately, COVID-19, like common influenza, is particularly difficult to control within correctional facilities, particularly because correctional facilities rarely allow for the maintenance of the six-foot separation between

[7] *Id.* at 1.

persons needed to allow social distancing. *Id.* ¶ 25.

Multiple other features common to prisons and jails heighten these risks, such as overcrowding, population density, insufficient ventilation, shared toilet and shower facilities, and limits on the opportunity to maintain personal hygiene. Persons involuntarily held in such facilities have typically been denied access to sanitizer because such products contain alcohol. Moreover, these facilities frequently have high rates of population turnover, which increases the risk that, if a person infected with COVID-19 is not identified during the intake process, the disease may spread silently within the population, with multiple new infections resulting. *Id*. ¶¶ 26-27.

For these reasons, Dr. Beyrer concludes that "additional outbreaks of COVID-19 are extremely likely," so that "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." *Id*. ¶ 34.

More than 200 public health experts, doctors, and nurses from the Johns Hopkins Bloomberg School of Public Health, School of Nursing, and School of Medicine recently wrote to Governor Hogan expressing their "urgent concern about the spread of COVID-19 in Maryland's prisons, jails, and juvenile detention centers." Fathi Decl. Ex. D at 1 (Letter from Johns Hopkins Faculty to Gov. Hogan ("Hopkins Faculty Letter")). The Hopkins Faculty highlighted that "[j]ails, prisons, detention facilities and other closed settings have long been known to be associated with high transmission probabilities for infectious diseases," and emphasized that the nature of these facilities "heighten[s] risks for exposure, acquisition, transmission, and clinical complications of COVID-19 and other infectious diseases." Fathi Decl. Ex. D at 1. And the risk is not limited to incarcerated people. Staff "may bring the virus into the facility and are also at risk of acquisition from infected incarcerated individuals. Once infected, staff may also transmit the virus back into

the communities and to their families." Fathi Decl. Ex. D at 2. *See United States v. Davis*, No. ELH-20-09, 2020 WL 1529158, at *4 (D. Md. Mar. 30, 2020) (citing the Hopkins Faculty Letter with approval).

As of April 5, 2020, there are 17 confirmed cases of COVID-19 among staff and incarcerated people in the Maryland Department of Public Safety and Correctional Services. Beyrer Decl., ¶ 6. Judges of this Court have already recognized the uniquely lethal risk that COVID-19 poses to incarcerated people. *See, e.g.*, *United States v. Martin*, Crim. No. CR PWG-19-140-13, 2020 WL 1274857, at *2 (D. Md. Mar. 17, 2020) ("While correctional officials at CDF and other facilities in Maryland may successfully have dealt with past viruses and outbreaks of communicable diseases, they pale in scope with the magnitude and speed of transmission of COVID-19"); *United States v. Davis*, *supra*, at *5 ("Experts agree that pretrial detention facilities are poorly equipped to manage a crisis resulting from this potentially deadly, highly contagious novel coronavirus within their walls"); *Coreas v. Bounds*, No. CV TDC-20-0780, 2020 WL 1663133, at *2 (D. Md. Apr. 3, 2020) ("Prisons, jails, and detention centers are especially vulnerable to outbreaks of COVID-19").

To mitigate these risks, the CDC Guidance instructs correctional facilities to implement "social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms)." Fathi Decl. Ex. C at 11. Indeed, social distancing "is a cornerstone of reducing transmission of respiratory diseases such as COVID-19" in jail environments. Fathi Decl. Ex. C at 4.

In addition to reconfiguring to allow for six feet between all individuals, the CDC Guidelines instruct correctional facilities to prepare for managing patients who screen or test positive for COVID-19. *See* Fathi Decl. Ex. C at 11, 14-15, 19. Facilities must designate sufficient

space to allow for multiple, separate quarantine areas. In particular, correctional facilities must have (1) sufficient individual medical isolation space for individuals with confirmed or suspected COVID-19, ideally assigning each individual to his or her own housing space and bathroom; (2) sufficient quarantine space for people who had close contact with a confirmed or suspected COVID-19 case, ideally in individual cells; [8] and (3) sufficient quarantine space for all new intakes to be held for 14 days before integration into the general population. *See* Fathi Decl. Ex. C at 14-15, 19.

Finally, the CDC Guidelines instruct facilities to ensure sufficient stocks of hygiene supplies, including free soap for all incarcerated people, cleaning supplies, personal protective equipment and medical supplies. Fathi Decl. Ex. C at 7-8. Frequently touched surfaces should be cleaned and disinfected several times per day using EPA-registered disinfectants at full strength. *Id.* at 9. And areas where people with confirmed or suspected cases of COVID-19 spent time should be closed off for up to 24 hours before being cleaned and disinfected. *Id.* at 17.

The Hopkins Faculty Letter makes the following recommendations:

> 1. Require correctional facility administrators to make their plans for prevention and management of COVID-19 in their institutions publicly available[.] …
>
> 2. Ensure that intake screening protocols are updated to include COVID-specific questions.
>
> 3. Ensure the availability of sufficient soap and hand sanitizer for incarcerated individuals without charge; restrictions on alcohol (in hand sanitizers) should be suspended.
>
> 4. Implement other precautions to limit transmission within prisons and jails without relying on widespread use of lockdowns and solitary confinement.

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[8] "Close contact" is defined as having been within six feet of someone with COVID-19 for a prolonged period of time, or had direct contact with an infected individual. This can occur while "caring for, living with visiting, or sharing a common space with a COVID-19 case." Fathi Decl. Ex. C at 3.

5. Consider pre-trial detention only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, or parole or probation violations, should be prioritized for release. No one in these categories should be sent to jail.

6. Expedite consideration of all older incarcerated individuals and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) for parole or other form of release from prison, with alternative forms of supervision and with supports in the community once released. Clemency power and expanded authority in Maryland law for administrative parole should be employed.

7. Invest in increased resources for discharge planning and re-entry transitions to facilitate prison release of people under these revised policies.

8. Arrange for COVID-19 testing of incarcerated individuals and correctional facility workers who become ill.

9. Cease any collection of fees or co-pays or medical care.[9]

10. Seek a Medicaid 1135 waiver to enable hospitals to provide an appropriate level of care to incarcerated individuals who are sick.

Fathi Decl. Ex. D at 2-3.

II. Defendants have failed to take reasonable steps to protect Plaintiffs from illness and death from COVID-19.

Unfortunately, Defendants in this case have failed to take effective steps to protect the health and safety of the hundreds of persons currently detained in BCDC in light of the COVID-19 pandemic. Because this failure both is inconsistent with the Settlement Agreement and poses a potentially lethal risk, Plaintiffs file this emergency motion seeking immediate corrective action.

Relying in large part upon the assessments of the independent monitor, Dr. Michael Puisis, Plaintiffs have identified the following critical deficiencies in Defendants' COVID-19 response:

[9] BCDC has previously abandoned such co-pays.

Failure to test for COVID-19. According to Defendants, *no* detainees at BCDC have been tested for exposure to the virus. Defendants have asserted that they are unable to procure tests for detainees at the facility. The basis of this claim is unclear, since MDPSCS has announced that multiple incarcerated people and staff have tested positive. Beyrer Decl., ¶ 6. As a result of Defendants' failure to test, "inmates suspicious for COVID-19 are placed in housing with persons who may not have the disease." Puisis Decl. at 3.

Unsafe intake procedures. "Intake is still operating otherwise as routine which places staff and inmates in close proximity to one another and is contrary to recommendations to keep 6 feet apart." *Id.* at 3.

Unsafe housing of persons suspected of having COVID-19. According to Dr. Puisis, "Inmates suspicious for COVID-19 based on fever or symptoms in intake are housed in cells located on a hall next to the commissioner's evaluation room. This potentially exposes staff and inmates who pass by this cell or who are in contact with surfaces surrounding these cells. This is not a good isolation location." Puisis Decl. at 2-3. Similarly, "the isolation unit for females is on a unit which houses other non-infected persons which places non-infected individuals at risk of infection." *Id.* at 3.

Failure to monitor vulnerable persons who are at elevated risk from COVID-19. As explained above, persons over the age of 50, and those with pre-existing medical conditions, are at increased risk of serious illness and death if they contract the virus that causes COVID-19. Defendants assert that detainees above 55 or with any immune-compromised condition or serious medical condition receive symptom screening every shift. However, this assertion is undermined by the fact that, in Defendants' most recent 6 month *Duvall* submission, audit results showed that vital signs were only completed 8% of the time. Puisis Decl. at 2.

Impossibility of complying with CDC recommendations for social distancing. "The jail has approximately 150 [people] living in dormitories with high risk of transmission of COVID-19. Also other inmates, even though in cells, still would have difficulty in maintaining recommended procedures to not congregate in groupings and to always maintain a 6 foot distance." *Id.* at 3. In certain housing units, recommended social distancing is simply impossible. "All south tower housing units on South 3, 4, and 5 are dormitories with about 40 beds on each dorm. The beds on these dorms are double bunked and each double bunk is about 3 feet apart. These housing unit makes it impossible for these inmates to maintain distancing as currently recommended by the CDC and public health authorities." *Id.* at 2.

Inadequate sanitation. Although enhanced sanitation is critical in slowing the spread of the virus that causes COVID-19, it is unclear whether this is occurring at BCDC. While the jail's current plan is to sanitize surfaces twice a shift, implementation of this plan has not been confirmed. *See* Puisis Decl. at 2 ("Hopefully, that is being done"). Moreover, "It isn't clear if soap is readily and freely available to inmates with frequently sanitized towels," *id.*, and "Equipment and supplies could be improved." *Id.*

Failure to reduce the detained population. Because the first-line public health responses to COVID-19 – enhanced sanitation and social distancing – are effectively impossible in detention

facilities, experts unanimously recommend immediately and substantially reducing the population of detention facilities in order to slow the spread of the virus. The Hopkins Faculty Letter concludes that "It is … an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible." Fathi Decl. Ex. D at 2. Dr. Puisis similarly states, "I strongly recommend depopulation of the jail to the extent it is safe to release inmates. The jail can't be made safe with respect to current public health recommendations regarding social distancing and sanitation." Puisis Decl. at 1.

ARGUMENT

I. This Court should order Defendants to take action to address COVID-19 in order to ensure compliance with the Settlement Agreement.

This Court has plenary power to enforce the Settlement Agreement. "Federal courts are not reduced to approving consent decrees and hoping for compliance. Once entered, a consent decree may be enforced." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 440 (2004); *accord*, *Thompson v. U.S. Dep't Of Hous. & Urban Dev.*, 404 F.3d 821, 833 (4th Cir. 2005) ("[E]ven if the district court had declined to modify the retention-of-jurisdiction clause, the court's inherent authority over its own judgment would have provided it with the continuing authority to enforce the Consent Decree against HUD"). Moreover, "[t]he Court need not wait until a death to require compliance with its orders." *Armstrong v. Brown*, 939 F. Supp. 2d 1012, 1022 (N.D. Cal. 2013); *see also Brown v. Plata*, 563 U.S. 493, 531-32 (2011) ("[A]ll prisoners in California are at risk so long as the State continues to provide inadequate care… in no sense are they remote bystanders in California's medical care system. They are that system's next potential victims").

COVID-19 has the potential to cause significant and life-threatening barriers to medical and mental health care and to Defendants' ability to comply with the Settlement Agreement. In light of the exponential spread of the virus in other jails (*see* Beyrer Decl., ¶ 28), it is entirely foreseeable that demand for medical care will explode. Should staff be exposed either in the Jail or in the community and show symptoms, they must be quarantined and/or treated, further reducing available staff to provide medical care or to facilitate such care by, for example, providing

security and transportation services. And Defendants' ability to rely on agency and as-needed medical staff may decrease as community demand for those services increases. For the same reason, the availability of community healthcare services, including for hospitalization and specialty appointments, may be substantially curtailed. When COVID-19 arrives in the Jail, demands on healthcare services generally—including medical and custody staff—will only increase as more patients require screening, isolation, testing, and clinical management.

Compliance with the Settlement Agreement's requirements that essential medical and mental health services be provided in a specified timeframe is particularly likely to become impossible, as the number of sick detainees explodes and significant numbers of both custody and health care staff are sidelined by illness. *See, e.g.,* Provision 18(b) (when any detainee admitted to the jail for screening has an urgent medical need, that person shall receive a physical assessment by a clinician within 24 hours of the intake screening, or sooner if clinically indicated).[10]

II. This Court should order Defendants to take action to address COVID-19 because their failure to do so violates the Constitution.

Although the Court is not required to find a Constitutional violation in order to enforce the Settlement Agreement (*see Frew, supra*), Defendants' failure to address the looming COVID-19 crisis violates Plaintiffs' constitutional rights.

Plaintiffs, as pretrial detainees, are protected by the Due Process Clause of the Fourteenth Amendment against conditions that constitute punishment. The Fourth Circuit has held that for due process claims by pretrial detainees of inadequate medical treatment, the Eighth Amendment

[10] *See also* provision 18(c) (initial diagnosis of ongoing conditions for the plan of care that do not require development at chronic care clinics or through specialist referral must be entered into record within 7 days); 19(e)(i) (clinician review of critical/seriously abnormal lab values must occur within 24 hours); 23(b) (setting time limits for review of requests for specialty care); 23(c) (sick call requests that include clinical symptoms must result in face to face encounter with a clinician within 48 hours (72 hours on weekends)).

deliberate indifference standard applies. *See, e.g.*, *Hill v. Nicodemus*, 979 F.2d 987, 991 (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.").[11]

In order to show that defendants violated the Eighth Amendment, a plaintiff must show that (1) the plaintiff was exposed to a substantial risk of serious harm, and (2) the defendants knew of or disregarded that substantial risk to the plaintiff's health or safety. *Farmer v. Brennan*, 511 U.S. 825, 834, 837–38 (1994); *Thompson v. Virginia*, 878 F.3d 89, 97-98 (4th Cir. 2017).

The Eighth Amendment is violated by conditions that pose an unreasonable *risk* of future harm, even if that harm has not yet come to pass.

> That the Eighth Amendment protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is "reasonable safety." DeShaney, *supra*, 489 U.S., at 200, 109 S.Ct., at 1005. … It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.

Helling v. McKinney, 509 U.S. 25, 33–34 (1993). The Court in *Helling* specifically recognized that communicable disease could constitute such an "unsafe, life-threatening condition:"

> In *Hutto v. Finney*, 437 U.S. 678, 682, 98 S.Ct. 2565, 2569, 57 L.Ed.2d 522 (1978), we noted that inmates in punitive isolation were crowded into cells and that some of them had infectious maladies such as hepatitis and venereal disease. This was one of the prison conditions for which the Eighth Amendment required a remedy, even though it was not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed. … **Nor**

[11] In *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015), the Supreme Court held that, unlike the standard applied to convicted prisoners' 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. While some courts have extended *Kingsley* to medical care claims brought by pretrial detainees (*see, e.g.*, *Gordon v. County. of Orange*, 888 F.3d 1118, 1124-25 (9th Cir. 2018)), the Fourth Circuit has not yet decided this issue.

> **can we hold that prison officials may be deliberately indifferent to the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms.**

Id. at 33 (emphasis added); *see also id.* at 34 (citing with approval *Gates v. Collier*, 501 F.2d 1291 (5th Cir. 1974), which held that prisoners were entitled to relief under the Eighth Amendment when they showed, inter alia, "the mingling of inmates with serious contagious diseases with other prison inmates"). Federal courts agree that exposure of detained persons to COVID-19 infection constitutes a substantial risk of serious harm. *See, e.g., Coreas, supra*, 2020 WL 1663133, at *9 (COVID-19 "presents an imminent risk to health and safety that satisfies the [Eighth Amendment's] objective prong"); Jones v. Wolf, No. 20-CV-361, 2020 WL 1643857, at *9 (W.D.N.Y. Apr. 2, 2020) ("the findings regarding the risk of contracting COVID-19 in a communal setting are true even though there presently are no reported cases at [the detention center]").

Deliberate indifference requires a showing that prison officials had actual knowledge of an excessive risk to the detainee's safety, or evidence that detention officials were aware of facts from which an inference could be drawn that a substantial risk of serious harm exists and that the inference was drawn. *Farmer,* 511 U.S. at 837. A plaintiff may "prove an official's actual knowledge of a substantial risk 'in the usual ways, including inference from circumstantial evidence'" so that "'a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.'" *Raynor v. Pugh*, 817 F.3d 123, 128 (4th Cir. 2016) (quoting *Farmer*, 511 U.S. at 842).

Here there is no doubt that Defendants have knowledge of the excessive risk to Plaintiffs; Dr. Puisis has conveyed his findings directly to Defendants' counsel. *See* Puisis Decl., at 1, 4. In any event, given the mounting death toll from COVID-19 both in prisons and jails and in the

community, the risk posed by this deadly contagious disease to persons involuntarily confined in cramped quarters is beyond obvious. Accordingly, Defendants' ongoing failure to meaningfully address this risk violates Plaintiffs' rights under the Fourteenth Amendment.

III. This Court should order Defendants to take specific steps to address COVID-19, including consideration of prisoner releases.

As both public health experts and courts have acknowledged, all of the steps the public is urged to take to counter COVID-19 are essentially impossible in a prison or jail. *See, e.g., United States v. Martin, supra*, at *2 ("[P]ublic health officials have been left to urge the public to practice 'social distancing,' frequent (and thorough) hand washing, and avoidance of close contact with others (in increasingly more restrictive terms)—all of which are extremely difficult to implement in a detention facility"). For this reason, public health experts unanimously recommend reducing incarcerated populations as an essential tool in the battle against the virus. *See* Hopkins Faculty Letter (Fathi Decl. Ex. D) at 2 ("It is … an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible"); Beyrer Decl., ¶ 34 ("[R]eleasing 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"). Dr. Puisis, the medical monitor in this case, agrees. Puisis Decl., at 1 ("I strongly recommend depopulation of the jail to the extent it is safe to release inmates. The jail can't be made safe with respect to current public health recommendations regarding social distancing and sanitation").

In an April 3, 2020 letter to Governor Hogan, Maryland Attorney General Brian E. Frosh called for swift release of detained persons from the state's prisons and jails:

> The reality is that we need a broader and faster release of a larger swath of inmates. Such action is necessary to stave off a catastrophe that will not only result in avoidable illness and death in the prisons, but will also put our correctional officers, who already put their

> lives on the line, at much greater risk. This increased danger will in turn augment spread of the disease in the community at large.

Fathi Decl, Ex. A at 1.

A number of courts have ordered pretrial detainees released from detention based upon the risk posed by COVID-19. *See, e.g.*, *United States v. Davis*, No. ELH-20-09, 2020 WL 1529158, at *1, *4 (D. Md. Mar. 30, 2020) (denying pretrial detention despite the fact that defendant had no underlying medical conditions, noting the defendant "will be removed from a custodial setting where the risk of infection is higher for everyone, including the healthy, and he will live in the community where he is able to practice social distancing, self-quarantine, self-isolate if infected, and seek medical treatment if necessary").[12] Defendants should be ordered to formulate a plan to release or otherwise remove detainees from the Jail, giving priority to those whose age and/or underlying medical conditions put them at especially severe risk from COVID-19.

CONCLUSION

This Nation faces an unprecedented and rapidly evolving public health crisis. While everyone is at risk, detained people are uniquely vulnerable. Prevented by their incarceration from following public health guidance or otherwise protecting themselves, the Plaintiffs in this case are

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[12] *See also United States v. Doshi*, No. 13-CR-20349, 2020 WL 1527186, at *2 (E.D. Mich. Mar. 31, 2020) ("The threat of COVID-19 within prisons has amplified the risks associated with [diabetes and hypertension]. The Court finds that Doshi is among those who should have their incarceration converted to home confinement . . . ."); *United States v. Gonzalez*, No. 2:18-CR-0232-TOR-15, 2020 WL 1536155, at *2 (E.D. Wash. Mar. 31, 2020) (granting compassionate release due to COVID-19 and finding that because "it is impossible to practice social distancing or isolation in a jail setting, the pandemic will be devastating when it reaches jail populations."); *United States v. McKenzie*, No. 18 CR. 834 (PAE), 2020 WL 1503669, at *3 (S.D.N.Y. Mar. 30, 2020) (granting application for release, justified by "the heightened threat posed by COVID-19 to an inmate with a documented respiratory condition in a detention facility with multiple confirmed cases"); *United States v. Ramos*, No. 18-CR-30009-FDS, 2020 WL 1478307, at *1 (D. Mass. Mar. 26, 2020) (granting pretrial release due to particular risks COVID-19 presents to defendant with asthma and diabetes).

sitting ducks, powerless to do anything except wait helplessly for the virus to rip through the Jail, leaving sickness and death in its wake.

In this case, Defendants' failure to take adequate steps to protect the people in their custody is well-documented. Urgent action is required. Accordingly, Plaintiffs respectfully request that this Court order Defendants to immediately:

1. Confine Plaintiffs under conditions that allow them to maintain at least six feet of distance from all other persons at all times.
2. In consultation with Dr. Puisis, formulate a plan for the release or transfer of detainees from the Jail in order to meaningfully mitigate the risk of transmission, giving priority to those whose age and/or underlying medical conditions put them at especially severe risk from COVID-19.
3. Provide prompt testing for the virus causing COVID-19 to all detainees, staff, and other persons in the Jail who display or report symptoms consistent with COVID-19.
4. House detainees suspected to be infected with COVID-19 in safe and appropriate locations that do not risk transmitting the disease to other persons.
5. In consultation with Dr. Puisis, formulate and implement a plan for monitoring of detainees who, because of their age and/or underlying medical condition, are at elevated risk from COVID-19.
6. Sanitize all surfaces to which detainees have access twice per shift.
7. Ensure that all detainees are provided, free of charge, soap and frequently sanitized towels.
8. Consult with Dr. Puisis to identify and promptly implement additional steps to mitigate the risk to Plaintiffs from COVID-19.

9. File a report with the Court within seven days of the date of the Court's order, and every seven days thereafter, detailing Defendants' compliance or noncompliance with the Court's order.

Respectfully submitted this 9th day of April, 2020.

/s/
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.,*	*	
Plaintiffs,	*	
v.	*	Civil Action No. ELH-94-2541
LAWRENCE HOGAN, *et al.,*	*	
Defendants.	*	

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DECLARATION OF CHRIS BEYRER, MD, MPH

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I, Chris Beyrer, M.D., M.P.H., 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 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]

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[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
[8] *Id.*
[9] *Id.*

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.

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[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/

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]

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

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[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/etRPVRl

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),

[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 WHOChina Joint Mission Report, *supra*).

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 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 schools[18] to places[19] of worship, from businesses[20] to legislatures[21] —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]

[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

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 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. In the United States, this is demonstrated by dramatic outbreaks in the Cook County jail,[25] and Rikers Island in

[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.

New York City, where the transmission rate for COVID-19 is estimated to be the highest in the world.[26]

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 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

[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

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 8th day of April, 2020.

Chris Beyrer, M.D., M.P.H.

References

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.*,	*	
Plaintiffs,	*	
v.	*	Civil Action No. ELH-94-2541
LAWRENCE HOGAN, *et al.*,	*	
Defendants.	*	

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DECLARATION OF MICHAEL PUISIS, DO

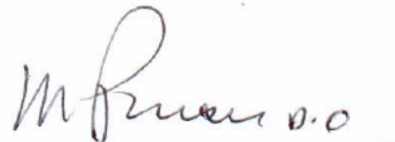
****

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I prepared the emails dated 3/26/20 and 4/3/20 attached to this declaration, and that it truly and accurately reflects my opinions regarding the minimal steps necessary to provide adequate protection from exposure to Covid-19 for detainees, staff, and any other persons who spend time in the housing units at the Baltimore City Booking and Intake Center.

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

Executed on April 6, 2020.



Dr. Michael Puisis

Michael Puisis [redacted]
Fri 3/27/2020 3:31 PM

---------- Forwarded message ---------
From: Michael Puisis [redacted]
Date: Thu, Mar 26, 2020 at 3:29 PM
Subject: COVID-19
To: Elizabeth Alexander [redacted], Laura Mullally -DPSCS- [redacted]
Cc: Raymond Patterson [redacted]

Laura and Elizabeth,

Elizabeth asked me what I would recommend related to the current Covid-19 pandemic. The following are my thoughts and comments. Regarding this I did call Dr. Tessema to find out what the current practices were. In a big picture sense, I strongly recommend depopulation of the jail to the extent it is safe to release inmates. The jail can't be made safe with respect to current public health recommendations regarding social distancing and sanitation. Multiple jails throughout the country are releasing inmates to some degree and many have modified procedures to reduce the jail intakes. In Cook County, a jail with approximately 100 intakes a day, I received an anecdotal report that intakes have been reduced to about 20. There are similar reports in the press nationwide. Also Wisconsin has put a moratorium on sending inmates from jails to the prison system, an effort to reduce transfers of inmates between jurisdictions. This should be considered for BCBIC as well.

Baltimore is experiencing a rapid rise in the number of COVID-19 cases. On Thursday, March 26, 2020 the City of Baltimore confirmed 53 COVID-19 cases. To date no inmates at the jail have been known to be infected but there has also been no testing of inmates for COVID-19. Only one inmate over the past week has been suspicious for COVID-19 and isolated as described in procedures below. That inmate has not been tested for COVID-19.

I discussed the current COVID plan with Dr. Tessema on March 26, 2020. This plan included:

- Sallyport temperature screening by nurses of all incoming inmates, employees, and police. Those coming in from another institution with fever or symptoms are rejected and sent back to the sending institution. Staff with symptoms or temperature are sent home immediately.

- If the inmate is brought in by police, a nurse screens at the door with temperature and symptoms. If a male or female is positive, a mask is put on the inmate and the inmate is sent to holding cells in the booking area which are adjacent to where the commissioner can interview for whether the patient will be accepted. These cells are at the end of a hall adjacent to the Commissioner's evaluation room. The cells have a door but as with TB, these rooms should be negative pressure and keeping persons with probable disease in a crowded intake area

unnecessarily exposes staff and other inmates who walk through the hall to transmission of infection.

· If accepted into the jail females suspicious for COVID 19 will be taken to one of two cells in 4 Center across from the showers. These persons with suspected COVID-19 will be housed in 4 Center which continues to house other females without the disease. These cells are not negative pressure and though they are single cells, it is not safe given that other inmates still live on the same housing unit with them and presumably daily pass by the cells of infected persons on their way to the showers. Males suspicious for COVID-19 will be housed in the 5 Center gym with their bunks spaced 6 feet apart. Suspects are not now being tested so some persons without COVID-19 but with symptoms and infected with other respiratory illnesses will be communally housed with others who may be positive. Even though this is a best solution, it is likely to result in spread of infection. Persons suspicious for COVID 19 must be tested but the jail has no current means to do this.

· Intake screening for persons with symptoms of COVID-19 or with fever is being done in the areas where inmates are isolated. This is a reasonable practice in order to remove potentially infected people from a busy intake area.

· All south tower housing units on South 3, 4, and 5 are dormitories with about 40 beds on each dorm. The beds on these dorms are double bunked and each double bunk is about 3 feet apart. These housing unit makes it impossible for these inmates to maintain distancing as currently recommended by the CDC and public health authorities.

· Dining halls are not being used and all inmates are fed in their cells and/or housing units.

· Inmates above 55 or with any immune compromised condition or serious medical condition have symptom screening every shift, according to Dr. Tessema. In practice, in the Commissioner's recent 6 month Duvall submission, vital signs were only completed 8% of the time on an audit for item 19C. This deficiency was thought to be due to malfunctions in the electronic record display of orders. While orders issuing from the electronic record may not be utilized for symptom screening of persons at risk for COVID-19 it still brings into question whether the temperatures and symptom screenings are actually being done. This plan is good, whether the execution is occurring is unknown.

· The current plan is to sanitize surfaces twice a shift. Hopefully, that is being done.

· It isn't clear if soap is readily and freely available to inmates with frequently sanitized towels.

· Equipment and supplies could be improved.

In summary, several points of vulnerability in the current plan are as follows.

1. Inmates suspicious for COVID-19 based on fever or symptoms in intake are housed in cells

located on a hall next to the commissioner's evaluation room. This potentially exposes staff and inmates who pass by this cell or who are in contact with surfaces surrounding these cells. This is not a good isolation location.

2. Intake is still operating otherwise as routine which places staff and inmates in close proximity to one another and is contrary to recommendations to keep 6 feet apart.

3. The isolation unit for females is on a unit which houses other non-infected persons which places non-infected individuals at risk of infection.

4. Tests for COVID-19 and influenza are not now available. So inmates suspicious for COVID-19 are placed in housing with persons who may not have the disease. Symptomatic persons even with fever may have an illness other than COVID-19. This risks spreading disease to those who have symptoms but not with COVID-19. Testing should be done definitely for all symptomatic patients and for contacts of persons known to have COVID-19. The facility should ask for testing material even if it is currently being rationed.

5. The jail has approximately 150 living in dormitories with high risk of transmission of COVID-19. Also other inmates, even though in cells, still would have difficulty in maintaining recommended procedures to not congregate in groupings and to always maintain a 6 foot distance. Handwashing is problematic in all jail settings. For this reason, to the extent it is possible given safety concerns, I strongly recommend that as many inmates, as can safely be released from confinement, should be released from confinement pending their trial. While current procedures may be the best solution, under current circumstances, they don't consistently conform to CDC or public health recommendations.

Mike Puisis

From: Michael Puisis [redacted]
Sent: Friday, April 3, 2020 4:37 PM
To: Laura Mullally -DPSCS- [redacted]; Elizabeth Alexander [redacted]
Cc: Tessema, Isaias [redacted]; Sharon Baucom -DPSCS- [redacted]; Michael Resnick [redacted]
Subject: Update

Laura and Elizabeth

To update you, I spoke with Dr. Tessema today. The recommendations I made previously have been enacted. There are currently no inmate cases in BCBIC which is great news. One transportation officer was identified as positive but is at home. One clerk with no patient care responsibilities had symptoms over a week ago and is at home. All employees (officers and staff) are symptom screened with temperature before their shift and sent home for positive screen.

There are 3 special areas for housing: one for quarantine of new inmates for 14 days; another area is set aside for COVID19 + (single cells)- but none yet; and another area for suspicious cases.

Fortunately, the census of the jail is decreased to 600 inmates and only 30 inmates per day are booked. If you can reduce further it would help. But the reduction to date is helpful.

The only recommendation I have is if there are COVID positive, the single cells should be on a tier with no non-infected persons. Same for the suspects (PUI).

The Warden should continue the twice daily sanitation. Inmate workers should wear masks and be trained on hand washing after working. Staff should wear masks. Should you have inmates develop cases, you should consider giving inmates masks. But if there are no cases, it is best to restrict to health care workers and officers who are most likely to infect inmates at this juncture as they have outside contacts. Asymptomatic persons can infect others so there could be staff who are infected without symptoms come in which is why a mask is useful for them. FYI, in jails and prisons, I am familiar with the apparent transmission into the jail and prisons is from staff so strict military enforcement of symptom screening and temperature of EVERYONE coming in every shift is critical.

If you develop cases, please let me know.

Otherwise, sounds like you are doing well. Hopefully you will not have cases. Tessema, if any of this is inaccurate please correct. Thanks.

Be Safe

Mike Puisis

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.*,	*	
Plaintiffs,	*	
v.	*	Civil Action No. ELH-94-2541
LAWRENCE HOGAN, *et al.*,	*	
Defendants.	*	

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[PROPOSED] ORDER

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The Court having considered Plaintiffs' Emergency Motion for Relief from Risk of Injury and Death From COVID-19, and good cause appearing, **IT IS ORDERED:** Defendants shall immediately:

1. Confine Plaintiffs under conditions that allow them to maintain at least six feet of distance from all other persons at all times.
2. In consultation with Dr. Puisis, formulate a plan for the release or transfer of detainees from the Jail in order to meaningfully mitigate the risk of transmission, giving priority to those whose age and/or underlying medical conditions put them at especially severe risk from COVID-19.
3. Provide prompt testing for the virus causing COVID-19 to all detainees, staff, and other persons in the Jail who display or report symptoms consistent with COVID-19.
4. House detainees suspected to be infected with COVID-19 in safe and appropriate locations that do not risk transmitting the disease to other persons.
5. In consultation with Dr. Puisis, formulate and implement a plan for monitoring of detainees who, because of their age and/or underlying medical condition, are at elevated risk from COVID-19.

6. Sanitize all surfaces to which detainees have access twice per shift.
7. Ensure that all detainees are provided, free of charge, soap and frequently sanitized towels.
8. Consult with Dr. Puisis to identify and promptly implement additional steps to mitigate the risk to Plaintiffs from COVID-19.
9. File a report with the Court within seven days of the date of this Order, and every seven days thereafter, detailing Defendants' compliance or noncompliance with this Order.

IT IS SO ORDERED.

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Hon. Ellen L. Hollander
UNITED STATES DISTRICT JUDGE

Dated: