IN THE

SUPREME COURT OF ILLINOIS

JAMES MONEY, et al., Petitioners, v. ROB JEFFREYS, Director of the Illinois Department of Corrections Respondent	)	Original Petition for Writ of Mandamus Case No.

PETITION FOR WRIT OF MANDAMUS

Without urgent action by the Illinois Department of Corrections ("IDOC") Director Rob Jeffreys to drastically reduce Illinois's prison population, the novel coronavirus is likely to spread not just inside the walls of Illinois's 28 prisons, but throughout prison communities as well.

Director Jeffreys has the constitutional duty, *see* U.S. CONST. Am. XIII; ILL. CONST. Art. 1 § 11, and the statutory authority to release from physical custody thousands of people through the use of medical furlough, home detention, and discretionary sentence credit for early release. 730 ILCS 5/3-11-1(a)(2) (authorizing medical furlough); 730 ILCS 5/5-8A-1 et seq. (authorizing home detention for certain categories of prisoners) 730 ILCS 5/3-11-1 (authorizing director to grant 180 days of good time credits); 20 Ill. Admin. Code § 107.210 (same). Over 2,650 of the people eligible for home detention are in custody for non-violent offenses, including

theft under $300, possession of a controlled substance, forgery, and damage to property. People eligible for release also include 5,308 people with less than six months to serve and over 12,000 people who by virtue of age or medical conditions have an increased risk of death if they contract COVID-19.[1] Director Jeffreys has failed to exercise his authority to transfer, furlough, or release these eligible individuals.

To mitigate the continued spread of the COVID-19 infection in prison and in surrounding communities, Petitioners seek a writ of mandamus ordering Director Jeffreys to medically furlough, transfer to home detention, or release all who qualify under the law, particularly those who are elderly and medically vulnerable, those who have a place in the community where they can safely self-quarantine and those who can be released without jeopardizing public safety. In the alternative, Petitioners seek a writ of mandamus ordering Director Jeffreys to identify such individuals and determine, pursuant to his authority under Illinois law, whether each such individual should be medically furloughed, transferred to home detention, or released.

Nearly 37,000 people are incarcerated in Illinois, living in close quarters where all aspects of daily life, including healthcare and food service, take place. Social distancing guidelines can never be fully or effectively implemented in the prison.[2] And each day,

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[1] [1] Population Data Sets, Illinois Department of Corrections, available at https://www2.illinois.gov/idoc/reportsandstatistics/Pages/PopulationDataSets.aspx

[2] On March 30, 2020, following the death of a COVID-19 patient at Stateville, Illinois Department of Public Health Director Ngozi Dr. Ezike again acknowledged the heightened risk posed by correctional settings and the inability to conform them to public health standards:

"Congregate settings such as Stateville, any other correctional center, pose unique challenges in stopping the spread of disease and protecting the health of individuals who live and work there. Those who are incarcerated obviously live and work and eat and study and recreate all within that same environment, heightening the potential for COVID-19 to spread really quickly once it's introduced.

thousands 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.

As of April 1, 2020, there are 52 confirmed prisoners who have COVID-19 in two different correctional centers (Stateville and North Lawndale ATC) and 25 confirmed staff who have the virus in seven different correctional centers (Stateville NRC, Stateville, Sheridan, North Lawndale ATC, Menard, Joliet Treatment Center, and Crossroads ATC).[3] There are 187 additional prisoners who were tested and are awaiting results.[4] The actual number of individuals with COVID-19 in IDOC is likely much higher.

To understand the devastating impact that COVID-19 is already having on the Illinois prison system and the communities that house those prisons, one need look no further than The Stateville Prison. St. Joseph Hospital in Joliet, Illinois, where Stateville prisoners had been hospitalized, announced on March 30, 2020 that it was "overwhelmed" by inmates suffering

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The options for isolation of COVID-19 cases are limited in this focused setting and it becomes very difficult depending on the size of the facility and the population that's already in the facility. Ideally, all cases should be isolated individually and close contact should be quarantined individually. I know our partners at the Department of Corrections are working innovatively to try to create the best situations for these, for these facilities. But some facilities and correctional centers do not have enough individual cells, and so we are considering isolating multiple laboratory confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group."

The Governor's Press Conferences are available for streaming at: https://www.nbcchicago.com/news/local/watch-live-daily-coronavirus-briefing-from-illinois-health-officials/2234359/ (last visited March 31, 2020).

[3] COVID-19 Response, Illinois Department of Correction, https://www2.illinois.gov/idoc/facilities/Pages/Covid19Response.aspx (last visited April 1, 2020).

[4] *Id.*

from the effects of coronavirus and staff already were "maxed out."[5] The following day, Governor Pritzker confirmed at least one prisoner had died from the virus, while the number of confirmed cases among staff and prisoners continues to grow.[6]

Stateville and St. Joseph's Hospital's reality might have been avoided if the Governor and IDOC had exercised his authority to release numerous incarcerated individuals who have homes in which they could safely self-quarantine. Instead, IDOC has continued to house thousands of elderly, disabled, and medically vulnerable prisoners who could be furloughed, transferred to home detention or released. A writ of mandamus is warranted to protect the constitutional rights of thousands of incarcerated individuals and the lives and health of millions of Illinois residents.

I. This Court has the Authority to Issue a Writ that will Significantly Reduce the Risk of COVID-19 to Illinois Prisons and Surrounding Communities

1. The COVID-19 pandemic is an extraordinary circumstance that presents an unprecedented public health risk to both people in prison and the general public. A failure to adequately respond to the risk of COVID-19 in prison will heighten the risk faced by the communities surrounding prisons both because the spread of COVID-19 behind prison walls places prison employees and their families at risk and because sick prisoners will tax already over-burdened health systems. This precise scenario has played out in Joliet, Illinois.

2. Public health experts with experience in correctional settings have recommended the release from custody of people most vulnerable to COVID-19 to protect the communities

[5] Chuck Goudie et al., *Illinois Prisoners Sick With COVID-19 "Overwhelm" Joliet Hospital*, ABC News (Mar. 30, 2020), https://abc7chicago.com/health/illinois-prisoners-sick-with-covid-19-overwhelm-joliet-hospital/6064085/.

[6] The Governor's Press Conferences are available for streaming at: https://www.nbcchicago.com/news/local/watch-live-daily-coronavirus-briefing-from-illinois-health-officials/2234359/ (last visited March 31, 2020)

inside and outside the prisons, and to slow the spread of the COVID-19 infection. When the COVID-19 virus occurs and spreads within a prison, all persons, staff and prisoners alike, are at heightened risk of contracting the virus and, in turn, spreading the virus to others with whom they come in contact in their own homes and neighborhoods.[7] Population reduction protects the people with the greatest vulnerability to COVID-19 from transmission of the virus, and also allows for greater risk mitigation for all people held or working in a correctional facility. Because prisons are often located in small communities (like Joliet, IL), removing the most vulnerable people from custody also reduces the burden on those region's limited health care infrastructure by reducing the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time and require hospitalization in these small communities.

3. On March 26, 2020, the Governor acknowledged that "certain populations are at a higher risk of experiencing more severe illness as a result of COVID-19, including older adults and people who have serious chronic health conditions, such as heart disease, diabetes, lung disease or other mental or physical conditions."[8] The Governor also acknowledged that "the vast majority" of those housed within IDOC are in "close proximity and contact with each other in housing units and dining halls," making them "especially vulnerable to contracting and spreading COVID-19."[9] The Governor further acknowledged that "the IDOC currently has limited housing capacity to isolate and quarantine inmates who present as symptomatic of, or test positive for, COVID-19."[10] Public health experts across the nation have affirmed the

[7] Greifinger Aff., Exhibit 1.
[8] Executive Order 2020-13 (March 26, 2020), https://www2.illinois.gov/IISNews/21288-Gov._Pritzker_Stay_at_Home_Order.pdf (last visited Apr. 1, 2020).
[9] *Id.*
[10] *Id.*

Governor's statements about the harm facing people in IDOC custody, concluded that COVID-19 outbreaks in prison threatened surrounding communities and call for the release of all eligible people in custody as a measure to mitigate these risks. At the Governor's March 29, 2020, daily briefing on the coronavirus situation, IDPH Director Dr. Ngozi Ezike acknowledged the present danger that when the infection enters prisons, the congregate nature of these facilities, with staff coming and going from the community each day in large numbers, will "increase the rate of infection and its fast spread through these facilities."[11]

4. Public health experts across the nation corroborate the Governor's and Dr. Ezike's statements about the harm facing people in IDOC custody, conclude that COVID-19 outbreaks in prison threaten surrounding communities, and call for the release of all eligible people in custody as a measure to mitigate these risks Dr. Robert Greifinger, a correctional health expert, has concluded that "[r]isk mitigation is the only viable public health strategy available to limit transmission of infection, morbidity and mortality in prisons, and to decrease the likely public health impact outside of the prisons. Even with the best-laid plans to address the spread of COVID-19 in prisons, the release of individuals, prioritizing the most medically vulnerable individuals, is a key part of a risk mitigation strategy . . . Additionally, the release of detainees who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of detainees in a facility."[12] Dr. Greifinger explains that reducing the prison population "has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows

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[11] The Governor's Press Conferences are available for streaming at: https://www.nbcchicago.com/news/local/watch-live-daily-coronavirus-briefing-from-illinois-health-officials/2234359/ (last visited March 31, 2020).

[12] Greifinger Aff. Ex. 1.

easier provision of preventive measures such as soap for handwashing, disinfecting supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff, which will likely be reduced by illness, such that they can continue to ensure the safety of detainees."[13]

5. Similarly, Dr. Craig W. Haney, a Distinguished Professor of Psychology and UC Presidential Chair at the University of California Santa Cruz, recommends that "adult prisons must reduce their populations urgently in order to allow the necessary social distancing in response to the COVID-19 Pandemic."[14]

6. Corrections systems around the country have heeded the call of public health experts and taken urgent action to reduce their prison population. In California, Governor Newsom announced his plans to accelerate the release of over 3,500 people from state prisons in an effort to reduce the population as COVID-19 infections continue to spread in the prisons.[15] This announcement comes in advance of a court hearing schedule to begin later this week to determine if more individuals should be released. The Iowa Department of Corrections has announced that the DOC is expediting the release of about 700 prisoners, or 7% of its population, who are approved for parole or work release.[16] In New York, Governor Cuomo ordered the release of more than 7% people who are in prisons and jails across the state on the

[13] *Id*.
[14] Haney Decl. Ex. 3.
[15] Paige St. John, *California to release 3,500 inmates early as coronavirus spreads inside prisons*, LA Times (Mar. 31, 2020), https://www.latimes.com/california/story/2020-03-31/coronavirus-california-release-3500-inmates-prisons.
[16] *Officials Cut Prison, Jail Numbers; Iowa Virus Cases Hit 105,* Newton Daily News (Mar. 24, 2020), https://www.newtondailynews.com/2020/03/23/officials-cut-prison-jail-numbers-iowa-virus-cases-hit-105/acs5xbk/.

basis of a parole violation.[17] In Colorado, Governor Polis issued an executive order that suspended the caps and criteria Colorado places on the accrual of good time credits in order to allow the DOC to award earned time credits to "facilitate the reduction of the population of incarcerated persons and parolees to prevent an outbreak in prisons."[18] The Vermont Department of Corrections has worked to reduce its population by over 11%, "[t]he goal is to reduce our (inmate) population so we can start spreading out the remaining population."[19] Cleveland, Ohio has reduced its jail population by 17% and the population of the LA County jail was reduced by almost 4%.[20]

7. In sharp contrast, on March 31, 2020, the IDOC publicly stated that it has released less than 1% of the overall IDOC population—despite the fact that 12,000 of the people in IDOC custody are eligible for transfer to medical furlough or home detention.[21] Director Jeffreys failure to take reasonable action to ameliorate the risk COVID 19 poses to Illinois prisons and communities is in violation of the U.S. Constitution and his duties under state law.

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[17] Brendan J. Lyons, *NY to Release 1,100 Parole Violators as Coronavirus Spreads*, Times Union (Mar. 27, 2020), https://www.timesunion.com/news/article/Deaths-surge-again-in-New-York-from-coronavirus-15160973.php.

[18] State of Colorado, *Executive Order D 2020 016* (March 25, 2020) at pg. 2, available at: https://drive.google.com/file/d/18o0yWHzZleHJ87hmgLuBmXwpM8R74Q5x/view.

[19] Anna Merriman, "*It's Very Difficult to Control": Many Vermont Inmates Released so That Those Who Remain Can be Spread Out*, Valley News (Mar. 26, 2020), https://www.vnews.com/Vermont-NH-prisons-working-to-reduce-population-to-prevent-virus-spread-33512589.

[20] Cory Shaffer, *Courts, Attorneys Reduce Cuyahoga County Jail Population by 300 Inmates in "Herculean" Eight Days Prompted by Coronavirus*, Cleveland.com (Mar. 20, 2020), https://www.cleveland.com/court-justice/2020/03/courts-attorneys-reduce-cuyahoga-county-jail-population-by-300-inmates-in-herculean-eight-days-prompted-by-coronavirus.html.

[21] The Governor's Press Conferences are available for streaming at: https://www.nbcchicago.com/news/local/watch-live-daily-coronavirus-briefing-from-illinois-health-officials/2234359/ (last visited March 31, 2020).

8. "If public officials have failed to comply with requirements imposed upon them [by law] a court may compel them to do so by a writ of mandamus." *Noyola v. Board of Educ. of the City of Chicago*, 179 Ill. 2d 121, 132 688 N.E.2d 81, 86 (Ill. 1997). A writ of mandamus must "must allege facts which establish a clear right to the relief requested, a clear duty of the respondent to act, and clear authority in the respondent to comply with the writ." *Id*. Each of these three requirements are met here.

9. First, as described more fully below, in the absence of action from this Court the Petitioners in custody will continue to experience violations of their constitutional rights and face the risk of serious illness or death. The family member Petitioners face the risk of losing a loved one to a preventable illness. These Petitioners have a clear right to seek the relief requested here. *See Noyola*, 179 Ill. 2d at 134-35 (in a mandamus action regarding the misuse of public school funds, finding that the parents of student meant to benefit from those funds could seek relief through a mandamus).

10. Second, mandamus is an appropriate remedy for constitutional violations. *See Crump v. Illinois Prisoner Review Bd*., 181 Ill. App. 3d 58, 62 536 N.E.2d 875, 878 (1st Dist. 1989) (explaining that "in certain cases, allegations of constitutional violations . . . can state a cause of action for mandamus relief"); *Clayton-El v. Lane, 203 Ill. App*. 3d 895, 561 N.E.2d 183 (5th Dist. 1990) (analyzing the prisoner's constitutional claims in the context of a mandamus petition). As described in detail below, the threat of COVID 19 poses a serious risk to the lives of people in IDOC custody. The United States Supreme Court has long held that when state officials "strip [prisoners] of virtually every means of self-protection and foreclose[] their access to outside aid, [they] are not free to let the state of nature take its courts." *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). State officials instead have a responsibility under the Eighth

Amendment to "take reasonable measures to guarantee the safety of the inmates." *Id*. at 832. In *Helling v. McKinney*, 509 U.S. 25, 35 (1993), the Supreme Court held that the Eighth Amendment forbids deliberate indifference to something that "pose[s] an unreasonable risk of serious damage to . . . future health." The Supreme Court itself addressed exposure to secondhand smoke, but it explicitly recognized that "deliberate indifference to the exposure of inmates to a serious, communicable disease" would be similarly infirm under the Eighth Amendment, even if a prisoner currently shows no serious symptoms. *Id*. at 33. Art. 1, § 11 of the Illinois Constitution provides identical prohibitions against conditions that constitute cruel and unusual punishment. *See People v. Boeckmann*, 932 N.E.2d 998, 1007(Ill. 2010) ("The proportionate penalties clause in the Illinois Constitution is coextensive with the federal constitution's prohibition of cruel and unusual punishment."). As demonstrated by the expert declarations attached to this petition, a constitutional response to the threat of COVID-19 requires transferring a significant percentage of the current IDOC population from IDOC prisons to medical furlough or home detention.[22] Director Jeffreys is ultimately responsible for ensuring that the IDOC comply with all aspects of state and federal law, so mandamus here is appropriate.

11. Third, and finally, Director Jeffreys has the authority to comply with the relief request in this writ. Illinois law explicitly empowers Director Jeffreys with the ability to transfers eligible individuals from IDOC prisons to medical furlough or home detention and to provide release to certain other indviduals. Pursuant to 730 ILCS 5/3-11-1(a)(2), the IDOC may release a person from prison on medical furlough "to obtain medical, psychiatric or psychological services when adequate services are not otherwise available." Director Jeffreys

[22] *See* Greinfinger Aff. Ex. 1; Meyer Decl. Ex. 2; Haney Decl. Ex. 3; Beyrer Decl. Ex. 4; Pacholke Decl. Ex. 5.

therefore has statutory authority to release on medical furlough individuals who are medically vulnerable to COVID-19 either due to age or pre-existing medical conditions and who therefore need to quarantine in a place where social distancing is possible.

12. Pursuant to the Electronic Monitoring and Home Detention Law, 730 ILCS 5/5-8A-1 et seq. ("Home Detention Law"), Director Jeffreys has the authority and obligation to implement procedures through which eligible prisoners may serve a portion or all of their custodial sentence in home detention. The Home Detention Law directs the Department to issue administrative directives to allow for categories of state prisoners to serve portions of their sentence in home detention. Pursuant to 730 ILCS 5/5-8A-3(d), Director Jeffreys may place a prisoner in an electronic monitoring or home detention program if that person is over 55 years old, has 12 months or less to serve on their sentence, has served at least 25% of their sentenced prison term, and is serving a sentence for conviction of an offense other than for certain sex offenses.

13. Pursuant to 730 ILCS 5/5-8A-3(e), Director Jeffreys may place a person of any age serving a sentence for conviction of a Class 2, 3, or 4 felony offense which is not an excluded offense in an electronic monitoring or home detention program at any time.

14. Illinois law also provides Director Jeffreys the authority to award to eligible prisoners up to 180 days of discretionary good conduct credit, pursuant to 730 ILCS 5/3-6-3(a)(3) and 20 Ill. Adm. Code 107.210.

15. Over 2,650 of the people eligible for home detention are in custody for non-violent offenses, including theft under $300, possession of a controlled substance, forgery, and damage to property. People eligible for release also include 5,308 people with less than six months to serve and over 12,000 people who by virtue of age or medical conditions have an

increased risk of death if they contract COVID-19. [23] Director Jeffreys has failed to exercise his authority to transfer, furlough, or release these eligible individuals.

16. If Director Jeffreys does not act immediately to reduce the Illinois prison population, COVID-19 will spread rapidly throughout IDOC, overburdening IDOC's medical care program and resulting in entirely preventable seriously illness—the risk of death. Petitioner's continued confinement while COVID-19 spreads unabated through IDOC facilities constitutes cruel and unusual punishment under the United States and Illinois Constitutions. U.S. Const. amend. VIII; Ill. Const art. 1 § 11.

17. A writ of mandamus may also be sought in order to prevent or correct a manifest injustice. *See People ex rel. PPG Indus., Inc. v. Schneiderman*, 92 Ill. App. 3d 546, 548, 414 N.E.2d 1059, 1061 (1981). The inevitable result of Director Jeffrey's continued failure to fully employ his authority to transfer people from the physical custody of IDOC to medical furlough or home detention is that thousands of people including prisoners who are not eligible for transfer, furlough, or release, IDOC staff, and members of the public at large, will become seriously ill and that many of those people will die. There is no not greater injustice than a preventable, unnecessary loss of life.

18. This Petition requests that the IDOC take immediate action to protect the health and wellbeing not only of people in its custody but also people who live in communities surrounding prisons. This Court regularly issues mandamus to prevent a manifest injustice in disputes with far less serious consequences. *See Guzzo v. Snyder*, 326 Ill. App. 3d 1058, 1063, 762 N.E.2d 663, 668 (2001) (mandamus issued to compel the IDOC director to release a prisoner

[23] Population Data Sets, Illinois Department of Corrections, available at https://www2.illinois.gov/idoc/reportsandstatistics/Pages/PopulationDataSets.aspx

to correct the manifest injustice of miscalculated good time); *Kermeen v. City of Peoria*, 65 Ill. App. 3d 969, 973, 382 N.E.2d 1374, 1376-77 (1978) (mandamus issued to prevent the manifest injustice that would result from a financial investment in building permits); *Shell Oil Co. v. City of Chicago*, 9 Ill. App. 3d 242, 246, 292 N.E.2d 84, 87 (1972) (mandamus issued to prevent the manifest injustice that would result from the withholding of construction permits); *People ex rel. Collins v. Young, 83 Ill. App. 2d 312,.* 318-19, 227 N.E.2d 524, 526-27 (1967) (mandamus issued to prevent a manifest injustice related to public school boundary lines).

19. Finally, in the event that this Court finds that the Constitution does not require the full use of Director Jefferey's authority medical furlough, transfer or release eligible prisoners to mitigate the risk of COVID-19, it still has the authority to direct Director Jeffreys to take action. Approximately 12,000 in IDOC are eligible for medical furlough, transfer or release. Director Jeffreys has failed to act and to exercise the discretion afforded to him by the Illinois Legislature to decide whether these people should remain in custody during this public health emergency or if public safety and public health concerns mandate their transfer to medical furlough or home detention. "Although mandamus may not be used to direct or alter the manner in which discretion is to be exercised, it may be used to compel a public official to in fact exercise the discretion that he possesses." *Freeman v. Lane*, 129 Ill. App. 3d 1061, 1063, 473 N.E.2d 584, 585–86 (1985). Petitioners therefore ask, in the alternative, that this Court issue a writ of mandamus ordering Director Jeffreys to identify all eligible individuals and determine whether to transfer them out of IDOC prisons.

II. The COVID-19 Outbreak Has Created a National and Global Health Emergency

20. We are living in the midst of an extreme, unprecedented worldwide health emergency caused by the rapid spread of the coronavirus, COVID-19. The World Health

Organization has declared COVID-19 to be a global pandemic.[24] On March 9, 2020, Illinois Governor J.B. Pritzker issued a proclamation declaring a disaster in the State of Illinois.[25] On March 13, 2020, President Trump declared a national emergency.[26]

21. The number of known COVID-19 infections is increasing daily. As of April 1, 2020, there were more than 823,600 reported COVID-19 cases throughout the world and more than 40,598 people had died as a result of the virus.[27] In the United States alone, there are over 186,10 confirmed cases and over 3,600 deaths.[28] In Illinois, there are over 6,900 confirmed cases and 141 deaths.[29] The number of COVID-19 cases in the United States is expected to grow exponentially. The Centers for Disease Control and Prevention ("CDC") projects that without swift and effective public health interventions, over 200 million people in the U.S. could be infected with COVID-19 over the course of the epidemic, with as many as 1.7 million deaths.[30]

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[24] *Rolling Updates on Coronavirus Disease (COVID-19)*, World Health Organization (Mar. 31, 2020), https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.

[25] *Gubernatorial Disaster Proclamation* (Mar. 9, 2020), https://www2.illinois.gov/sites/gov/Documents/APPROVED%20%20Coronavirus%20Disaster%20Proc%20WORD.pdf.

[26] *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, The White House (Mar. 13, 2020), https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/

[27] *Coronavirus Disease 2019 (COVID-19) Situation Report – 72*, World Health Organization (Apr. 1, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200401-sitrep-72-covid-19.pdf?sfvrsn=3dd8971b_2.

[28] *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, Centers for Disease Control and Prevention (Apr. 1, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html.

[29] *Coronavirus Disease 2019 (COVID-19)*, Ill. Dept. of Pub. Health (Apr. 1, 2020), http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus.

[30] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths*, The New York Times, (Mar. 13, 2020), https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

22. On March 20, 2020, Illinois Governor Pritzker took the strictest measure yet to fight the virus's spread, issuing a "stay at home" executive order for all residents effective starting March 21, 2020 through at least April 7, 2020, which was then extended to April 30, 2020.[31] The order directs all non-essential business and operations to cease. People are allowed to leave their homes only for essential activities. Any gathering larger than 10 people is prohibited, and people are recommended to stay at least six feet away from others. Restaurants, bars, schools, parks, and libraries have all been shut down. In a statement to the public, Governor Pritzker explained that his order was based on his conversations with "some of the best medical experts, epidemiologists, mathematicians, and modelers," and all recommended a stay at home order "to avoid the loss of potentially tens of thousands of lives."[32] Governors around the country, including in California, New York, and Connecticut, have issued similar stay at home orders to curb the spread of the virus.[33]

III. Incarcerated People Are Particularly Vulnerable to Infection from COVID-19

23. None of the recommended measures for mitigating the spread of COVID-19 are available for persons confined in correctional facilities and for those who must interact with them. Correctional facilities are inherently congregate environments, where large groups of people live, eat, and sleep in close contact with one another. It is impossible to achieve social

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[31] *Executive Order In Response to COVID-19 (COVID-19 Executive Order No.8)*, https://www2.illinois.gov/IISNews/21288-Gov._Pritzker_Stay_at_Home_Order.pdf (last visited Apr. 1, 2020); *Illinois' Stay-at-Home Order Extended Through April, Pritzker Announces*, NBC Chicago (Mar. 31, 2020) https://www.nbcchicago.com/news/local/illinois-stay-at-home-order-expected-to-be-extended-sources/2247274/.

[32] Dan Petrella et al., *Gov. J.B. Prizker Issues Order Requiring Residents to "Stay at Home" Starting Saturday*, Chicago Tribune (Mar. 20, 2020), https://www.chicagotribune.com/coronavirus/ct-coronavirus-illinois-shelter-in-place-lockdown-order-20200320-teedakbfw5gvdgmnaxlel54hau-story.html.

[33] *Id.*

distancing standards in these settings.[34] Therefore infectious diseases, particularly airborne diseases, such as COVID-19, are more likely to spread rapidly between individuals in correctional facilities.[35]

26. The risk of contracting an infectious disease is also higher in correctional facilities because the facilities are not sanitary environments. People share toilets, sinks, and showers, and often have limited access to soap, hand sanitizer, hot water, and other necessary hygiene items. Surfaces are infrequently washed, if at all, and cleaning supplies are in short supply.[36] These needs are now multiplied and also compounded by the lack of personal protective equipment (PPE) such as masks and gloves for either staff or prisoners.

27. Given the history of epidemiologic outbreaks in correctional facilities, such as Tuberculosis, influenza, and MRSA, medical and public health experts expect that COVID-19 will also readily spread in prisons, especially when people cannot engage in proper hygiene and adequately distance themselves from infected residents or staff. [37]

28. The people who live in these environments—environments that defy all current public safety standards— are themselves at high risk due to the high rates of chronic health conditions, substance use, mental health issues, and aging and chronically ill populations who may be vulnerable to more severe illnesses, and to death, after infection from COVID-19.[38] As Dr. Craig Haney, a correctional health expert, explains, prisoners are "unusually vulnerable to stress-related and communicable diseases. Formerly incarcerated persons suffer higher rates of

[34] Greifinger Aff. Ex. 1; Haney Decl. Ex. 3.
[35] Beyrer Aff. Ex. 4; Meyer Decl. Ex. 2.
[36] Greifinger Aff. Ex. 1; Meyer Decl. Ex. 2; Beyrer Decl. Ex. 4; Haney Decl. Ex. 3.
[37] Beyrer Decl. Ex. 4.
[38] *Id.*

certain kinds of psychiatric and medical problems. Incarceration leads to higher rates of morbidity (illness rates) and mortality (i.e., it lowers the age at which people die)."[39]

29. 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 disorder (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, and asthma, are at elevated risk of death if they contract COVID-19.[40] People over the age of fifty-five also face greater chances of serious illness or death from COVID-19. In the WHO-China Joint Mission Report, the preliminary mortality rate analyses showed that individuals age 70-79 had an overall 8% mortality rate, individuals age 60-69 had a 3.6% mortality rate, and individuals age 50-59 had a 1.3% mortality rate.[41] For individuals age 40-49, the mortality rate was 0.4%, and for individuals 40 years and younger, the mortality rate was as low as 0.2%.

30. According to one study, "asthma prevalence is 30%–60% higher among individuals with a history of incarceration as compared with the general population."[42] One study estimates that up to 15% of people who are in custody have asthma, 10% of people in custody live with a heart condition that requires medical care, 10% live with diabetes, and 30%

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[39] Haney Aff. Ex. 3.
[40] *Coronavirus Disease 2019 (COVID-19): People Who Need Extra Precautions*, CDC, https://www.cdc.gov/coronavirus/2019ncov/needextraprecautions/peopleathigherrisk.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fhigh-risk-complications.html (last visited Apr. 1, 2020).
[41] *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart*, Worldometers (Feb. 29, 2020), https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/ (data analysis based on WHO-China Joint Mission Report).
[42] Emily A. Wang et al., *Cardiovascular Disease in Incarcerated Populations*, 69 J. Am. C. Cardiology 2967 (2017).

have hypertension.[43] There are currently 4,807 people in IDOC physical custody who are age 55 or older. Based on these estimates and assuming some overlap between these categories, a conservative approximate calculation is that 12,000 people in IDOC prisons live with one or more of these medical vulnerabilities that greatly increase the chances of death upon contracting COVID- 19. In the absence of this writ, 12,000 people face exposure to a substantial risk of serious illness and death.

31. Additionally, many correctional facilities lack an adequate medical care infrastructure to treat high-risk people in custody.[44] Prison health units are not equipped with sufficient emergency medical equipment, such as oxygen tanks, nasal cannulae, and oxygen face masks, to respond to an outbreak of patients with respiratory distress. For these reasons, among others, experts have warned that, "widespread community transmission of COVID-19 within a correctional institution is likely to result in a disproportionately high COVID-19 mortality rate."[45] Prisons and jails rely on outside community hospitals to provide more advanced and intensive medical care, and during an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves, as has already occurred at St. Joseph's Hospital in Joliet.[46]

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[43] Elizabth M. Vigilanto et al., *Mass Incarceration and Pulmonary Health: Guidance for Clinicians*, 15 Ann. Am. Thoracic Soc. 409, 409 (2019); Laura M. Marushack et al., *Medical Problems of State and Federal Prisoners and Jail Inmates,* 2011-12, U.S. Dept. of Justice (2014).

[44] Greifinger Aff. Ex. 1; Meyer Decl. Ex. 2.

[45] AMEND, *COVID-19 in Correctional Settings: Unique Challenges and Proposed Responses*, (March 23, 2020), https://amend.us/wp-content/uploads/2020/03/COVID-in-Corrections-Challenges-and-Solutions-1.pdf; *see also* Brie Williams et al., *Correctional Facilities in the Shadow Of COVID-19: Unique Challenges and Proposed Solutions*, Health Affairs Blog (Mar. 26, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200324.784502/full/.

[46] Meyer Decl. Ex. 2.

32. Prisons are not closed environments. By necessity, members of the free community, including correctional officers, social workers, attorneys, medical personnel, and many others must enter and leave the prisons on a daily basis. Staff arrive and leave each facility three times a day in large numbers, and it is impossible to adequately screen staff for new, asymptomatic infection. When the COVID-19 virus occurs and spreads within a prison, all persons, staff and prisoners alike, are at heightened risk of contracting the virus and, in turn, spreading the virus to others with whom they come in contact in their own homes and neighborhoods.[47]

IV. IDOC's Medical Care Program is Gravely Under-Resourced and Under-Functioning, and is Not Capable of Managing COVID-19

33. Even before COVID-19, IDOC's medical care program was ill-equipped to meet the medical needs of prisoners in its care. For over a decade, IDOC has been mired in litigation over its consistent failure to maintain a minimally adequate system. *See Lippert v. Jeffreys*, No. 10 cv 4603 (N.D. Ill. filed May 30, 2013). In 2014 and again in 2018, the *Lippert* court appointed teams of independent experts to conduct exhaustive reviews of IDOC's medical system, both of which exposed a system in dire need of reform. In October 2018, the team of experts issued a 1200-page report, reaching the following the conclusions:

a. The clinical care provided within IDOC was "extremely poor" and "resulted in preventable morbidity and mortality";

b. IDOC lacked an adequate infections disease control program;

c. IDOC's Infectious Disease Coordinator position was vacant and had been vacant since at least 2014;

[47] Greifinger Aff. Ex.1.

d. Systemic sanitation problems existed in at multiple IDOC facilities;

e. IDOC's medical staff vacancy rates were "very high" and staffing was a "critical problem" throughout IDOC;

f. Physician staffing at IDOC was "very poor," with "persistent and ongoing vacancies" in site medical director positions, high rates of turnover, and an overreliance on "traveling" medical directors who go from site to site;

g. Physicians who worked at IDOC were improperly credentialed, which was "a major factor in preventable morbidity and mortality" and "significantly increase[ed] the risk of harm to patients within IDOC."[48]

34. Less than one year ago, IDOC agreed to a consent decree, which was approved and entered by the Court in May 2019, to begin needed reforms. *See Lippert v. Jeffreys*, No. 10 cv 4603 (N.D. Ill.), Doc. No. 1238 (consent decree). The consent decree called for the appointment of an independent monitor and a near complete overhaul of IDOC's medical system.

35. In the nine months since the *Lippert* consent decree was entered, IDOC has taken preliminary steps to comply, but circumstances within the facilities remain largely unchanged. IDOC is still only in early stages of developing a compliance plan. There has been no meaningful on the ground change yet; facilities are still critically under-staffed and under-resourced. IDOC is simply unable to adequately meet the serious medical needs of IDOC's population even under non-pandemic circumstances.

36. Even before the COVID-19 outbreak, in November 2019, the *Lippert* court monitor warned that the prevalence of elderly and infirm individuals in IDOC was straining the

[48] *Lippert* Expert Report Ex. 6 (October 2018), at 9–10, 21–31, 84–91.

system.[49] Regarding this population, the monitor noted: "It is the position of the monitor that in the short term additional IDOC resources must be directed to properly house and care for this population but in the near future the IDOC must take the lead to create a pathway to discharge those men and women whose mental and medical conditions make them no longer a risk to society to appropriate settings in the community."[50]

40. Since the outbreak of COVID-19, IDOC administrators have issued memos to prisoners notifying them that their medical resources were "stretched thin" and that they needed to focus "on [their] most vulnerable patients at this time."[51]

V. Petitioners In IDOC Custody are Particularly Vulnerable to Serious Illness and Death

41. James Money (S11097) is 28 years old and is housed at Illinois River Correctional Center in Canton, Illinois. In 2016, Mr. Money was diagnosed with Stage 3 metastatic thyroid cancer. He has undergone several surgeries, most recently in January 2020, resulting in the removal of over 80 lymph nodes and a full thyroidectomy, and is now immunocompromised. He was scheduled to begin chemotherapy treatment on March 24, 2020, but IDOC cancelled his treatment, presumably to focus instead on COVID-19. Mr. Money has already served nearly 5 years of his sentence for residential burglary out of Adams County, and he is currently scheduled to be released on June 19, 2020. He is eligible for medical furlough pursuant to 730 ILCS 5/3-11-1 and discretionary good time pursuant to Ill. Admin. Code tit. 20, § 107.210. Mr. Money is also within 90 days of his release date, is eligible for release to home detention pursuant to 730 ILCS 5/5-8A-3(b). Mr. Money's parole conditions have already been

[49] *Lippert* Court Monitor Report, Ex. 7 (November 24, 2019), at 9-10.
[50] *Id.*
[51] IDOC Memorandum, COVID-19 Response, Ex. 8.

determined and he is approved to reside with his fiancée's residence in Warsaw, Illinois. His fiancée is fully prepared to provide for his medical needs.

42. William Richard (M52774) is 66 years old and lives in the healthcare unit at Dixon Correctional Center. Mr. Richard has COPD, emphysema, and heart disease, and uses a wheelchair for movement. His respiratory disease requires continuous oxygen and a breathing treatment two to three times per day. He shares his roughly 12 feet by 15 feet cell with three other individuals, making social distancing impossible--his bunk is less than 5 feet from his cellmate's bunk, and all four men share a toilet, sink, and the chuckhole through which they receive their meals. Mr. Richard has less than four months remaining on his sentence and is eligible under 730 ILCS 5/5-8A-3(d) to transfer to home detention at his mother's home.

43. Gerald Reed (N32920) is housed at the Northern Reception Center. He is 57 years old. Mr. Reed has heart failure, hypertension, and is pre-diabetic. Mr. Reed uses a wheelchair for mobility because of a decades-old leg injury that adversely affects his mobility. Within the last year, Mr. Reed has been hospitalized for a heart attack and for pneumonia. At the NRC, he is prohibited from accessing commissary and is only provided a single, small bar of soap. Pursuant to 75 ILCS 5/3-11-1, Mr. Reed is eligible for medical furlough at his mother's home.

44. Amber Watters (Y39454) is 30 years old and is housed at Logan Correctional Center in Lincoln, Illinois. Ms. Watters has neurological complications from a broken back she suffered prior to her incarceration in 2019. Prior to her incarceration, Ms. Watters was the primary caretaker for her three minor children. She is serving two three-year sentences for low level drug offenses out of Livingston County; a Class 4 sentence for possession of heroin, and a Class 2 sentence for possession with the intent to distribute a small amount of heroin. Ms.

Watters is scheduled to be released on May 1, 2020, and is eligible under 730 ILCS 5/5-8A-3(e) to transfer to home detention to her mother's home.

45. Tewkunzi Green (R84568) is housed at Logan Correctional Center in Lincoln, Illinois. She has asthma and severe hypertension for which she takes multiple medications. In January 2019, she fainted related to hypertension and was held in the cardiology unit of an off-site hospital for several days. At Logan, Ms. Green shares a room with three other women. Ms. Green has a pending commutation petition, which was filed by the January 23, 2020, filing deadline; her hearing date of April 7, 2020 was postponed and she is now being scheduled for a non-public hearing. She is also eligible for medical furlough under 730 ILCS 5/3-11-1. Ms. Green has a stable housing plan in that her mother, who owns her own home in Peoria, Illinois, where she also cares for Tewkunzi's 13-year-old son, is willing and able to receive Ms. Green at any time.

46. Danny Labosette (B23629) is currently housed at Robinson Correctional Center in Robinson, Illinois. Mr. Labosette is 56 years old and is a double amputee; his left leg has been amputated above the knee, and his right foot has been amputated. Mr. Labosette uses a wheelchair. Mr. Labosette also has untreated Hepatitis C. Mr. Labosette is housed in the Transitions Unit, a treatment facility within Robinson Correctional Cell. Social distancing is impossible for Mr. Labosette—he resides in a dorm with roughly 20 other men. He sleeps in the bottom bunk of a bunk bed, which is 3 feet away from the neighboring beds. Mr. Labosette has less than six months remaining on his sentence, and is eligible under 730 ILCS 5/5-8A-3(d) to be transferred to home detention at his mother's home in Florida, which has already been modified to accommodate his disabilities.

47. Carl Reed (R48993) is currently housed at Graham Correctional Center in Hillsboro, Illinois. He is 59 years old and he suffers from chronic kidney disease—requiring dialysis three days per week—diabetes, hypertension, and underlying neurological impairments. A doctor who is an expert in correctional health care has reviewed Mr. Reed's medical records and recommends his immediate release for Mr. Reed's health and safety. Mr. Reed has eight years left on his sentence, and he is eligible for medical furlough pursuant to 730 ILCS 5/3-11-1. He has a pending petition for executive clemency, and he has a stable housing plan for his release: he can live with his sister in Chicago.

48. Carl "Tay Tay" Tate (R12529) is a 40-year-old transgender woman diagnosed with Gender Dysphoria, who is housed at Danville Correctional Center. Ms. Tate has almost six years left of her sentence to serve. Ms. Tate lives with hypertension, for which she takes medication. Ms. Tate also lives with severe anxiety, and the COVID-19 outbreak has only increased her anxiety. She shares a small cell with one other person. Even with current limits on the number of people in the unit who are allowed out of their cells to use the communal dayroom, Ms. Tate estimates that around 24 people may be in the dayroom at a time. She estimates that around 75 people may be in the yard. Ms. Tate also works as a laundry porter, which places her in frequent contact with other prisoners and staff. She has asked for gloves to use, and has been denied. She has also asked for more cleaning supplies to clean the dayroom, including the phones, and has been denied. It is impossible for Ms. Tate to practice social distancing in her living situation. Ms. Tate has a pending clemency petition—which has the support of 40 organizations across the state—and her hearing date of April 7, 2020 was postponed and is being rescheduled. Ms. Tate has a stable housing plan in place for when she is released: she will live with her sister who resides in Lansing, Illinois.

49. Patrice Daniels (B70662) is 45 years old, serving a life sentence and not eligible for release. He is incarcerated at Joliet Treatment Center. Although this is one of the few facilities that has single occupant cells, he still shares a shower and dayroom with the other residents of this housing unit. Even with current limits on the number of people in the unit who are allowed out of their cells to use the communal dayroom, up to 8 people may be in the dayroom at a time. Mr. Daniels also works as a dietary aide, which places him in frequent contact with other prisoners and staff from outside of his housing unit each day. Mr. Daniels estimates that even with in-unit meal delivery, each person's meal is handled by approximately 6-8 other people between preparation and delivery. Mr. Daniels describes feeling "like a sitting duck" waiting for the coronavirus to strike. Mr. Daniels is a member of the Class.

50. Anthony Rodesky (R47057) is currently housed at Pontiac Correctional Center in Pontiac, Illinois. He is 49 years old and has diabetes and other chronic health conditions, and in 2015 he had a below-knee amputation. Mr. Rodesky is a New Jersey prisoner who is in Illinois custody pursuant to an interstate compact agreement between New Jersey and Illinois and he is not eligible for release. Mr. Rodesky has ongoing medical needs, and he must interact with Pontiac health care staff at least twice daily, in order to receive his insulin shots. He also must stand next to other prisoners when he leaves his cell to obtain his insulin shots. Mr. Rodesky is deeply fearful of contracting COVID-19 on account of his pre-existing medical vulnerabilities. Even if Mr. Rodesky is not exposed to COVID-19, an outbreak at Pontiac would drain medical resources at Pontiac that he and other prisoners with chronic health conditions rely on for every day survival.

VI. Petitioners Include the Family Members of People in Custody Who will Provide Their Loved Ones with A Safe Place to Self-Quarantine

51. Amanda Shackleford is Petitioner Gerald Reed's mother. She lives in fear that her son, who lives with serious medical issues that increase his likelihood of death should he contract COVID-19, will contract the virus and die while in the physical custody of the IDOC. If Mr. Reed were to receive a medical furlough she would allow him to live with her for the duration of the furlough.

52. Sharon Gray is John Shores's mother. Mr. Shores is currently confined at Hill Correctional Center. Hill Correctional Center has taken few precautions to manage COVID-19 and social distancing is impossible. If John were to be released, Sharon Gray would allow him to live in her home and he would be welcome in many of his family members' homes throughout Illinois.

53. Oholibamah Clark is Duane Moore's fiancé. Mr. Moore is currently confined at Dixon Correctional Center. Mr. Moore has underlying medical issues and is living in fear of the transmission of COVID-19. If Mr. Moore were to be released, he can live with Ms. Clark for the duration of his furlough.

54. LaTonya Jenkins-Lucas is Petitioner Frank Sykes's mother. Frank Sykes is currently confined at Stateville Correctional Center. Mr. Sykes has had asthma since he was born and lived with weak lung capacity while growing up. Ms. Jenkins-Lucas lives in fear that COVID-19 could be deathly for her son and that Stateville Correctional Center and the IDOC are not able to manage COVID-19. If Mr. Sykes were to be released on furlough, he would have a safe place to live with Ms. Jenkins-Lucas.

VII. Conclusion and Request for Relief

55. For the forgoing reasons, the Petitioners respectfully request this Court to issue a Writ of Mandamus requiring Director Jeffreys to:

56. Satisfy his duties under art. 1, § 11 of the Illinois Constitution, and the Eighth Amendment of the United States Constitution, by identifying and ensuring the immediate medical furlough and/or transfer to home detention of all people incarcerated in any IDOC facility who have a home in the community in which they can safely quarantine and who fall into any one of the following six categories:

i. People who have serious underlying medical conditions that put them at particular risk of serious harm or death from COVID-19, including but not limited to: people 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; people who have had or are at risk of stroke; and people with any other condition specifically identified by CDC either now or in the future as being a particular risk for severe illness and/or death caused by COVID-19, and who are eligible for medical furlough pursuant to 730 ILCS 5/3-11-1;

ii. People who are medically vulnerable to COVID-19 because they are 55 years of age and older and who are eligible for medical furlough pursuant to 730 ILCS 5/3-11-1;

iii. People who are 55 years of age and older with less than one year remaining on their sentence and eligible for home detention pursuant to 730 ILCS 5/5-8A-3(d);

iv. People who are currently in custody for Class 2, 3, or 4 offences and who are eligible for home detention pursuant to 730 ILCS 5/5-8A-3(e);

v. People who are currently in custody for Class 1 or Class X offenses with less than 90 days remaining on their sentence and eligible for home detention pursuant to 730 ILCS 5/5-8A-3(b) and (c);

vi. People who and are scheduled to be released within 180 days and eligible to receive sentencing credit pursuant to 20 Ill. Adm. Code 107.210.

vii. Or, in the alternative, order Director Jeffreys to identify all individuals who fall into these categories and determine whether they should be transferred or released.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned, an attorney, certifies that on April 3, 2020 she both filed the foregoing document and served it upon:

Brent D. Stratton
Chief Deputy Attorney General
Office of the Illinois Attorney General
100 W. Randolph Street, 12th Floor
bstratton@atg.state.il.us

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

/s/ Sheila A. Bedi
Sheila A. Bedi

EXHIBIT

1

Affidavit of Robert B. Greifinger, MD

I, Robert B. Greifinger, certify 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 very familiar with correctional facilities, having toured and evaluated the medical care in several hundred correctional facilities across the nation. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of today, according to the World Health Organization, more than 465,915 people have been diagnosed with COVID-19 around the world and 21,031 have died.[2] In the United States, at least 85,724 people have been diagnosed and at least 1,275 people have died thus far.[3] These numbers are likely a severe 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 and there is unlikely to be a vaccine for at least a year. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 transmission is to use scrupulous hand hygiene and social distancing.

5. When infected, people in the high-risk category for COVID-19, i.e., the elderly or those with underlying disease, are likely to suffer serious illness and death. The U.S. Centers for Disease Control and Prevention (CDC) recently reported that the risk of

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[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] See https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd, accessed March 27, 2020.

[3] See https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1, accessed March 27, 2020.

serious disease and death among those with COVID-19 increases with age, with 78% of reported deaths occurring in people over the age of 65. More than 50% of COVID-19 related intensive care admissions and more 80% of COVID-19 deaths were among people 65 years old or older.[4] Early reports from China show that nearly half of those with the coronavirus had comorbidities, or underlying health conditions.

6. In the United States, younger adults with COVID-19 have been severely affected by the disease as well. While people under the age of 20 have largely been protected from severe effects of the coronavirus, 55% of COVID-19 hospitalizations and 20% of deaths were from people between the ages of 20 and 64.[5]

7. Mortality is high among those with COVID-19 who become severely affected. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are in very short supply.

8. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that 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, and neurological and neurologic and neurodevelopmental conditions.

9. A primary concern of medical and public health experts and public officials is the effect that the pandemic is having and will have on health systems. Because severe COVID-19 cases require extended hospitalization and intensive medical care, a significant number of COVID-19 cases can quickly overwhelm a health system. This is true in urban areas but is particularly true in rural areas where health care facilities have far more limited capacity to respond to an increase in patients who need hospitalization and intensive care.

10. The only way to mitigate the rapid spread of COVID-19 is to use scrupulous hand hygiene and social distancing, self-quarantine for individuals who may have been exposed, and isolation at a home or care facility for those who have been infected. The recommended hand hygiene measures are frequent handwashing with soap and water, and the use of alcohol-based sanitizers when handwashing is unavailable. Surfaces such as doorknobs and light switches which have a high degree of human contact should be cleaned and disinfected regularly with bleach.

11. Recognizing the urgency and severity of the pandemic, 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 a risk mitigation strategy.

12. Illinois has been hit hard by COVID, with at least 2,538 cases and at least 26 deaths

[4] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w, accessed March 22, 2020.
[5] *Id.*

reported as of March 26, 2020.[6] The cases of COVID-19 have spanned the State, including in central and southern Illinois. As a result, Illinois Governor J.B. Pritzker has issued an order to "stay at home" for the entire State.[7]

13. COVID-19 has now reached the correctional facilities in Illinois, with cases reported in the Illinois Department of Corrections and the Cook County Jail. [8] In New York, we have seen the rate of infection in city jails far outpace the rate of infection of the general population, by seven.[9] The same can be expected in Illinois facilities.

14. The conditions of congregate settings, such as prisons, poses a heightened public health risk for the spread of COVID-19.

15. Correctional facilities are enclosed environments, much like the cruise ships and nursing homes that were the sites of the largest concentrated outbreaks of COVID-19 initially. Correctional facilities have even greater risk of transmission of infection because of a) crowding for prolonged periods of time; b) the high proportion of vulnerable people detained; and c) often scant medical care resources.

16. In prisons, people live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. In most congregate settings, it is impossible for those detained to maintain a six-foot distance from others or to avoid groups.

17. Food preparation and food service is communal, with little opportunity for surface disinfection. Toilets, sinks, and showers are shared, without disinfection between use.

18. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

19. Many correctional facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. Even where they do have formal linkages with local health departments or hospitals, correctional facilities are often in under-resourced areas where the local health department or hospital would quickly become overwhelmed in the face of an infectious disease outbreak.

20. Prisons are ill-equipped to diagnose and manage the spread of a disease like COVID-19. In the event of exposure in a prison, all individuals should be tested. Those who test positive should be isolated. Health care providers should have access to personal

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[6] *See* http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus, accessed March 27, 2020.

[7] https://www.chicagotribune.com/coronavirus/ct-coronavirus-illinois-shelter-in-place-lockdown-order-20200320-teedakbfw5gvdgmnaxlel54hau-story.html

[8] *See* https://www2.illinois.gov/idoc/facilities/Pages/Covid19Response.aspx, accessed March 26, 2020; https://chicago.suntimes.com/coronavirus/2020/3/25/21193871/cook-county-jail-coronavirus-covid-19-cases, March 25, 2020.

[9] https://www.nydailynews.com/coronavirus/ny-coronavirus-nyc-jails-rikers-island-legal-aid-20200325-o5du2jczc5agrhj42y5tk4gfmi-story.html (March 25, 2020).

protective equipment, including masks. Access to resources for testing, personal protective equipment, and necessary supplies are often inadequate in prisons. Those infected and symptomatic should be isolated in airborne negative pressure rooms, which rarely exist in prisons. Where such negative pressure rooms do exist, there are rarely enough to be available in the event of an outbreak.

21. There is a nationwide shortage of tests for COVID-19. It is my understanding that Illinois correctional facilities do not have sufficient access to these tests. As people may be asymptomatic or have no fever, COVID-19 may be spread in prisons and infect many prisoners and staff without warning.

22. The heightened risk of infectious disease transmission in prisons threatens the health of prisoners, staff and the broader population. Releasing vulnerable patients reduces the risk of widespread intramural outbreak, and thereby reduces the risk to staff who return to their homes on a daily basis.

23. Indeed, I monitor a correctional facility for the Federal Court that has already had an outbreak of COVID-19 among vulnerable people living on a medical housing unit. A Nurse Practitioner, four correctional officers, and two inmates have confirmed COVID-19. Several other inmates have pending tests. Three nurses are hospitalized with COVID-19. As such, I have firsthand knowledge of the serious effects of this virus in correctional facilities and the lack of preparedness in these institutions. Correctional facilities are not equipped to manage and treat an onslaught of this disease. It is a dangerous and rapidly evolving situation.

24. Risk mitigation is the only viable public health strategy available to limit transmission of infection, morbidity and mortality in prisons, and to decrease the likely public health impact outside of the prisons. Even with the best-laid plans to address the spread of COVID-19 in prisons, the release of individuals, prioritizing the most medically vulnerable individuals, is a key part of a risk mitigation strategy. In my opinion, the most urgent public health need is to release people from prison, prioritizing those who are most vulnerable, 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.

25. Additionally, the release of detainees who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of detainees in a facility.

26. Combined, this has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, disinfecting supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff, which will likely be reduced by illness, such that they can continue to ensure the safety of detainees.

27. The prison is a microcosm of the broader community. Social distancing and scrupulous hygiene and sanitation are required to avoid an outbreak. If there is inadequate social

distancing, hygiene and sanitation, there will almost certainly be infection and an outbreak. In the event of an outbreak, those who are medically vulnerable will be most immediately at risk, but eventually the effect will be felt by all as the health care infrastructure will be inadequate to respond to the needs.

28. For an airborne disease, the most effective mitigation strategy to limit the spread of the virus is to reduce crowding, as this increases the opportunity for social distancing. In a prison, even if everyone is isolated in a single cell, there is still an increased risk of transmission among prisoners and staff because the institutional setting requires the delivery of food, cleaning supplies, documents, and other items.

29. Isolation, e.g., segregation or solitary confinement, is not an acceptable mitigation strategy. People who are isolated are monitored less frequently, due to decreased visualization. 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 there will be increases in suicide attempts 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 prisoners—in the form of increased handcuffing, escorting to and from the showers, and increased use of force due to the increased psychological stress of isolation. My expert opinion is that the use of isolation or lockdown is not a medically appropriate method for abating the substantial risks of COVID-19.

Under penalties as provided by law pursuant to § 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he verily believes the same to be true.

Executed this *27th* day in March 2020 in New York City, New York.

Robert B. Greifinger, M.D.

EXHIBIT

2

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I am being paid $1,000 for my time reviewing materials and preparing this report.

6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

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

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

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

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[4]

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

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

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

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

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

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[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.
[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext
[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.
[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice*: *New Jersey*, *Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.

26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

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[9] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690.

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.

38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.

39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.

40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

41. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

March 15, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

EXHIBIT

3

DECLARATION OF DR. CRAIG W. HANEY, PHD

I, Craig W. Haney, declare as follows:

1. I am a Distinguished Professor of Psychology and UC Presidential Chair at the University of California Santa Cruz in Santa Cruz, California, where I engage in research applying social psychological principles to legal settings including the assessment of the psychological effects of living and working in institutional environments, especially the psychological effects of incarceration. I was a co-founder and co-director of the UC Criminal Justice & Health Consortium – a collaborative effort of researchers, experts and advocates from across the University of California system working to bring evidence-based health and healthcare solutions to criminal justice reform in California and nationwide.

2. I also have served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations on jail- and prison-related issues. Those agencies and organizations include the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the United States Department of Justice, the Department of Health and Human Services (HHS), the Department of Homeland Security, and the White House (under both the Clinton and Obama Administrations). In 2012, I testified as an expert witness before the Judiciary Committee of the United States Senate in a hearing that focused on the use and effects of solitary confinement and was appointed as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. My research, writing, and testimony have been cited by state courts, including the California Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court[1].

3. COVID-19 is a serious, highly contagious disease and has reached pandemic status. At least 741,774 people around the world have received confirmed diagnoses of COVID-19 as of March 30, 2020, including 140,570 people in the United States. At least 35,334 people have died globally as a result of COVID-19 as of March 30, 2020, including 2,443 in the United States[2]. These numbers are predicted by health officials to increase, perhaps exponentially. For example, the CDC has estimated

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[1] For example, see *Brown v. Plata*, 563 U.S. 493 (2011).

[2] World Health Organization, *Coronavirus disease (COVID-19) Outbreak*, https://www.who.int/emergencies/diseases/novel-coronavirus-2019; and Center for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

that as many as 214 million people may eventually be infected in the United States, and that as many as 21 million could require hospitalization[3].

4. The COVID-19 Pandemic poses such a threat to the public health and safety in the State of Illinois, that on March 20, 2020 Governor Pritzker declared all counties in Illinois to be disaster areas and ordered all Illinois residents to stay home or at their place of residence except to facilitate certain authorized necessary activities[4]. On March 26, 2020, Illinois' Governor Pritzker issued Executive Order 13[5], which barred all transfers of people from the county jails to the Illinois Department of Corrections, based on (among others) the following findings:

> **WHEREAS**, the Illinois Department of Corrections ("IDOC") currently has a population of more than 37,000 male and female inmates in 28 facilities, the vast majority of whom, because of their close proximity and contact with each other in housing units and dining halls, are especially vulnerable to contracting and spreading COVID-19; and,
>
> **WHEREAS**, the IDOC currently has limited housing capacity to isolate and quarantine inmates who present as symptomatic of, or test positive for, COVID-19...

5. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. Currently, the most effective ways to control the virus are to use preventive strategies, including social distancing, in order to maximize our healthcare capacity for a manageable number of patients. Otherwise, healthcare resources will be overwhelmed and the Pandemic will worsen.

6. Social distancing presents serious challenges for everyone in every part of our society, but nowhere more than in penal institutions, where living conditions are unusually sparse and prisoners necessarily live in unescapably close quarters with one another.

7. Moreover, jails and prisons are already extremely stressful environments for the persons confined in them.[6] They can be psychologically and medically harmful

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[3] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths,* N.Y. TIMES (Mar. 18, 2020), https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html

[4] Executive Order 2020-10 (https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-10.aspx)

[5] Executive Order 2020-13 (https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-13.aspx)

[6] Much of this evidence is summarized in several book-length treatments of the topic. For example, see: Haney, C., Reforming punishment: Psychological limits to

in their own right, rendering prisoners unusually vulnerable to stress-related and communicable diseases. Formerly incarcerated persons suffer higher rates of certain kinds of psychiatric and medical problems.[7] Incarceration leads to higher rates of morbidity (illness rates) and mortality (i.e., it lowers the age at which people die).[8]

8. Prisons lack the operational capacity to address the needs of persons in custody in a crisis of this magnitude. These facilities are ill-equipped to provide incarcerated persons with ready access to cleaning and sanitation supplies, or to assure that staff sanitize all surfaces during the day. Prisoners are surrounded by and enveloped in hard metal surfaces, precisely the kind on which the COVID-19 virus lives longest.

9. Most correctional facilities were already operating at or beyond the limits of their capacities to provide mental health or medical care long before the COVID-19 Pandemic began. Many are located in remote geographical locations where access to ICU beds and ventilators in surrounding community hospitals are extremely limited. The demand for such services in this crisis will only grow, and already

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the pains of imprisonment. Washington, DC: American Psychological Association (2006); Liebling, A., & Maruna, S. (Eds.), The effects of imprisonment. Cullompton, UK: Willan (2005); and National Research Council (2014). The Growth of Incarceration in the United States: Exploring the Causes and Consequences. Washington, DC: The National Academies Press. In addition, there are numerous empirical studies and published reviews of the available literature. For example, see: Haney, C., Prison effects in the age of mass incarceration. Prison Journal, 92, 1-24 (2012); Johns, D., Confronting the disabling effects of imprisonment: Toward prehabilitation. Social Justice, 45(1), 27-55.

[7] E.g., see: Schnittaker, J. (2014). The psychological dimensions and the social consequences of incarceration. Annals of the American Association of Political and Social Science, 651, 122-138; Turney, K., Wildeman, C., & Schnittker, J., As fathers and felons: Explaining the effects of current and recent incarceration on major depression. Journal of Health and Social Behaviour, 53(4), 465-481 (2012). See, also: Listwan, S., Colvin, M., Hanley, D., & Flannery, D., Victimization, social support, and psychological well-being: A study of recently released prisoners. Criminal Justice and Behavior, 37(10), 1140-1159 (2010).

[8] E.g., see: Binswanger, I., Stern, M., Deyo, R., et al., Release from prison: A high risk of death for former inmates. New England Journal of Medicine, 356, 157-165; Massoglia, M. Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses. Journal of Health and Social Behavior, 49(1), 56-71; and Massolglia, M., & Remster, B., Linkages Between Incarceration and Health. Public Health Reports, 134(Supplement 1), 85-145 (2019); and Patterson, E. (2013). The dose-response of time served in prison on mortality: New York state, 1989-2003. American Journal of Public Health, 103(3), 523-528.

scarce treatment resources will be stretched even more. If Illinois does not act immediately to reduce its prison population, COVID-19 is likely going to spread rapidly throughout its prisons, overburdening the prison medical care program and surrounding community hospitals, resulting in likely deaths. In fact, the first death of an Illinois prisoner (at Stateville prison) was announced on March 30, 2020. More are sure to follow if action is not taken.

10. In addition, prisons typically provide very limited access to telephonic or other forms of remote visiting. Yet precisely these ways of connecting to others will become critically important if contact visiting is limited. Furthermore, prisons have only limited means of protecting incarcerated persons from contact with staff who regularly enter facilities after having been in the outside world. Staff members are at risk of having contracted COVID-19 and then transmitting it to all those inside the institutions, including staff and incarcerated persons.

11. In penal settings, the social distancing that is now required in response the COVID-19 Pandemic will most likely take the form of solitary confinement. Indeed, I have seen precisely this form of social distancing utilized as a matter of course in numerous correctional institutions throughout the country, where medical quarantines are conducted in prison infirmaries or other housing units by effectively placing prisoners in solitary confinement.

12. Yet solitary confinement subjects people to a separate set of very serious harmful effects, ones that significantly undermine their mental and physical well-being. The scientific literature on the harmfulness of solitary confinement in jails and prisons is now widely accepted and the research findings are consistent and alarming.[9] This research has led a number of professional mental and physical health-related, legal, human rights, and even correctional organizations to call for

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[9] These many studies have been carefully reviewed in a number of publications. For example, see: K. Cloyes, D. Lovell, D. Allen & L. Rhodes, Assessment of psychosocial impairment in a super-maximum security unit sample, Criminal Justice and Behavior, 33, 760-781 (2006); S. Grassian, Psychiatric effects of solitary confinement. Washington University Journal of Law & Policy, 22, 325-383 (2006); C. Haney, Restricting the use of solitary confinement. Annual Review of Criminology, 1, 285-310 (2018); C. Haney & M. Lynch, Regulating prisons of the future: The psychological consequences of solitary and supermax confinement. New York Review of Law & Social Change, 23, 477-570 (1997); and P. Smith, The effects of solitary confinement on prison inmates: A brief history and review of the literature, in Michael Tonry (Ed.), Crime and Justice (pp. 441-528). Volume 34. Chicago: University of Chicago Press (2006).

severe limitations on the degree to which solitary confinement is employed—specifically limiting when, for how long, and on whom it can be imposed.[10]

13. I was retained as an expert by the plaintiffs in the Illinois case, *Davis v. Jeffreys*, 3:16-cv-600, pending in the United States District Court for the Southern District of Illinois. In connection with my work in that case, I toured the segregation units, yards, health care units, and crisis cells in six Illinois prisons: Stateville, Pontiac, Menard, Dixon, Logan, and Lawrence.

14. After touring these prisons, interviewing scores of prisoners both at cell front and in longer confidential interviews, and reviewing hundreds of medical records and master files, I concluded then that the conditions that existed there created very serious risks to the lives and well-being of persons with mental illness. I concluded that even those without a pre-existing mental illness were at a considerable risk of psychological harm if they were to be housed in these segregation units. I urged that strict time limits on such confinement be applied and that significant out of cell time with other prisoners would be required to reduce these risks.

15. Based on my many years of studying correctional systems and practices across the country, I know that ameliorative measures such as increased treatment and out of cell time will be among the first things that are suspended as the prison system diverts staff to address the Pandemic. I am told that much of the mental health treatment and programming in Illinois prisons has stopped, including that the Department will be reducing out of cell contacts and relying more heavily on non-confidential and cell front checks in lieu of needed confidential treatment and out of cell time.

16. In fact, the Illinois Department of Corrections has already announced on its COVID-19 update page[11] that it has imposed an "Administrative Quarantine" statewide, which has (despite the claim that "leisure time services and mental health treatment will continue) generally limits movement and person-to-person contact, and thus shifted virtually the entire prison system to programs (or lack thereof) that are even more restrictive that the solitary confinement or segregation programs that I observed and critiqued throughout the system during my tours.

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[10] For a list of these organizations and their specific recommendations, see: Haney, C. (2018) Restricting the use of solitary confinement. Annual Review of Criminology, 1, 285-310; Haney, C., Ahalt, C., & Williams, B., et al. (2020). Consensus statement of the Santa Cruz summit on solitary confinement. Northwestern Law Review, in press.

[11] https://www2.illinois.gov/idoc/facilities/Pages/Covid19Response.aspx (last accessed March 30, 2020).

Mentally ill prisoners are especially likely to suffer and be harmed as a result of these policies

17. It is my opinion that, unless immediate measures are taken to reduce the population of persons with serious mental illness in the Illinois prison system needless suffering and loss of life are likely to occur.

18. With these things in mind, it is my professional opinion that adult prisons must reduce their populations urgently in order to allow the necessary social distancing in response to the COVID-19 Pandemic.

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

Executed on March 31, 2020 at Santa Cruz, California.

Dr. Craig W. Haney Ph.D.

DR. CRAIG W. HANEY, PHD

EXHIBIT

4

Declaration for Persons in Detention and Detention Staff
COVID-19

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

I, Chris Beyrer, declare as follows:

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

The nature of COVID-19

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

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

8. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 160 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 today, March 29th, 2020, there have been 713,171 confirmed human cases globally, 33,597 known deaths, and some 149,000 persons have recovered from the infection. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.
9. SARS-nCoV-2 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.
10. The U.S. CDC estimates that the reproduction rate of the virus, the R_0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again, is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

The risks of COVID-19 in detention facilities

11. COVID-19 poses a serious risk to inmates and workers in detention facilities. Detention Facilities, including jails, prisons, and other closed settings, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.
12. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities from which inmates derive.
13. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as 6-foot distancing and proper decontamination of surfaces is virtually impossible. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May, 2019.
14. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilet, shower, and eating environments and limits on hygiene and personal protective equipment such as masks and gloves in some facilities. Limits on soap (copays are common) and hand sanitizer, since it can contain alcohol, are also risks for spread.
15. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in

multiple detention facilities in China, associated with introduction into facilities by staff. The current outbreak in the detention facility of Riker's Island in New York City is a example—and in the first days of that outbreak the majority of cases were among prison staff, not inmates.

16. In addition to the nature of the prison environment, prison and jail populations are also at additional risk, due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after infection, and to death from COVID-19 disease.

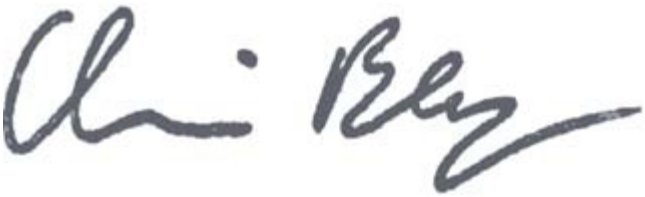
17. While every effort should be made to reduce exposure in detention facilities, this may be extremely difficult to achieve and sustain. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.

18. Pre-trial detention should be considered only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, should be prioritized for release. Immigrants awaiting decisions on their removal cases who are not a flight risk can be monitored in the community and should be released from immigration detention centers. Older inmates and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) should be considered for release.

19. Given the experience in China as well as the literature on infectious diseases in jail, 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.

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

Executed this 16th day of March, 2020.



Professor Chris Beyrer

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EXHIBIT

5

I, Dan Pacholke, declare as follows:

1. I am over the age of 18, have personal knowledge of the facts set forth herein, and, if called as a witness, I could and would testify competently as set forth below.

2. I have more than 37 years of experience, training, and education in the field of adult institutional corrections. This experience includes over three decades as an employee of the Washington State Department of Corrections (WDOC), beginning as a correctional officer and retiring as Secretary. In that time, I served as Chief of Emergency Operations; Superintendent of three correctional facilities (Cedar Creek Corrections Center, Stafford Creek Corrections Center, and Monroe Correctional Complex); Deputy Director; Director of Prisons; and Deputy Secretary. In October 2015, Governor Inslee appointed me to serve as Secretary of Corrections, a position I held until March 2016. As a WDOC employee in administration and leadership positions, I was one of the individuals responsible for the development and implementation of correctional policies, practices, and procedures.

3. My experience also includes work as a consultant for the National Institute of Corrections, a federal agency with a legislative mandate to provide specialized services to corrections from a national perspective, and as a Senior Research Scholar with New York University Marron Institute of Urban Management. Currently, I am a principal at Dan Pacholke Consulting, LLC and frequently consult with and collaborate with correctional systems, researchers, and policymakers on strategies to create safer correctional institutions. Attached as Exhibit 1 is a copy of my curriculum vitae.

4. In my capacity as a correctional practices consultant in 2016--17 I visited and toured several prisons operated by the Illinois Department of Corrections (IDOC) including Pinckneyville, Stateville, Hill, East Moline and Pontiac.

5. As a result of my many years of experience in corrections, I have extensive knowledge of correctional policies and practices relating to the operation of prisons, including the standards regarding when and how individuals are released from custody, and, how and when corrections can exercise its discretion to take immediate affirmative actions to address issues impacting the health and safety of people in custody into account.

6. In my opinion, COVID-19 represents a serious and unprecedented risk to the health and safety of people in IDOC custody and IDOC staff. This risk makes it imperative that IDOC immediately take steps to proactively respond to the virus to protect those individuals. Among those steps is considering how IDOC can exercise its authority and discretion (along with any other body which has the authority or discretion to order release, such as the Prisoner Review Board, using its power to grant parole or to decline to revoke parole, and the Governor, using his power of Executive Clemency) to reduce the prison population. This includes awarding good time credits, transferring people to home detention, and authorizing medical furloughs. All of these and any other options should be fully utilized to allow individuals to maintain social distancing and have better access to testing and treatment. This will also help mitigate the impact of staff shortages and lessens the burden on prison medical services. Reducing the population will improve the health and safety of people in custody who are currently symptomatic and/or test positive as well as individuals who have been exposed to COVID-19 but are not yet showing symptoms and have not yet been tested. As in the community outside IDOC facilities, the numbers of individuals in both categories will increase exponentially.

7. Shortly after I was appointed Secretary of WDOC, I was faced with a crisis that, though different from the current COVID-19 emergency, was similar in that it required immediate and decisive action. In December of 2015, it was brought to my attention that WDOC

had, for thirteen years, miscalculated certain sentences, resulting in approximately 3,600 inmates being released from prison an average of approximately 60 days early. We employed a number of strategies to resolve this error, one of which was the use of the furlough statute. This was used when it was determined that an offender released early had: (1) performed and continued to perform appropriately on community supervision; (2) had an appropriate residence; and (3) had not absconded while on supervision or committed additional felony offenses. If these conditions were met, I authorized a furlough for 30 days, completed a follow-up check-in, and subsequently extended the furlough for an additional 30 days. This helped the impacted individuals maintain their job, living arrangement, and family responsibilities. Illinois appears to have a similar mechanism allowing various classes of prisoners to be transferred to home confinement.

8. If faced with the current Covid-19 crisis, I believe that immediate action is needed to reduce the prison population for the benefit of inmates and staff. I would determine who, including those still housed in prisons, and those on work release, is within the categories that the IDOC or other body has the legal authority to release or transfer, and establish objective criteria, such as having an appropriate release address, to establish who could safely be released or transferred to a non-prison setting, even though many might still remain in IDOC custody. The criteria adopted should be designed to greatly increase the number of releases, to significantly reduce the prison population.

9. The timely implementation of measures to reduce the prison population will decrease the density and slow the spread of this virus in our state prisons and work releases. It will allow IDOC the space it needs to accomplish more effective social distancing, allow more effective quarantining of impacted individuals, and greatly reduce the burden on medical staff and local hospitals. In many cases, this will return those individuals who would otherwise be

released within the next year to their homes now, where they can more effectively self-isolate with their families, provide child and elder care, and receive testing and treatment as needed.

10. The staff and the people who live in prisons and work releases are placed at greater risk for the spread of diseases. It is imperative that IDOC do everything in its power to "flatten the curve" in these facilities during this crisis to protect the health and safety of its staff and the people in its custody. The best way to do this is to quickly implement strategies to reduce the population, in a way that supports public health and safety, to reduce the spread of this virus and maintain increasingly limited staff and medical resources.

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

Dan Pacholke
April 1, 2020

DAN PACHOLKE

PROFILE

Served the Washington State Department of Corrections for 33 years, starting as a Correctional Officer and retiring as Secretary. Leader in segregation reform and violence reduction in prisons. Extensive experience in program development and implementation, facility management, and marshaling and allocating resources. Proven ability to make change. Led efforts resulting in a 30% reduction in violence and a 52% reduction in use of segregation in Washington State Prisons. Co-founder of Sustainability in Prisons Project. Champion of humanity, hope and legitimacy in corrections.

EMPLOYMENT HISTORY

Principal, Dan Pacholke Consulting, LLC. 2018 to Present

Offering a full range of consulting services in the field of corrections.

New York University, Litmus at Marron Institute of Urban Management
Associate Director 2016-2017

Collaborate with researchers and practitioners to develop alternatives to segregation and transform corrections management. Advance stakeholder-led research and innovation by soliciting, supporting, and disseminating the best new strategies to create safer, more rehabilitative corrections environments.

Washington State Department of Corrections
Secretary 2015-2016

Governor appointee providing executive oversight of the agency with a yearly operating budget of 850 million and 8,200 full time employees. Reorganized agency to allow for greater emphasis on effective reentry. Led department through response and recovery from a crisis resulting from the discovery of a sentencing calculation error that had occurred for over 13 years.

Deputy Secretary 2014-2015

Oversight over operations divisions: Offender Change; Correctional Industries; Community Corrections (16 Work Releases and 150 field offices); Prisons (15 facilities); and Health Services. These combined operations had a yearly operating budget of 700 million and 7,166 full time employees. Emphasis on core correctional operations, violence reduction, and performance management leadership to affect positive and sustainable system wide change.

Director, Prisons Division 2011-2014

Oversight over 15 institutions and contract relationships with jails and out of state institutions incarcerating approximately 18,000 offenders. Also responsible for providing emergency response and readiness oversight to all facilities and field offices of all divisions. Advanced multi-faceted violence reduction strategy to include the development and implementation of the “Operation Ceasefire” group violence reduction strategy for application in close custody units in prisons. Expanded Sustainability in Prisons Project programs to all prison facilities. Implemented classroom-setting congregant programming in intensive management units.

Deputy Director, Prisons Division 2008-2011

Administrator over 6 major facility prisons, multi-custody level for adult male offenders with a biennial budget of 290 million. Provided leadership and appointing authority decision making to six facility Superintendents. Through Great Recession implemented staffing reductions, offender movement alterations and cost savings initiatives while maintaining safety and security. Represented the Department in legal issues, labor relations, media, staff discipline hearings, union relations and bargaining. Oversaw statewide operations of Emergency Preparedness and Response, Intelligence & Investigations, Intensive Management Units, Offender Grievance Program, Offender Disciplinary Program, Food Service, Sustainability and Close Custody Operations. Implemented statewide system of security advisory councils and security forums to improve staff safety.

Monroe Correctional Complex
Interim Superintendent 2008

Led a 2,486-bed, multi-custody facility for adult male offenders.

Stafford Creek Corrections Center
Superintendent 2007-2008

Led a 2,000-bed, multi-custody facility for adult male offenders with a biennial budget of 39 million. Implemented Sustainability in Prisons Project initiatives to include large scale composting to include zero-waste garbage sorting. Initiated first dog training programs for male offenders.

Cedar Creek Corrections Center
Superintendent 2003-2007

Led a 400-bed, minimum-security adult male correctional facility, with a biennial budget of 7.3 million. Directed operational and related program activities to include security and custody programs, medical services, plant maintenance, education, and food service. Co-founded the Sustainability in Prisons Project with Nalini Nadkarni, PhD.

Monroe Correctional Complex
Special Assignment Deputy Superintendent 2002

Formulated new strategic direction in order to enhance operations and security at the Complex, which consists of four separate units and houses approximately 2,300 adult male felons. Managed unit operations and security. Supervised the Intelligence Investigative Unit and Offender Grievance System. Developed and implemented capital construction initiatives at the Special Offender Unit and the Washington Reformatory Unit to enhance security of these Units.

Headquarters
Performance System Administrator 1999-2002

Led the development and implementation shift from staff training department to an organizational performance system. Administered staff performance academies, supervised five regional teams, four Program Managers and provided leadership for policy development to support this department wide program. Administered the Department's Emergency Response Plan, Emergency Operations, Officer Safety Program and Firearms Training Unit.

Headquarters
Emergency Response Manager 1995-1999

Developed and implemented statewide emergency response system. Directed the

development of departmental policy, emergency response team academies and response protocols. Managed emergencies and security events. Directed Critical Incident Review Teams in the post incident analysis of critical incidents department wide. Led development of security plans for the management of high-risk operations to include 400 offenders out of state, Y2K, and execution security.

Clallam Bay Corrections Center
Correctional Captain 1989-1995

Responsible for the security management of a maximum, close, and medium custody male facility. Oversaw facility mission changes including: close custody conversion; implementation of blind feeding; facility double bunking; opening of an intensive management unit; opening of first direct supervision unit; and developed the facility's Emergency Response Plan.

Clallam Bay Corrections Center
Correctional Lieutenant 1986 -1989

Washington Corrections Center
Correctional Sergeant 1985-1986

McNeil Island Corrections Center
Correctional Officer 1982-1985

PUBLICATIONS

Useem, Bert, Dan Pacholke, and Sandy Felkey Mullins. "Case Study–The Making of an Institutional Crisis: The Mass Release of Inmates by a Correctional Agency." *Journal of Contingencies and Crisis Management* (2016)
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AWARDS

Olympia Rotary Club, Environmental Protection Award, 2013
Governor's Distinguished Managers Award, 2012
Secretary of State, Extra Mile Award, 2007

Attachment 1
Governor's Sustaining Leadership Award, 2003

CONSULTING

Sustainability in Prisons Project, Co-Director
2004-2015

Nebraska Department of Correctional Services
2015

With Bert Useem, PhD, provided system assessment following May 2015 disturbance at Tecumseh State Correctional Institution in which two inmates were killed. Identified underlying causal factors and provided recommendations.

National Institute of Corrections
1998 to 2002

Provided training and consultation services to state, territory and federal correctional systems. Responsible for delivering of training to include: Management of Security, Entry Level Supervision, Emergency Preparedness Assessment, Disturbance Management and Basic Security.

Defensive Technology Corporation
Senior Instructor
1995 to 1998

Provided tactical and specialty munitions training to correctional and law enforcement personnel throughout the U.S.

Security Auditing & Critical Incident Reviews
Lead Auditor

Completed security audits and critical incident fact finding reviews in facilities throughout the Washington State Department of Corrections and two correctional jurisdictions in other states, one of which involved multi-jurisdictional entities.

EDUCATION:

The Evergreen State College, BA, Olympia, Washington

Attachment 3

Career Highlights

- Reduced violence in Washington State prison system by over 30% while also reducing the number of people held in long-term administrative segregation by over 50%.

- Designed and implemented congregate group programming in the intensive management units (IMU's). The programs offered included evidence based programs and other complimentary offerings. Today all IMU's in Washington State prisons offer congregate programming.

- Designed and implemented the first prison Ceasefire model. This deterrence-based model reduced serious violent incidents (assault against staff, use of a weapon and multi on single man fights) by 50% and continues to be utilized in Washington State close custody (Level IV) prison to reduce serious violence.

- Co-authored a protocol for in-custody Swift, Certain and Fair sanctioning. This deterrence-based model offers a strategy for the reduction of low-level in-custody violations.

- Implemented the Correctional Officer Pre-Service training model at Clallam Bay Corrections Center. This 10-week program offered half-time course work and half-time OJT in order to certify newly hired correctional officers. This program was implemented state wide as the CORE Program, a six-week standardized training required of all staff that work in prisons.

- Served as a lead design team member on the creation and implementation of the Correctional Officer Achievement Program (COACH), a yearlong, on-the-job training program accredited by the WA State Board for Technical and Community Colleges.

- Led the design and development of a comprehensive agency-wide Emergency Response Plan and complimentary learning academies: Emergency Response Instructor (40 hrs.); Emergency Response Team (40 hrs.); Special Emergency Response Team (40 hrs.); Crisis Negotiator (40 hrs.); Joint Operations (24 hrs.); and the Designated Incident Management Team (multiple ICS certifications).

- Co-Authored, *Keeping Prisons Safe, Transforming the Corrections Workplace* and accompanying field guide which are used in CORE and Annual In-Service Training at WA DOC.

- Co-founder and past co-director of the Sustainability In Prisons Project; this program brings nature into prison and features science education. It is recognized internationally and features programs to restore endangered species e.g., Oregon Spotted Frog, Taylor Checker spot Butterfly, Indigenous Box Turtles and over fifty different rare and endangered native prairie plants. http://sustainabilityinprisons.org.

- Offered two TEDx events in prison. These events featured inmates, staff and volunteers as TEDx speakers.

- Implemented Dog retraining programs in all Washington State Prisons.

EXHIBIT

6

Statewide Summary Report Including Review of Statewide Leadership and Overview of Major Services

Report of the 2nd Court Appointed Expert

Lippert v. Godinez

October 2018

Prepared by the Medical Investigation Team

Mike Puisis DO
Jack Raba, MD
Madie LaMarre MN, FNP-BC
Catherine M. Knox RN, MN, CCHP-RN
Jay Shulman, DMD, MSPH

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There is a direct correlation between the FTEs per 1,000 inmates and per-inmate annual spending. A low number of staff can reflect a more efficient system of care or understaffing with its attendant negative consequences for provision of health care. In our study, we found that in 2018 there were 25 employees per 1,000 inmates, which still places Illinois approximately in the lower 10% of state prison systems based on 2015 data. This will be discussed later in this report.

Key Findings

Overall, the health program is not significantly improved since the First Court Expert's report. Based on record reviews, we found that clinical care was extremely poor and resulted in preventable morbidity and mortality that appeared worse than that uncovered by the First Court Expert.

Governance of the IDOC medical program is subordinated to custody leadership on a statewide level and at the facility level. The subordination of health care to custody leadership has resulted in a medical program that is not managed on sound medical principles and one that is without medical leadership.

The existing IDOC system of care was established to have a more robust central office capable of monitoring vendor activity. The IDOC central office has been progressively diminished over the years to the point where it is incapable of effective monitoring.

The medical program does not have a separate budget. The IDOC could not provide to us a document that included expenditures for medical care. Authorization and responsibility for medical expenditures does not reside with the health authority.

IDOC Administrative Directives are inadequate policies for this state system. The IDOC medical policies need to be refreshed, augmented, and address all National Commission on Correctional Health Care (NCCHC) standards.

The IDOC does not have a staffing plan that is sufficient to implement IDOC policies and procedures. The staffing plan does not incorporate a staff relief factor.

Custody staffing has also not been analyzed relative to health care delivery to determine if there are sufficient custody staff to deliver adequate medical care.

Budgeted staffing was increased but vacancy rates were higher than noted in the First Court Expert's report. Staff vacancy rates are very high.

The vendor, Wexford, fails to hire properly credentialed and privileged physicians. This appears to be a major factor in preventable morbidity and mortality, and significantly increases risk of harm to patients within the IDOC. This results from ineffective governance.

Wexford and the IDOC fail to monitor physician care in a manner that protects patient safety. There is no meaningful monitoring of nurse quality of care. If care is provided it is presumed to be adequate, when in fact it may not be adequate.

The inability to obtain consultation reports and hospital reports appears to be a long-standing system wide problem. This is a significant patient safety issue.

The collegial review process of accessing specialty care is a patient safety hazard and should be abandoned until patient safety is ensured.

Specialty care is not tracked with respect to whether it is timely. The Wexford system of utilization management is ineffective and for many patients is a barrier to timely care. The use of free care at UIC appears to have resulted in unacceptable delays. Waiting for unacceptable time periods for free care when care needs to be performed timelier has harmed patients.

Patients are not consistently referred for specialty care when it is warranted. We view this as a problem of hiring unqualified physicians and as a problem of the utilization process itself.

The paper medical record system creates significant barriers to delivery of safe health care, including inaccessibility of prior reports and prior diagnostic tests. The current paper medication administration records (MARs) are inconsistently filled out, filed, or able to be viewed by clinicians. The paper record also makes monitoring health care processes exceedingly difficult. An electronic medical record is needed.

Sanitation, maintenance, and equipping health care units is not standardized. Many clinical areas are inadequately sanitized.

The reception process does not ensure a thorough initial medical evaluation that will correctly identify all of a patient's problems in order to develop an appropriate therapeutic plan. Provider medical histories are inadequate. Follow up of abnormal findings is inconsistent. Laboratory tests and other studies needed for an initial evaluation of a patient's chronic illnesses are inconsistently obtained. Tuberculosis (TB) screening is improperly performed due to custody rules at NRC.

The chronic disease system promotes fragmentation of care and fails to adequately address all of a patient's problems from the perspective of the patient. Patient problems are lost to follow up or are not addressed in the context of a patient's complement of diseases.

The chronic care disease guidelines need to be updated. Alternatively, contemporary existing guidelines by major specialty organizations should be used in lieu of IDOC-specific chronic care

IDOC positions. Nursing staff can be either IDOC or Wexford, making it difficult, because of co-employment rules,[45] to properly supervise line staff.

Of the 78 leadership positions (Medical Director, DON, and HCUA) at the 26 facilities, 16.5 (21%) are vacant. The vacant positions are compounded by co-employment issues[46] and use of two HCUAs as Regional Coordinators. The leadership vacancies are significant on a statewide basis. The lack of Medical Directors is dramatic and is compounded by using physicians in these positions who are, in our opinion, unqualified by virtue of not having primary care training.

In summary, administrative supervision by HCUAs is adequate but clinical-medical supervision and management, particularly physician care, is inadequate and places patients at significant risk of harm. The clinical supervision at the facility level is inadequate based on Medical Director and DON vacancies, and poor qualifications of physicians.

IDOC Policy

The IDOC provides policy direction on clinical care through its Administrative Directives and chronic care guidelines. The medical Administrative Directives are a part of the larger IDOC Administrative Directives which include all custody policy. We will discuss the chronic disease guidelines in the section on Chronic Disease and dental guidelines in the Dental section. The Medical Administrative Directives are inadequate with respect to the breadth of guidance that is necessary for a correctional medical program. The IDOC has only 18 Administrative Directives. In comparison, the National Commission on Correctional Healthcare[47] has 68 standards, which is a minimum panel of policies for a large prison system. There are essential areas of service that are not governed by Administrative Directives and thereby are not guided by policy and not standardized statewide. Though each facility can have additional institutional policies and procedures, the lack of statewide guidance means that practices are not standardized. The Office of Health Services needs to be responsible for statewide policy guidance in all areas of service, with local policy following statewide policy. The 18 medical Administrative Directives are inadequate for this purpose. The National Commission on Correctional Health Care standards are a reasonable guideline to determine the scope of processes of care that should be governed by Administrative Directives.

Wexford Provider Staffing and Physician Credentialing

It is our opinion that the quality of physicians in the IDOC is the single most important variable in preventable morbidity and mortality, which is substantial. The first step in provision of quality of care is to ensure appropriately credentialed medical staff. In its response to the First

[45] Co-employment means that there are two employers (IDOC and Wexford), each of whom has some legal responsibility for the same employees.

[46] When a State employee HCUA is responsible for managing the health care unit but staff are Wexford, there are some limitations with respect to discipline and assignment as a result of union rules. When a DON is a Wexford employee and staff nurses are state employees, the same occurs. These co-employment issues affect multiple facilities we visited.

[47] The National Commission on Correctional Healthcare is the leading organization establishing standards for correctional health programs.

Court Expert's report,[48] on page 4 an attorney for the State states that, "More than 80% of WHS' [Wexford Health Services] physicians are either Board Certified in Family Practice or Internal Medicine, or have more than 10 years of Family/Internal Medicine practice experience or correctional medical experience." This is a misleading statement that gives an inaccurate representation of the credentials of physicians. Credentialing information provided by Wexford shows that only six (20%) of the physicians are board certified in a primary care field. Because physicians typically work alone in these facilities, experience alone is no guarantee that performance will improve to be consistent with current standards of care. We document multiple preventable deaths in the mortality review section of this report. It is our opinion that poorly credentialed physicians contribute significantly to those preventable deaths.

Currently, there are 30 Wexford physicians working in IDOC facilities. Of these, only 16 (53%) have completed training in primary care. Of the 16 that completed primary care training, only six (20% of the 30) are board certified in primary care. Two doctors are obstetricians who work at LCC doing women's care, for which they are appropriately credentialed and privileged; one of these is board certified. These doctors only provide obstetrical and gynecological care, not primary care. Five physicians have an internship or a year or two of primary care training but did not complete a residency.[49] The remaining seven include:

- One anesthesiologist
- One doctor with two years of occupational medicine
- One doctor with some training in pathology
- One doctor with a year of physical medicine
- One surgeon
- Two radiologists, one of whom did not complete residency training.

Credentialing is a process whereby a physician's qualifications are evaluated by reviewing their education, training, experience, licensure, malpractice history, and professional competence with respect to the work they will be expected to perform. Proper credentialing is the foundation of protecting patient safety. Credentialing must ensure that a physician is properly trained for the work they will be performing. Credentialing protects patient safety by preventing incompetent, *poorly trained*, or impaired physicians from engaging in patient care. In correctional facilities, the scope of practice required and the health care needs of patients are mostly primary care, which requires physicians who have residency training in a primary care field. However, the only requirement in the IDOC with respect to credentialing is to verify that a physician has a license. A Regional Coordinator testified that the only review of credentials is to verify that the doctor has a license, and that their training, board certification, or disciplinary history is not part of credentialing review.[50]

[48] Letter via email to Dr. Shansky, First Court Expert from William Barnes, representing the IDOC dated 11/3/14.
[49] This information comes from items 42Z9081-42Z8845-Part 1; 42Z9082-42Z8845-Part 2; 42Z9085-42Z8845-Part 4; 42Z9088-42Z8845-Part 3; and 42Z9090-42Z8845-Part 5. This credentialing information was provided by Wexford Health Sources, Inc.
[50] Deposition of Joseph Ssenfuma, Regional Coordinator, on September 28, 2017.

Privileges are the services and procedures that a physician is qualified to perform based on training and experience. The credentials and training of a physician determine what privileges that physician should have. As an example, a doctor who is trained and credentialed in general surgery can obtain privileges to perform appendectomies and cholecystectomies. A physician trained and credentialed in obstetrics can obtain privileges to deliver babies. Physicians trained and credentialed in internal medicine or family practice can obtain privileges to practice primary care. Physicians trained and credentialed in internal medicine cannot obtain privileges to deliver babies or perform appendectomies. And physicians trained and credentialed in radiology or general surgery cannot obtain privileges to provide primary care. Because the scope of practice and needs of the patients in a correctional medical program are primary care, physicians should be credentialed and privileged in primary care. In IDOC, physicians are credentialed to perform primary care even when they have no training in primary care. This is a serious problem with the credentialing process. For this reason, we agree with the First Court Expert that Medical Directors be board certified in a primary care specialty. Given the size of the IDOC facilities, there is only one physician on staff at most facilities. When this physician is not trained in primary care, there is no other available physician to care for the patient.

Because there are so many physicians who have not completed a primary care residency, the level of supervision of their care should be at a higher level than for board certified physicians. This is not the case. There is no special monitoring for this group. All physicians receive the same type of peer review.

Peer review is a means to monitor the quality of physician and other provider care, and thereby protects patient safety. Peer review of physicians in the community is typically of two types. One type of peer review is done on a routine basis for all physicians and is done as a monitoring device to ensure quality of care. This type of peer review is often called performance evaluation program or PEP. A second type of peer review is done when a member of the medical staff may have committed a serious gross or flagrantly unacceptable error or exhibits a serious character or behavior problem and needs to be evaluated with respect to possible reduction of privileges or referral to a medical board. The latter type of peer review is generally a formal quasi-legal procedure that has significant implications for the physician's employment and professional status. We found that the first type of peer review is done for all physicians and mid-level providers in the IDOC, but the second type of peer review does not appear to occur in IDOC, based on information made available to us. As will be detailed later in the mortality review section of this report, there were numerous grossly and flagrantly unacceptable episodes of care that should have resulted in peer review but did not. Peer review in the IDOC is ineffective, as physicians who commit repeated egregious medical errors continue to practice and continue to harm patients.

The first type of peer review which is performed by Wexford is a structured questionnaire performed by one Wexford physician on another Wexford physician. We noted at one facility that a general surgeon performed the peer review of the primary care work of a nuclear radiologist. It is our opinion that this type of performance evaluation is defective and unlikely to

result in meaningful evaluation, as neither doctor is adequately trained to practice primary care and would not be able to know when care was adequate.

Also, the peer review that is done is so poor that it is unlikely to identify problems. The Wexford peer review consists of a review of 10 single episodes of care for five areas of service. For each of these areas of service there are a series of questions ranging from 10 to 15. Some of the questions are not relevant to clinical quality, such as:

- Is the handwriting legible?
- Is the signature with professional designation legible?
- Is the patient enrolled in all relevant clinics?
- Are all medications written on a script?
- Does the clinic include pertinent vital signs?

While it is important to write a legible note, legibility does not evidence clinical competence. Many questions require an interpretation. For example, the question "Was treatment appropriate for this visit" requires that a physician know the appropriate treatment. The problem is that when only 20% of doctors are board certified and 23% have no training in primary care, many doctors will not know the appropriate treatment. Doctors performing these evaluations need to be expected to know what the appropriate treatment is, otherwise the test will not perform as expected. Also, these episodes of care are picked at random and may not include patients that have serious illness. When someone does not have a serious illness, it is difficult to test the clinician, because it is very difficult to make an error if there is no decision to make with respect to the treatment. Additionally, it appears that these reviews are not taken seriously and appear to be done merely because these are requirements of the contract. For these reasons, it is not surprising that almost all peer reviews were scored 100% adequate. When we compare these results with death chart reviews we performed, there is dramatic discrepancy. Most chart reviews we performed contained many errors. We reviewed the care provided over two years prior to the death. Of 33 death charts we reviewed, there were over 1700 errors. Many had serious errors. Some had egregious errors that resulted in death. We noted the same level of medical error in chart reviews we performed on site visits. The Wexford methodology of peer review does not appear to accurately review physician practice, based on a comparison to our record review of clinical care. This process is not working as intended.

The First Court Expert opined that Wexford hired underqualified physicians, and recommended that facility Medical Directors be trained in primary care and be board certified. We agree with this finding, based on the credentialing information above, and we agree with his recommendation.

In reviewing the Defendants' comments to the First Court Expert's Draft Report,[51] the Defendants challenged the assertion of the First Court Expert that Wexford Health Services has hired "underqualified clinicians." In their attempt to refute that assertion, the Defendants

[51] Re: Lippert v. Godinez – Defendants' comments regarding Confidential Draft Report via email dated November 3, 2014, authored by William Barnes.

stated that, "The community standard, as espoused by the American Medical Association, requires physicians to possess only a license to practice medicine." This is misleading and inaccurate. This statement implies that the current community standard of medicine is for physicians to only have a license to practice medicine, presumably in any field. We disagree. It is our opinion that the community standard in the U.S. is for physicians working in primary care to have residency training in a primary care field. One would never see a pathologist delivering babies. The Defendants' statement also implies that the American Medical Association (AMA) endorses their position. This statement of Defendants is neither the community standard nor is it a standard we could identify as espoused by the AMA.

It is true that it is legal for a doctor without residency training to open a private practice in the community and practice primary care medicine without any training in primary care. However, it is becoming increasingly uncommon, and particularly in urban areas, it is now extremely uncommon to find doctors without residency training in primary care who work in general practice. The standard in the community is for physicians in organized medical practices to undergo credentialing and privileging, and to have residency training consistent with their scope of practice.

With respect to the recommendation to hire board certified physicians, the State's response said,

> "This recommendation, along with any recommendations dictating specific training or certification for licensed correctional physicians, lacks any justification or support in state law and community, ACA, AMA, and NCCHC standards. Accordingly, this recommendation *exceeds minimum constitutional standards of adequacy*" [my emphasis].[52]

With respect to the assertion that use of board certified primary care physicians exceeds minimum constitutional standards of adequacy, we note as an example that there has been Federal Court intervention requiring use of primary care trained physicians when that training was necessary to protect inmate-patients. For years, the California Department of Corrections and Rehabilitation (CDCR) had poorly credentialed physicians, which resembled the current situation in the IDOC. In 2004, in the California prison system, many physicians were not trained in primary care; instead, they had training in surgery, radiology, gynecology, pathology, etc., similar to the IDOC situation in 2018. Many physicians had prior or current sanctions of their licenses and evidence of clinical incompetence by virtue of malpractice claims, which we were unable to evaluate for Wexford physicians. It was the opinion of the Court in California that the lack of qualified physicians resulted in increased morbidity and preventable death. We believe that the situation in California is similar to the situation in the IDOC. In California, as a result of that situation, the Federal Court issued an order[53] requiring the use of physicians who were

[52] Letter via email to Dr. Shansky, First Court Expert from William Barnes, representing the IDOC dated 11/3/14.

[53] Proposed Stipulated Order Re: Quality of Patient Care and Staffing; Marciano Plata, et al., v. Arnold Schwarzenegger, et al.; United States District Court Northern District of California No. C-01-1351 T.E.H., originally filed 9/17/04. In that order, the Court stated: "As of January 15, 2005, defendants shall not hire independent contractor primary care physicians who are not board-eligible or board certified in internal medicine or family practice." p. 3.

board certified or board eligible[54] in internal medicine or family practice.[55] We note that in the California prison system in 2007, there were 18 preventable and 48 potentially preventable deaths, and in 2017, when all physicians were required to be board certified, there were 0 preventable deaths and 18 potentially preventable deaths.[56] Although there were other systemic improvements that helped reduce the number of preventable deaths, improvements in physician credentialing played the major role. Improving credentials of physicians and removal of unqualified physicians has been shown to reduce mortality.[57]

We have learned that in the mid-1980s, approximately 12 IDOC prison facilities were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). At that time, the Agency Medical Director approved all facility Medical Directors and his requirement was that Medical Directors completed primary care training. Accreditation by JCAHO required privileging based on appropriate credentials. At that time, the IDOC placed into its Administrative Directives the requirement that all physicians have one-time primary source verification of their credentials, which was a requirement to verify training. The IDOC ended their accreditation with JCAHO but kept in the Administrative Directives the requirement of primary source verification. Over the years this practice was ignored and currently the HCUAs we interviewed do not even know what primary source verification is. The only credentialing review is to ensure at the annual CQI meeting that every physician has a license.

Physician Staffing

Physician staffing in IDOC is very poor. The Vice President of Operations for Wexford could not remember the last time there was a full physician staff. She thought in 2014 there was only one vacancy, but that was as close to full staffing as the program got. We noted earlier in this report that IDOC lacks adequately trained physicians. This is compounded by vacancies in physician positions. Persistent and ongoing vacancies in the Medical Director position title contribute significantly to physician staffing deficiencies. In addition to vacancies of Medical Directors, all five facilities we visited were missing a physician. Two facilities had replaced a physician position with a nurse practitioner because of the inability to fill physician positions. Statewide, the total days of missing Medical Directors totaled 22% of total days these positions were supposed to be filled,[58] an unacceptable vacancy rate.

Because of vacancies, physicians are moved from site to site as "Traveling Medical Directors." One of the facilities we investigated, NRC, had a Traveling Medical Director. This individual did

[54] Board eligible is a term used to describe a physician who has completed a residency training in a field and is therefore qualified to take a board certification test for that specialty. For example, a board eligible internist is one who has completed a residency in internal medicine and is qualified to take the board certification test but has not yet done so.
[55] Since this order, the California Department of Corrections and Rehabilitation, through the Receiver's office, requires board certification in family practice or internal medicine.
[56] Based on annual analyses of inmate deaths as reported by Dr. Imai, consultant to the medical receiver in California as found under the heading of Death Review at https://cchcs.ca.gov/reports/.
[57] Terry Hill, Peter Martello, Julie Kuo; A case for revisiting peer review: Implications for professional self-regulation and quality improvement. Plos One at https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0199961&type=printable.
[58] Document 42P5621-IDOC Facilities lacking permanent medical directors 7-1-15 to 11-26-17 Bates number 550.

not participate meaningfully in quality improvement, did not show any evidence of oversight of the medical program, and had clinical issues.

The turnover of Wexford physicians is also very high. Of 33 physicians listed on a 9/19/14 report[59] by Wexford, only 18 (54%) are still working three and a half years later. The inability of Wexford to hire and *retain* qualified physicians is a serious problem and was mentioned as a significant problem by every HCUA we spoke with. There has been no formal analysis of this that we could find. The Vice President of Operations for Wexford told us that it was harder to recruit to corrections because of the impression that if you worked in corrections, you were a bad doctor. We disagree. In our opinion and from experience, recruitment in corrections depends on establishing conditions of work that are professional and foster a sense of providing a worthwhile service. When that occurs and when doctors are properly supported, qualified doctors can be found and retained in correctional environments and elsewhere.

At the five sites we visited, none had a long-tenured Medical Director. LCC had a Medical Director who had the longest tenure of the five facilities we inspected. She had been Medical Director since May of 2016. The Medical Director at Dixon started in October of 2017. The Medical Director at MCC has been in his position since June of 2017. One Medical Director was at Dixon for a short period of time before being moved to NRC. After several months at NRC, he was moved to SCC. About two months after being moved to SCC, he resigned. His position at NRC was filled in coverage by the ex-Medical Director at Hill, who the First Court Expert stated had identified clinical issues. This musical chairs rearrangement of Medical Director assignments is demonstration of the failure to create an environment likely to attract qualified physicians. The IDOC needs to determine why it is that their vendor cannot recruit and retain qualified physicians.

Physician leadership was not improved based on the First Court Expert's comment that,

> "the Medical Directors were functioning in primarily clinical roles and spent little if any time reviewing the clinical practice of other providers or engaging in other important administrative duties."[60]

Several of the HCUAs spoke about poor physician quality as an issue. Two of the Medical Director positions were vacant. A coverage physician at one facility with a vacant Medical Director position did not participate meaningfully in quality work or in providing clinical leadership. In two of the remaining three facilities we visited, the HCUA spoke of having problems with the Medical Director. One was described as only doing chart reviews, not wanting to see patients, not reviewing deaths, and having to be urged to see patients. When leadership and quality of physicians is inadequate, patients are placed at risk because poor quality will not be identified or corrected.

[59] 40C0134- IL Physicians Report 9 19 14 Key Produced by Wexford Health Services.
[60] Final Report of the Court Appointed Expert, Lippert v. Godinez December 2014 p. 7.

Non-Physician Staffing

On a statewide basis, exclusive of dialysis and the HIV and hepatitis C telemedicine program, there are 1119.6 medical staff in the IDOC program, with an inmate population at mid-year 2017 of 43,075. This amounts to 26 staff per 1000 inmates, which places IDOC approximately in the lowest 10% of state prison systems in the country[61] with respect to staffing numbers *based on 2015 data*. Of the 1119.6 staff, 401 (36%) are employed by IDOC and 718.6 (64%) are employed by Wexford Health Sources. Of the 1119.6 medical staff, there are 245.8 (22%) vacancies, not including leave of absences, which would increase this number a few points. Wexford has an 18% vacancy rate for its 718.6 employees and IDOC had a 29% vacancy rate for its 401 employees. These are very high vacancy rates and compound a very low staffing level, making staffing a critical problem statewide. This was confirmed by HCUAs at sites we visited.

We compared facility staffing for mutually visited facilities. In 2014, the First Court Expert determined that for the five facilities we visited there were 303.41 budgeted positions, an 18% vacancy rate, and 25 staff per 1000 inmates.

Positions, Vacancies, and Positions per 1000; First Court Expert's 2014 visit[62]

Facility	Positions	Vacancies	% Vacancy	Population	Staff per 1000
SCC & NRC	73.90	23	31%	4078	18
LCC	62.21	4	6%	1997	31
Dixon	66.30	18	27%	2349	28
MCC	101	9	9%	3750	27
Total	**303.41**	**54**	**18%**	**12174**	**25**

For the same five sites we visited, there were 405.05 budgeted positions. There were 99 (23.5%) vacancies. This is a very large vacancy rate, which makes it difficult to effectively operate a health program.[63] Four of the five facilities we visited had unacceptable vacancy rates.[64] We note several key differences in the staffing differences between 2014 and 2018. The population in the five facilities we reviewed decreased by 2177 (18%). The number of positions

[61] Prison Health Care: Costs and Quality, Pew Charitable Trusts, October 2017. We note that the staffing levels given in the Pew study reflect 2015 numbers. However, these 2018 IDOC staffing numbers still would rank Illinois in the lowest 10% of state prison systems comparing IDOC 2018 staffing to nationwide 2015 numbers.

[62] This table is constructed from data taken from tables presented in the First Court Expert's report.

[63] In Defendants' comments on our report they noted that there is a national nursing shortage and cite a survey of readily available health care facilities in the United States in January 2018 by Nursing Solutions, Inc. a recruitment firm. Defendants note that over 25% of the hospitals in this country who responded to the survey have Registered Nurse (RN) vacancy rates of greater than 10%. This same study reported that the average vacancy rate for Registered Nurses is 8.2%. In either case, nursing vacancies in the IDOC facilities we visited exceeded the average from this survey and were much more than the maximum of 12.5% used in the study.

[64] Except for LCC, all IDOC facilities had vacancy rates of 20% or greater. These vacancy rates are much higher than Federal Bureau of Prisons policy that establishes that vacancy rates not exceed 10% during any 18-month period (Program Statement P3000.03: Human Resources Management Manual, Chapter 3, page 11 obtained at https://www.bop.gov/PublicInfo/execute/policysearch#. There are no published reports comparing vacancy rates amongst health care providers working in state prison settings.

increased by 101.64 (33%).[65] The staff per 1000 inmates increased by 16 (64%). But the vacancy rate increased from 18% to 23.5%, a 30% increase.

Positions, Vacancies, and Positions per 1000 Inmates; 2018 visits

Facility	Wexford and IDOC staff	Vacancies	% Vacancy	Population	Staff per 1000
SCC	98.00	24	24%	1183	83
NRC	69.00	29	42%	1681	41
LCC	53.15	1	2%	1806	29
Dixon	93.80	19	20%	2298	41
MCC	91.10	26	29%	3029	30
Total	**405.05**	**99**	**23.5%**	**9997**	**41**

While budgeted staffing increased at three of five facilities we visited, it decreased at two of five facilities. There are 44 additional staff working at these facilities than there were when the 2014 report was written.

Four of five facilities we visited had significant vacancy rates, as high as 42%, which are mostly nursing staff. Almost every HCUA told us that there were insufficient nursing staff. This was confirmed in the deposition of the Agency Medical Coordinator, who noted that over the past several years there have been nursing shortages at SCC, Pontiac, Decatur, Graham, Southwestern, and MCC.[66]

Most HCUAs told us that if all their positions were filled they believed that there would be adequate staff. We do not agree. The IDOC has not performed a staffing analysis based on expectations of the Administrative Directives and special care needs, including infirmaries and geriatric care. Relief factors have not been included in staffing considerations and budgeted staffing numbers do not appear to be adequate. In our opinion, despite increased nurse budgeted staffing and even when vacancies are filled, there will still be nursing shortages. The IDOC, in their comments on our report, assert that the IDOC in the current fiscal year and Wexford in the past year spent a total of $8,283,718 on overtime wages. We acknowledge that this is a significant expenditure. Based on our investigation, overtime is used to cover some but not all vacant shifts. However, reliance on overtime contributes to staff fatigue, increased errors, staff dissatisfaction and turnover as well as higher incidence of poor patient outcomes.[67] While we did not evaluate working conditions for staff, we did find ample evidence of error and

[65] Dixon appears to have had a significant increase in staffing, but as the HCUA related to us, this is artefactual, as 22 nurses were moved from the mental health program to the medical program but still had assignments in mental health. Their reassignments did not create increased staffing for the medical program, but gave the impression that there had been a large increase in staffing. If these 22 nurses are removed from the Dixon staffing, the actual increase in staffing would be 79.64 positions or a 26% increase, not a 33% increase.

[66] Deposition of Kim Hugo, Agency Medical Coordinator pp. 25-31, April 11, 2018.

[67] Institute of Medicine (2004) Keeping Patients Safe: Transforming the Work Environment of Nurses. National Academies Press, Washington, D.C., Stanton, M. (2004). Hospital nurse staffing and quality of care. Agency for Healthcare Research and Quality. Research in Action, Issue 14.

poor patient outcomes in our review of health care provided to IDOC prisoners. The use of overtime does not change our opinion that a staffing analysis is needed or that there is lack of adequate staffing.

The Wexford component of staffing is memorialized in a contract document called a Schedule E. Based on interviews with senior leadership of Wexford and IDOC, we could not determine who is responsible for developing staffing levels found in the Schedule E. The Wexford Vice President of Operations told us that the Schedule E staffing is the recommended staffing of the IDOC to which the vendor can make suggestions. Mr. Brunk, the Chief Financial Officer, told us that the Schedule E is developed by the Wexford Regional Manager and reviewed by the IDOC Office of Health Services. The Agency Medical Director told us that he had input into the Schedule E for new facilities but otherwise had no input into the Schedule E, and that Mr. Brunk or Wexford developed the Schedule E, which the Office of Health Services approved. The Chief of Programs and Support Services, who is the health authority, told us that the Agency Medical Director was responsible for development of the Schedule E. Development of the Schedule E is not in the job description of the Agency Medical Director. The lack of a central health authority, we believe, contributes to this confusion. Furthermore, the Schedule E as represented in the current contract does not include input from HCUAs, Regional Coordinators, or even the Agency Medical Director in addressing clinical needs in their facilities. Given these responses, it is our opinion that the Schedule E does not reflect actual staffing need, as it does not appear based on any staffing analysis we could identify after discussions with health leadership who we thought would be responsible for this document.

No one we spoke with has responsibility for determining if total staff (state and Wexford) is adequate. The IDOC Agency Medical Director and the Agency Medical Coordinator told us that an Assistant Warden of Programs (AWP) from Sheridan, who also was a nurse, was engaged in analyzing staffing at various sites, but the extent of this analysis was not known to the Agency Medical Director. The Illinois Nursing Association (INA) is the union for the registered nurses in the IDOC. The Agency Medical Coordinator participates on an INA standing committee that meets monthly to discuss INA related nursing issues. The INA has raised issues with respect to staffing at certain facilities. When this occurs, the AWP from Sheridan performs a staffing analysis, brings it to the standing committee, which then considers staffing recommendations, and forwards them the Agency Medical Director for review. Other than this effort, we could identify no analysis of staffing need state wide.

Based on conversations with senior IDOC leadership, staffing increases at NRC and SCC were a result of union negotiations. Senior IDOC Office of Health Services staff were not involved in this decision,[68] although a Regional Coordinator gave recommendations on how many nurses were needed. These increases were not based on a thorough staffing analysis, as relief factors were not used and because no positions other than RN positions were considered. At no facility has there been an analysis of staffing need based on adherence to the Administrative Directives. This creates a gap between clinical need and staffing levels that affects all facilities.

[68] See pages 14-16 of deposition of Kim Hugo, Agency Medical Coordinator, April 11, 2018.

Because we only visited a small number of facilities, the true staffing deficiency is unknown. The program should undertake a staffing analysis, considering all job classifications with relief factors. This was a recommendation of the First Court Expert and we agree with that recommendation. This analysis should not be performed by a custody person and probably should be performed by an outside expert.

We noted at four sites there were inadequate supervisory nurses. At MCC, SCC, Dixon, and LCC, we felt that budgeted supervisory nurse positions were inadequate. At Dixon, SCC, and LCC, the HCUA provides some nursing supervision due to vacancies.

Custody staffing was not addressed by the First Court Expert. At several facilities we visited, there were issues related to insufficient officer staffing to properly accompany nurses in medication administration or to escort patients for scheduled appointments. While we did not study this in depth and lack the ability to review officer staffing, the numbers of officers need to be sufficient to ensure that medical services can be timely and appropriately provided. For this reason, we believe that officer staffing with respect to medical services needs to be studied and additional officers hired as indicated.

Statewide Use of University of Illinois

Current Findings

The First Court Expert did not address services provided by University of Illinois at Chicago (UIC). UIC provides laboratory services statewide. We found no problems with laboratory services at any facility we visited. UIC also provides HIV and some hepatitis C services via telemedicine statewide. Everyone we spoke with commented on the high quality of these services. All patients with HIV are scheduled for care by UIC clinicians. The First Court Expert found that coordination of care between UIC and IDOC providers could be improved. We agree, but found that overall when patients are referred, care was of very good quality.

For hepatitis C, IDOC physicians evaluate patients with hepatitis C in a hepatitis C chronic clinic. We found that these clinics were not performing well. When patients reached a level of fibrosis that is equivalent to stage 3 fibrosis, the IDOC physician refers the patient to a Wexford internist, who evaluates whether the patient should be referred to UIC and whether any other testing needs to occur. In our opinion, this process only serves to delay access to hepatitis C care and we found multiple cases of delayed hepatitis C care that caused harm.

Furthermore, because IDOC physicians lack primary care training, they appear to not know how to manage cirrhosis. There is no evidence that patients with cirrhosis from hepatitis C obtain timely baseline esophagogastroduodenoscopy (EGD) to screen for varices or every six month ultrasound screening for hepatocellular carcinoma, which is a standard of care. We noted on death reviews a patient who died of bleeding varices who never had an EGD to screen for this condition.

counseling of individuals, but there has been no review or analysis done to identify root causes for these persistent failures, and no effort made to eliminate systemic causes of failure or improve performance through corrective action planning. In the meantime, inmates are subjected to delays and interruptions of treatment, unsanitary conditions, and medication errors.

We note that some of the root cause problems appear to be related to custody control of medical processes within the institution and the apparent reluctance of health staff to openly discuss with custody the need for their cooperation in the process of medication administration. The governing bodies of CQI committees at several facilities were mostly custody-trained staff. This is an impediment to effective monitoring of clinical processes, such as medication treatment. Participation and support of custody staff in CQI is very important; however, medical staff must direct and control the monitoring of health care and be able to drive necessary performance improvements.

Infection Control

Infection control is an essential element of an adequate health care system. The inmate population has a high prevalence of communicable and infectious diseases. Because of the high prevalence of communicable diseases, a highly functioning infection control program must be in place to identify, track, and assist in management of these illnesses.

Approximately 4-6% of TB cases reported in the United States occur among people incarcerated at the time of diagnosis. The incarcerated population contains a high proportion of people at greater risk of TB than the overall population.[164] In 2013, there were 36,064 persons with HIV infection in the civilian population of Illinois, with a population over 18 years old of 9.7 million or 0.4% of the population. In 2010-2015, IDOC had 686 inmates with HIV infection or 1.5% of its population.[165] The IDOC HIV prevalence was almost four times as high as the civilian HIV prevalence. It is estimated that approximately 160,000 persons in Illinois have hepatitis C or about 1.6% of the Illinois population, as opposed to 5.6% known cases in IDOC and an estimated 10% overall estimated prevalence. The IDOC had at least 3.5-6.25 times the rate of hepatitis C infection of the civilian population. The burden of sexually transmitted disease, MRSA, and scabies are also typically higher in prison systems.

Conditions of confinement promote the spread of disease because of environmental conditions within the prisons. Inmates are housed in close quarters. In our IDOC Prison Overview section we spoke about how crowded the IDOC prisons are. The overcrowded conditions, particularly in antiquated facilities, promote transmission of multiple types of infections and contagious diseases. Individuals have no control over the quality of air they breathe via the facility ventilation system; they live in cells or dormitories that have been occupied by others and are

[164] TB in Correctional Facilities in the United States, Centers for Disease Control and Prevention as found at https://www.cdc.gov/tb/topic/populations/correctional/default.htm.

[165] HIV in Prisons, 2015 – Statistical Tables , Laura Maruschak and Jennifer Bronson, Ph.D., *BJS* Statisticians; August 2017, NCJ 250641, US, Department of Justice *Bureau of Justice Statistics.*

expected to clean their living area with supplies that are available; they are provided food prepared by inmate workers to eat with silverware and plates cleaned by inmate workers; they are provided linens and clothing that are washed by inmate workers or wash linens themselves with laundry soap that is available; they use toilets, sinks, and showers that are used by many others. Every one of these activities of daily living carries multiple opportunities for communicable or infectious disease transmission and illness for both staff and inmates. Infection control programs in the correctional setting establish and monitor procedures to prevent exposure to diseases that can be transmitted in the correctional setting. Infection control programs also identify sources of infection through screening and take steps to prevent or mitigate infection of others, to treat persons with infectious diseases, and improve the health and safety of staff and inmates by providing information on prevention, education on self-care, and immunizations.[166] These efforts require surveillance of disease by accurate statistical means, both for required reporting purposes and so that the IDOC medical program can understand how to study, plan, and prepare for the care they will need to provide. The infection control program is usually coordinated by a registered nurse with consultation from a designated provider with expertise in infectious diseases,[167] and supported by data collection methods that can reasonably track diseases within the prison system.

First Court Expert Findings

The First Court Expert found IDOC's infection control program was a moving target across the system, with some facilities having well developed infection control programs and other facilities having programs described as being in their infancy. Facility health care staff had been provided with an exposure control manual, but IDOC provided no oversight of infection control. At some facilities, no one was clearly designated with responsibilities for infection control, and the duties were simply added to those of the HCUA or DON. Other facilities had identified a specific nurse responsible for infection control, but the duties of the position had not been defined. In addition, no training in how to operate an effective infection control program had been provided to those individuals who had been assigned responsibility for infection control.

Examples of systemic issues described by the First Court Expert which occurred as a result of the disarray in infection control monitoring and lack of oversight from IDOC included the failure to launder bed linens of infirmary patients in water temperatures hot enough to destroy pathogens transmitted by blood and body fluids; negative pressure rooms that were not functional and not monitored to ensure that negative pressure was maintained to prevent transmission of airborne illnesses; lack of proper sanitation of medical equipment; and lack of disinfection procedures to provide clean surfaces when examining patients.

Current Findings

The systemic issues described in the First Court Expert Report still occur today. While there has been some improvement in the use of paper barriers on examination tables, little else has

[166]Bick, J. (2006) Infection Control in the Correctional Setting. In M. Puisis, (Ed.) *Clinical practice of Correctional Medicine*. (2nd ed.) Philadelphia: Mosby Elsevier. 230-231.

[167] Lane, M. (2006) The infection control program. In M. Puisis, (Ed.) *Clinical practice of Correctional Medicine*. (2nd ed.) Philadelphia: Mosby Elsevier. 460-461.

changed with regard to the infection control program. The following summary of our findings reinforces the findings of the First Court Expert. We had multiple additional findings that give us concern.

The IDOC has had numerous recent outbreaks of contagious and infectious diseases. Since 2008, there have been several outbreaks of scabies in Illinois prisons. The latest was in Taylorville in 2016, in which the prison was locked down and 214 inmates were treated.[168] In 2012, a norovirus outbreak sickened 140 inmates at SCC.[169] The numbers of inmates affected in these outbreaks reflects poorly on the surveillance and typical preventative measures enacted by infection control procedures to abort the contagion earlier and prevent the widespread infections that occurred at these facilities. An inmate at SCC also contracted Legionnaire's disease in 2015.[170] At the Danville Correctional Center, 78 persons were affected by histoplasmosis in 2013, likely from soil disruption. This outbreak was initially thought to be adenovirus, but required investigation by the federal Centers for Disease Control and Prevention and was found to be histoplasmosis.[171, 172]

Typically, outbreaks such as these are monitored and sometimes managed by the infection control program. Yet in the IDOC, there was no designated individual responsible for infection control at four of five facilities we visited, including at SCC, where one of the outbreaks described above occurred, as well as the isolated case of Legionnaire's disease. At SCC, infection control duties were dispersed amongst several staff nurses, the DON, and the HCUA, and the program was not effective. The norovirus outbreak at SCC was large, and typically early infection control measures would be expected to reduce the size of such an outbreak. At the same four facilities there were no schedules for routine sanitation and disinfection of health care areas. Basic maintenance of rooms was lacking. MCC has an extensive collection of policies and procedures that detail cleaning and sanitation of every room in the health care building.

At MCC, responsibility for infection control resides with one of the nursing supervisors. Her responsibilities are managing TB surveillance, performing sanitation inspections, ensuring food handlers are cleared for work, monitoring skin infections, interface with the Illinois Department of Public Health, monitoring negative pressure rooms, and monitoring hygiene in clinical spaces. In addition, she manages HIV and hepatitis C clinics, coordinates follow-up of patients treated for TB infection, and provides supervision of inmate peer educators. It is our opinion that the infection control nurse is an essential component of the health care program at IDOC facilities and is a full-time position.

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[168] Scabies Outbreak Causes Temporary Lockdown of Taylorville Prison, Doug Finke, The State Journal Register, September 19, 2016.

[169] Norovirus Outbreak Hits Illinois Prison; Food Safety News December 29, 2012.

[170] Stateville Inmate Diagnosed with Legionnaire's Disease, Dawn Rhodes, Chicago Tribune August 12, 2015.

[171] New details regarding illness among inmates at Danville Correctional Center. Found at https://www2.illinois.gov/idoc/news/2013/pages/danvilleccillness.aspx.

[172] Centers for Disease Control and Prevention website Outbreaks and Investigations lists Histoplasmosis in an Illinois Prison. Details given were that this occurred in August-September 2013 with 78 cases and likely related to disruption of soil containing bird droppings. Found at https://www.cdc.gov/fungal/outbreaks/index.html.

We observed significant challenges to safety and sanitation at every facility visited. For example, at SCC we observed cockroaches, gnats, and flies in the infirmary; the room used for hemodialysis (considered a sterile procedure) had peeling paint on the walls, there was standing water on the floor, and the garbage can was not covered. The kitchen/dining area was occupied by birds, and their droppings were evident on the walls and floors. At Dixon, all three floors of the medical building had missing floor tiles, which is a sanitation issue in an area dedicated to the delivery of health care.

NRC is the only facility among the five we visited that does not conduct monthly safety and sanitation inspections. At the other facilities, safety and sanitation inspections do not adequately identify problems requiring remediation. For example, we found faulty negative pressure isolation rooms and nonfunctional dental equipment that were not identified because they are not included in the safety and sanitation inspections. We also found furniture, equipment, and hard surfaces (floors, ceilings, sinks, cabinetry) were rusted, broken, or deteriorated in health care areas at all facilities, which had not been documented as issues needing repair on safety and sanitation rounds.

Moreover, review of safety and sanitation findings in the minutes of CQI meetings document the persistent failure or lengthy delay in remedying identified problems. Safety and sanitation inspections should inspect or monitor the condition, function, and annual certification of clinical equipment, functionality of the negative pressure rooms, integrity of bed and chair upholstery, completeness of medical cart and emergency response bag logs, the training of health care unit porters, and other health care issues.

The TB prevention and control program in IDOC is not effective. The hallmarks of an effective TB program in correctional facilities are: initial and periodic TB screening, successful treatment of TB disease and infection, appropriate use of airborne precautions, comprehensive discharge planning, and thorough and efficient contact investigation when a case of TB disease is identified.[173]

At IDOC, TB screening is improperly performed, treatment of infection is delayed, and negative pressure rooms (an airborne precaution) often are not functional or monitored. We did not evaluate TB discharge planning or contact investigation, although in the absence of an individual assigned responsibility for infection control, these interventions are most likely sporadic and haphazard as well. At NRC, nurses do not read tuberculin skin tests properly and only document results in the health record when they have time. Instead of inmates being escorted to the medical clinic for nurses to read their tuberculin skin tests, nurses must go cell to cell. In addition, NRC officers do not open the food port for inmates to extend their arm for nurses to palpate and measure the results of the test. Instead, nurses read the test by looking through the glass window of the cell door, which is inappropriate technique.[174] There was

[173] TB in Correctional Facilities at https://www.cdc.gov/tb/topic/populations/correctional/, Epidemiology of Tuberculosis in Correctional Facilities 1993-2014 at https://www.cdc.gov/tb/publications/slidesets/correctionalfacilities/default.htm.

[174] A tuberculin skin test is read by manually palpating the size of induration of the test site with good overhead lighting. To read a tuberculin skin test through a glass window is inappropriate.

evidence in the review of records that other sites distrust TB screening performed at reception centers and rescreen inmates upon arrival at their parent facility. We also observed that nurses at Dixon merely look at the skin test site through the cell door rather than palpating and measuring induration in a well-lit area. We did not observe nurses reading tuberculin skin tests at all facilities, but based upon the two sites where we observed poor practices, we conclude that TB screening at IDOC is not adequate.

We reviewed the records of four patients who had completed treatment for latent TB infection. In three cases, the patient was subjected to multiple skin tests (which were positive) and multiple chest radiographs, which were unnecessary, before treatment was finally initiated. In the other case, treatment was initiated even though skin testing was ordered but never completed, based upon a history of a positive skin test reported by the inmate when he requested treatment initiation. Initiation of treatment for latent infection was haphazard and delayed.

Negative pressure isolation rooms were either not functional or the monitor was not working at three of the five sites we visited. At NRC, the monitor in one room was not working and in the other room the vent was taped shut, disabling the negative pressure. At SCC, neither room was functional and the equipment had not been serviced for years. At LCC, two of three rooms were not functional. Negative pressure rooms need to be maintained and ready for use; this is not the case in the IDOC, and places patients and staff at risk of airborne infection.

The UIC provides treatment of inmates with HIV and hepatitis C via telemedicine. For hepatitis C, UIC has no role in managing hepatitis C patients before referral and after antiviral treatment and has no role in screening for these diseases. UIC provides no assistance in managing other complications of hepatitis C including cirrhosis, varices, or ascites as examples. IDOC facility providers are responsible for that care but do not appear to know how to provide it. One or more nurses are designated at each site to coordinate these clinics and the care of these patients. The quality is highly dependent upon the interest and capability of each nurse assigned these responsibilities. There is no one identified to monitor or oversee the work of the clinic coordinators, who must negotiate with all the other users of the telemedicine space to schedule clinics timely. Coordination between the UIC infectious disease specialists and primary care providers is problematic, as evidenced in the example of one patient with HIV; the specialist recommended lowering the patient's dose of metformin (a medication used to treat diabetes) because of an interaction with one of the HIV medications prescribed.[175] The primary care provider at the facility responsible for the patient's diabetic care never acted on the recommendation. The HIV specialist reduced the dose of metformin at the next visit. The patient was at risk of clinical deterioration because of the primary care provider's omission for five months.

IDOC has adopted what it describes as opt-out HIV testing at intake, but policy and practice are not consistent with the use of this term. Opt-out testing is recommended by the Centers for

[175] Dixon Infection Control Patient #3.

Disease Control because it supports early identification and treatment.[176] The IDOC Administrative Directive still requires that consent be obtained before drawing blood for HIV, and in practice this consent is still obtained.[177] The practical effect is that fewer newly arriving inmates are screened for HIV as compared to hepatitis C. The IDOC should revise the Administrative Directive to eliminate the requirement for written consent and initiate opt-out HIV testing.

We also question the effectiveness of periodic screening programs for HIV and hepatitis C infections. We noted on one death review[178] a man who was not known to be HIV infected and was not offered HIV screening at two annual health evaluations we reviewed, despite having a history of multiple sexual partners, prior blood transfusions, and a history of sexually transmitted disease all of which were risk factors for HIV infection. He ultimately developed severe HIV disease, which was unrecognized for several years until he was finally admitted to a hospital, where he died of severe complications of his undiagnosed and untreated HIV disease. Sentinel cases such as these should prompt an investigation into why the system failed to timely screen, diagnose, and treat this patient, whose death was preventable. The infection control nurse should monitor results of HIV and HCV screening to verify that policies to screen for communicable diseases are effective.

All five of the facilities visited report cases of culture positive *Methicillin-resistant Staphylococcus Aureus* (MRSA) as is required by IDOC. However, only MCC tracks all skin and soft tissue infections (independent of whether a culture is performed) as recommended by the First Court Expert. In addition, tracking should include culture and sensitivity results to ensure correct antibiotic selection and housing location of the patient. Infection control nurses should review tracking results to identify clusters of infections by housing unit, perform additional case-finding, and identify environmental factors that may be promoting infection. Factors in correctional settings found to contribute to skin and soft tissue infections include sharing towels and soap, ineffective laundry practices, poor sanitation of exercise equipment and showering facilities, poor hygiene practices, unnoticed infections that leak pus, and poor access to medical care.[179] Tracking enables sources of infection to be identified and steps taken to eliminate factors associated with disease transmission. For example, at MCC one of two cases of skin infection reviewed was a patient who developed infection six days after hernia surgery and having been returned immediately to general population at the facility.[180] This case of soft tissue skin infection raises questions about the ability of the patient to adhere to wound care instructions and suggests consideration of a policy of admitting inmates to the infirmary only after it is determined that the patient is stable and able to adhere to wound care instructions.

[176] Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and it is performed only upon patient consent. The IDOC has large rates of refusal of HIV testing, unlike other similar correctional centers that offer opt-out testing. Opt-out testing generally raises the rates of screening.
[177] Administrative Directive 04.03.11 Section5 II. F. 5. d.
[178] Mortality Review Patient #22.
[179] Smith, S. (2013) Infectious Diseases. In L. Schoenly and C. Knox (Eds.) *Essentials of Correctional Nursing*. New York: Springer. P. 189.
[180] MCC Infection Control Patient #7.

The IDOC requires a monthly report of communicable diseases and infection control data. This report includes items such as the number of MRSA cases, HIV and HCV tests performed, the number of tuberculin skin tests administered, the use of negative pressure rooms, etc. We found that these reports are submitted to the Quality Improvement Committee (QIC) and included in the monthly minutes. However, there is no trending or analysis of infection control data. There is no discussion in the infection control report or CQI minutes of, for example, why only half of incoming inmates are tested for HIV, given the statewide opt-out policy. A more notable example of the lack of introspection about communicable and infectious disease are three needle stick injuries which occurred in 2017 at Dixon, and the fact that there has been no focused review of these injuries to determine what measures would increase worker safety.

We found numerous examples of poor infection control practices on the part of health care professionals. At all facilities, inmates are not routinely provided eye protection during dental procedures. At NRC, the dentist examined patients without changing gloves between patients and reached into a bag of sterile mirrors to select one for use, contaminating all the other mirrors which were then used on subsequent patients. At SCC, the hemodialysis unit does not have a dedicated chair and technician for dialysis of patients who have hepatitis B, thereby exposing other dialysis patients to this blood borne infection. At NRC and SCC, paper barriers are not available to use on any of the examination tables and they are not cleaned between patients. Finally, the order in which instruments were sterilized was incorrect in four of five facilities we visited. The placement of sterilization equipment and procedures should proceed from dirty to sterilized. At four of five facilities we visited, the placement of the ultrasonic cleaner required clean instruments to pass over the dirty area, thus contaminating their sterilization. At SCC, sterilized instruments were removed from their packages and put in an open bin in the trauma room, making them clean, rather than sterile, instruments. The nursing supervisor could not explain why these instruments were clean rather than sterile.

Inmate porters are assigned to work in the health care areas of each of the five facilities we visited. At only two of the facilities had the inmate porters received training in how to clean and sanitize patient care areas, and how to take personal protective measures before working in the health care area. Only two facilities had vaccinated the inmate porters for viral hepatitis. The assignment of untrained and unvaccinated inmates to clean and sanitize health care areas exposes these inmates as well as patients receiving care to several infectious diseases with potentially serious health consequences, and is deliberately reckless.

Infirmary linens are still laundered in residential style washers and dryers at all the facilities we visited, except NRC. At NRC, a log provided by the institution showed water temperatures were less than the 165°F required by AD 05.02.180 about 30% of the days reviewed. Water temperatures were not hot enough to effectively sanitize laundry from the infirmary at any facility we visited. We also observed furniture and equipment throughout each of the health care areas at every facility we visited that was torn, frayed, rusted, and corroded. These objects, including stretchers, exam tables, stools, cabinets, and work surfaces cannot be properly sanitized and are sources of communicable disease in a setting that treats and cares for patients who are ill, medically fragile, and immunocompromised. While some have been

identified as needing repair or replacement, the safety and sanitation rounds do not often include these health care areas and there is no effective tracking of the repair or replacement of these items. It is understood that it takes time to repair or replace worn equipment, but in IDOC the volume of items needing repair and the length of time that unacceptable conditions linger indicate pervasive and systemic problems with environmental controls to prevent communicable disease.

The First Court Expert noted that the Communicable and Infectious Diseases Coordinator in the Office of Health Services retired some time ago and that the position was never filled. That is true today as well. There is no one in the Office of Health Services who has responsibility statewide to direct and oversee infection control in the IDOC. The IDOC also does not have an infectious disease physician responsible for directing infection control activity within the department. The Infection Control Manual was last updated in 2012, and many of the resources in the manual are out of date or more current material is available. The facility health care programs have some policies and procedures for infection control, but we found these also not up to date. Nursing Treatment Protocols are also provided by the IDOC for possible infections such as scabies, rash, urinary infection, pediculosis, chicken pox, and skin infections. These were last updated in March 2017 and are adequate, but stand-alone rather than as part of a comprehensive infectious disease program. The need for statewide oversight is evident to resolve issues, such as the conflict between the IDOC practice of HIV opt-out testing and the AD, to eliminate the continued insufficient laundering of infirmary linens, to address the problem of needle stick injuries, to provide meaningful analysis of communicable disease surveillance, and to provide guidance to facility health care programs on infection control performance expectations.

Mortality Reviews

Methodology: We interviewed the Agency Medical Director and senior leadership of Wexford, reviewed death summaries, and reviewed death records.

First Court Expert Findings

The First Court Expert and his team evaluated a total of 63 deaths records. There were one or more significant lapses of care in 38 (60%) of cases. Of cases with significant lapses, 34 (89%) had more than one lapse. The internal IDOC mortality review process was seriously flawed. Reviews are performed by the doctor most closely involved in care of the patient. Twenty (52%) of death summaries were reviewed. In none were any lapses of care identified. Only a few deaths were reviewed by the Office of Health Services, but these were selected based on lapses identified by local review. The First Court Expert found that for many patients who were chronically ill with terminal conditions there were no resources in place to assist health care staff with management of end of life symptoms. As well, the First Court Expert found that once a patient signed a do-not-resuscitate order, they were no longer treated even for simple reversible illness.

Current Findings

EXHIBIT

7

Lippert V Jeffreys Consent Decree
First Report of the Monitor
November 24, 2019

Prepared by:
John M. Raba, MD
Monitor

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I. Overview

The "Lippert v Jeffreys" Consent Decree was approved and signed by Judge Jorge L Alonso on May 9, 2019. John M. Raba, MD was selected as Monitor for the Consent Decree on March 29, 2019 with his IDOC contract being finalized on April 26, 2019. Provision V.G. of the consent decree states that "Every six months for the first two years and yearly thereafter, Defendants shall provide the Monitor and Plaintiffs with a detailed report containing data and information sufficient to evaluate Defendants' compliance with the Decree and Defendant's progress towards achieving compliance, with the Parties and Monitor agreeing in advance of the first report on the data and information that must be included in such report." From May 20, 2019 through October 18, 2019, the monitor submitted requests on twenty separate dates for forty-three individual reports or categories of documents, data and information. The IDOC attorneys and clinical leadership have supplied the monitor with the majority of the requests with only few requests not yet fully received. On November 2, 2019, the monitor also submitted to the IDOC a more detailed comprehensive request for data and information for each and every provision of the consent decree. This comprehensive request will require a notable commitment of time and resources to compile; this additional data and information will provide a basis for the monitor's second report that will be due in the Spring of 2020.

Since his appointment, the monitor has had regular meetings with IDOC Chief of Health Services (Agency Medical Director) and Deputy Chiefs of Health Services (Deputy Medical Directors) and regular communications with both the Plaintiffs' and Defendants' attorneys. The monitor interviewed the IDOC Director, the IDOC Deputy Director of Program & Support Services, the IDOC Electronic Health Record project manager, clinical and administrative leadership of medical/dental care vendor (Wexford Correctional Health Services), and the Rasho Consent Decree monitor.

concerned that the Collegial Review process presents a barrier to the access to offsite specialty consultation and tests, delays needed consultations, procedures, and testing, potentially puts patient-inmates' health at risk, and consumes an significant amount of physician, HCUA, medical records staff, Regional Health Coordinator, Agency Medical Director, and Deputy Chief resources. It is the preliminary opinion of the monitor that the Collegial Review should be eliminated and replaced by a selective utilization review process.

The Consent Decree (III.A.3) states that physicians who are not Board Certified (BC) in Internal Medicine, Family Medicine and Emergency Medicine or have not successfully completed a three residency (Board Eligible) in these three clinical fields shall be reviewed to determine whether they are providing a level of care that is consistent with competent BC and BE physicians. The physician credentials spread sheet provided to the monitor on October 14, 2019 revealed that twelve (34%) of the 35 physicians providing primary care in IDOC facilities had not completed a residency in Internal Medicine or Family Medicine (or Emergency Medicine). Seven of these twelve had been trained in non-primary care fields including Anesthesia, General Surgery, Nuclear Medicine/Radiation Therapy, Pediatrics/Neonatology, Surgery, Pathology, and Radiology. Three had only completed rotating general internships and two had not successfully completed their internal medicine residency programs. Methodology is being developed that would objectively determine whether the quality of care provided by these twelve non-Board Certified or non-Board Eligible physicians is safe and clinically appropriate. It is the opinion of the monitor that it is in the best interest of the IDOC patient population that all physicians providing primary care services in the IDOC should have successfully completed residency training programs in adult primary care fields. The only physician hired since the Consent Decree was approved had successfully completed a residency in Internal Medicine. The monitor is very supportive of the Office of Health Services efforts to establish relationships with the primary care training programs at University of Illinois at Chicago Medical Center and the Southern Illinois University School of Medicine that could assist IDOC with delivery of primary care and with future recruitment and retention of physicians with Board Certification or Board Eligibility in Internal Medicine or Family Medicine.

Data sheets provided to the monitor on August 6, 2019 documented that 7,265, nineteen percent (19%) of the IDOC were fifty years of age or older, nearly one thousand (2.6%) were between 65 and 79 years old and 61 were older than eighty years of age. The aging population in the IDOC is placing an increasing burden on the functioning of the correctional facilities and on the correctional health care

system. Men and women with various types of dementia, cerebrovascular accidents (CVA), advanced cancers, cardiovascular disease, and increasing fragility with risk of falls are housed in many of the IDOC facilities. The infirmaries are becoming filled with patient-inmates who are confused, incontinent, and require assistance with the basic activities of daily living including dressing, feeding, bathing, and toileting. The final staffing analysis will include significant augmentation in nursing personnel and support staff; many of whom will be assigned to infirmaries and geriatric units. The health care and correctional resources including staff, physical space, equipment, onsite support services and offsite specialty consultation, diagnostic testing, and hospitalization required to meet the needs of this aging population is staggering and will only increase if there is not a concerted and strategic effort to comprehensively address this situation. It is the position of the monitor that in the short term additional IDOC resources must be directed to properly house and care for this population but in the near future the IDOC must take the lead to create a pathway to discharge those men and women whose mental and medical conditions make them no longer a risk to society to appropriate settings in the community. This effort will need to include the judicial system, parole boards, influential advocacy groups, state legislatures, the governor's office, and other entities. It is also the monitor's position that the IDOC should not attempt to construct large long-length-of-stay skilled nursing or nursing home correctional facilities which would present notable difficulties to meet and maintain state certification standards.

The monitor will be asking the Plaintiffs' and the Defendants' legal counsel to modify three sections of the Consent Decree.

1) Provision III.M.2.b: "Federal Bureau of Prisons" should be replaced with "Center for Disease Control Adult Immunization Guidelines". The Federal Bureau of Prisons' (FBOP) immunization guidelines are generally aligned with the Center for Disease Control (CDC) guidelines but the FBOP policies are only changed at some length of time after the CDC updates its recommendations.

2) Provision III M. 2.c: The language on the Prostate Specific Antigen (PSA) testing is no longer consistent with the national guidelines and needs to be modified to be in alignment with the recommendations of the United States Preventive Services Task Force (USPSTF) which now recommends that men between the ages of 55 and 69 years be informed of the potential harms and benefits of the PSA testing and allowed to make an individual decision about their preference. Men should not be screened who do not express a preference for PSA screening. Give that national recommendations will invariably change as more research is performed, it

EXHIBIT

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ILLINOIS DEPARTMENT OF CORRECTIONS

DIRECTOR'S OFFICE
SPRINGFIELD 62702

COVID-19 RESPONSE

JB PRITZKER
Governor

ROB JEFFREYS
Director

Please be aware that our medical and mental health staff are stretched thin and need to be focusing on our most vulnerable patients at this time. Please continue to utilize proper procedure for sick call and mental health evaluations.

To ensure your voice is being heard, we are instituting a virtual "suggestion box" via GTL, in addition to physical suggestion boxes at all facilities. We have also partnered with GTL to provide additional free services that will be announced at a later date.

Thank you for your cooperation as we work through this difficult situation together.

Alyssa Williams
Chief of Programs and Support Services

[redacted]

[redacted]

ILLINOIS DEPARTMENT OF CORRECTIONS

DIRECTOR'S OFFICE
SPRINGFIELD 62702

COVID-19 RESPONSE

JB PRITZKER
Governor

ROB JEFFREYS
Director

Memorandum

To: Men and Women in Custody

From: Alyssa Williams, Chief of Programs and Support Services

Date: March 20, 2020

Subject: Administrative Quarantine

Dear Men and Women in the care of the Illinois Department of Corrections:

We are facing unprecedented circumstances across the United States and State of Illinois. Out of an abundance of caution, we are instituting an Administrative Quarantine effective immediately. Administrative Quarantine is an intentional form of restricted movement within a facility to accommodate for unusual needs or circumstances, such as a pandemic outbreak. This measure must be taken to ensure the health and safety of those who live and work in our facilities. We are asking for your assistance to minimize the difficulties you will face during this time.

We will continue to ensure you receive all necessary treatment and services, while finding creative ways to deliver programs vital to your success. We are working to minimize the impact on current Earned Program Sentence Credit contracts through alternative programming.

The Department will continue offering the following services:

- Showers
- Access to the phone and GTL kiosks
- Cleaning supplies
- Law Library
- Commissary