UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS
Central Detention Facility
1901 D Street SE
Washington, DC 20003,

D'ANGELO PHILLIPS
Central Detention Facility
1901 D Street SE
Washington, DC 20003,

KEON JACKSON
Correctional Treatment Facility
1901 E Street SE
Washington, DC 20003,

ERIC SMITH
Correctional Treatment Facility
1901 E Street SE
Washington, DC 20003,

Plaintiffs-Petitioners

v.

QUINCY BOOTH, in his official capacity as Director of the District of Columbia Dep't of Corrections,
2000 14th Street NW, 7th Floor
Washington, DC 20009

LENNARD JOHNSON, in his official capacity as Warden, D.C. Dep't. Corrections
1901 D Street SE
Washington, DC 20003

Defendants-Respondents.

No. 1:20-cv-849

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND PETITION FOR WRITS OF HABEAS CORPUS

Plaintiffs Edward Banks, D'Angelo Phillips, Keon Jackson, and Eric Smith (collectively, "Plaintiffs") on behalf of a class of similarly situated detained people in the custody of the District of Columbia's Department of Corrections ("DOC"), of Quincy Booth, Director of the DOC, and of Lennard Johnson, Warden of the DOC (collectively, "Defendants"), allege as follows:

PRELIMINARY STATEMENT

1. The District of Columbia's Department of Corrections now has five confirmed cases of COVID-19, the disease caused by the highly contagious SARS-CoV-2 virus. For those who become infected, COVID-19 creates significant odds of death or severe illness, which can include extreme chest pain and difficulty breathing, and can in some cases require highly invasive and psychologically traumatic life-support treatments. The global pandemic caused by COVID-19 has been predicted by epidemiologists to be the worst since the 1918 influenza pandemic, one of the deadliest in human history.

2. In the past month, the vulnerable residents of the District of Columbia's correctional facilities watched in panic as the COVID-19 epidemic spread across the world, the United States, and the District of Columbia, wondering what, if anything, the Department of Corrections would do to keep them safe. Now that the virus is confirmed to have entered the DOC, the answer is clear: too little and far too late. Like much of society, these residents watched the news and saw the President of the United States and the Mayor of the District of Columbia imploring — and in some instances requiring — all Americans to practice "social distancing," to avoid congregating in groups, to wash their hands and use hand sanitizer regularly, to disinfect frequently touched surfaces, and to seek prompt medical attention if symptoms develop. Unlike the rest of society — people who are able to, and must, heed this guidance — DOC residents cannot. Although they are fully aware of the risks of COVID-19 and the precautions that need to

be taken to prevent those risks, Plaintiffs are systematically denied the opportunity to take the same preventative care that others are required or urged to take by local and federal officials. That is because, despite knowledge of these directives, the DOC has failed to implement many basic procedures — steps as simple as distributing sufficient hygienic products and providing prompt medical attention and testing to those with COVID-19 symptoms — and has waited far too long to implement others. Consequently, experts predict that COVID-19 will "spread like wildfire" in DOC facilities. The DOC has violated Plaintiffs' rights under the Fifth Amendment's Due Process Clause and the Eighth Amendment's protection against cruel and unusual punishment.

3. Defendants are the leadership of the Department of Corrections, which operates two physically connected jail buildings, the Correctional Treatment Facility ("CTF") and the Central Detention Facility ("CDF"), between which staff pass back and forth each day. The named plaintiffs in this lawsuit are four people who are currently in Defendants' custody. The named plaintiffs include a pretrial detainee at CTF, a pretrial detainee at CDF, a post-conviction detainee at CTF, and a post-conviction detainee at CDF.

4. Defendants' ongoing failure to take reasonable precautions to prevent the spread and severity of a COVID-19 outbreak gravely jeopardizes the safety of Plaintiffs and all of the approximately 1,600 individuals confined in the CDF or CTF. While the world watched COVID-19 spread in January and February, Defendants did not act until March 11, 2020 — over six weeks after the World Health Organization declared a "public health emergency of international concern" and four days after the first positive COVID-19 test in the District of Columbia — to begin even the most basic screening of visitors to their facilities. Since then, despite multiple declarations of emergency and guidance regarding practices for correctional institutions, Defendants have not taken necessary steps to ensure Plaintiffs' safety.

5. While Defendants have moved slowly and meekly in response to the threat of COVID-19, jurisdictions around the world and in the United States have taken bold actions to save lives for inmates and for the community. Germany released "1,000 prisoners who are close to the end of their sentences"; Canada released "1,000 inmates in the state of Ontario"; and Iran "temporarily release[d] 85,000 prisoners, with 10,000 of them being granted pardons."[1] Closer to home, the New Jersey Supreme Court announced that it would release "as many as 1,000 people from its jails"[2] and New York City is releasing more than 1,000 people from its jails.[3] This effort to downsize facilities like prisons and jails, which are breeding grounds for the highly contagious virus, is not limited to the East Coast. It is an urgent nationwide effort. Cuyahoga County, Ohio, announced plans to rapidly release around 600 people from the county jail just two days after President Trump declared a national emergency; Washington County, Oregon, released more than 120 people from the local jail; Alameda County, California, released 314 people from their jail; the Iowa Department of Corrections began to release 700 people from state prisons; Mercer County, Pennsylvania, released 60 of 308 people in their jail.[4]

6. The District of Columbia Department of Corrections has not taken similar precautions. Defendants' failures to act are recorded and documented by the people in Defendants' custody, by lawyers who have observed first-hand the lack of preparation, and perhaps most alarmingly of all, by the union of Defendants' correctional officers, who unanimously voted "no

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1 Michael Nienaber et al., *Lock 'Em Up or Let 'Em Out? Coronavirus Prompts Wave of Prisoner Releases*, REUTERS, March 25, 2020.

2 Tracey Tully, *1,000 Inmates Will Be Released From N.J. Jails to Curb Coronavirus Risk*, N.Y. TIMES, March 23, 2020.

3 *NYC to Release More Than 1,000 Prison Inmates Due to Coronavirus Concerns*, ASSOC. PRESS, March 25, 2020.

4 Kimberly Kindy et al., *'Disaster Waiting to Happen': Thousands of Inmates Released as Jails and Prisons Face Coronavirus Threat*, WASH. POST, March 25, 2020.

confidence" in Defendants' leadership for "guaranteeing and accelerating the rampant spread of COVID-19."[5] In a damning rebuke of Defendants' preparedness, DOC staff wrote on March 25, 2020, that staff have "no masks, insufficient gloves, no gowns, no disinfectants, and [that] no comprehensive cleaning occurs on a regular basis."[6] They report that residents "coming into the Jail are not screened for symptoms of COVID-19," that residents "are not required to engage in any of the behaviors which the Mayor recommends for the general population, such as 'social distancing', repeated hand-washing, and health monitoring"; and that "[t]here is no distancing [for staff] at entrances, no distancing at roll calls, [and] no attempt to obtain or record health concerns of each officer."[7] These observations are the canary in the coalmine.

7. Corrections experts recognize that the only way to minimize the harm done by COVID-19 is through "thoughtful downsizing of the incarcerated population . . . in tandem with aggressive, responsive prevention measures that are developed and guided by public health and medical experts."[8]

8. Defendants violate the due process rights of pretrial detainees — who are presumed innocent — when they "recklessly fail[] to act with reasonable care to mitigate the risk" of a condition that Defendants "knew, or should have known" posed an excessive risk to health or safety. *Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017).

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[5] Sophie Kaplan, *Union Votes 'No Confidence' in D.C. Jail Leaders for Handling of COVID-19*, WASH. TIMES, March 20, 2020.

[6] Letter from J. Michael Hannon to Quincy L. Booth ("Labor Committee Letter") at 3 (March 25, 2020), https://www.hannonlawgroup.com/wp-content/uploads/sites/379/2020/03/here.-1.pdf.

[7] *Id.*

[8] Exhibit A, Declaration of Dr. Marc Stern ("Stern Decl."), at ¶ 9.

9. Defendants violate the Eighth Amendment by acting with "deliberate indifference" to an "unreasonable risk of serious damage" to a post-conviction detainee's health. *Helling v. McKinney*, 509 U.S. 25, 33–35 (1993).

10. Because of Defendants' ongoing, systemic violations of Plaintiffs' constitutional rights, Plaintiffs seek class-wide relief requiring Defendants to join other jurisdictions in reducing the population in their facilities and to implement other basic policies and procedures that would mitigate the risk to Plaintiffs' health and safety.

JURISDICTION AND VENUE

11. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because it arises under the Constitution and laws of the United States, specifically 28 U.S.C. § 2241 and 42 U.S.C. § 1983.

12. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201–02, by Federal Rules of Civil Procedure 57 and 65, and by the inherent equitable powers of this Court.

13. Venue is proper in this District under 28 U.S.C. § 1391(e)(1) because a substantial part of the events or omissions giving rise to this action occurred, and continue to occur, in this District.

PARTIES

14. Plaintiff-petitioner D'Angelo Phillips is currently in the custody of the DOC at the Central Detention Facility, where he is at risk of death or serious injury if exposed to COVID-19. He is being held in pre-trial custody and is presumed innocent.

15. Plaintiff-petitioner Edward Banks is currently in the custody of the DOC at the Central Detention Facility, where he is at risk of death or serious injury if exposed to COVID-19. He has pleaded guilty and is awaiting sentencing.

16. Plaintiff-petitioner Eric Smith is currently in the custody of the DOC at the Correctional Treatment Facility, where he is at risk of death or serious injury if exposed to COVID-19. He is being held in pre-trial custody and is presumed innocent.

17. Plaintiff-petitioner Keon Jackson is currently in the custody of the DOC at the Correctional Treatment Facility, where he is at risk of death or serious injury if exposed to COVID-19. He is being held post-conviction.

18. Defendant-respondent Quincy Booth is the Director of the District of Columbia's Department of Corrections and is being sued in his official capacity. The DOC is responsible for the safekeeping, care, protection, instruction, and discipline of "all persons committed to" the "Jail." D.C. Code § 24-211.02(a). As the Director of the DOC, Defendant Booth is responsible for developing, administering, and enforcing DOC policies. *Id.* § 24-211.01.

19. Defendant-respondent Lennard Johnson, Plaintiffs' immediate custodian, is the Warden of the Central Detention Facility (CDF) and the Correctional Treatment Facility (CTF) and is being sued in his official capacity.

STATEMENT OF FACTS

a. COVID-19 is a highly contagious virus that poses a serious risk of injury and death for anyone who is infected.

20. COVID-19 is the disease caused by the SARS-CoV-2 virus that has caused a global pandemic. The World Health Organization ("WHO") estimates that as of March 30, 2020, there

are 638,146 confirmed cases, 30,039 confirmed deaths, and 203 countries, areas, or territories with confirmed cases.[9]

21. The Centers for Disease Control and Prevention ("CDC") estimates that as of March 30, 2020, there are 122,653 confirmed cases and 2,112 confirmed deaths in all 50 states and the District of Columbia.[10]

22. COVID-19 is highly contagious. COVID-19 is thought to survive for three hours in the air in droplet form that can be inhaled or transferred to surfaces, up to twenty-four hours on cardboard, up to two days on plastic, and up to three days on steel.[11]

23. Due to the highly contagious nature of COVID-19, data and statistical modeling show that absent intervention, the rate of COVID-19 infections has grown, and is expected to grow, exponentially.[12]

24. People in all age brackets are at risk of serious injury and death from COVID-19.[13]

25. Although only about "one person in six becomes seriously ill" from COVID-19, the virus causes excruciating pain to those who become ill. One respiratory physician explained

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[9] *See* WORLD HEALTH ORG., *Coronavirus disease (COVID-19) Pandemic* (last visited March 30, 2020, 11:00 AM), https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

[10] *See* CTRS. DISEASE CONTROL & PREVENTION, *Cases in U.S.* (last visited March 30, 2020, 11:00 AM), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[11] Neeltje van Doremalen et al., Correspondence, *Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1*, NEW ENGLAND J. MEDICINE, March 17, 2020, https://www.nejm.org/doi/full/10.1056/NEJMc2004973.

[12] Kenneth Chang, *A Different Way to Chart the Spread of Coronavirus*, N.Y. TIMES, March 20, 2020 ("Unconstrained, the coronavirus spreads exponentially, the caseload doubling at a steady rate.").

[13] CTRS. DISEASE CONTROL & PREVENTION, *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020* tbl. (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

that the lungs "become filled with inflammatory material" and "are unable to get enough oxygen to the bloodstream."[14]

26. The virus leads to acute respiratory distress syndrome, in which fluid displaces the air in the lungs. The sensation of that illness is akin to being drowned.[15] Some individuals who have survived the illness experienced fatigue so extreme they cannot get out of bed or walk to the bathroom and a cough severe enough to prevent sleep.[16] In more serious forms, the individual can experience excruciating pain, days or weeks of fever and chills, uncontrollable diarrhea and inability to keep down food or water, and extremely labored breathing requiring oxygen therapy.[17] The most severe forms — of which symptoms such as vomiting and diarrhea are thought to be early signs — require hospitalization and often artificial ventilation to preserve life. The artificial ventilation process is highly invasive and many who have undergone the process describe it as psychologically traumatic. Some patients are placed in medically induced comas for such treatment. Some do not survive.

27. Emerging medical research also demonstrates that, in addition to the short-term risk of death posed by COVID-19, contracting the virus can lead to other serious long-term medical conditions, including cardiovascular disease and permanent reduction of lung function.[18]

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[14] Graham Readfearn, *What Happens to People's Lungs When They Get Coronavirus*, GUARDIAN, March 24, 2020.

[15] Lizzie Presser, A Medical Worker Describes Terrifying Lung Failure From COVID-19 — Even in His Young Patients, PROPUBLICA, March 21, 2020.

[16] *Id.*

[17] Leah Groth, *Is Diarrhea a Symptom of COVID-19? New Study Says Digestive Issues May Be Common With Coronavirus*, HEALTH, March 20, 2020.

[18] Tian-Yuan Xiong et al., *Coronaviruses and the Cardiovascular System: Acute and Long-Term Implications*, EURO. HEART J, ehaa231 (2020).

28. Because of these short-term and long-term dangers, treating COVID-19 requires a team of health care providers, including nurses, respiratory therapists, and intensive care physicians.[19]

29. The available data from the CDC to date shows that, in total, 20.7 to 31.4 percent of people who tested positive for COVID-19 require hospitalization, 4.9 to 11.5 percent require admission to the ICU, and 1.8 to 3.4 percent die.[20] Patients in DOC custody who require hospitalization will also require, by DOC policy, a round-the-clock guard by law enforcement and constant shackling while hospitalized, which inhibits emergency medical care.

30. The WHO estimates that the COVID-19 mortality rate is between three and four percent. The CDC estimates that the COVID-19 mortality rate in the United States is between 1.8 and 3.4 percent.[21] By comparison, the mortality rate of seasonal influenza is well below 0.1 percent.[22]

31. The CDC reports that in China, the mortality rate was "as high as 12 percent in the center of the epidemic."[23]

32. There is no vaccine or cure for COVID-19.[24]

b. COVID-19 has already, and will, spread with vicious speed in correctional institutions.

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[19] Pauline W. Chen, *The Calculus of Coronavirus Care*, N.Y. TIMES, March 20, 2020.

[20] *Id.*

[21] CTRS. DISEASE CONTROL & PREVENTION, *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020* tbl. (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

[22] WORLD HEALTH ORG., CORONAVIRUS DISEASE 2019 (COVID-19) SITUATION REPORT – 46 p. 2 (2020).

[23] Kenji Mizumoto, *Estimating Risk for Death from 2019 Novel Coronavirus Disease, China, January–February 2020*, 26 J. EMERGING INFECTIOUS DISEASES (2020).

[24] CTRS. DISEASE CONTROL & PREVENTION, WHAT YOU NEED TO KNOW ABOUT CORONAVIRUS DISEASE 2019 (COVID-19) (2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf.

33. Like nursing homes, cruise ships, and college dormitories, correctional facilities are environments that enable, and in fact facilitate, the spread of COVID-19.

34. Because people — staff, residents, contractors, community members, and others — constantly cycle in and out of correctional facilities, there is an ever-present risk that new carriers will bring the virus into the facility.

35. In Jining, China, 207 people in a correctional facility contracted COVID-19 because a prison guard contracted it outside of the facility and then came to work, not knowing he was infected.[25]

36. Even if correctional institutions screen outsiders, including staff and visitors, for symptoms of COVID-19, that will not stop the introduction of COVID-19 from the outside because the CDC confirms that COVID-19 can be spread "before people show symptoms."[26]

37. Correctional facilities also are highly susceptible to rapid person-to-person transmission of the virus because cramped conditions place residents and staff in close proximity.[27]

38. History also bears out that prisons and jails become breeding grounds for epidemics that eventually spread out to broader communities.

39. Public health research shows that an "influenza epidemic in San Quentin prison" spread to 26 percent of prisoners and became "one of the primary foci" of the 1918 flu epidemic.[28]

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[25] N.Y. TIMES, *New Clusters of the Virus are Found in China's Prisons*, Feb. 21, 2020, https://www.nytimes.com/2020/02/21/world/asia/china-coronavirus.html.

[26] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *How It Spreads*, https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html (last accessed March 23, 2020).

[27] Kindy et al., *supra* note 4.

[28] Niyi Awofeso, *Prison Show Prophylaxis for Close Contacts May Indeed Help in Next Flu Pandemic*, 329 BMJ 173, 173 (2004).

The outbreak at San Quentin was started by the introduction of a "newly received prisoner" who had the influenza.[29]

40. During the H1N1 epidemic in 2009, jails and prisons were also epicenters for transmission.[30]

41. In New York City, the first case of COVID-19 infection in a jail detainee was diagnosed on March 18, 2020. Within two days, thirty-eight cases had been diagnosed at the Rikers Island Correctional Complex.

42. As of March 30, 2020, the rate of COVID-19 infection in New York City jails is 3.00 percent. This is over seven times higher than the rate of infection in New York City generally (0.40 percent), over seven times higher than the rate of infection in Lombardy, Italy (0.41 percent), and 25 times higher than the rate of infection in Wuhan, China (0.12 percent).[31]

43. Approximately one month into the pandemic in the province of Hubei, China, where the COVID-19 outbreak started, over half of reported COVID-19 cases were from jails.[32]

44. In South Korea, which has enacted radical and effective public health measures to slow and stop the spread of the virus, "the single largest COVID-19 outbreak and mortality cluster was from the Daenam Prison Hospital, where 101 inmates were infected and seven died."[33]

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[29] Stuart A. Kinner et al., Comment, *Prisons and Custodial Settings Are Part of a Comprehensive Response to COVID-19*, LANCET, March 17, 2020.

[30] Nicole Westman, *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, VERGE, March 12, 2020.

[31] LEGAL AID SOCIETY, *Analysis of COVID-19 Infection Rate in NYC Jails* (last visited March 30, 2020, 11:00 AM), https://legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/.

[32] Zi Yang, *Cracks in the System: COVID-19 in Chinese Prisons*, DIPLOMAT, March 9, 2020, https://thediplomat.com/2020/03/cracks-in-the-system-covid-19-in-chinese-prisons/.

[33] Nancy Gertner & John Reinstein, Opinion, *Compassionate Release Now for Prisoners Vulnerable to the Coronavirus*, BOSTON GLOBE, March 23, 2020.

45. The spread of COVID-19 in District of Columbia correctional institutions is not only a risk to Plaintiffs and Defendants' staff, it is a risk to the entire D.C. community.

46. "Substantial epidemiological research shows that mass incarceration raises contagion rates for infectious disease — both for people in jails, and for the community at large."[34]

47. Empirical evidence shows how outbreaks in correctional institutions quickly reflect back into the greater community: In 1997, near the height of the HIV epidemic, fully 20 percent of all HIV-infected Americans had been in a correctional facility at least once during that year.[35]

c. While many jurisdictions took decisive action as COVID-19 rapidly spread, the Department of Corrections failed to take necessary precautions.

48. As COVID-19 spread around the world from December through early March, nearly every level and sector of government, from international organizations, to countries, states, cities, and the District of Columbia, issued emergency declarations warning of the spread of the virus.

49. Despite these clear calls of emergency, of which Defendants were no doubt aware, Defendants did not take sufficient precautions.

50. On January 21, 2020, the first confirmed COVID-19 case was diagnosed in the United States.[36]

51. On January 30, 2020, the WHO declared a "public health emergency of international concern."[37]

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[34] Sandhya Kajeepeta & Seth J. Prins, *Why Coronavirus in Jails Should Concern All of Us*, THE APPEAL, March 24, 2020, https://theappeal.org/coronavirus-jails-public-health/.

[35] Anne C. Spaulding et al., *HIV/AIDS Among Inmates of and Releasees from US Correctional Facilities, 2006: Declining Share of Epidemic but Persistent Public Health Opportunity*, 4 PLOS ONE 7558 (2009).

[36] Derrick Bryson Taylor, *A Timeline of the Coronavirus*, N.Y. TIMES, March, 2020 https://www.nytimes.com/article/coronavirus-timeline.html (last visited March 24, 2020).

[37] *Id.*

52. By February 12, 2020, the death toll in China reached 1,113, and the total number of confirmed COVID-19 cases worldwide reached 44,653.[38]

53. By February 23, 2020, Italy locked down a vast region of the country, closing schools and cancelling events in order to promote social distancing.[39]

54. By February 25, 2020, the CDC "warned of an almost certain outbreak" in the United States.[40]

55. On February 28, 2020, the United States saw its first COVID-19 death.[41]

56. On February 28, 2020, Mayor Bowser ordered the activation of the District's Emergency Operations Center to coordinate responses to COVID-19, requiring Defendants to "remind their staff and constituencies" of "basic infection practices," including to "[w]ash hands with soap and water" or an "alcohol-based hand sanitizer," to "[a]void close contact with people who are sick," and to "[c]lean and disinfect frequently touched objects and surfaces."[42] The Executive Order specifically requires that "[a]ll relevant District agencies shall review their copy of the District Response Plan to evaluate the potential impacts of COVID-19 on emergency roles and responsibilities and take necessary steps to ensure continued performance."[43]

57. By March 3, 2020, about 3,000 people worldwide had died from COVID-19.[44]

58. On March 7, 2020, the District of Columbia announced that the first COVID-19 case in the District had been confirmed by laboratory testing.

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38 *Id.*

39 *Id.*

40 *Id.*

41 *Id.*

42 D.C. Mayor's Order 2020-035, § 10(a).

43 *Id.* § 3(a).

44 *Id.*

59. On March 13, 2020, President Trump declared a national emergency.[45]

60. On March 15, 2020, the CDC issued guidance advising no gatherings of 50 or more people in the United States.[46]

61. On March 16, 2020, Mayor Bowser ordered District of Columbia bars and restaurants to close.[47]

62. On March 25, 2020, Mayor Bowser ordered all non-essential District of Columbia businesses to close.[48]

63. Defendants' response was slow and insufficient.

64. On March 3, 2020, Defendant Booth wrote a letter to all DOC employees informing them of symptoms of COVID-19, that the virus travels "[b]etween people who are in close contact with one another (within about 6 feet)," and asking employees who are "impacted by COVID-19" to "contact [their] immediate supervisor to request to be placed on sick or annual leave, leave without pay, or other earned leave."

65. On March 11, 2020, Defendants for the first time began to ask visitors to the jail whether they had visited countries with high rates of infection in the preceding 14 days and whether they felt ill.[49] The form specifically asked about China, Iran, South Korea, Italy, and Japan, but did not ask about travel to other countries or domestic travel, even though other countries and

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[45] President Donald J. Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak,* March 13, 2020.

[46] CTRS. DISEASE CONTROL & PREVENTION, *Interim Guidance for Coronavirus Disease 2019 (COVID-19)* (March 15, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/mass-gatherings-ready-for-covid-19.html.

[47] D.C. Mayor's Order 2020-048, § I(C).

[48] D.C. Mayor's Order 2020-053.

[49] *See* Exhibit B, Department of Corrections Visitor Questionnaire.

states had greater numbers of confirmed cases or higher rates of infection than one of the listed countries.[50]

66. Around March 11, 2020, Defendants represented in public statements that they began to broadcast regular announcements over the Jail's loudspeaker reminding residents to wash their hands.

67. Facility residents state that they have rarely or never heard such announcements, and visitors who spent as long as five hours inside of the facility on days after March 11 did not hear any announcements. Residents who did hear sporadic announcements report that they did not see staff washing their hands in response to the announcement and that no hand soap or towels were provided to residents so that they could wash their hands in response to the announcement.

68. On March 13, 2020, Defendants' staff began to take entrants' temperatures with non-contact, infrared thermometers.

69. These thermometers are either broken or mis-used by Defendants' staff. One visitor was permitted in after a temperature reading 93 degrees — a temperature that signals severe and near-fatal hypothermia. Another visitor was admitted after the thermometer displayed an error message and never registered a temperature reading.

70. On at least one occasion after implementing their screening protocols, Defendants' staff forgot to screen several visitors to CTF until after they had entered that facility and were on units where residents live.

71. On March 14, 2020, Defendants halted social visits, but legal and mental health visits continued, and caseworkers were still cycling in and out of the facility.

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[50] *Id.*

72. While Defendants implemented screening protocols for visitors and staff, Defendants did not implement screening protocols for new residents coming into the jail. Defendants' staff state that as of March 25, 2020, "[i]nmates coming into the Jail are not screened for symptoms of COVID-19."[51]

73. Around this time, Defendants provided a single bar of soap to most residents at CDF. Prior to that distribution, new entrants to the jail had not been provided with free hygiene packets at entry and had been told since March 3, 2020 that the jail was out of soap and had none to provide. Residents without access to the Jail's commissary due to lack of funds, status, or new entry to the facility, therefore had no soap for at least a week during the escalation of COVID-19 in the District.

74. Defendants have not provided additional soap free of charge since the first distribution of the single bar of soap, nor did Defendants inform residents when they will receive more soap. Consequently, some residents have already run out of their single allotted bar, while others are not using the single bar because they do not know when the next bar will come.

75. Defendants also have not provided access to hand sanitizer, have denied residents' requests to use hand sanitizer, and have removed hand sanitizer that was previously available to residents and made it so that only staff could use hand sanitizer.

76. Defendants did not provide staff and residents adequate cleaning supplies, free of charge and in the proper concentration, to prevent transmission of the virus from surfaces in housing units or other parts of common space in the facilities. The units are cleaned primarily by DOC residents, whose work is not inspected by staff. The people cleaning the units are not

[51] Labor Committee Letter at 3.

provided with masks, gloves, or other equipment that would allow them to protect themselves from germs while conducting a thorough cleaning.

77. Nor have Defendants provided residents and staff with cleaning supplies to clean their own cells, ensuring that residents who share a cell will quickly transmit illness to each other. Residents are instructed to clean their own cells with water and their own soap, and officers have no access to cleaning materials or clean rags to provide residents to wipe down surfaces within their cells. They are then required to use the same bath towels and washrags to clean and dry their own hands and bodies when they wash their hands or bathe. On at least one unit, a closet full of cleaning supplies and clean rags is present, but residents are told they will be punished if they attempt to access or use those supplies to clean the unit, their own cells, or their hands and bodies.

78. Defendants do not regularly disinfect surfaces in Defendants' facilities. In at least one instance, a unit ran out of the watered-down cleaning solution residents use to clean common areas, and were told to use just water. In another unit, Defendants took away all cleaning materials that contained bleach.

79. Defendants also did not make soap or hygiene supplies available in common areas, recreational areas, or food preparation areas. Defendants have provided neither paper towels nor other means to dry hands after washing them, meaning that residents who do wash their hands must reuse the same bath towels repeatedly, or wipe their hands on their jail-issued uniforms, which are laundered infrequently and are exposed to surfaces that could be contaminated.

80. On March 19, 2020, the DOC announced that it had quarantined 65 residents whom it believed had contact with a law enforcement officer who had tested positive for COVID-19.[52]

[52] Kyley Schultz, *65 Inmates in Self-Quarantine, 1 Tested Positive for Coronavirus at DC Jail*, WUSA9, March 19, 2020.

81. This was a "quarantine" in name only and was ineffective to prevent the spread of the virus. Defendants' staff report that "[t]hese inmates were not 'quarantined' in any meaningful manner. They were housed two to a cell, and the corrections officers on the unit were not provided with any [personal protective equipment] or other means for protection against infections."[53]

82. Further, this "quarantine" policy is ineffective at preventing the spread of COVID-19 among residents and staff. Residents perceive quarantine as punitive because the conditions of the quarantine are even worse than conditions of punitive solitary confinement, as residents in quarantine cannot access recreation or other programming opportunities. Residents are thus deterred from self-reporting COVID-19 symptoms. Residents also worry that quarantining will interrupt their programming, which is part of DOC's "good time credit" calculation and can influence residents' release.

83. Defendants had in their custody residents who complained of cough, fatigue, and shortness of breath — some of the most common early symptoms of COVID-19. Nevertheless, Defendants did not test any residents, even those who presented with symptoms consistent with COVID-19, until around March 20, 2020.

84. Many residents have exhibited symptoms of COVID-19 and have not received a test for the virus. For instance, on March 20, 2020, a resident at CTF with a cough, chest pains, fever, and chills, was seen by medical staff, but was denied a COVID-19 test. The resident was returned to his unit, risking his own health and possibly infecting additional residents of his unit.

85. Defendants have also failed to provide DOC staff with sufficient personal protective equipment, nor have Defendants' staff used what little equipment they may have. Defendants' staff members regularly work with bare hands and do not wear gloves or masks. Staff

[53] Labor Committee Letter at 3-4.

members and jail residents who prepare food, clean and pass out food trays, and clean dining areas are not provided with masks or gloves. Residents report that they receive trays that appear not to have been cleaned between uses, showing remnants of food and dirt from the previous user.

86. Defendants' staff state that "[t]he corrections officers assigned to housing units have no masks, insufficient gloves, no gowns, no disinfectants, and no comprehensive cleaning occurs on a regular basis in these units."[54] DOC staff also report that "Corrections Officers receiving and discharging inmates have no [personal protective equipment]," even though those officers "must have direct contact with these inmates."[55]

87. Defendants also have failed to provide sufficiently prompt access to responsive medical treatment. Many residents wait days after submitting requests to see medical personnel, even when they complain of having difficulty breathing — a common symptom of COVID-19.

88. Defendants have not implemented the required social distancing policies, and in fact, have encouraged actions that run directly counter to social distancing protocols. Residents of Defendants' facilities are constantly in close contact with each other and with staff, have limited agency to relocate or increase their personal space, and have no control over the movements of others with whom they are required to congregate on a daily basis. They are required to remain in the areas where Defendants order them to be, and are punished if they move without permission, even if they are moving in an attempt to self-quarantine or move away from a person displaying symptoms of illness.

89. Unless special circumstances apply, cells are shared by more than one resident. Those cells are enclosed rooms where social distancing is impossible. The cell's toilet is within a

[54] Labor Committee Letter at 3.

[55] *Id.*

few feet of the bed and other areas of the cell. The cell doors are closed and locked during periods when people are required to be in their cells, preventing air circulation.

90. Residents regularly congregate, and interact freely, in the unit common spaces — often the only place that they can go when they are not locked in their cells. Even residents who voluntarily seek to avoid close contact with others are forced to break social distancing rules in order to obtain food, seek medical care, attend professional visitation, and engage in daily population counts and other activities required by Defendants.

91. On March 25, 2020, Defendants encouraged legal visits to take place in person.

92. Legal visiting rooms are small and unventilated. In order to obtain the necessary privacy to maintain privilege, the door must remain closed throughout the visit. In order to consult about case-related matters, counsel and a client often pass papers back and forth, view a small laptop screen at the same time, or use the same writing utensil. Legal visiting rooms are not cleaned or sanitized between attorney visitors or between residents when an attorney visits more than one person on the same day.

93. When counsel and professional visitors initially inquired about the availability of secure phone or video visitation, all such requests were turned down. The only way for counsel and a client to speak, other than in person, was via a telephone call that is monitored by Defendants' staff throughout the call. When asked to provide privacy for a legal call, one DOC staff member told a client that they were not permitted, under Defendants' regulations, to leave a resident alone in an office with a phone, even to talk to counsel. Some limited arrangements have been provided in the last few days.

94. As of March 24, 2020, residents were still required to engage in programming in groups of 30, where they sat for hours, less than one foot apart. Residents who choose not to go

to programs can be punished for failing to attend, or can lose credit that allows them to seek early release from incarceration. Defendants are, for example, providing additional good time credits only to residents who engage in programming.

95. Defendants have also made social distancing impossible by continuing to require "[c]ase workers [to] meet with inmates in small offices with no [personal protective equipment] or other distancing measures."[56]

96. Compared to other correctional facilities, Defendants acted unreasonably slowly, and have still not implemented an adequate response to the pandemic.

97. By way of example, in Washington State, the Department of Corrections ("WADOC") contacted all staff members on February 20, 2020 and provided information about COVID-19. On March 3, 2020, WADOC staff began to track all "staff call ins due to flu like symptoms" to understand whether any staff might have COVID-19.[57]

98. On March 3, 2020 — before any positive COVID-19 test in the state — Indiana's Department of Corrections issued a "Preparedness and Response Plan" that:

- Required facilities to "obtain and distribute hand sanitizer throughout the institution and make it available to staff and offenders";
- Required facilities to clean "high touch surfaces" on "a more frequent schedule";
- Required facilities to "arrange for the immediate evaluation and treatment of any offender with symptoms";
- Required visitors to be "questioned about illness prior to entering the facility" and required facilities to deny entrance to anyone with "observed current symptoms."[58]

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[56] Labor Committee Letter at 3.

[57] WASHINGTON STATE DEP'T OF CORRECTIONS, SIGNIFICANT EVENTS TIMELINE 13 (2020), *available at* https://www.doc.wa.gov/news/2020/docs/daily-situation-report.pdf.

[58] INDIANA DEP'T OF CORRECTION, PREPAREDNESS AND RESPONSE PLAN 5-8 (2020), *available at* https://www.in.gov/idoc/files/IDOC%20Pandemic%20Response%20Plan%203-3-2020.pdf#response%20plan

d. Conditions in Department of Corrections facilities are so poor, and the procedures in place so inadequate, that the spread of virus will be rapid.

99. As of March 30, 2020, there are 1,620 people in DOC custody in the CDF or CTF.[59]

100. On March 19, 2020, the DOC announced that it had quarantined 65 residents whom it believed had contact with a law enforcement officer who had tested positive for COVID-19.[60]

101. On March 25, 2020, after performing four total tests on detained people, the DOC confirmed that a resident of CTF had tested positive for COVID-19.[61]

102. As of March 26, 2020, the DOC has publicly stated that it "has quarantined 36 inmates."[62]

103. As of March 26, 2020, the DOC claimed to have tested four residents for the virus, that one test was positive, two tests were negative, and one test result is pending.[63]

104. On March 27, 2020, the DOC confirmed that a second resident of CTF had tested positive for COVID-19.[64]

105. The next day, the DOC announced that two more residents tested positive.

106. On March 29, 2020, the DOC announced its fifth positive case of COVID-19.

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[59] The precise number of residents at the CDF and CTF fluctuates daily and even hourly. This number is based on the latest information available to undersigned counsel.

[60] Kyley Schultz, *65 Inmates in Self-Quarantine, 1 Tested Positive for Coronavirus at DC Jail*, WUSA9, March 19, 2020.

[61] Keith L. Alexander, *After D.C. Jail Confirms First Inmate With COVID-19, Officials Isolate 36 Other Inmates* ("*First Positive Test*"), WASH. POST, March 26, 2020.

[62] *Id.*

[63] *Id.*

[64] Keith L. Alexander, *Second D.C. Jail Inmate Tests Positive for Coronavirus* ("*Second Positive Test*"), WASH. POST, March 28, 2020.

107. Defendants claim that they do not know how the first resident came in contact with the virus.[65]

108. Defendants state that the first resident "has been jailed since July 29 [2019]."[66]

109. Defendants state that "the [first] two inmates [who tested positive] were not in the same unit."[67]

110. Because the first resident to test positive has been incarcerated since before the COVID-19 outbreak began, it is certain that the resident contracted COVID-19 while he was in Defendants' custody.

111. According to Defendants, the first resident who tested positive "complained of being sick" and was then placed in isolation on or about March 20, 2020.[68]

112. Because the virus can be transmitted before symptoms develop, it is highly likely that the five residents who have tested positive have already transmitted the virus to other residents, staff members, visitors, or contractors.

113. It is also highly likely that whoever infected the first resident to test positive who has already tested positive has infected other residents at CTF.

114. Department of Corrections facilities feature many of the characteristics, and operate by many policies, that will lead to rapid spread of COVID-19.

115. A February 2019 report by the Office of the District of Columbia Auditor found that Defendants were "repeatedly cited by [the Department of Health] for violations of industry standards related to environmental conditions, including water penetration through the walls from

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65 Alexander, *First Positive Test*, *supra* note 61.

66 *Id.*

67 Alexander, *Second Positive Test*, *supra* note 62.

68 Alexander, *First Positive Test*, *supra* note 61.

a leaking roof, mold growth on walls, damaged shower stalls and temperatures outside of allowable standards."[69] The Department of Health has also "cited both DOC and the food service provider Aramark for repeated violations of District regulations related to public health and food service."[70]

116. Ventilation in Defendants' facilities is poor.[71]

117. Between FY 2014 and FY 2018, Defendants sought $62.4 million for facility improvements and received only $15.7 million.[72]

118. COVID-19 will continue to spread to Defendants' facilities because numerous people in the District of Columbia law enforcement community, who interact with Plaintiffs and proposed class members, have already tested positive for COVID-19.

119. On March 18, 2020, a Deputy United States Marshal working in the Superior Court of the District of Columbia testified positive for COVID-19.[73]

120. The Deputy Marshal who tested positive worked in Courtroom C-10 cellblock of the D.C. Superior Court (the high-volume courtroom where dozens of arraignments and presentments occur daily) and thus interacted with people who are now in Defendants' custody.[74]

121. On March 23, 2020, two court security officers in D.C. Superior Court tested positive for COVID-19.[75]

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69 OFFICE OF THE D.C. AUDITOR, POOR CONDITIONS PERSIST AT AGING D.C. JAIL; NEW FACILITY NEEDED TO MITIGATE RISKS i (2019).

70 *Id.* at 7.

71 *Id.* at 9.

72 *Id.* at i.

73 *See* Dana Hedgpeth & Justin Jouvenal, *D.C. Superior Court to Cut Back Operations*, WASH. POST, March 18, 2020.

74 *Id.*

75 Keith Alexander, *Two D.C. Court Security Officers Test Positive*, WASH. POST, March 23, 2020.

122. As of March 27, 2020, at least three Metropolitan Police Department ("MPD") officers have tested positive for COVID-19.[76]

123. MPD officers lack the personal protective gear that would decrease the risk that they will spread the disease.[77]

124. COVID-19 will spread rapidly in Defendants' facilities because of the belated and inadequate policies discussed above and the failures to take other policies that are recommended and required by the CDC and other experts.

e. Incarcerated people are, by definition, at elevated risk for death or serious injury if they contract COVID-19.

125. Like residents of nursing homes, residents of prisons and jails face greater risk of serious injury or death if they become infected with COVID-19.

126. Public health officials writing in *The Lancet* explain the characteristics that increase mortality rates among incarcerated people who become infected:

> Prisons are epicentres for infectious diseases because of the higher background prevalence of infection, the higher levels of risk factors for infection, the unavoidable close contact in often overcrowded, poorly ventilated, and unsanitary facilities, and the poor access to healthcare services relative to that in community settings.[78]

127. Incarcerated people in America have poorer health than the general population. The Department of Justice estimates that "half of state and federal prisoners and local jail inmates

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[76] Metro. Police Dep't, *Third MPD Member Tests Positive for COVID-19* (March 26, 2020), https://mpdc.dc.gov/release/third-mpd-member-tests-positive-covid-19.

[77] Simone Weichselbaum, *D.C. Cops Balance Bravado and Caution During COVID-19 Pandemic*, MARSHALL PROJECT, March 18, 2020

[78] Kinner et al., *Prisons and Custodial Settings Are Part of a Comprehensive Response to COVID-19* p.1, LANCET.

reported ever having a chronic condition," and "[t]wenty-one percent of prisoners . . . reported ever having an infection disease."[79]

128. Individuals incarcerated in Defendants' facilities also have poorer health than the general population.

129. Plaintiffs and proposed class members are also at heightened risk because they lack access to quality medical care equipped to handle a disease outbreak.

130. Plaintiffs and proposed class members regularly wait days to receive any medical care, even when they complain of difficulty breathing.

131. Plaintiffs and proposed class members are not given masks or gloves even after they exhibit symptoms of COVID-19, including chronic coughing. Defendants' staff do not have masks to provide to sick residents, or do not provide them if they are made available to staff.

132. Several residents have requested masks after observing other residents in their unit coughing, sneezing, and exhibiting other signs of COVID-19, but those requests were denied.

f. Rapid and systemic downsizing of the number of people in Defendants' custody is necessary to protect the community.

133. Downsizing the population in Defendants' custody is the only strategy to ensure the reasonable health and safety of Plaintiffs and proposed class members.

134. On March 17, 2020, the New York City Board of Correction called on New York City to "immediately remove from jail all people at higher risk from COVID-19 infection."[80]

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[79] U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONS AND JAIL INMATES, 2011-12 p. 1 (2016).

[80] Press Release, N.Y.C. Bd. of Corr., New York City Board of Correction Calls for City to Begin Releasing People from Jail as Part of Public Health Response to COVID-19 (March. 17, 2020).

135. Dr. Marc Stern, a correctional health expert, declares that "[t]houghtful downsizing [of the jail population] should be implemented in tandem with aggressive, responsive prevention measures that are developed and guided by public health and medical experts."[81]

136. Dr. Stern, reviewing the specific conditions in Defendants' facilities, and in light of "the four confirmed cases of COVID-19 inside of DOC facilities," specifically recommends that "downsizing the inmate population as much as possible will reduce the risk of contraction and transmission of COVID-19—and the attendant risks of serious harm and death—within DOC facilities."[82]

137. Dr. Robert Greifinger, another correctional health expert, declares that "even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of individuals is a key part of a risk mitigation strategy." Dr. Greifinger goes on to say that in his opinion, "the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage."[83]

138. Defendants have the authority to downsize the population of the CDF and CTF via the COVID-19 Response Emergency Amendment Act of 2020, which allows the Department of Corrections "to award additional credits beyond the limits described . . . to effectuate the immediate release of persons sentenced for misdemeanors[.]" 67 D.C. Reg. 3106 (March 20, 2020).

g. In addition to downsizing, proper hygiene and other procedures must be implemented to ensure the safety of Plaintiffs and proposed class members.

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81 Stern Decl. ¶ 12.

82 Stern Decl. ¶ 11.

83 Decl. of Robert Greifinger ¶ 13, Docket No. 4, *Dawson v. Asher*, No. 20-cv-409 (MAT) (W.D. Wash., March 16, 2020).

139. Proper access to free and effective hygiene supplies and precautionary measures is necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members.

140. Immediate testing of all residents who require testing — where that requirement is based not on Defendants' subjective and inadequate criteria, but rather on guidance from knowledgeable medical professionals and public health organizations — is necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members.

141. This testing must include all residents, including asymptomatic residents, who have been in contact with positive COVID-19 cases.

142. Effective screening protocols of visitors and staff is necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members.

143. Non-punitive quarantine, with full access to phones, mail, video visitation, commissary, recreation, and other privileges, for all individuals believed to be exposed to COVID-19 is necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members. Only by ensuring that quarantine does not pose a danger to individuals' rights and their mental and physical health can Defendants' incentivize residents to promptly and fully disclose their symptoms and avoid spreading infection.

144. Free and effective liquid hand soap, hand sanitizer, sanitizing cleaning solution, paper towels or rags, and frequently laundered and replaced personal towels and clothing, are necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members.

145. Regular cleaning of common areas and high-touch surfaces using effective disinfectants is necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members.

146. Requiring staff members to wear gloves and masks and to replace gloves between close contacts with residents is necessary to reduce the transmission of COVID-19 and ensure the health and safety of Plaintiffs and proposed class members.

147. Authorizing regular, in-person monitoring of Defendants' facilities by an independent expert on correctional health is necessary to ensure that the DOC implements practices proven to reduce the transmission of COVID-19 and to ensure the health and safety of Plaintiffs and proposed class members.

CLASS ALLEGATIONS

148. Pursuant to Federal Rule of Civil Procedure 23(b)(1) and 23(b)(2), Plaintiffs bring this action as a class consisting of all persons confined or to be confined in the D.C. Department of Corrections ("DOC") Central Detention Facility or Correctional Treatment Facility, including as subclasses: (i) persons confined pre-trial, and (ii) persons confined pursuant to a judgment of conviction. Plaintiffs reserve the right to amend the class definition or establish sub-classes as appropriate if discovery or further investigation reveals the class should be expanded or otherwise modified.

149. Numerosity: The class is so numerous that joinder is impracticable. Based upon information and belief, the size of the class is approximately 1,600 people and is therefore so numerous that joinder is inherently impracticable for that reason alone. Joinder is also inherently impracticable for other, independent reasons. The class includes unnamed, future class members who cannot by definition be joined. Further, proposed class members are highly unlikely to file

individual suits on their own, as all are incarcerated and many are indigent, and thus have limited access to their retained or court-appointed counsel due to Defendants' policies, are currently incarcerated, fear retaliation from filing suits against Defendants, and lack access and financial resources to obtain qualified counsel to bring such suits.

150. Commonality: The claims of the class share common issues of fact and law, including but not limited to whether Defendants' policies regarding health and hygiene as relevant to the COVID-19 pandemic — policies that systemically affect all proposed class members — violate the Fifth and Eighth Amendments to the United States Constitution. The resolution of this question will drive the outcome of the litigation.

151. Typicality: The claims of Plaintiffs are typical of those of the class as a whole, because each Plaintiff is currently in Defendants' custody and Plaintiffs' claims arise from the same policies and procedures (or lack thereof) that provide the basis for all proposed class members' claims.

152. Adequacy: Plaintiffs are adequate class representatives who meet all of the requirements of Rule 23(a)(4). They have no conflicts of interest in this case with other class members. They will fairly and adequately represent the interests of the class, and each understands the responsibilities of a representative. Counsel for Plaintiffs will vigorously prosecute the interests of the class and include attorneys with extensive experience with the factual and legal issues involved in representing jail and prison inmates, in asserting constitutional rights, and/or in pursuing class actions.

CAUSES OF ACTION

FIRST CLAIM FOR RELIEF
FIFTH AMENDMENT

153. The Fifth Amendment to the United States Constitution guarantees pretrial detainees the right to be free from punitive conditions of confinement.

154. Defendants are violating Plaintiffs' and proposed class members' Fifth Amendment rights because "the challenged governmental action is not rationally related to a legitimate governmental objective or that it is excessive in relation to that purpose." *Kingsley v. Hendrickson*, 576 U.S. 389, 135 S. Ct. 2466, 2473–74 (2015).

155. Defendants are also violating Plaintiffs and proposed class members' Fifth Amendment rights because they "recklessly failed to act with reasonable care to mitigate the risk that the condition posed to the pretrial detainee even though the defendant-official knew, or should have known, that the condition posed an excessive risk to health or safety." *Darnell*, 849 F.3d at 35.

156. Defendants have recklessly failed to act with reasonable care to mitigate the risk of COVID-19 to Plaintiffs and proposed class members.

157. Defendants knew of, or should have known, about the risks of COVID-19 to Plaintiffs and proposed class members.

158. Defendants have acted with deliberate indifference towards Plaintiffs and proposed class members by failing to safeguard their health and safety adequately.

159. Defendants have exposed Plaintiffs and proposed class members to a substantial — indeed grave — risk of serious harm, including death.

160. Defendants knew of and disregarded the substantial risk to Plaintiffs and proposed class members' health or safety.

161. Defendants have subjected Plaintiffs and proposed class members to conditions of confinement that increase their risk of contracting COVID-19, for which there is no known vaccine, treatment, or cure.

162. Defendants continued detention of Plaintiffs and proposed class members fails to protect them adequately from the risks of contracting COVID-19.

163. As a result of Defendants' unconstitutional actions, Plaintiffs and the proposed class are suffering irreparable injury.

SECOND CLAIM FOR RELIEF

EIGHTH AMENDMENT

164. The Eighth Amendment to the United States Constitution protects Plaintiffs and proposed class members from cruel and unusual punishment.

165. To amount to the infliction of cruel and unusual punishment (1) jail or prison conditions must pose "an unreasonable risk of serious damage" to a prisoner's health (an objective test) and (2) prison officials must have acted with deliberate indifference to the risk posed (a subjective test). *Helling*, 509 U.S. at 33–35.

166. Plaintiffs and proposed class members are subject to a risk of harm that today's society does not tolerate.

167. Society does not tolerate the risk of exposure to COVID-19 to which Defendants' policies and procedures (or lack thereof) have subjected Plaintiffs and proposed class members.

168. Indeed, the District of Columbia has warned against the dangers of the very behaviors in which Plaintiffs and proposed class members are required daily to engage as a direct result of Defendants' policies and procedures (or lack thereof).

169. Plaintiffs and proposed class members suffer a substantial risk of serious harm to their health and safety due to the presence of, and spread of, COVID-19.

170. Defendants have acted with deliberate indifference to the risks posed to Plaintiffs and proposed class members by COVID-19.

171. Defendants knew of, and know of, the risks that COVID-19 poses to Plaintiffs and proposed class members.

172. The risk of COVID-19 was, and is, obvious to Defendants.

173. Defendants' response to COVID-19 has not been reasonable.

174. As a result of Defendants' actions, Plaintiffs and proposed class members are suffering irreparable injury.

RELIEF REQUESTED

WHEREFORE, Plaintiffs and proposed class members respectfully request that the Court:

A. Certify the proposed class and subclasses;

B. Enter a temporary restraining order, preliminary injunction, and permanent injunction and/or writs of habeas corpus requiring Defendants to:

1. Immediately take all actions within their power to reduce the inmate population of the D.C. Jail and CTF including, but not limited to, releasing as many people as possible through the COVID-19 Response Emergency Amendment Act of 2020, which allows the Department of Corrections "to award additional credits beyond the limits described . . . to effectuate the immediate release of persons sentenced for misdemeanors[.]" 67 D.C. Reg. 3106 (March 20, 2020);
2. Appoint an expert under Federal Rule of Evidence 706 to make recommendations to the Court regarding how many and which class members to order released so as to ensure that the number of prisoners remaining at the CDF and CTF can be housed

consistently with CDC guidance on best practices to prevent the spread of COVID-19, including the requirement that prisoners be able to maintain six feet of space between them and further order that such recommendations take into account CDC guidance concerning health factors that put individuals at elevated risk of death from COVID-19;

3. Ensure that each inmate receives, free of charge, an individual supply of hand soap, sufficient to allow frequent hand washing; paper towels; toilet paper; running water; and facial tissue;
4. Provide no-touch trash receptacles for tissue and paper towel disposal;
5. Ensure that all inmates, when not in cells with access to hand soap and running water, have access to hand sanitizer containing at least 60% alcohol;
6. Provide access to daily showers for each inmate and daily access to clean laundry, including clean personal towels and washrags after each shower;
7. Require that all DOC staff wear personal protective equipment, including masks and gloves when interacting with visitors and residents or when touching surfaces in common areas;
8. Provide an anonymous mechanism for residents to report staff who violate these guidelines so that appropriate corrective action can be taken to ensure staff compliance.
9. Take each inmate's temperature daily (with a functioning and properly operated thermometer) to identify potential COVID-19 infections;
10. Assess (through questioning) each inmate daily to identify potential COVID-19 infections;
11. Conduct immediate testing for anyone displaying known symptoms of COVID-19;

12. Immediately provide masks for any individual displaying or reporting COVID-19 symptoms until they can be evaluated by a qualified medical professional or placed in non-punitive quarantine;
13. Frequently communicate to inmates to provide information about COVID-19, reducing the risk of transmission, and any changes in policies or practices;
14. Provide inmates with an adequate supply of disinfectant hand wipes or disinfectant products effective against the virus that causes COVID-19 (at the manufacturer's recommended concentration), to clean their cells and other surfaces;
15. Clean and disinfect frequently touched surfaces with disinfectant products effective against the virus that causes COVID-19 (at the manufacturer's recommended concentration), as well as surfaces in common areas, every two hours during waking hours, and at least once during the night;
16. Ensure that individuals identified as having COVID-19 or having been exposed to COVID-19 are properly quarantined in a non-punitive setting, with continued access to showers, recreation, mental health services, reading materials, commissary, phone and video visitation with loved ones, communication with counsel, and personal property;
17. Respond to all emergency (as defined by the medical community) requests for medical attention within an hour;
18. Provide access to unmonitored, confidential legal calls and video visits with counsel to reduce the need for defense teams to enter into the facility and meet with clients in dangerously close quarters;

19. Facilitate video conferencing and telephonic conferencing, when requested, as an alternative to in-person court appearances; and

20. Appoint an independent monitor with medical expertise to ensure compliance with these conditions, and provide the monitor with unfettered access to medical units, confidential communication with detained individuals in and out of quarantine, and surveillance video of public areas of the facilities; and

C. Award such further relief as this Court deems appropriate.

DATED: March 30, 2020
Washington, D.C.

Respectfully submitted,

/s/ Steven Marcus
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DECLARATION OF DR. MARC STERN, MD MPH IN SUPPORT OF PLAINTIFF'S EMERGENCY MOTION

On this 29th day of March, 2020, I hereby declare:

1. My name is Marc Stern. I am a board certified internist specializing in correctional health care. I have managed health care operations and practiced health care in multiple correctional settings. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections. In terms of educational background, I received a Bachelor of Science degree from State University of New York (Albany) in 1975, a medical degree from State University of New York (Buffalo) in 1982, and a Master of Public Health from Indiana University in 1992. I am an Affiliate Assistant Professor at the University of Washington School of Public Health.

2. On a regular basis, I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts. My prior experience includes working with the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails.

3. Through 2013, I taught the National Commission on Correctional Health Care's (NCCHC) correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course.

4. In the past four years alone, I have been qualified as an expert in several

jurisdictions on correctional health care systems and conditions of confinement. My full *curriculum vitae* is attached hereto as Exhibit A.

5. I am not receiving payment in exchange for providing this affidavit to the D.C. Public Defender Services regarding appropriate correctional healthcare measures during the COVID-19 pandemic. In light of the emergency conditions occurring in jails and prisons across the country, I am providing my services *pro bono.*

6. Due to the recent COVID-19 pandemic affecting the nation and world, I have familiarized myself with the virus from a clinical perspective, including its causes and conditions, its transmission – especially in crowded and unsanitary conditions – and its ability to quickly spread through correctional facilities.

7. In the context of a pandemic like the one we currently face, public health and public safety interests are closely intertwined. When and if correctional staffing challenges arise due to the need for staff to quarantine, seek treatment, or care for dependents, managing internal safety in carceral settings becomes even more challenging. Understaffing in the correctional setting is dangerous for staff as well as incarcerated people, and the stress and fear of the current crisis only serve to increase those risks.

8. I have reviewed the March 25, 2020, letter sent from the union to the D.C. DOC, spelling out in the public health dangers at the D.C. DOC. If accurate, such conditions heighten the urgency of addressing these problems.

9. For example, if true, the grievance's allegations that correctional officers responsible for receiving and overseeing inmates do not any, or sufficient, personal protective equipment (PPE) for use when indicated,[1] and that officers are not required to participate in social distancing during shift changes, raise serious concerns that those officers may contract and transmit COVID-19 to their co-workers, families, and inmates in the facility. Accordingly, reducing the number of inmates with whom those

[1] Grievance at 3.

correctional officers must interact will reduce the risk that those correctional officers will contract COVID-19 or transmit it to others in the community.

10. I have also reviewed the declarations of four inmates detained in DOC facilities. As with the union's grievance letter, the inmates' allegations, if true, heighten the urgency of taking immediate and aggressive action. For example, the housing of multiple inmates within a single cell and lack of adequate cleaning supplies increases the probability that COVID-19 is already spreading throughout the facilities. Accordingly, housing only one inmate per cell and either providing sufficient cleaning supplies or reducing the amount of space requiring thorough cleaning will decrease the virus's ability to spread within DOC facilities.

11. In light of the conditions described in the documents that I have reviewed, the four confirmed cases of COVID-19 inside of DOC facilities, and the apparent resource-shortages facing the DOC, I am even more firmly convinced that downsizing the inmate population as much as possible will reduce the risk of contraction and transmission of COVID-19—and the attendant risks of serious harm and death—within DOC facilities and the communities around them.

12. Thoughtful downsizing should be implemented in tandem with aggressive, responsive prevention measures that are developed and guided by public health and medical experts.

13. Institutional settings such as jails, prisons, shelters, and inpatient treatment programs are congregate environments where people live, eat, and sleep closely together. In these environments, infections like COVID-19 can spread more rapidly. Downsizing jail populations serves two critical public health aims: (1) targeting residents who are at elevated risk of suffering from severe symptoms of COVID-19; and (2) allowing those who remain incarcerated to better maintain social distancing and avoid other risks associated with forced communal living. Because vulnerable populations are at the highest risk of severe complications from COVID-19, and because when they develop severe complications they will be transported to community hospitals—thereby using scarce community

resources (ER beds, general hospital beds, ICU beds)—avoiding disease in this population is a critical contribution to public health overall.

14. Downsizing jail populations by releasing high risk individuals and others the court system deems eligible for release will help to "flatten the curve" overall—both within the jail setting and without. Early reporting on the impacts of COVID-19, based in part on preliminary data emerging from China, seemed to indicate that the virus' impact would remain relatively mild for younger people. Recent data released by the CDC suggests that this initial narrative is incorrect, and that adults aged 20-44 also face a risk of experiencing severe health outcomes as a result of contracting the disease. The CDC released data based on the reported cases in the United States between February 12 and March 16, 2020. This data showed the thirty-eight percent (38%) of the hospitalizations from coronavirus occurred in patients under 55 years old.[2] French health officials have released statements saying that half of intensive care admission in that country involve individuals under 65. In the Netherlands, half of intensive care admissions were for people under the age of 50.[3]

15. While the highest risk of death remains among the elderly, it is becoming clear that younger individuals are not protected from severe complications requiring hospitalization and placement in intensive care, using valuable community resources that are expected to become more scarce.

16. At the same time criminal justice authorities work to downsize jail populations, it is critical that the D.C. Department of Corrections, the D.C. Department of Behavioral Health, and any other public agency responsible for maintaining congregate living conditions of detained individuals in the D.C. system immediately undertake the following prevention and planning measures:

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[2] *Severe Outcomes Among Patients with Coronavirus Disease* 2019 (COVID-19) — United States, February 12–March 16, 2020, *available at* https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w

[3] https://www.washingtonpost.com/health/2020/03/19/younger-adults-are-large-percentage-coronavirus-hospitalizations-united-states-according-new-cdc-data/

a. **Immediate testing**. Patients who require testing, based on public health recommendations and the opinion of a qualified medical professional, should be tested for COVID-19.

b. **Immediate Screening**. Correctional authorities must be required to screen each employee or other person entering the facility *every day* to according to current CDC or local health department guidelines A record should be made of each screening.

c. **Quarantine.** The jail must establish non-punitive quarantine for all individuals believed to have been exposed to COVID-19, but are not yet symptomatic, and non-punitive isolation for those believed to be infected with COVID-19 and potentially infectious. Any individual who must interact with those potentially or likely infected with COVID-19 must utilize protective equipment as directed by public health authorities. In short, every possible effort must be made to separate infected or potentially infected individuals from the rest of the incarcerated population. Individuals requiring continued quarantine, isolation, or health care after release from incarceration should be transferred from the institution to the appropriate outside venue.

d. **Institutional Hygiene.** The jail must be required to provide adequate sanitation of high use/high touch areas and cells in accordance with CDC or local health authority guidelines.

   i. This includes a prompt way to dispose of tissues used by incarcerated individuals as well as staff.

e. **Personal Hygiene.** The jail must be required to provide hand soap, disposable paper towels, and access to water to allow residents to wash their hands on a regular basis, **free of charge** and ensure replacement products are available as needed. Correctional staff should be allowed to carry hand sanitizer with alcohol on their person, and residents should be allowed to use hand sanitizer with alcohol when they

are in locations or activities where hand washing is not available.

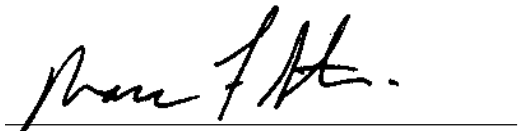
i. Inmates should be permitted access to cleaning supplies so they may clean their individual cells. This will both keep cells cleaner, and also stem panic amongst the incarcerated population.

f. **Access to treatment.** It is critical that inmates have rapid access to responsive medical treatment. Those with a cough should be provided masks as soon as they inform staff of this symptom or staff notice this symptom.

17. The measures I propose above are baseline steps to help slow the spread of COVID-19 in all facilities. However, each correctional facility has its own unique combination of physical structure and layout, operations, policies, logistics, inmate characteristics, and staffing factors that determine what additional measures may be necessary to minimize the spread of COVID-19. Only a public health expert who is able to review a particular facility firsthand can account for all of those factors and provide a meaningful and facility-specific opinion about what additional measures are necessary to reduce the risk of transmission.

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

Executed on March 29, 2020.



Marc Stern, MD MPH

EXHIBIT A

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

March, 2020

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SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

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

Current activities include:

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

Previous activities include:

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

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

OLYMPIA BUPRENORPHINE CLINIC, OLYMPIA, WASHINGTON **2019 - PRESENT**

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

OLYMPIA FREE CLINIC, OLYMPIA, WASHINGTON **2017 - PRESENT**

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

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

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

WASHINGTON STATE DEPARTMENT OF CORRECTIONS **2002 – 2008**

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

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

- As the first incumbent ever in this position, ushered the health services division from an operation of 12 staff in headquarters, providing only consultative services to the Department, to an operation with direct authority and

responsibility for all departmental health care staff and budget. As part of new organizational structure, created and filled statewide positions of Directors of Nursing, Medicine, Dental, Behavioral Health, Mental Health, Psychiatry, Pharmacy, Operations, and Utilization Management.

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

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

Regional Medical Director, Northeast Region, 2001 – 2002

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

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

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

Regional Medical Director, New York Region, 2000 – 2001

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

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

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

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

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

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

Acting Facility Medical Director, 1998 – 1999

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

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

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

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

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

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

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

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

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

Staff Physician, 1988 – 1990

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

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

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

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

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

FACULTY APPOINTMENTS

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

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

OTHER PROFESSIONAL ACTIVITIES

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

1972 – 1975	Chief of Service or Assistant Chief of Operations, 5 Quad Volunteer Ambulance Service, University at Albany.
1972 – 1975	Emergency Medical Technician Instructor and Course Coordinator, New York State Department of Health, Bureau of Emergency Medical Services

REVIEWER/EDITOR

2019 – present	Criminal Justice Review (reviewer)
2015 – present	PLOS ONE (reviewer)
2015 – present	Founding Editorial Board Member and Reviewer, Journal for Evidence-based Practice in Correctional Health, Center for Correctional Health Networks, University of Connecticut
2011 – present	American Journal of Public Health (reviewer)
2010 – present	International Advisory Board Member and Reviewer, International Journal of Prison Health
2010 – present	Langeloth Foundation (grant reviewer)
2001 – present	Reviewer and Editorial Board Member (2009 – present), Journal of Correctional Health Care
2001 – 2004	Journal of General Internal Medicine (reviewer)
1996	Abstract Committee, Health Services Research Subcommittee, Annual Meeting, Society of General Internal Medicine (reviewer)
1990 – 1992	Medical Care (reviewer)

EDUCATION

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

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

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

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

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

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

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

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

CERTIFICATION

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

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

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

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

MEMBERSHIPS

2019 – present	Washington Association of Sheriffs and Police Chiefs
2005 – 2016	American Correctional Association/Washington Correctional Association
2004 – 2006	American College of Correctional Physicians (Member, Board of Directors, Chair Education Committee)
2000 – present	American College of Correctional Physicians

RECOGNITION

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

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

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

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

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

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

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

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Turning Sick Call Upside Down. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas, 2015.

Diagnostic Maneuvers You May Have Missed in Nursing School. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas. 2015

The Challenges of Hunger Strikes: What Should We Do? What Shouldn't We Do? Annual Conference. National Commission on Correctional Health Care. Dallas, Texas. 2015

Practical and Ethical Approaches to Managing Hunger Strikes. Annual Practitioners' Conference. Washington Department of Corrections. Tacoma, Washington. 2015

Contracting for Health Services: Should I, and if so, how? American Jail Association Annual Meeting. Dallas, Texas. 2014

Hunger Strikes: What should the Society of Correctional Physician's position be? With Allen S, May J, Ritter S. American College of Correctional Physicians (Formerly Society of Correctional Physicians) Annual Meeting. Nashville, Tennessee. 2013

Addressing Conflict between Medical and Security: an Ethics Perspective. International Corrections and Prison Association Annual Meeting. Colorado Springs, Colorado. 2013

Patient Safety and 'Right Using' Nurses. Keynote address. Annual Conference. American Correctional Health Services Association. Philadelphia, Pennsylvania. 2013

Patient Safety: Overuse, underuse, and misuse…of nurses. Keynote address. Essentials of Correctional Health Care conference. Salt Lake City, Utah. 2012

The ethics of providing healthcare to prisoners-An International Perspective. Global Health Seminar Series. Department of Global Health, University of Washington, Seattle, Washington. 2012

Recovery, Not Recidivism: Strategies for Helping People Who are Incarcerated. Panelist. NAMI Annual Meeting, Seattle, Washington, 2012

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center. Salem, Oregon. 2011

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center. Spokane, Washington. 2011

Patient Safety: Raising the Bar in Correctional Health Care. With Dr. Sharen Barboza. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee. 2010

Patient Safety: Raising the Bar in Correctional Health Care. American Correctional Health Services Association, Annual Meeting, Portland, Oregon. 2010

Achieving Quality Care in a Tough Economy. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee, 2010 (Co-presented with Rick Morse and Helena Kim, PharmD.)

Involuntary Psychotropic Administration: The Harper Solution. With Dr. Bruce Gage. American Correctional Health Services Association, Annual Meeting, Portland, Oregon. 2010

Evidence Based Decision Making for Non-Clinical Correctional Administrators. American Correctional Association 139th Congress, Nashville, Tennessee. 2009

Death Penalty Debate. Panelist. Seattle University School of Law, Seattle, Washington. 2009

The Patient Handoff – From Custody to the Community. Washington Free Clinic Association, Annual Meeting, Olympia, Washington. Lacey, Washington. 2009

Balancing Patient Advocacy with Fiscal Restraint and Patient Litigation. National Commission on Correctional Health Care and American College of Correctional Physicians "Medical Directors Boot Camp," Seattle, Washington. 2009

Staff Management. National Commission on Correctional Health Care and American College of Correctional Physicians "Medical Directors Boot Camp," Seattle, Washington. 2009

Management Dilemmas in Corrections: Boots and Bottom Bunks. Annual Meeting, American College of Correctional Physicians, Chicago, Illinois. 2008

Public Health and Correctional Health Care. Masters Program in community–based population focused management – Populations at risk, Washington State University, Spokane, Washington. 2008

Managing the Geriatric Population. Panelist. State Medical Directors' Meeting, American Corrections Association, Alexandria, Virginia. 2007

I Want to do my own Skin Biopsies. Annual Meeting, American College of Correctional Physicians, New Orleans, Louisiana. 2005

Corrections Quick Topics. Annual Meeting, American College of Correctional Physicians. Austin, Texas. 2003

Evidence Based Medicine in Correctional Health Care. Annual Meeting, National Commission on Correctional Health Care. Austin, Texas. 2003

Evidence Based Medicine. Excellence at Work Conference, Empire State Advantage. Albany, New York. 2002

Evidence Based Medicine, Outcomes Research, and Health Care Organizations. National Clinical Advisory Group, Integrail, Inc., Albany, New York. 2002

Evidence Based Medicine. With Dr. LK Hohmann. The Empire State Advantage, Annual Excellence at Work Conference: Leading and Managing for Organizational Excellence, Albany, New York. 2002

Taking the Mystery out of Evidence Based Medicine: Providing Useful Answers for Clinicians and Patients. Breakfast Series, Institute for the Advancement of Health Care Management, School of Business, University at Albany, Albany, New York. 2001

Diagnosis and Management of Male Erectile Dysfunction – A Goal–Oriented Approach. Society of General Internal Medicine National Meeting, San Francisco, California. 1999

Study Design and Critical Appraisal of the Literature. Graduate Medical Education Lecture Series for all housestaff, Albany Medical College, Albany, New York. 1999

Male Impotence: Its Diagnosis and Treatment in the Era of Sildenafil. 4th Annual CME Day, Alumni Association of the Albany–Hudson Valley Physician Assistant Program, Albany, New York. 1998

Models For Measuring Physician Productivity. Panelist. National Association of VA Ambulatory Managers National Meeting, Memphis, Tennessee. 1997

Introduction to Male Erectile Dysfunction and the Role of Sildenafil in Treatment. Northeast Regional Meeting Pfizer Sales Representatives, Manchester Center, Vermont. 1997

Male Erectile Dysfunction. Topics in Urology, A Seminar for Primary Healthcare Providers, Bassett Healthcare, Cooperstown, New York. 1997

Evaluation and Treatment of the Patient with Impotence: A Practical Primer for General Internists. Society of General Internal Medicine National Meeting, Washington D.C. 1996

Impotence: An Update. Department of Medicine Grand Rounds, Albany Medical College, Albany, New York. 1996

Diabetes for the EMT First–Responder. Five Quad Volunteer Ambulance, University at Albany. Albany, New York. 1996

Impotence: An Approach for Internists. Medicine Grand Rounds, St. Mary's Hospital, Rochester, New York. 1994

Male Impotence. Common Problems in Primary Care Precourse. American College of Physicians National Meeting, Miami, Florida. 1994

Patient Motivation: A Key to Success. Tuberculosis and HIV: A Time for Teamwork. AIDS Program, Bureau of Tuberculosis Control – New York State Department of Health and Albany Medical College, Albany, New York. 1994

Recognizing and Treating Impotence. Department of Medicine Grand Rounds, Albany Medical College, Albany, New York. 1992

Medical Decision Making: A Primer on Decision Analysis. Faculty Research Seminar, Department of Family Practice, Indiana University, Indianapolis, Indiana. 1992

Effective Presentation of Public Health Data. Bureau of Communicable Diseases, Indiana State Board of Health, Indianapolis, Indiana. 1991

Impotence: An Approach for Internists. Housestaff Conference, Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Using Electronic Databases to Search the Medical Literature. NIH/VA Fellows Program, Indiana University, Indianapolis, Indiana. 1991

Study Designs Used in Epidemiology. Ambulatory Care Block Rotation. Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Effective Use of Slides in a Short Scientific Presentation. Housestaff Conference, Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Impotence: A Rational and Practical Approach to Diagnosis and Treatment for the General Internist. Society of General Internal Medicine National Meeting, Washington D.C. 1991

Nirvana and Audio–Visual Aids. With Dr. RM Lubitz. Society of General Internal Medicine, Midwest Regional Meeting, Chicago. 1991

New Perspectives in the Management of Hypercholesterolemia. Medical Staff, West Seneca Developmental Center, West Seneca, New York. 1989

Effective Use of Audio–Visual Aids. Nurse Educators, American Diabetes Association, Western New York Chapter, Buffalo, New York. 1989

Management of Diabetics in the Custodial Care Setting. Medical Staff, West Seneca Developmental Center, West Seneca, New York, 1989

Effective Use of Audio–Visuals in Diabetes Peer and Patient Education. American Association of Diabetic Educators, Western New York Chapter, Buffalo, New York. 1989

Pathophysiology, Diagnosis and Care of Diabetes. Nurse Practitioner Training Program, School of Nursing, University of Buffalo, Buffalo, New York. 1989

Techniques of Large Group Presentations to Medical Audiences – Use of Audio–Visuals. New Housestaff Training Program, Graduate Medical Dental Education Consortium of Buffalo, Buffalo, New York. 1988

PUBLICATIONS/ABSTRACTS

Borschmann, R, Tibble, H, Spittal, MJ, … Stern, MF, Viner, KM, Wang, N, Willoughby, M, Zhao, B, and Kinner, SA. *The Mortality After Release from Incarceration Consortium (MARIC): Protocolfor a multi-national, individual participant data meta-analysis.* Int. J of Population Data Science 2019 5(1):6

Binswanger IA, Maruschak LM, Mueller SR, **Stern MF**, Kinner SA**.** *Principles to Guide National Data Collection on the Health of Persons in the Criminal Justice System.* Public Health Reports 2019 134(1):34S-45S

Stern M. *Hunger Strike: The Inside Medicine Scoop.* American Jails 2018 32(4):17-21

Grande L, **Stern M.** *Providing Medication to Treat Opioid Use Disorder in Washington State Jails.* Study conducted for Washington State Department of Social and Health Services under Contract 1731-18409. 2018.

Stern MF, Newlin N. *Epicenter of the Epidemic: Opioids and Jails.* American Jails 2018 32(2):16-18

Stern MF. *A nurse is a nurse is a nurse…NOT!* Guest Editorial, American Jails 2018 32(2):4,68

Wang EA, Redmond N, Dennison Himmelfarb CR, Pettit B, **Stern M**, Chen J, Shero S, Iturriaga E, Sorlie P, Diez Roux AV. *Cardiovascular Disease in Incarcerated Populations.* Journal of the American College of Cardiology 2017 69(24):2967-76

Mitchell A, Reichberg T, Randall J, Aziz-Bose R, Ferguson W, **Stern M.** *Criminal Justice Health Digital Curriculum*. Poster, Annual Academic and Health Policy Conference on Correctional Health, Atlanta, Georgia, March, 2017

Stern MF. *Patient Safety (White Paper).* Guidelines, Management Tools, White Papers, National Commission on Correctional Health Care. http://www.ncchc.org/filebin/Resources/Patient-Safety-2016.pdf. June, 2016

Binswanger IA, **Stern MF**, Yamashita TE, Mueller SR, Baggett TP, Blatchford PJ. *Clinical risk factors for death after release from prison in Washington State: a nested case control study.* Addiction 2015 Oct 17

Stern MF. Op-Ed on Lethal Injections. The Guardian 2014 Aug 6

Stern MF. *American College of Correctional Physicians Calls for Caution Placing Mentally Ill in Segregation: An Important Band-Aid.* Guest Editorial. Journal of Correctional Health Care 2014 Apr; 20(2):92-94

Binswanger I, Blatchford PJ, Mueller SR, **Stern MF**. *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009.* Annals of Internal Medicine 2013 Nov; 159(9):592-600

Williams B, **Stern MF,** Mellow J, Safer M, Greifinger RB. *Aging in Correctional Custody: Setting a policy agenda for older prisoner health care.* American Journal of Public Health 2012 Aug; 102(8):1475-1481

Binswanger I, Blatchford PJ, Yamashita TE, **Stern MF.** *Drug-Related Risk Factors for Death after Release from Prison: A Nested Case Control Study*. Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Blatchford PJ, Forsyth S, **Stern MF**, Kinner SA. *Death Related to Infectious Disease in Ex-Prisoners: An International Comparative Study*. Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Lindsay R, **Stern MF**, Blatchford P. *Risk Factors for All-Cause, Overdose and Early Deaths after Release from Prison in Washington State Drug and Alcohol Dependence.* Drug and Alcohol Dependence Aug 1 2011;117(1):1-6

Stern MF, Greifinger RB, Mellow J. *Patient Safety: Moving the Bar in Prison Health Care Standards.* American Journal of Public Health November 2010;100(11):2103-2110

Strick LB, Saucerman G, Schlatter C, Newsom L, **Stern MF**. *Implementation of Opt-Out HIV testing in the Washington State Department of Corrections*. Poster Presentation, National Commission on Correctional Health Care Annual Meeting, Orlando, Florida, October, 2009

Binswanger IA, Blatchford P, **Stern MF**. *Risk Factors for Death After Release from Prison*. Society for General Internal Medicine 32nd Annual Meeting; Miami: Journal of General Internal Medicine; April 2009. p. S164-S95

Stern MF. Force Feeding for Hunger Strikes – One More Step. CorrDocs Winter 2009;12(1):2

Binswanger I, **Stern MF**, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. *Release from Prison – A High Risk of Death for Former Inmates*. New England Journal of Medicine 2007 Jan 11;356(2):157–165

Stern MF, Hilliard T, Kelm C, Anderson E. *Epidemiology of Hepatitis C Infection in the Washington State Department of Corrections.* Poster Presentation, CDC/NIH *ad hoc* Conference on Management of Hepatitis C in Prisons, San Antonio, Texas, January, 2003

Phelps KR, **Stern M**, Slingerland A, Heravi M, Strogatz DS, Haqqie SS. *Metabolic and skeletal effects of low and high doses of calcium acetate in patients with preterminal chronic renal failure.* Am J Nephrol 2002 Sep–Dec;22(5–6):445–54

Goldberg L, **Stern MF,** Posner DS. *Comparative Epidemiology of Erectile Dysfunction in Gay Men*. Oral Presentation, International Society for Impotence Research Meeting, Amsterdam, The Netherlands, August 1998. Int J Impot Res. 1998;10(S3):S41 [also presented as oral abstract Annual Meeting, Society for the Study of Impotence, Boston, Massachusetts, October, 1999. Int J Impot Res. 1999;10(S1):S65]

Stern MF. *Erectile Dysfunction in Older Men.* Topics in Geriatric Rehab 12(4):40–52, 1997. [republished in Geriatric Patient Education Resource Manual, Supplement. Aspen Reference Group, Eds. Aspen Publishers, Inc., 1998]

Stern MF, Wulfert E, Barada J, Mulchahy JJ, Korenman SG. *An Outcomes–Oriented Approach to the Primary Care Evaluation and Management of Erectile Dysfunction.* J Clin Outcomes Management 5(2):36–56, 1998

Fihn SD, Callahan CM, Martin D, et al.; for the **National Consortium of Anticoagulation Clinics**.* *The Risk for and Severity of Bleeding Complications in Elderly Patients Treated with Warfarin.* Ann Int Med. 1996;124:970–979

Fihn SD, McDonell M, Martin D, et al.; for the **Warfarin Optimized Outpatient Follow–up Study Group**.* *Risk Factors for Complications of Chronic Anticoagulation.* Ann Int Med. 1993;118:511–520. (*While involved in the original proposal development and project execution, I was no longer part of the group at the time of this publication)

Stern MF, Dittus RS, Birkhead G, Huber R, Schwartz J, Morse D. *Cost–Effectiveness of Hepatitis B Immunization Strategies for High Risk People*. Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. Clin Res 1992

Fihn SD, McDonell MB, Vermes D, Martin D, Kent DL, Henikoff JG, and the **Warfarin Outpatient Follow–up Study Group**. *Optimal Scheduling of Patients Taking Warfarin. A Multicenter Randomized Trial.* Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. Clin Res 1992

Fihn SD, McDonnell MB, Vermes D, Kent DL, Henikoff JG, and the **Warfarin Anticoagulation Study Group**. *Risk Factors for Complications During Chronic Anticoagulation.* Poster Presentation, Society of General Internal Medicine National Meeting, Seattle, May 1991

Pristach CA, Donoghue GD, Sarkin R, Wargula C, Doerr R, Opila D, **Stern M**, Single G. *A Multidisciplinary Program to Improve the Teaching Skills of Incoming Housestaff.* Acad Med. 1991;66(3):172–174

Stern MF. *Diagnosing Chlamydia trachomatis and Neisseria gonorrhea Infections.* (letter) J Gen Intern Med. 1991;6:183

Stern MF, Fitzgerald JF, Dittus RS, Tierney WM, Overhage JM. *Office Visits and Outcomes of Care: Does Frequency Matter?* Poster Presentation, Society of General Internal Medicine Annual Meeting, Seattle, May 1991. Clin Res 1991;39:610A

Stern MF. *Cobalamin Deficiency and Red Blood Cell Volume Distribution Width.* (letter) Arch Intern Med. 1990;150:910

Stern M, Steinbach B. *Hypodermic Needle Embolization to the Heart.* NY State J Med. 1990;90(7):368–371

Stern MF, Birkhead G, Huber R, Schwartz J, Morse D. *Feasibility of Hepatitis B Immunization in an STD Clinic.* Oral Presentation, American Public Health Association Annual Meeting, Atlanta, November 1990

EXPERT TESTIMONY

Pajas v. County of Monterey, *et al.* US District Court for the Northern District of California, 2019 (trial)

Dockery, *et al.* v. Hall *et al.* US District Court for the Southern District of Mississippi Northern Division, 2018 (trial)

Benton v. Correct Care Solutions, *et al.* US District Court for the District of Maryland, 2018 (deposition)

Pajas v. County of Monterey, *et al.* US District Court Northern District of California, 2018 (deposition)

Walter v. Correctional Healthcare Companies, *et al*. US District Court, District of Colorado, 2017 (deposition)

Winkler v. Madison County, Kentucky, *et al*. US District Court, Eastern District of Kentucky, Central Division at Lexington, 2016 (deposition)

US v. Miami-Dade County, *et al.* US District Court, Southern District of Florida, periodically 2014 - 2016

District of Columbia Department of Corrections
Coronavirus Screening Form for Employees

As part of its ongoing effort to combat and prevent the spread of the Coronavirus (COVID-19) in DOC facilities, the District of Columbia Department of Corrections (DC DOC) will screen all employees and visitors for the virus prior to their entry into all DOC facilities. This form should be completed for all DOC staff seeking entry into DOC facilities.

Employee's Name:		Employee's Badge Number (if applicable):	
Classification/Job Title:		Date/Time:	
1.	Does the employee admit to having or present with lower respiratory illness (e.g. cough, shortness of breath) or fever?	Yes	No
2.	Has the employee come into close contact with a person diagnosed or under investigation for COVID-19? *	Yes	No
3.	Has the employee recently traveled an area with known local spread of COVID-19 (e.g., China, Iran, South Korea, Italy, or Japan) within the last 30 days?	Yes	No

If the employee answers "yes" questions 1, 2, and 3, immediately provide them with a mask, send them home and refer them to their health care provider. They are not to enter DOC's facilities. Also, the Shift Commander and DOC medical staff must be notified.

If the employee answers "no" to questions 1, 2, and 3, they will be allowed to enter DOC's facilities.

Completed by:

Printed Name: _____ Signature _____ Date/Time: _____

Shift Commander Name: _____ Date/Time: _____

Note:

Close contact is defined as:

a. being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time while not wearing recommended personal protective equipment (i.e. gowns, gloves, respirator, eye protection); or

b. having direct contact with infectious secretions (e.g. being coughed on) while not wearing recommended personal protective equipment.

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

Edwards Banks, D'Angelo Phillips, Keon Jackson, and Eric Smith

Plaintiff(s)

v.

QUINCY BOOTH, in his official capacity as Director of the DOC and LENNARD JOHNSON, in his official capacity as Warden

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* LENNARD JOHNSON
1901 D Street SE
Washington, DC 20003

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Steven Marcus
Public Defender Service for the District of Columbia
633 Indiana Ave, NW
Washington, DC 20004

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

Edwards Banks, D'Angelo Phillips, Keon Jackson, and Eric Smith

Plaintiff(s)

v.

QUINCY BOOTH, in his official capacity as Director of the DOC and LENNARD JOHNSON, in his official capacity as Warden

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* MAYOR MURIEL BOWSER
1350 Pennsylvania Avenue NW
Washington, DC 20004

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Steven Marcus
Public Defender Service for the District of Columbia
633 Indiana Ave, NW
Washington, DC 20004

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

Edwards Banks, D'Angelo Phillips, Keon Jackson, and Eric Smith

Plaintiff(s)

v.

QUINCY BOOTH, in his official capacity as Director of the DOC and LENNARD JOHNSON, in his official capacity as Warden

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Office of the Attorney General for the District of Columbia
441 4th Street NW, 6th Floor South
Washington, DC 20001

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Steven Marcus
Public Defender Service for the District of Columbia
633 Indiana Ave, NW
Washington, DC 20004

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

Edwards Banks, D'Angelo Phillips, Keon Jackson, and Eric Smith *Plaintiff(s)*	)	
v.	)	Civil Action No.
QUINCY BOOTH, in his official capacity as Director of the DOC and LENNARD JOHNSON, in his official capacity as Warden *Defendant(s)*	)	

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* QUINCY BOOTH
2000 14th Street NW, 7th Floor
Washington, DC 20009

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Steven Marcus
Public Defender Service for the District of Columbia
633 Indiana Ave, NW
Washington, DC 20004

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

CIVIL COVER SHEET

JS-44 (Rev. 6/17 DC)

I. (a) PLAINTIFFS

Edward Banks, D'Angelo Phillips, Keon Jackson, and Eric Smith

(b) COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF 11001
(EXCEPT IN U.S. PLAINTIFF CASES)

DEFENDANTS

Quincy Booth, in his official capacity as Director of the D.C. Dep't of Corrections, and Lennard Johnson, in his official capacity as Warden of the D.C. Dep't of Corrections

COUNTY OF RESIDENCE OF FIRST LISTED DEFENDANT _____
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED

(c) ATTORNEYS (FIRM NAME, ADDRESS, AND TELEPHONE NUMBER)

Steven Marcus, Public Defender Service for D.C.
633 Indiana Avenue, NW
Washington D.C. 20004
(202) 824-2524

ATTORNEYS (IF KNOWN)

Fernando Amarillas
Office of the Attorney General for the District of Columbia
441 4th Street NW, Washington, D.C. 20001
(202) 727-3400

II. BASIS OF JURISDICTION
(PLACE AN x IN ONE BOX ONLY)

- ○ 1 U.S. Government Plaintiff
- ◉ 3 Federal Question (U.S. Government Not a Party)
- ○ 2 U.S. Government Defendant
- ○ 4 Diversity (Indicate Citizenship of Parties in item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (PLACE AN x IN ONE BOX FOR PLAINTIFF AND ONE BOX FOR DEFENDANT) FOR DIVERSITY CASES ONLY!

	PTF	DFT		PTF	DFT
Citizen of this State	○ 1	○ 1	Incorporated or Principal Place of Business in This State	○ 4	○ 4
Citizen of Another State	○ 2	○ 2	Incorporated and Principal Place of Business in Another State	○ 5	○ 5
Citizen or Subject of a Foreign Country	○ 3	○ 3	Foreign Nation	○ 6	○ 6

IV. CASE ASSIGNMENT AND NATURE OF SUIT
(Place an X in one category, A-N, that best represents your Cause of Action and one in a corresponding Nature of Suit)

○ A. *Antitrust*

- ☐ 410 Antitrust

○ B. *Personal Injury/ Malpractice*

- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Medical Malpractice
- ☐ 365 Product Liability
- ☐ 367 Health Care/Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Product Liability

○ C. *Administrative Agency Review*

- ☐ 151 Medicare Act

Social Security
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

Other Statutes
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 890 Other Statutory Actions (If Administrative Agency is Involved)

◉ D. *Temporary Restraining Order/Preliminary Injunction*

Any nature of suit from any category may be selected for this category of case assignment.

(If Antitrust, then A governs)

○ E. *General Civil (Other)* OR **○ F. *Pro Se General Civil***

Real Property
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent, Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

Personal Property
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

Bankruptcy
- ☐ 422 Appeal 27 USC 158
- ☐ 423 Withdrawal 28 USC 157

Prisoner Petitions
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☒ 555 Prison Conditions
- ☐ 560 Civil Detainee – Conditions of Confinement

Property Rights
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent – Abbreviated New Drug Application
- ☐ 840 Trademark

Federal Tax Suits
- ☐ 870 Taxes (US plaintiff or defendant)
- ☐ 871 IRS-Third Party 26 USC 7609

Forfeiture/Penalty
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

Other Statutes
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 430 Banks & Banking
- ☐ 450 Commerce/ICC Rates/etc.
- ☐ 460 Deportation
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions
- ☐ 470 Racketeer Influenced & Corrupt Organization
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Satellite TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes
- ☐ 890 Other Statutory Actions (if not administrative agency review or Privacy Act)

○ G. *Habeas Corpus/ 2255* ☐ 530 Habeas Corpus – General ☐ 510 Motion/Vacate Sentence ☐ 463 Habeas Corpus – Alien Detainee	○ H. *Employment Discrimination* ☐ 442 Civil Rights – Employment (criteria: race, gender/sex, national origin, discrimination, disability, age, religion, retaliation) *(If pro se, select this deck)*	○ I. *FOIA/Privacy Act* ☐ 895 Freedom of Information Act ☐ 890 Other Statutory Actions (if Privacy Act) *(If pro se, select this deck)*	○ J. *Student Loan* ☐ 152 Recovery of Defaulted Student Loan (excluding veterans)
○ K. *Labor/ERISA (non-employment)* ☐ 710 Fair Labor Standards Act ☐ 720 Labor/Mgmt. Relations ☐ 740 Labor Railway Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Empl. Ret. Inc. Security Act	○ L. *Other Civil Rights (non-employment)* ☐ 441 Voting (if not Voting Rights Act) ☐ 443 Housing/Accommodations ☐ 440 Other Civil Rights ☐ 445 Americans w/Disabilities – Employment ☐ 446 Americans w/Disabilities – Other ☐ 448 Education	○ M. *Contract* ☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholder's Suits ☐ 190 Other Contracts ☐ 195 Contract Product Liability ☐ 196 Franchise	○ N. *Three-Judge Court* ☐ 441 Civil Rights – Voting (if Voting Rights Act)

V. ORIGIN

◉ 1 Original Proceeding ○ 2 Removed from State Court ○ 3 Remanded from Appellate Court ○ 4 Reinstated or Reopened ○ 5 Transferred from another district (specify) ○ 6 Multi-district Litigation ○ 7 Appeal to District Judge from Mag. Judge ○ 8 Multi-district Litigation – Direct File

VI. CAUSE OF ACTION (CITE THE U.S. CIVIL STATUTE UNDER WHICH YOU ARE FILING AND WRITE A BRIEF STATEMENT OF CAUSE.)

Defendant violates 28 USC 2241 and 42 USC 1983 by violating Plaintiffs' rights under the Fifth and Eighth Amendments.

VII. REQUESTED IN COMPLAINT | CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23 | DEMAND $ | JURY DEMAND: | Check YES only if demanded in complaint YES ☐ NO ☒

VIII. RELATED CASE(S) IF ANY (See instruction) YES ☐ NO ☒ If yes, please complete related case form

DATE: March 30, 2020 SIGNATURE OF ATTORNEY OF RECORD _____

INSTRUCTIONS FOR COMPLETING CIVIL COVER SHEET JS-44
Authority for Civil Cover Sheet

The JS-44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and services of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. Listed below are tips for completing the civil cover sheet. These tips coincide with the Roman Numerals on the cover sheet.

I. COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF/DEFENDANT (b) County of residence: Use 11001 to indicate plaintiff if resident of Washington, DC, 88888 if plaintiff is resident of United States but not Washington, DC, and 99999 if plaintiff is outside the United States.

III. CITIZENSHIP OF PRINCIPAL PARTIES: This section is completed only if diversity of citizenship was selected as the Basis of Jurisdiction under Section II.

IV. CASE ASSIGNMENT AND NATURE OF SUIT: The assignment of a judge to your case will depend on the category you select that best represents the primary cause of action found in your complaint. You may select only one category. You must also select one corresponding nature of suit found under the category of the case.

VI. CAUSE OF ACTION: Cite the U.S. Civil Statute under which you are filing and write a brief statement of the primary cause.

VIII. RELATED CASE(S), IF ANY: If you indicated that there is a related case, you must complete a related case form, which may be obtained from the Clerk's Office.

Because of the need for accurate and complete information, you should ensure the accuracy of the information provided prior to signing the form.