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IN THE SUPREME COURT OF PENNSYLVANIA

In re: the Petition of the Pennsylvania Prison Society, Brian McHale, Jeremy Hunsicker, Christopher Aubry, Michael Foundos, and Frederick Leonard, on behalf of all similarly situated individuals *Petitioners.*	**No. _____**

APPLICATION FOR EXTRAORDINARY RELIEF UNDER THE COURT'S KING'S BENCH JURISDICTION

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Constitutions

Statutes

Court Orders and Guidance

Other Authorities

I. INTRODUCTION

This petition presents an extraordinary issue of public safety: the urgent need to protect the health of all Pennsylvania residents and save lives by limiting the spread of COVID-19 among incarcerated people and staff in Pennsylvania's county jails.[1] Leading public health officials have warned that unless courts act **now**, the "epicenter of the pandemic will be jails and prisons."[2] The U.S. Centers for Disease Control and Prevention ("CDC") has explained that correctional and detention facilities "present unique challenges for control of COVID-19 transmission among incarcerated persons, detention center staff, and visitors."[3] As Dr. Joseph Amon, Director of Global Health at Drexel University states, "County jails were not built for the needs of this kind of pandemic" and the "spread of COVID-19 within the jails will affect not only those who are being held there, but

[1] For purposes of this petition, "county jail" means "county correctional institution," as that term is defined in 61 Pa.C.S.A. § 102.

[2] Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, The New York Times (Mar. 12, 2020), https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.html.

[3] U.S. Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* ("CDC Guidance") (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

also the correctional officers who work there, and the communities they go back to." Amon Decl. ¶¶ 19, 40.[4]

Across Pennsylvania, it is not possible for county jails to implement the most critical preventive measures set forth in the CDC Guidance: social distancing, preventive hygiene, and the medical isolation of confirmed or suspected COVID-19 cases.[5] Governor Wolf, Health Secretary Levine and this Court (in its March 16th and 18th Orders) have made efforts to enforce social distancing and limit the spread of the virus and prospective death toll. However, jails and prisons—by necessity, but in direct contravention of all public health and medical advice— force detainees and staff into tight quarters where frequent touching and unhygienic practices are the norm.[6] County jails simply do not have the space to keep incarcerated individuals six feet apart. Pennsylvania jails routinely double- or triple-cell people, and confine large numbers together in one room, where they

[4] Dr. Amon's Declaration is attached as Exhibit A to this Petition ("Amon Decl."), with his C.V. attached as Exhibit B. Dr. Amon is an internationally recognized authority on infectious disease control, clinical care, and obligations of government related to individuals in detention settings.

[5] *See generally*, CDC Guidance; *see also* Amon Decl. ¶¶ 45-46; Declaration of Dr. Jonathan Golob at ¶ 13 (attached as Exhibit C). Dr. Golob is on the faculty of the University of Michigan School of Medicine, where he specializes in the study of spread of infection in immunocompromised patients and is actively involved in planning for the care of patients with COVID-19. *See* Ex. D.

[6] Petitioners are submitting the declarations of several witnesses to attest to current jail conditions, including volunteers with the Petitioner Pennsylvania Prison Society (Exibits J, K, and L) and the individual Petitioners, each of whom is currently incarcerated (Exhibits E, F, G, H, and I).

sleep arm's length apart, eat shoulder to shoulder, and share rarely sanitized bathrooms. Nor do jails have the capacity to isolate symptomatic individuals. Many of these facilities lack adequate onsite health care services to evaluate or quarantine infected individuals in the manner dictated by infection-control guidance.

Under these conditions, once COVID-19 enters a correctional facility, it is virtually certain to spread like wildfire through the prison population, correctional staff, and into the nearby community. This is already happening in places like New York, where viral spread is a week or more ahead of Pennsylvania.[7] This is not just a prisoners' rights issue. Once the virus enters the jails, the regular movement of staff and visitors in and out means that prison walls and razor wire can neither slow nor stop viral spread. This impending viral explosion – imminently likely to occur in all sixty-seven counties – will directly impact all Commonwealth residents, including correctional staff, their families, and their respective communities. Failure to address the spread of the virus in jails will

[7] In a court filing last week, the Legal Aid Society of New York noted that the virus's exponential rate of infection in New York City jails far outpaces the national average, with Riker's Island experiencing an infection rate *roughly 85 times* the rate in the community-at-large. Verified Petition for Writ of Habeas Corpus ("NYLAS Petition"), *People ex rel. Stoughton v. Brann*, No. 260154/2020, at ¶ 3 (N.Y. Sup. Ct. Mar. 25, 2020).

undermine the effectiveness of government-mandated measures to enforce social distancing, which now cover millions of Pennsylvanians.

Of the approximately 37,000 people currently detained in Pennsylvania's county jails, more than half are in pre-trial status, and therefore presumed innocent.[8] Many are held on probation detainers due to technical violations or minor offenses, cannot afford modest bail, or have been deemed eligible for work release by a judge. Of the people serving a jail sentence in a Pennsylvania county jail—which, by law, includes only those individuals sentenced to a maximum term of two years or less, 42 Pa.C.S. § 9762(b)(3)—many have already completed their minimum terms of incarceration or are mere weeks away from doing so.

In light of the looming public health catastrophe, keeping such persons imprisoned where they face unnecessary health risks is inhumane and violates their rights under the Fourth, Fifth, Eighth, and Fourteenth Amendments to the United States Constitution and Article I, Sections One, Thirteen, and Fourteen of the Pennsylvania Constitution. Indeed, for some individuals who are older or suffer from pre-existing medical problems, continued detention may literally be consigning them to a death sentence.

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[8] Vera Institute, *Incarceration Trends in Pennsylvania*, www.vera.org/downloads/pdfdownloads/state-incarceration-trends-pennsylvania.pdf (noting that, as of 2015, people held pretrial constituted 62% of the total jail population in Pennsylvania).

This Court, recognizing the public health threat presented by COVID-19 and acknowledging the need to "restrict person-to-person contact," issued emergency orders on March 16th and 18th closing Pennsylvania Courts to the public. Public health imperatives require that this Court take far more dramatic steps. Indeed, for this same reason, courts in many other jurisdictions around the country have recognized that the public health emergency compels evaluation and release of significant numbers of people who pose little threat to public safety and will be endangered by continued imprisonment. Most notably, last week, in response to the "dangers posed by the Coronavirus," the New Jersey Supreme Court ordered the presumptive release of all people currently serving a county jail sentence, an order likely to result in the release of more than 1,000 people. *In the Matter of the Request to Commute or Suspend County Jail Sentences*, Consent Order, (N.J. No. 084230 March 22, 2020). New Jersey is not alone; jurist in the highest courts of Washington, South Carolina, Maine, and Montana have all taken similar measures.

This Court has the legal authority to follow the precedent set by New Jersey and these other jurisdictions. Justice demands no less. While a limited number of counties in the Commonwealth have adopted incremental case-by-case measures to limit jail populations, and one county (Allegheny County) has taken systemic steps to reduce its jail population, most judicial districts are taking a business-as-usual approach, failing to address, or even recognize, the looming public health

catastrophe. Such a piecemeal approach, relying on individual law enforcement and judicial officers to decide what action to take, is insufficient to address the urgency of the moment.

This Court has the power under Pennsylvania Constitution Article V, Sections 2 and 10(a), 42 Pa. Const. Stat. § 502, and Rule of Judicial Administration 1952(A) to provide for the necessary broad-based reduction of county jail populations. It is this relief that petitioners respectfully urge the Court to order. Specifically, for the reasons outlined below, petitioners request that the Court (1) direct the presumptive release, subject to challenge by district attorneys, of discrete categories of incarcerated people; and (2) direct the courts of the Commonwealth to institute measures that will further limit jail populations. This relief is warranted, reasonable, and, above all, essential in light of the unprecedented public health risk facing the Commonwealth's residents.

II. PETITIONERS

Petitioner, the **Pennsylvania Prison Society**, founded in 1787, is the nation's oldest human rights organization. Petitioner's mission is to ensure humane prison conditions and to advocate for a restorative approach to criminal justice. The Prison Society advances its mission through three programmatic areas: (1) prison monitoring, (2) social services support to family members with incarcerated loved ones, and (3) education and advocacy. Written into Pennsylvania law, the

Prison Society is the Commonwealth's prison ombuds, working to stop abuse and trauma. Every month, more than 250 incarcerated people and their families ask the Society for help with issues they face inside prison. Society staff and volunteers respond to these complaints by going into correctional facilities, meeting with incarcerated people, working to resolve concerns, and providing real-time information on prison conditions. The Prison Society is the only organization that provides public witness to what happens behind prison walls. Declarations of several Prison Society volunteers attesting to current conditions in certain jails in support of this Petition are attached as Exhibits J, K, and L.

Individual petitioners are five incarcerated individuals currently in custody at different county facilities, all of whom are incarcerated for minor offenses, and are at increased risk of contracting COVID-19 as a result of their incarceration. As each individual petitioner testifies in his declaration, current living situations in each facility, including shared living quarters, make it impossible for incarcerated individuals to maintain the recommended six-foot distance from one another.

1. Petitioner **Brian McHale**, 44, is in custody on a probation detainer at the Montgomery County Correctional Facility ("MCCF") as a result of alleged technical violations of his probation for retail theft convictions. Ex. E, Declaration of Brian McHale at ¶¶ 2-3. Because of several serious health conditions, *see id.* at ¶¶ 4-7, Petitioner McHale faces an elevated likelihood of serious harm and death should he contract the virus. At MCCF, he shares a cell with two other men. *Id.* at ¶ 8.

Petitioner McHale filed an emergency habeas petition for release due to his medical condition and susceptibility to COVID-19. The Montgomery County Court of Common Pleas deferred consideration until after "the expiration of the judicial emergency." *Id.* ¶¶ 12-16.

2. Petitioner **Jeremy Hunsicker**, 33, is detained at a Community Correction Center ("CCC") in Lehigh County. Ex. F, Declaration of Jeremy Hunsicker at ¶ 2. While on parole for driving under the influence, Petitioner Hunsicker was arrested for driving with a suspended licensed. *Id.* at ¶ 3. His parole was revoked and he was resentenced to six to twelve months, with another six to twelve months for driving with a suspended license. *Id.* Petitioner Hunsicker is eligible for work release, and is currently housed in a pod with about twenty other people. *Id.* at ¶¶ 5, 8.

3. Petitioner **Christopher Aubry**, 55, is incarcerated at MCCF on a one to twenty-three month sentence for simple assault and related misdemeanor charges. Ex. G, Declaration of Christopher Aubry at ¶¶ 2-3. He is work release eligible and currently housed in a pod with approximately fifty other people. *Id.* at ¶¶ 5-6.

4. Petitioner **Michael Foundos**, 39, is detained at George W. Hill Correctional Facility in Delaware County. Ex. H, Declaration of Michael Foundos at ¶¶ 2. Charged with retail theft, he has a probation detainer and a $50,000 bond. Foundos Decl. at ¶¶ 4-6. At his facility, each cell block contains 30 cells, and cells are generally shared by two people. *Id.* at ¶ 9.

5. Petitioner **Frederick Leonard**, 29, is incarcerated at Pike County Correctional Facility for a six to twenty-three-and-a-half month sentence for driving under the influence, driving with a suspended license, and fleeing. Ex. I, Declaration of Frederick Leonard at ¶¶ 2-3. He has several health conditions that place him at elevated risk of serious harm and death should he contract the virus. *Id.* at ¶ 4. At his facility, he shares a cell with two other individuals. *Id.* at ¶ 5.

III. JURISDICTION

The Court has jurisdiction pursuant to its King's Bench authority to decide this application and order the requested relief to "cause right and justice to be

done" in this matter involving "an issue of immediate public importance." 42 Pa.C.S.A. § 726 and Pa. Const. art. V, § 10(a).

IV. FACTUAL BACKGROUND

A. In the absence of preventive measures, COVID-19 is a rapidly spreading public health crisis, resulting in serious medical conditions or death for large numbers of high-risk individuals.

COVID-19 is a disease that has reached pandemic status. According to the World Health Organization, as of March 29, there were more than 638,146 confirmed cases of COVID-19 worldwide and more than 30,105 confirmed deaths. The United States has the highest number of confirmed cases in the world—more than 135,499—and 2,381 confirmed deaths. Amon Decl. ¶ 5. In Pennsylvania, as of March 29 at 4:30 p.m., there are 3,394 confirmed cases and 38 reported deaths, more than twice the number reported three days earlier and seven times the numbers reported just a week earlier. *Id.*[9] CDC's projections show that, without effective public health intervention, more than 200 million people in the United States could be infected with COVID-19, with as many as 1.5 million deaths in the most severe projections. Golob Decl. ¶ 11.

[9] The rapid rise of the pandemic means that at the time of submission, the number of confirmed cases and deaths discussed in Dr. Amon's Declaration will have grown exponentially. The declaration was prepared based on the data available to Dr. Amon at the time.

People over the age of 45 and those with certain medical conditions face a greater risk of serious illness from COVID-19, and those over the age of 55 face the highest risk of death. Amon Decl. ¶ 9; Golob Decl. ¶ 3. The medical conditions that increase the risk of serious complications from COVID-19 include lung disease, heart disease, chronic liver or kidney disease (including patients with hepatitis and those requiring dialysis), diabetes, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, and developmental delay. Golob Decl. ¶ 3. People with these conditions are at an increased risk of developing serious complications or dying from COVID-19, regardless of age. Golob Decl. ¶ 3; Amon Decl. ¶¶ 7-9.

The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 than from influenza. Golob Decl. ¶ 4. According to recent estimates, the fatality rate for people with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems. *Id*. For people in the highest risk populations, the fatality rate of COVID-19 is about 15 percent. Golob Decl. ¶ 4. This means about one in seven infected individuals in this high-risk group will die from COVID-19. Patients in high-risk categories who do not die from COVID-19 should expect a prolonged recovery, including the need for extensive rehabilitation for profound

reconditioning, loss of digits, neurologic damage, and the loss of respiratory capacity. Golob Decl. ¶¶ 4, 5 & 8.

B. The key measures to prevent spread of COVID-19 are impossible in county jails, making severe outbreaks likely in those facilities and the communities around them.

The only known effective measure to reduce the risk of serious illness and death that COVID-19 presents for vulnerable people is to prevent them from being infected in the first place. Golob Decl. ¶ 10; Amon Decl. ¶ 6. There is no vaccine to inoculate against COVID-19 and there is no known medication to treat COVID-19. Golob Decl. ¶ 10; Amon Decl. ¶ 6. Social distancing, quarantining or remaining physically separated from known or potentially infected individuals, and vigilant hygiene, including washing hands with soap and water, are the only known effective measures for protecting vulnerable people. Golob Decl. ¶ 10; Amon Decl. ¶ 13.

People detained in county jails cannot take these necessary measures to mitigate the risk of exposure. They are, therefore, at heightened risk of COVID-19 infection. Amon Decl. ¶¶ 24-26. County jails are "congregate settings," places where people live or sleep in close proximity. Such enclosed group environments, like cruise ships or nursing homes, have become the sites for the most severe outbreaks of COVID-19. Amon Decl. ¶¶ 19, 20. Conditions in correctional facilities create heightened public health risks for the spread of COVID-19 far

greater than in non-custodial institutions because of crowding, security-related restrictions, scant medical resources, and the proportion of vulnerable people detained. *Id*. at ¶ 20; Golob Decl. ¶ 13. Recent experience in the Rikers Island facility in New York City bears out the devastating impact of COVID-19 infection in a jail setting. The Legal Aid Society in New York reported that the COVID-19 infection rate at Rikers is more than *seven times* higher than the rate across New York City and *85 times* greater than the country at large.[10]

As the rate of infection increases in Pennsylvania,[11] the same phenomenon seen at Rikers Island is likely to repeat itself in the Commonwealth's county jails. COVID-19 has already been reported in Delaware County's jail. *See* Amon Decl. ¶¶ 19, 20, 30. And, on March 27, 2020, Philadelphia reported that both an employee and an inmate tested positive for COVID-19 in its jails. Amon Decl. ¶ 30.

Transmission in jails will endanger not only the incarcerated, but also the broader community. As correctional staff enter and leave the facility, they will

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[10] *See NYLAS Petition*, n.1.

[11] Dr. P.J. Brennan, Chief Medical Officer of the University of Pennsylvania Health System, has stated that the Philadelphia area is "no more than two weeks behind New York City" in the rate of infection. Marie McCullough & Lisa Gartner, *Philadelphia-area hospitals brace for the coronavirus surge: 'We are no more than 2 weeks behind N.Y.C.,'* The Philadelphia Inquirer (March 27, 2020), www.inquirer.com/health/coronavirus/philadelphia-coronavirus-cases-hospitals-testing-covid-20200327.

carry the virus with them. Amon Decl. ¶ 19.[12] Like the incarcerated people in the facilities where they work, correctional officers face an increased risk of COVID-19 exposure because they are less able to engage in required social distancing. Amon Decl. ¶ 32. In addition to staff testing positive in Philadelphia and Delaware Counties, several jurisdictions across the country have reported that correctional officers have tested positive for the virus. Amon Decl. ¶¶ 29, 30. Beyond the risk they pose to those incarcerated at the facility when they enter, correctional officers expose their families and broader communities to substantial risk every time they leave a correctional facility at the end of their daily shifts. [13]

The possibility of a COVID-19 outbreak among incarcerated people, the staff, and the communities around them is exacerbated because county jails cannot implement the CDC's recommended preventative measures in at least four respects.

1. Social distancing is not possible in county jails at their current population levels.

Social distancing is the most important means to prevent the spread of COVID-19 because the disease is primarily transmitted between people who are in

[12] Josiah Rich, et al.**,** *We Must Release Prisoners to Lessen the Spread of Coronavirus,* The Washington Post (Mar. 17, 2020), www.washingtonpost.com /opinions/2020/03/17/we-must-release-prisoners-lessen-spread-coronavirus (The authors (including a professor of medicine and epidemiology) warn that unless we act swiftly to release people from jails and prisons, the virus threatens not only prisoners and corrections workers but the general public as well).

[13] *See* Rich, et al., *supra* n. 12.

close contact with one another (within about six feet) via respiratory droplets produced when an infected person coughs or sneezes. Amon Decl. ¶ 13. Social distancing is so imperative that Governor Wolf has ordered people in 19 counties not to leave their homes. Amon Decl. ¶ 14. As of March 27, at least 25 states, 74 counties, and 14 cities were under similar stay-at-home orders. Governors in 40 states have barred even small social gatherings. The extraordinary impact on more than 200 million people due to stay-at-home orders and mandatory business closures, including several million throughout Pennsylvania, has been deemed necessary for one reason: to ensure appropriate social distancing.

CDC guidance on correctional and detention facilities specifically recommends implementing social distancing ("ideally 6 feet between individuals, regardless of the presence of symptoms")[14] to increase the physical space between incarcerated persons. Amon Decl. ¶ 21. Yet individuals in county jails in the Commonwealth have no ability to practice social distancing.

For example, in Montgomery County Correctional Facility, numerous cells throughout the facility are shared by three people—meaning that three people share the same confined space, one toilet, and one sink. In addition to their cellmates, each incarcerated person has close contact with thirteen other individuals on his unit and up to fifty other people on his "pod." Amon Decl. ¶ 24. In Lehigh

[14] CDC Guidance at 11.

County's Community Corrections Center, up to seventy people eat meals together at one time, and close contact with other incarcerated persons is unavoidable during regular medical checks. *Id.* In Blair County Prison, beds are just three to four feet apart. Amon Decl. ¶ 25. In Allegheny County, newly arrested individuals typically are held for more than a day in an intake cell, usually with ten or more people sharing a single toilet and sink. Amon Decl. ¶ 25.

In these circumstances, county jails will not be able to prevent COVID-19 transmission once the virus is inevitably introduced into the jail.

2. County jails do not have sufficient supplies for the enhanced hygiene and disinfecting necessary to prevent the spread of COVID-19.

The CDC Guidance also describes procedures necessary for individual hygiene and to thoroughly clean and disinfect areas where a person with confirmed or suspected COVID-19 spent time. Amon Decl. ¶ 22. In county jails, people share toilets, sinks, and showers, without disinfection between each use. *Id*. at ¶ 20. Food preparation and service is communal with little opportunity for surface disinfection. *Id*. County jails do not have enough supplies for individuals to wash their hands or to disinfect the space around them. Amon Decl. ¶ 26. There is not sufficient hand sanitizer in Lehigh County's Community Corrections Center or the Montgomery County Correctional Facility. Amon Decl. ¶ 24. Soap is limited in Blair County Prison and Allegheny County Jail. Amon Decl. ¶ 25. Failure to

provide these supplies while requiring individuals in custody to use shared bathroom facilities and to eat in common spaces creates an intolerably high risk of infectious spread.

3. Proper isolation for symptomatic people is not possible in county jails.

The CDC guidance recommends "medical isolation of confirmed or suspected COVID-19 cases."[15] Yet, once a person in a county jail has symptoms, proper isolation is not possible due to population size and the physical limitations of the facility. Amon Decl. ¶¶ 25-26. Because of forced contact between many individuals in crowded facilities, people who are exposed will need to be quarantined. Because most jails are at or near capacity, there simply is insufficient space to house people consistent with the CDC-recommended quarantine protocol, which requires separating people to prevent further spread of the disease, or to house those who test positive in true isolation units.[16]

4. County jails do not have the capacity to properly screen individuals entering their facilities.

County jails cannot implement screening measures necessary to prevent introduction of the virus into the jails. The CDC recommends that jails adopt intensive pre-intake screening of all prisoners, and screen all staff and individuals

[15] CDC Guidance at 15-16.
[16] CDC Guidance at 19.

entering the facility.[17] Non-test based verbal screens—i.e., asking a person for a subjective report of symptoms—cannot adequately screen for new, asymptomatic or pre-symptomatic infections. *Id.* at ¶ 27. As COVID-19 has a typical incubation period of five days, and transmission often occurs before presentation of symptoms, such inadequate screening presents a critical problem. Golob Decl. ¶ 6. The possibility of asymptomatic transmission means that monitoring staff or incarcerated people for fevers is inadequate to identify all who may be infected and preventing transmission. Amon Decl. at ¶ 27.

Given the shortage of COVID-19 test kits in the United States, jails will not be able to test people newly admitted to the facility, individuals on work release, staff, visiting attorneys, or any other people who enter facilities daily. Amon Decl. ¶¶ 27, 28.

C. Population reduction is the only way to prevent an outbreak of COVID-19 in the county jails and to prevent the death of those at highest risk.

Significant reduction of county jail populations is the only viable option to protect incarcerated persons from COVID-19. Amon Decl. ¶ 47. Without reduction in the numbers of detained individuals, jails will be unable to implement the only scientifically recognized procedures that can reduce the risk of infection. *Id.* Reducing county jail populations will allow the facilities to reduce the risk of

[17] *Id.* at 7-11.

infection for both incarcerated people and correctional officers, which in turn protects the communities to which the officers return. *Id.*

People in prisons and jails are disproportionately likely to have chronic health conditions, including diabetes, high blood pressure, and HIV, that put them at higher risk of severe health consequences upon contracting the virus. Amon Decl. ¶ 41.[18] Large numbers of seriously ill incarcerated people will strain the limited medical infrastructure in the jails, heightening the risk that infected individuals will suffer serious harm.

Some county jails simply lack the necessary medical infrastructure to address the spread of infectious disease and treatment of people most vulnerable to illness. Once COVID-19 spreads throughout a jail, the burden of caring for these sick individuals will shift to local community medical facilities. Because many rural parts of the Commonwealth have limited access to hospitals with intensive care units or trained infectious disease practitioners, and limited personal

[18] Jennifer Gonnerman, *How Prisons and Jails Can Respond to the Coronavirus*, The New Yorker (Mar. 16, 2020), https://www.newyorker.com/news/q-and-a/how-prisons-and-jails-can-respond-to-the-coronavirus; *see also* I.A. Binswanger, et al., *Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population*, 63 Journal of Epidemiology & Community Health 912–919 (2009), https://www.ncbi.nlm.nih.gov/pubmed/19648129 (concluding that people incarcerated in U.S. jails and prisons had a higher burden of most chronic medical conditions than the general population, even when adjusting for sociodemographic differences and alcohol consumption).

protective equipment and other life-sustaining supplies, thus there is an increased likelihood of death for all individuals living in such rural communities who become ill and require treatment. Amon Decl. ¶ 44.

* * *

In sum, to effectively mitigate the risk of infection and subsequent spread of the virus, the jail population must be reduced. Amon Decl. ¶ 47. Reducing the overall number of individuals in detention facilities allows social distancing for all inside, and allows infected individuals and their contacts, to be properly quarantined and monitored for health complications that require transfer to a local hospital. *Id.* It also lessens the risk to corrections officers, who, if short-staffed, will have difficulty maintaining order and proper personal protective measures. *Id.* Protecting corrections staff in turn protects the communities they come from. *Id.* Unless this Court orders measures to reduce the jail population, contagion will be more widespread, already taxed hospitals strained further, and the mortality rate likely to increase. The time to act is now.

V. ARGUMENT

A. This Court has the legal authority to use its broad King's Bench jurisdiction to order the requested relief.

The Court has King's Bench jurisdiction to decide this application in order to "cause right and justice to be done" in a matter involving "an issue of immediate public importance." 42 Pa.C.S.A. § 726 and Pa. Const. art. V, § 10(a). This case

raises "an issue of immediate public importance affecting operation of government throughout the Commonwealth." *Silver v. Downs*, 493 Pa. 50, 56 (1981).

As a result of its enduring King's Bench authority, this Court possesses "every judicial power that the people of the Commonwealth can bestow under the Constitution of the United States." *In re Bruno*, 101 A.3d 635, 666 (Pa. 2014) (quoting *Stander v. Kelly*, 250 A.2d 474, 484 (Pa. 1969)). This Court's precedent has long "described the King's Bench power in the broadest of terms" and, as such, has recognized that the Court "would be remiss to interpret the Court's supervisory authority at King's Bench in narrow terms, contrary to precedent and the transcendent nature and purpose of the power." *In re Bruno*, 101 A.3d at 679.

The Court's exercise of its King's Bench authority is appropriate here, as the COVID-19 public health crisis is an unprecedented matter of public importance, which "requires timely intervention by the court of last resort to avoid the deleterious effects arising from delays incident to the ordinary process of law." *Commonwealth v. Williams*, 129 A.3d 1199, 1206 (Pa. 2015).

This Court has already recognized, in its two emergency orders of March 16th and 18th, that the COVID-19 pandemic warrants extraordinary steps to protect the public. This Petition calls upon the Court to meet this unprecedented health challenge by directing each judicial district to take reasonable and necessary measures to prevent widespread contagion. Petitioners call upon the Court to take

this necessary action to protect not just the people held within county jails, but correctional staff, their families, their respective communities and ultimately the public health of all Commonwealth residents.

Time is of the essence. Immediate intervention by this Court is necessary to avoid "the deleterious effects arising from delays incident to the ordinary process of law." *Williams*, 129 A.3d at 1206. The risk to the general public of delaying further review cannot be overstated. To date, individual judicial districts or jurists throughout the Commonwealth have relied on a piecemeal strategy without any guidance from this Court. The lack of an urgent, unified, and concerted effort to address the grave public health risk will result in future measures that, quite simply, will be too little, too late. There will be outbreaks in county jails, an inevitable community spread, and, increased suffering.

Application of the King's Bench power is particularly suited to this case, which asks that this Court exercise its "general supervisory and administrative authority over all the courts." Pa. Const. art. V, § 10(a). This Court further has power under Section 10(a) "to prescribe general rules governing practice, procedure and the conduct of all courts." *Id.* "By its 'supreme' nature, the inherent adjudicatory, supervisory, and administrative authority of this Court at King's Bench 'is very high and transcendent.'" *In re Bruno*, 101 A.3d at 669 (quoting *Commonwealth v. Chimenti*, 507 A.2d 79, 81 (Pa. 1986)). This "supervisory power

over the Unified Judicial System is beyond question." *In re Bruno,* 101 A.3d at 678.

Under its King's Bench authority, this Court has the power to exercise general jurisdiction over the Unified Judicial System even "where no matter is pending in a lower court." *In re Avellino*, 690 A.2d 1138, 1140 (Pa. 1997). When exercising King's Bench authority, this Court's "principal obligations are to conscientiously guard the fairness and probity of the judicial process and the dignity, integrity, and authority of the judicial system, all for the protection of the citizens of this Commonwealth." *Williams*, 129 A.3d at 1206 (quotation and citation omitted).

The issues raised by Petitioners plainly fall within the Court's King's Bench authority. The urgency to respond to this historic public health crisis cannot be gainsaid.

B. Extraordinary measures in other jurisdictions demonstrate the need for population reduction in the county jails.

In recognition of the extraordinary public health risk posed by the transmission of COVID-19 in custodial settings, courts across the country have taken steps within the past week to reduce prison populations in their respective states, including the following:

- On March 22, 2020, the Supreme Court of New Jersey ordered the release of *all* prisoners serving county jail sentences.[19]

- In Montana, the Chief Justice of the Supreme Court wrote to all judges in the state asking each to "review your jail rosters and release, without bond, as many prisoners as you are able, especially those being held for non-violent offenses."[20]

- The chief justice of the South Carolina Supreme Court ordered that everyone held in jail on bond in a non-capital case be released, unless there exists an "unreasonable danger" or "extreme flight risk."[21]

- The Washington Supreme Court directed that all trial courts in the state prioritize hearings that could result in the release of a defendant in custody, providing that courts "shall hear motions for pretrial release on an expedited basis" and that any person fitting within the CDC's definition of vulnerable populations would be presumed to have demonstrated a "material change in circumstances" justifying reconsideration of previously ordered bail conditions.[22]

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

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

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

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

- In an effort to prevent new admissions to county jails, the chief judge of Maine's trial courts, with the approval of the chief justice of the Maine Supreme Court, vacated all outstanding warrants for unpaid fines, restitution, fees, and failures to appear.[23] The order resulted in the vacatur of more than 12,000 warrants.[24]

In addition to state Supreme Courts taking action, in Maryland[25] and Colorado,[26] executive officers urged courts to take similar measures. Similarly, in other jurisdictions, local authorities have acted to sharply reduce prison populations:

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

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

[25] Letter from Marilyn J. Mosby, State's Attorney for Baltimore City, to Governor Larry Hogan (Mar. 23, 2020), https://content.govdelivery.com/attachments/MDBALTIMORESAO/2020/03/23/file_attachments/1408962/Gov%20Hogan%20Proposal.pdf (calling for wide-ranging releases "to reduce the prison population to enable social distancing and self-isolation, and to facilitate adequate health care resources inside these institutions").

[26] Governor Jared Polis, *Guidance to Counties Municipalities, Law Enforcement Agencies, and Detention Centers* at 5 (Mar. 24, 2020), https://drive.google.com/file/d/17wBJHdmlu3yRyF2CYQiLTVGjCgLPAB4P/view (encouraging "the courts together with prosecutors and defense attorneys, to work to evaluate the detention centers' populations and determine how to reduce the number of individuals in custody").

- Cuyahoga County, Ohio, which encompasses Cleveland, has decreased its prison population by more than 30 percent, releasing approximately 600 out of a total of 1,900 incarcerated people.[27]

- The Los Angeles County Sheriff authorized the release of 1,700 people, reducing the county jail population by 10 percent.[28]

- Officials in two other California counties, Alameda County and Santa Clara County, released more than 300 prisoners from each jurisdiction's respective jails.[29]

- In Colorado, the Jefferson County Sheriff's Office announced it would release all prisoners who had served more than half of their sentence,[30] and Larimer County temporarily released all 142 people sentenced to its work release program.[31]

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

[28] Marissa Wenzke, *1,700 inmates in L.A. County released over coronavirus concerns* (Mar. 24, 2020), https://ktla.com/news/local-news/1700-jail-inmates-in-l-a-county-released-over-coronavirus-concerns-sheriff-says/

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

[30] Elise Schmelzer, *Uneven response to coronavirus in Colorado courts leads to confusion, differing outcomes for defendants*, The Denver Post (Mar. 21, 2020), https://www.denverpost.com/2020/03/21/colorado-courts-coronavirus-judges/?fbclid=IwAR0Da1qjZSsU48THOo-Hi24ibgCW_ed1nMVfmRJ1BaZNFJJlsVo1BJO0lsk.

[31] Carina Julig, *Larimer County inmate in community corrections program tests positive for coronavirus*, The Denver Post (Mar. 22, 2020), https://www.denverpost.com/2020/03/22/coronavirus-larimer-county-inmate/?fbclid=IwAR0_M2BhVxD42BjIfTh_bYVwSfg6nH68cwLArtGt7GPpl58FqpE4g_Bnfgo.

Officials in Pennsylvania have just begun to address the pending crisis in county jails. Allegheny County, through a concerted effort and collaboration by the courts, the public defender, and the sheriff, released nearly 550 people from the county jail.[32] It did so to address "fear that the jail would become a giant Petri dish for the virus."[33] In Lackawanna County, to "minimize people in and out of the prison," the President Judge initiated a review of the file of "every low-level offender," including prisoners assigned to work release or those close to reaching their minimum release date.[34]

The actions of Allegheny and Lackawanna Counties are important, but they are limited exceptions to what has otherwise been a business-as-usual approach by almost all other county courts. Most Pennsylvania counties have released very few, if any, people to reduce prison population levels. Without immediate statewide actions, these remaining counties are likely to become the "petri dishes" that

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[32] WTAE Action News, *545 inmates released from Allegheny County Jail due to coronavirus concern* (March 27, 2020), https://www.wtae.com/article/545-inmates-released-from-allegheny-county-jail-due-to-coronavirus-concerns/31953103#

[33] Andy Sheehan, *Coronavirus In Pittsburgh: Amid Virus Pandemic, Allegheny County Jail Releases More Than 200 Inmates*, KDKA News (Mar. 20, 2020), https://pittsburgh.cbslocal.com/2020/03/20/allegheny-county-jail-released-inmates/.

[34] Kevin Hayes, *Lackawanna County reviews possible release of low level inmates to mitigate spread of COVID-19* (March 18, 2020), https://www.pahomepage.com/top-news/lackawanna-county-to-release-low-level-inmates-to-mitigate-spread-of-covid-19/.

officials in Allegheny County rightly feared will spread contagion to surrounding communities throughout the Commonwealth.

The actions taken by state courts and local executive officials across the country as described above provide a template for actions this Court must take to protect the health and safety of the county jail population, the correctional staff in those jails, and the surrounding communities.

C. This court should exercise its plenary and supervisory jurisdiction to expeditiously reduce county jail populations.

This Court's intervention is necessary to protect the people of Pennsylvania. As outlined above, the path to doing so requires a reduction in county jail populations to minimize spread of the virus among those in custody and their custodians, and thereby minimize contagion in surrounding communities.

Under 42 Pa.C.S. § 726, "[t]his Court may assume, at its discretion, plenary jurisdiction over a matter of immediate public importance . . . ." *Bd. of Revision of Taxes v. City of Phila.*, 4 A.3d 610, 620 (Pa. 2010). If ever there were a case that is of "immediate public importance," it is this one, which necessarily involves a myriad of rights under the Fourth, Fifth, Eighth and Fourteenth Amendments to the Federal Constitution, as well as Article I, Sections One, Thirteen, and Fourteen of the Pennsylvania Constitution. *See, e.g.*, *Natale v. Camden Cty. Corr. Facility*, 318 F.3d 575, 581 (3d Cir. 2003) ("the Fourteenth Amendment affords pretrial detainees protections 'at least as great as the Eighth Amendment protections available to a

convicted prisoner'") (quoting *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983)); *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (citing *Hutto v. Finney*, 437 U.S. 678, 682 (1978)) (the government violates the Eighth Amendment when it crowds prisoners into cells with others who have "infectious maladies").

Experts urge this Court to act now to mitigate a swelling public health catastrophe. For the reasons stated above, Petitioners respectfully request that this Court exercise its extraordinary jurisdiction over this matter and instruct the President Judge of each Judicial District to take measures that both expeditiously reduce their jail populations and limit the likelihood of near-term increase in their populations.

The numerous actions taken by state supreme courts and local law enforcement authorities in other parts of the country illustrate the variety of measures available to this Court to accomplish the necessary reduction of the Commonwealth's jail populations. These recent developments show that the Court can grant relief leading to the release of broad categories of prisoners who are in county jails as a result of minor charges or violations, prisoners who are nearing completion of their sentences, and prisoners who are at the greatest level of risk for serious complications or death from COVID-19 infections. Release of people in these categories poses little risk to public safety. To the contrary, as shown throughout this Petition, these releases and the resulting reduction in jail

populations are critically necessary to ensure public safety in the face of an unprecedented risk to public health.

Petitioners, based on their good faith understanding of the components of populations in the Commonwealth's county jails, urge the Court to:

1. Instruct all courts in the Commonwealth to immediately order county jails within their respective jurisdictions to release the following categories of people, subject to the objection provision outlined in ¶ 2 below:
    a. Those who are within three months of, or beyond, their minimum sentence;
    b. Those under a probation detainer (or serving a sentence) for a violation of probation or county parole where the violation does not arise out of the commission of a new felony offense;
    c. Those eligible to periodically leave their correctional facilities, such as those eligible for work release or serving intermittent sentences (e.g., weekends);
    d. Those detained pretrial solely due to an order imposing cash bail; and
    e. Any incarcerated person at increased risk of severe COVID-19 complications and death as defined by the CDC, including those

over the age of 45, and people with any of the following underlying medical conditions: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

2. Order that, if a district attorney objects to the release of a particular person within the above categories on the ground that release of that individual would pose a significant risk to the safety of a specific person or to the public, the district attorney shall, within twenty-four (24) hours of this Court's order, lodge an objection with a judicial authority appointed by the President Judge of each district.

   a. In the event of a district-attorney initiated objection, the appointed judicial authority shall provide counsel for the detained person, who will have an opportunity to respond to the objection prior to the judicial authority ruling on the objection.

   b. The judicial authority shall not force the release of any detained person who opposes release for reasons of personal or family safety.

3. Order that all courts in the Commonwealth, after releasing individuals identified above, take the following measures to maintain the reduction in the jail populations:

   a. Cease setting cash bail for any newly arrested indigent defendant, and order them released on reasonable and appropriate non-monetary conditions;

   b. Implement a process to review and lift all probation and parole detainers;

   c. Prioritize arraignments and preliminary hearings for any in-custody defendant;

   d. Ensure the availability of a venue to conduct guilty pleas and sentencing hearings for any defendant where the parties anticipate that the proceeding will result in release of the defendant from detention within 30 days; and

   e. Ensure the availability of a venue for prosecutors to file motions to nolle pros or otherwise dismiss charges.

4. Appoint a special master to administer and monitor compliance with this order; and direct the President Judge of each Commonwealth judicial district, or such official(s) designated by each President Judge, to provide

compliance reports to the special master and petitioners' counsel in this case, in a manner, and at a time interval, directed by this Court.

VI. CONCLUSION

The country, and this Commonwealth, face a public health crisis of epic proportions. COVID-19 presents risks to all of us, and has forced us as a country to come together and do what is right for the community and the public health. We must allow and encourage everyone to engage in practices that flatten the curve—social distancing and vigorous hygiene. This protects the most vulnerable among us and, hopefully, gives our overtaxed healthcare systems the chance to treat those most gravely affected by COVID-19. Absent decisive action, our overcrowded jails will become petri dishes that overwhelm both correctional and healthcare systems. The only humanitarian and constitutional solution is to immediately order the release of as many people as possible from our county jails. We urge this Court, in the strongest terms, to join the growing chorus of courts who have decided to act in an effort to save lives. The time to act is now.

Dated: March 30, 2020

Respectfully submitted,

/s/ *Witold Walczak*

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CERTIFICATE OF COMPLIANCE WITH Pa.R.A.P. 127

I hereby certify, pursuant to Pa.R.A.P. 127, that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

Dated: March 30, 2020 /s/ *Witold Walczak*

Exhibits

A. Declaration of Dr. Joseph Amon

B. Curriculum Vitae of Dr. Joseph Amon

C. Declaration of Dr. Jonathan Golub

D. Curriculum Vitae of Dr. Jonathan Golub

E. Declaration of Brian McHale

F. Declaration of Jeremy Hunsicker

G. Declaration of Christopher Aubry

H. Declaration of Michael Foundos

I. Declaration of Frederick Leonard

J. Declaration of Malik Neal

K. Declaration of Bret Grote

L. Declaration of Ernest Fuller

EXHIBIT A

Declaration of Joseph J. Amon, Ph.D. MSPH

I, Joseph J. Amon, declare as follows:

Background and Expertise

1. I am an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health. I also hold an appointment as an Associate in the department of epidemiology of the Johns Hopkins University Bloomberg School of Public Health. My Ph.D. is from the Uniformed Services University of the Health Sciences in Bethesda, Maryland and my Master's of Science in Public Health (MSPH) degree in Tropical Medicine is from the Tulane University School of Public Health and Tropical Medicine.

2. Prior to my current position, I have worked for a range of non-governmental organizations and as an epidemiologist in the Epidemic Intelligence Service of the US Centers for Disease Control and Prevention. Between 2010 and 2018, I was a Visiting Lecturer at Princeton University, teaching courses on epidemiology and global health. I currently serve on advisory boards for UNAIDS and the Global Fund against HIV, TB and Malaria and have previously served on advisory committees for the World Health Organization.

3. I have published 60 peer-reviewed journal articles and more than 100 book chapters, letters, commentaries and opinion articles on issues related to public health and health policy.

4. One of my main areas of research focus relates to infectious disease control, clinical care, and obligations of government related to individuals in detention settings, in which I have published a number of reports assessing health issues in prison and detention settings and more than a dozen peer-reviewed articles. In 2015-2016, I was a co-editor of a special issue of the British journal, "The Lancet," on HIV, TB and hepatitis in prisons. I also serve on the editorial boards of two public health journals. My resume is attached as Exhibit A.

Information on COVID-19 and Vulnerable Populations

5. COVID-19 is a coronavirus disease that has reached pandemic status. As of today (3/29), according to the World Health Organization more than 638,146 cases have been diagnosed in 203 countries or territories around the world and more than 30,105 confirmed deaths.[1] In the United States, which has the highest number of reported cases in the world, more than 135,499 people have been diagnosed with the disease and 2,381people have died thus far,[2] though these numbers likely underreport the actual infections and deaths.[3] In Pennsylvania, as of 4:30 pm on March 29, 2020, there were 3,394 confirmed cases and 38 deaths.[4] There has been an exponential increase in cases

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[1] See https://www.who.int/emergencies/diseases/novel-coronavirus-2019 accessed March 29, 2020.

[2] See https://coronavirus.jhu.edu/map.html accessed March 29, 2010

[3] See https://www.washingtonpost.com/national/us-deaths-from-coronavirus-top-1000-amid-incomplete-reporting-from-authorities-and-anguish-from-those-left-behind/2020/03/26/2c487ba2-6ad0-11ea-9923-57073adce27c_story.html accessed March 26, 2020.

[4] See https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/COVID-19%20Situation%20Reports/20200325nCoVSituationReportExt.pdf; accessed March 26, 2019 see also:

and deaths in Pennsylvania over the past two weeks:

Date	Cases (cumulative)	Deaths (cumulative)
12-Mar	28	0
13-Mar	41	0
14-Mar	58	0
15-Mar	63	0
16-Mar	76	0
17-Mar	96	0
18-Mar	133	1
19-Mar	185	1
20-Mar	268	1
21-Mar	371	2
22-Mar	479	3
23-Mar	644	6
24-Mar	851	7
25-Mar	1127	11
26-Mar	1687	16
27-Mar	2218	22
28-Mar	2751	34
29-Mar	3394	38

6. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The specific mechanism of mortality of critically ill COVID-19 patients is uncertain but may be related to virus-induced acute lung injury, inflammatory response, multiple organ damage and secondary nosocomial infections.

7. The World Health Organization (WHO) identifies individuals at highest risk to include those over 60 years of age and those with cardiovascular disease, diabetes, chronic respiratory disease, and cancer.[5] The WHO further states that the risk of severe disease increases with age starting from around 40 years.

8. The US CDC identifies "older adults [65 and older] and people of any age who have serious underlying medical conditions" as at higher risk of severe disease and death.[6] The CDC identifies underlying medical conditions to include: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease ("including asthma or chronic obstructive pulmonary disease [chronic bronchitis or emphysema] or other chronic conditions associated with impaired lung function"), neurological and neurologic and

https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx accessed March 29, 2019

[5] See https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_4 accessed March 21, 2020

[6] See https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html accessed March 21, 2020

neurodevelopmental conditions, and current or recent pregnancy.[7]

9. Data from US COVID-19 cases published by the CDC on March 19, 2020, found that hospitalization rates and intensive care unit (ICU) admission rates were nearly identical for individuals aged 45-54 and individuals aged 55-64 (between approximately 20-30% for both groups for hospitalization and between 5-11% for both groups for ICU admission).[8] This suggests that individuals >45 years could be considered high risk for severe disease while those ≥54 years could be considered high risk for severe disease and death.

Health profile of plaintiffs

11. I have reviewed the declaration of Brian McHale and Fredrick Leonard.

12. Mr. McHale is 44 years old and detained in the Montgomery County Correctional Facility. He has a number of medical conditions including hemochromatosis and chronic hepatitis C. He reports a 30 year history of smoking. Due to the likely impact of these conditions on his lungs, liver and heart, he should be considered at high risk for severe illness and death from COVID-19. Mr. Leonard is 29 years old and detained at Pike County Correctional Facility. He has a 17 year history of smoking. His declaration states that he has a history of chronic bronchitis, which is a type of chronic obstructive pulmonary disease that is most frequently caused by smoking. Due to this history, he should be considered at high risk for severe illness and death from COVID-19.

Understanding of COVID-19 Transmission

13. According to the U.S. CDC, the disease is transmitted mainly between people who are in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.[9] It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.[10] People are thought to be most contagious when they are most symptomatic (the sickest), however some amount of asymptomatic transmission is likely.[11] **This suggests that, while hand washing and disinfecting surfaces is advisable, the main strategy for limiting disease transmission is social distancing and that for such distancing to be effective it must occur before individuals display symptoms.**

14. Recognizing the importance of social distancing, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools,

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[7] See https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf accessed March 21, 2020

[8] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm, accessed March 21, 2020

[9] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html accessed March 21, 2020

[10] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020

[11] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020; See also: Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19.JAMA. Published online February 21, 2020. doi:10.1001/jama.2020.2565 and Zhang W, Du RH, Li B, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. Emerg Microbes Infect. 2020;9(1):386-389.

courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. 50 states, 7 territories, and the District of Columbia have taken some type of formal executive action in response to the COVID-19 outbreak.[12] Through one form or another, these jurisdictions have declared, proclaimed, or ordered a state of emergency, public health emergency, or other preparedness and response activity for the outbreak. Earlier this month Pennsylvania Governor, Tom Wolf, declared a state of emergency, which he buttressed on March 19 with an order closing non-essential businesses.[13] On Monday, March 23, 2020, Governor Wolf issued a stay at home order for residents of Allegheny, Bucks, Chester, Delaware, Monroe and Montgomery counties. On Tuesday, March 24, Governor Wolf extended the stay at home order to Erie;[14] the next day, March 25, Governor Wolf further extended the order to Lehigh and Northampton.[15] On Friday, March 27, 2020, Governor Wolf extended the order to include nine additional counties: Berks, Butler, Lackawanna, Lancaster, Luzerne, Pike, Wayne, Westmoreland, and York.[16] Philadelphia has been under a stay at home order since Saturday, March 21, 2020.[17] In total, nineteen counties are under stay at home orders in Pennsylvania.

15. As of March 28, in response to the threat of COVID-19 transmission, fifteen states prohibit gatherings of any size (California; Colorado; Idaho Illinois; Indiana; Montana; Michigan; New Jersey; New Mexico; New York; Ohio; Oregon; Washington; West Virginia; and Wisconsin); one state prohibits gatherings > 5 individuals (Connecticut); twenty-one states and the District of Columbia prohibit gatherings of >10 individuals (Alaska; Hawaii; Iowa; Kansas; Louisiana; Maine; Maryland; Massachusetts; Mississippi; Missouri; Nevada; New Hampshire; North Carolina; Oklahoma; Rhode Island; South Dakota; Tennessee; Texas; Vermont; Virginia; and Wyoming); one state prohibits gatherings of >25 individuals (Alabama) and two states prohibit gatherings of >50 individuals (Delaware; South Carolina). Many states, including California, Illinois, New Jersey, and New York have also issued quarantine orders directing residents to stay at home except under certain narrow exceptions.[18] These orders are expanding, increasing. Whereas at least 158 million people in 16 states, nine counties and three cities were being urged to stay home on March 23, the numbers increased on March 24, 2020 to at least 163 million people in 17 states, 14 counties and eight cities. As of March 27, at least 228 million people in 25 states, 74 counties and 14 cities and one territory are being urged to stay home.[19]

16. These public health measures aim to "flatten the curve" of the rates of infection so that those most vulnerable to serious complications from infection will be least likely to be

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[12] See https://www.astho.org/COVID-19/ accessed March 21, 2020

[13] See https://www.governor.pa.gov/wp-content/uploads/2020/03/20200319-TWW-COVID-19-business-closure-order.pdf

[14] https://www.governor.pa.gov/newsroom/governor-wolf-and-health-secretary-expand-stay-at-home-order-to-erie-county-to-mitigate-spread-of-covid-19/ Accessed March, 26, 2020.

[15] https://www.governor.pa.gov/newsroom/governor-wolf-and-health-secretary-expand-stay-at-home-order-to-lehigh-and-northampton-counties-to-mitigate-spread-of-covid-19-counties-now-total-10/ Accessed March 26, 2020.

[16] https://www.governor.pa.gov/newsroom/governor-wolf-and-health-secretary-expand-stay-at-home-order-to-nine-more-counties-to-mitigate-spread-of-covid-19-counties-now-total-19/ accessed March 28, 2020.

[17] See https://www.wtae.com/article/stay-at-home-order-to-begin-tonight-for-several-pa-counties-including-allegheny/31900786 accessed March 23, 2020.

[18] See https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#socialdistancing accessed March 28, 2020.

[19] See https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html accessed March 28, 2020.

exposed and, if they are the numbers of infected individuals will be low enough that medical facilities will have enough beds, masks, and ventilators for those who need them.

17. In countries where the virus's course of infection began earlier, and where death rates grew steadily, governments have imposed national emergency measures to prevent contagion from human contact. In Italy and Spain, for example, the governments have imposed national lockdowns to keep people from coming into contact with each other.[20]

18. US cities are starting to see the level of COVID-19 cases seen in previous global hotspots. On Thursday, March 26, Governor Cuomo announced that 100 people had died of the coronavirus between Wednesday and Thursday morning. [21] As of Friday, March 27, the cumulative death toll in the state stood at 450.[22] In response, the city's health commissioner again urged all New Yorkers to follow the stay at home order, emphasizing the impact on the city's already strained health system.[23] Pennsylvania is roughly 10 days behind New York City, following a similar trendline of cases and deaths.[24]

Risk of COVID-19 in Jails

19. The conditions in jails pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions. Spread of COVID-19 within the jails will affect not only those who are being held there, but also the correctional officers who work there and the communities they go back to.

20. County jails are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care. People live in close quarters and are also subject to security measures which prohibit successful "social distancing" that is needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. The crowded conditions, in both sleeping areas and social areas, and the shared objects (bathrooms, sinks, etc.) will facilitate transmission.

21. CDC guidance on correctional and detention facilities,[25] posted March 23, 2020,

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[20] See https://www.cnbc.com/2020/03/14/spain-declares-state-of-emergency-due-to-coronavirus.html accessed March 23, 2020

[21] See https://www.nytimes.com/2020/03/26/world/coronavirus-news.html?action=click&pgtype=Article&state=default&module=styln-coronavirus&variant=show&region=TOP_BANNER&context=storyline_menu?action=click&pgtype=Article&state=default&module=styln-coronavirus&variant=show&region=TOP_BANNER&context=storyline_menu#link-18cce12f accessed March 26, 2020.

[22] https://nypost.com/2020/03/27/another-84-people-killed-by-coronavirus-in-new-york-city/ accessed March 28, 2020.

[23] See https://nypost.com/2020/03/25/de-blasio-warns-half-of-all-new-yorkers-will-get-covid-19/ accessed March 26, 2020.

[24] See https://www.businessinsider.com/new-york-city-coronavirus-cases-over-time-chart-2020-3 accessed March 26, 2020.

[25] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons "ideally 6 feet between all individuals, regardless of the presence of symptoms" including: 1) increased space between individuals in holding cells, as well as in lines and waiting areas such as intake; stagger time in recreation spaces; restrict recreation space usage to a single housing unit per space; stagger meals; rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); provide meals inside housing units or cells; limit the size of group activities; reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.

22. The CDC guidance also describes necessary disinfection procedures including to thoroughly clean and disinfect all areas where a confirmed or suspected COVID-19 case spent time.[26]

23. In addition to declaration of Mr. McHale and Mr. Leonard, as identified in paragraph 11, I have also reviewed the declarations of the following individuals: Jeremy Hunsicker, Christopher Aubry, Michael Foundos, Ernest Fuller, a volunteer with the Pennsylvania Prison Society, Malik Neal, a volunteer with the Pennsylvania Prison Society, and Bret Grote, Co-Founder and Legal Director of the Abolitionist Law Center.

24. Conditions as described in the declarations reinforce the high risk of COVID-19 transmission. For example, in Montgomery County Correctional Facility, Mr. McHale reports sharing a cell, including a toilet and sink, with two other individuals and having close contact with 13 other men in his unit. In Lehigh County Community Corrections, Mr. Hunsicker reports being housed in a "pod" with 20 other people, sharing a bathroom and exposure to individuals working in the community and lack of hand sanitizer available. He also reports eating meals with up to 70 people at one time and being in close contact with other detainees during regular medical checks. Also detained in Montgomery County Correctional Facility, Mr. Aubry reports working in the community and sharing a "pod" with approximately 50 other people, sleeping in bunk beds, and sharing a bathroom. He reports no available hand sanitizer. In Delaware County's George W. Hill Correctional Facility, Mr. Foundos reports close contact with his cell mate and during meals. In Pike County Correctional Facility, Mr. Leonard reports being confined three to an eight by twelve foot cell with a single shared toilet and sink in the cell. He reports having insufficient soap to last a full day. He also reports eating six to a table with little space between each individual.

25. Based upon Mr. Fuller's declaration regarding Blair County Prison, between 2 and 20 detainees may be housed together in rooms, with the largest being roughly 20 x 30 feet and with bunk beds or beds placed 3 to 4 feet apart. Soap is limited and physicians are rarely present. Based upon Mr. Grote's declaration, the infrastructure and routine practice of Allegheny County Jail raise significant challenges to maintaining distancing between detainees in the facilities. These physical infrastructure and security challenges, which are typical of most detention centers, include:

    a) Individuals are held for extended periods of time in the intake area, typically with 10 or more people sharing a single toilet and sink. Only cursory medical screening is conducted.

[26] Ibid

b) A significant number of people housed at ACJ are double-celled.

c) Access to soap is a constant problem in ACJ as is, in some pods, access to personal hygiene and cleaning supplies.

d) There are only a few showers per pod, with many people sharing the same shower area, without any sanitation between individual uses.

e) Dining tables are small and fit four people, with one person on each side. A table is only four feet by four feet, at most, so no one can social distance from others during meal times.

f) As is true in detention facilities generally, communal bathroom facilities pose a risk of transmission and it is not usually possible for an incarcerated person to move throughout ACJ without coming into contact with many other people. The use of elevators also poses a problem bringing individuals in close contact. If someone is housed in a special unit or restrictive housing, they must also be closely escorted everywhere in the facility and security incidents can put an incarcerated person into close contact with staff members.

g) Access to medical care is inadequate at ACJ. There are extreme delays in individuals' ability to access care, as well as huge staffing shortages.

Based on Mr. Neal's declarations regarding conditions at Curran-Fromhold Correctional Facility ("CFCF"), Riverside Correctional Facility ("RCF"), and the Detention Center ("DC"), the Philadelphia facilities share the following characteristics that heighten the risk of transmission:

h) The majority of cells contain two people who sleep on bunk beds and share a single toilet and sink that is in close proximity to the bed.
i) Showers are shared between many individuals without being sanitized between use. Other shared surfaces, like phones, are also not sanitized between use.
j) Individuals in custody are responsible for custodial tasks, and people do not have access to sanitization products to clean their cells.
k) In DC, people are brought to meals in large groups in a cafeteria. At the other facilities, Mr. Neale observed common areas on each block with tables that are not even six feet across.
l) Intake at CFCF takes place in a single holding cell that holds upwards of ten people for the eight to twelve hours it takes to process a new intake.
m) Access to medical care is inadequate at all facilities: individuals housed at these facilities reported that the facilities did not respond to the "sick slips" they submitted even before there was a possibility of COVID-19 infection.

26. Based upon the information provided to me, and my prior knowledge of detention facilities, I am concerned that Pennsylvania jail facilities do not have the ability to implement the critically important principle of social distancing, such as maintain six feet of separation at all times including meals and location of beds, nor are they apparently taking extraordinary measures to identify and properly isolate individuals at high risk, those with potential exposure (e.g., from work detail) or those with symptoms consistent with COVID-19. These steps are essential to preventing transmission of COVID-19. Where jails are housing detained individuals in small cells where they are bunked

together and where they are crowded together to eat meals, they will not be able to prevent COVID-19 transmission once introduced into the jail. Upon review of the declarations, jails also do not appear to have sufficient supplies available for detainees for handwashing or disinfecting. Further, through work programs and staff, detainees at each of these facilities are at risk of being exposed to COVID-19.

27. Introduction of new people into detention facilities who have had contact with the community outside the facility—be it correctional officers and other staff, new individuals coming into custody, people on work release, or individuals serving intermediate sentences—creates a link from transmission occurring in the community to those who are detained. The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is inadequate for identifying all who may be infected and preventing transmission. This is also true because not all individuals infected with COVID-19 report fever in early stages of infection.

28. The alternative is to test all staff and detainees entering the facility. However, this would require frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. In addition to the cost and labor required to implement this approach, the United States is currently facing a shortage of COVID-19 tests that make such a solution impracticable: In a survey of U.S. cities (that included Philadelphia, Pittsburgh, Erie, and Easton), 92.1% of cities reported that they do not have an adequate supply of test kits.[27] Shortages are likely to become more severe over the next three to four weeks when there will be a major shortage of chemical reagents for COVID-19 testing and enormous increases in demand.[28] Given the shortage of COVID-19 testing in the United States, it is likely that jails are and will continue to be unable to conduct aggressive, widespread testing to identify all positive cases of COVID-19. The lack of widespread testing in communities and the current presence of COVID-19 in all 50 states means that it is impractical to ask detainees about their travel history– all communities should be assumed to have community transmission which is why statewide and national restrictions on movement and gatherings have been put in place.

Heightened Rates of COVID-19 Infection and Spread Within Detention Facilities

29. As COVID-19 has spread in the United States, it has begun to enter detention facilities and spread among individuals who are held and who work there. As of March 28, in California, at least twelve state prison workers[29] and one individual incarcerated in state prison[30] had tested positive. At least three people in custody tested positive in the Orange County Jail[31] and one at the Santa Clara County Jail.[32] In Santa Clara, at least four county deputies had also contracted the virus.[33] A nurse at the Santa Rita jail tests positive for the

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[27] https://www.usmayors.org/issues/covid-19/equipment-survey/ accessed March 28, 2020.
[28] https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html accessed March 28, 2020.
[29] https://www.sacbee.com/news/politics-government/the-state-worker/article241531806.html accessed March 28, 2020
[30] https://ktla.com/news/local-news/inmate-at-state-prison-in-lancaster-tests-positive-for-covid-19/ accessed March 26, 2020.
[31] https://www.ocregister.com/2020/03/26/2-more-inmates-test-positive-for-coronavirus-at-oc-jail/ accessed March 28, 2020.
[32] https://www.mercurynews.com/2020/03/23/santa-clara-county-jail-inmate-tests-positive-for-covid-19/ accessed March 26, 2020.
[33] https://www.mercurynews.com/2020/03/24/coronasvirus-fourth-santa-clara-county-deputy-contracts-covid-19/ accessed March 28, 2020.

virus. It's the first confirmed case at the massive Alameda County complex.[34] In the Cook County Jail in Chicago, 89 inmates and 12 staff members have confirmed cases of the virus[35], up from 38 inmates two days prior.[36] There have been eighteen positive tests in Massachusetts, 11 inmates and 7 employees. The Massachusetts Treatment Center in Bridgewater has returned the most positives with ten inmates and two corrections officers and one medical provider testing positive.[37] The other positives have been one person held at Middlesex County Jail, one employee at the Plymouth County House of Correction, two staff members at MCI-Shirley, and a worker at the Norfolk County Sheriff's Office.[38] New Jersey has had twelve positive tests cases: A corrections officer[39] and an ICE detainee[40] at the Bergen County Jail, two inmates at Hudson County Correctional Facility,[41] one inmate in the Morris County Jail[42] and one officer in Morris County,[43] two correctional officers and an ICE detainee at Essex County Correctional Facility,[44] an inmate at Delaney Hall in Newark,[45] a medical staffer at Elizabeth Detention Center,[46] and an employee at the state department of corrections.[47] On March 29th a 49 year old prisoner who had been detained in a minimum security prison in Oakdale, Louisiana died after being transferred to a hospital and placed on a ventilator.[48]

30. Pennsylvania jails and prisons have had thirteen positive tests so far. Three inmates and nine staff members from the George W. Hill Correctional Facility in Delaware County have tested positive for COVI-19.[49] On March 27, 2020, Philadelphia reported that an individual in prison and the first employee in the city's Department of Corrections had tested positive and five inmates were in quarantine.[50] As of March 29 at noon, one individual in custody and three employees had tested positive within the Pennsylvania

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[34] https://www.mercurynews.com/2020/03/26/alameda-county-jail-reports-first-coronavirus-case-a-nurse/?utm_source=The+Marshall+Project+Newsletter&utm_campaign=0d0f98b15c-EMAIL_CAMPAIGN_2020_03_28_11_14&utm_medium=email&utm_term=0_5e02cdad9d-0d0f98b15c-174553411 accessed March 28, 2020.

[35] https://www.politico.com/news/2020/03/29/federal-prison-first-coronavirus-death-153387 accessed March 29, 2020.

[36] https://www.nbcchicago.com/news/local/cook-county-jail-says-17-inmates-have-tested-positive-for-coronavirus/2244652/ accessed March 26, 2020.

[37] https://www.masslive.com/coronavirus/2020/03/coronavirus-10-inmates-at-massachusetts-treatment-center-have-covid-19-5-department-of-correction-staff-members-also-test-positive.html accessed March 28, 2020.

[38] https://www.wbur.org/commonhealth/2020/03/23/coronavirus-massachusetts-prisoner accessed March 28, 2020.

[39] https://www.fox29.com/news/nj-jail-guard-tests-positive-for-coronavirus accessed March 26, 2020.

[40] https://www.northjersey.com/story/news/new-jersey/2020/03/24/coronavirus-nj-ice-detainee-first-nation-test-positive/2911910001/ accessed March 26, 2020.

[41] https://www.vice.com/en_us/article/epg744/2-confirmed-coronavirus-cases-in-hudson-county-correctional-facility accessed March 26, 2020.

[42] https://morristowngreen.com/2020/03/24/inmate-at-morris-county-jail-tests-positive-for-covid-19/ accessed March 26, 2020.

[43] https://patch.com/new-jersey/montclair/stuck-jail-during-pandemic-coronavirus-hits-nj-prisons accessed March 28, 2020.

[44] https://patch.com/new-jersey/newarknj/more-coronavirus-essex-county-prison-activists-keep-outcry March 26, 2020.

[45] https://patch.com/new-jersey/montclair/stuck-jail-during-pandemic-coronavirus-hits-nj-prisons

[46] https://www.themarshallproject.org/2020/03/19/first-ice-employee-tests-positive-for-coronavirus & https://mobile.twitter.com/Haleaziz/status/1240785593535041537 accessed March 26, 2020.

[47] https://www.nj.com/coronavirus/2020/03/first-person-in-njs-state-prison-system-tests-positive-for-coronavirus.html accessed March 26, 2020.

[48] See https://www.politico.com/news/2020/03/29/federal-prison-first-coronavirus-death-153387 accessed March 29, 2020

[49] https://www.delcopa.gov/publicrelations/releases/2020/coronavirusupdate_march26.html accessed March 28, 2020.

[50] https://www.inquirer.com/health/coronavirus/coronavirus-covid-19-pa-new-jersey-surge-cases-stay-at-home-20200328.html accessed March 28, 2020

Department of Corrections.[51]

31. The rates of spread in the facilities that have been testing for COVID-19 illustrates the dangers the conditions in these facilities pose to those who are detained there, and to the broader community. At Rikers Island in New York, on Saturday March 21, a jail oversight agency indicated that 21 inmates and 17 employees tested positive.[52] Four days later, on Wednesday, March 26, 75 inmates and 37 employees tested positive.[53] As of Saturday, March 28, 104 staff and 132 individuals in custody had tested positive at Rikers and city jails in New York City.[54] **The Legal Aid Society in New York recently reported that the infection rate for COVID-19 at local jails is more than seven times higher than the rate citywide and 87 times higher than the country at large.[55]**

32. The data above also confirms high rates of infection among correctional officers and other staff. These individuals all face an increased risk of COVID-19 exposure as they are less able to practice the recommended strategy of social distancing in carrying out their official duties. This is consistent with Mr. Leonard's reports that one of the correctional officers at Pike County Correctional Facility tested positive.

Infrastructure in County Jails Will Likely Be Insufficient to Address Needs of COVID-19 Patients

33. If COVID-19 enters into county jails, these facilities will likely be unable to address the infectious spread and the needs of infected individuals due to lack of testing and insufficient physical and medical infrastructure.

34. In cases where there are confirmed or suspected cases of COVID-19 in county jails, the CDC recommends medical isolation, defined by the CDC confining the case "ideally to a single cell with solid walls and a solid door that closes" to prevent contact with others and to reduce the risk of transmission. Individuals in isolation should also be provided their own bathroom space.[56]

35. Individuals in close contact of a confirmed or suspected COVID-19 case - defined by the CDC as having been within approximately 6 feet of the individual for a prolonged period of time or having had direct contact with secretions of a COVID-19 case (e.g., have been coughed on) – should be quarantined for a period of 14 days. The same precautions should be taken for housing someone in quarantine as for someone who is a confirmed or suspected COVID-19 case put in isolation.[57]

36. The CDC guidance recognizes that housing detainees in isolation and quarantine individually, while "preferred", may not be feasible in all county jail settings and discusses the practice of "cohorting" when individual space is limited. The term "cohorting" refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a particular case together as a

[51] https://www.cor.pa.gov/Pages/COVID-19-Dashboard.aspx accessed March 29, 2020.
[52] https://www.nbcnewyork.com/news/coronavirus/21-inmates-17-employees-test-positive-for-covid-19-on-rikers-island-officials/2338242/ accessed March 23, 2020.
[53] https://nypost.com/2020/03/25/new-coronavirus-cases-in-nyc-jails-outpacing-rest-of-the-city/ accessed March 26, 2020
[54] https://apnews.com/4e1e4ffaeb6bf9a9fabcc566fe5b110d accessed March 29, 2020.
[55] See: https://newyork.cbslocal.com/2020/03/26/coronavirus-rikers-island/ accessed March 26, 2020
[56] Ibid.
[57] Ibid

group. The guidance states specifically that "Cohorting should only be practiced if there are no other available options" and exhorts correctional officials: "**Do not cohort confirmed cases with suspected cases or case contacts."** [emphasis in original]. Individuals who are close contacts of different cases should also not be kept together.

37. The CDC guidance also says that correctional facilities should "Ensure that cohorted cases wear face masks at all times."[58] This is critical because not all close contacts may be infected and those not infected must be protected from those who are if individuals are cohorted. However, it's important to note that face masks are in short supply. In a joint letter to President Trump, the American Medical Association, the American Hospital Association, and the American Nurses Association called on the administration to "immediately use the Defense Production Act to increase the domestic production of medical supplies and equipment that hospitals, health, health systems, physicians, nurses and all front line providers so desperately need."[59] In a survey United States cities, 91.5% of the cities reported that they do not have an adequate supply of face masks for their first responders and medical personnel.[60] There are also widespread shortages of personal protective equipment — particularly N-95 masks — sufficient to provide even for health care workers, in our nation's hospitals, let alone medical providers and other individuals coming into contact with the virus in county jails .[61] Many public health leaders are calling for masks to be reserved for health care staff, who face increased risk and are vitally needed to sustain emergency care. Hospitals in the New York City area, unable to access masks locally, are reportedly turning to a private distributor to airlift millions of protective masks out of China.[62] Face masks are effective only when used in combination with frequent hand-cleaning with alcohol-based hand rub or soap and water. Detainees should be instructed in how to properly put on and take off masks, including cleaning their hands every time they touch the mask, covering the mouth and nose with the mask and making sure there are no gaps, avoiding touching the mask while using it; and replacing the mask with a new one if it becomes damp (e.g., from sneezing) and not to re-use single-use masks. There are times when detainees will necessarily not be able to wear masks, if available. For example, during meals. In these instances, detainees should eat individually or with proper distancing from others.

38. Where individual rooms are not available, the CDC guidance describes a hierarchy of next best options for cohorting, which in order from lesser risk to greater risk includes housing individuals under medical isolation: 1) in a large, well-ventilated cell with solid walls and a solid door that closes fully; 2) in a large, well-ventilated cell with solid walls but without a solid door; 3) in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells; 4) in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells.[63]

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[58] Ibid

[59] See: https://www.aha.org/lettercomment/2020-03-21-aha-ama-and-ana-letter-president-use-dpa-medical-supplies-and-equipment accessed March 26, 2020

[60] https://www.usmayors.org/issues/covid-19/equipment-survey/ accessed March 28, 2020.

[61] https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html accessed March 28, 2020.

[62] See: https://lancasteronline.com/news/health/hospital-suppliers-take-to-the-skies-to-combat-dire-shortages/article_0830ffb0-6f89-11ea-89ed-bbd859186614.html accessed March 26, 2020

[63] Ibid

39. When a single COVID-19 case is identified in a county jail, close contact and the inability of jails to implement social distancing policies due to overcrowding and the physical limitations of the facility, as described above, means that there will be many individuals who are exposed and will need to be quarantined.

40. County jails were not built for the needs of this kind of pandemic and if COVID is introduced there will likely be many more individuals identified as "close contacts" who need to be quarantined than there are safe spaces to isolate them. Some individuals identified as "close contacts" will likely be infected while others will not. "Cohorting" of all contacts together without strict attention to masking and proper hygiene and sanitation distancing could mean disease transmission will be facilitated rather than prevented. For example, according to Mr. Neal's declaration, the quarantine spaces at CFCF do not allow six feet of distance between the people housed together, potentially facilitating transmission among individuals in quarantine.

41. Individuals in jails are also more likely to have chronic health problems that put them at a higher risk of complications from COVID-19 infections.[64]

42. Many county jails lack adequate medical care infrastructure to address the treatment of high-risk people in detention. As examples, detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals. Delaware County, where the George W. Hill Correctional facility is located, for example, does not have a local health department. A COVID-19 outbreak would put severe strain on this already strained system.

43. If corrections officers and medical personnel are significantly affected by COVID-19, large numbers will also be unavailable to work due to self-quarantine or isolation, at the same time that large numbers of detainees who are potentially exposed will need to be put into individual isolation or transferred to advanced medical care, putting tremendous stress on detention facilities.

44. Large numbers of ill detainees and corrections staff will also strain the limited medical infrastructure in the rural counties in which these detention facilities are located. If infection spreads throughout the detention center, overwhelming the center's own limited resources, the burden of caring for these individuals will shift to local medical facilities. The few facilities will likely not be able to provide care to all infected individuals with serious cases. Statewide, Pennsylvania is facing a shortage the technology it needs to care for infected individuals. The state has only 2,000, ventilators, according to the state Health Department, but the state could need three times as many at the apex of the virus' spread, according to a study from the Harvard Global Health Institute.[65] If the virus spreads through county jails, it is likely that many individuals will need to be transferred (while in isolation) to community hospitals, and this system will be even more taxed. The inability for overwhelmed community hospitals to provide necessary care will increase the likelihood that individuals with COVID-19 will not be able to get proper care and die.[66]

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[64] https://www.prisonpolicy.org/health.html accessed March 26, 2020.

[65] https://www.inquirer.com/health/coronavirus/ventilator-coronavirus-hospital-covid-pennsylvania-new-jersey-health-20200324.html accessed March 28, 2020.

[66] See https://www.post-gazette.com/news/health/2020/03/20/Rural-counties-in-Pennsylvania-struggle-on-their- own-as-COVID-19-spreads/stories/202003180034 accessed March 23, 2002. Even in regions with highly developed

Conclusions

45. CDC guidance on correctional and detention facilities,[67] reiterates many of the points previously made in this declaration, including: 1) Incarcerated/detained persons are at "heightened" risk for COVID-19 infection once the virus is introduced; 2) There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including from staff and transfer of incarcerated/detained persons; 3) Options for medical isolation of COVID-19 cases are limited; 4) Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19; 5) The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants; and 6) Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

46. Under these circumstances, the only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, measures will be insufficient when crowding makes social distancing measures impossible. Facilities cannot follow CDC guidelines where people are double and triple-celled, housed in large rooms where people are forced into close contact, and where people are sharing common facilities like bathrooms that cannot be properly sanitized given the sheer numbers of people using them in a day. Where quarantine is necessary, it will not be possible to isolate individuals from each other where there are so many people in a confined space.

47. To effectively mitigate risk of infection and subsequent spread, the population will need to be reduced. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees, and allow individuals who are infected, and their close contacts, to be properly isolated or quarantined in individual rooms, according to the CDC's preferred practices, and properly monitored for health complications that may require transfer to a local hospital. It will also lessen the risk to corrections officers, who if short staffed, will have difficulty maintaining order and proper personal protective measures. Protecting corrections staff in turn protects the communities they come from.

48. The release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is also a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

49. To the extent that vulnerable detainees have had exposure to known cases with

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health systems, COVID-19 is straining ability to care, creating cause for alarm for less-equipped health care systems in regions that do not act to mitigate risk of infection. See https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html accessed March 23, 2020

[67] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test positive should be continuously monitored in individual rooms, released to home quarantine or transferred to local hospitals if medically indicated. Those who test negative should be released to home quarantine for 14 days while awaiting symptoms or a positive test result. Where there is not a suitable location for home quarantine available, these individuals could be released to housing identified by the county or state Department of Health.

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

Executed this 29th day in March 2020 in Princeton, New Jersey.

Joseph J. Amon, PhD MSPH

EXHIBIT B

Joseph J. Amon, PhD, MSPH

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EDUCATION

08/1998-10/2002	Dept. of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine *PhD, Dissertation: Molecular Epidemiology of Malaria in Kenya*	Bethesda, MD
08/1991-12/1994	Dept. of Parasitology and Tropical Medicine, Tulane University School of Public Health & Tropical Medicine *MSPH, Tropical Medicine*	New Orleans, LA
08/1987-05/1991	Hampshire College *BA, Interdisciplinary Studies*	Amherst, MA

ACADEMIC APPOINTMENTS

9/2018 – Present	Dornsife School of Public Health, Drexel University *Director, Global Health* *Clinical Professor, Dept of Community Health and Prevention*	Philadelphia, PA
01/2010 – Present	Dept. of Epidemiology and Center for Public Health and Human Rights, Bloomberg School of Public Health, Johns Hopkins *Associate*	Baltimore, MD
09/2010 – 06/2018	Woodrow Wilson School of Public and International Affairs, Princeton University *Visiting Lecturer*	Princeton, NJ
01/2015 – 05/2018	Dept. of Epidemiology, Mailman School of Public Health, Columbia University *Adjunct Associate Professor*	New York, NY
06/2014 – 07/2014	School of Social Science, Institute for Advanced Study *Short-term Visitor*	Princeton, NJ
09/2012 – 12/2012	Institut d'Études Politiques de Paris (SciencesPo) *Distinguished Visiting Lecturer*	Paris, France
01/2003–06/2007	Dept. of Preventive Medicine, Hebert School of Medicine, Uniformed Services University of the Health Sciences *Adjunct Assistant Professor*	Bethesda, MD

TEACHING EXPERIENCE

Professor		
2019 - Present	Drexel University	Theory and Practice of Community Health (graduate) Health and Human Rights (undergrad/graduate) Community Health: Cuba (graduate)
2011 – 2018	Princeton University	Health and Human Rights (undergraduate) Epidemiology (undergraduate)
09-12/2012	SciencesPo	Health and Human Rights (graduate)
Co-Instructor		
2012-2013	Global School of Socioeconomic Rights, Harvard University	Health Rights Litigation (graduate)

COMMITTEES AND ADVISORY BOARD MEMBERSHIP

Editorial

09/2019 – Present	Senior Editor, Health and Human Rights Journal
01/2010 – Present	Journal of the International AIDS Society, Editorial Board
07/2012 – Present	Journal of the International AIDS Society, Ethics Committee
01/2015 – 07/2016	Co-Editor, The Lancet HIV Special Issue on HIV and Prisoners
09/2017 – 06/2018	Co-Editor, Health and Human Rights Journal Special Issue on NTDs and Human Rights

Advisory

09/2016 – Present	The Global Fund, Working Group on Monitoring and Evaluating Programmes to Remove Human Rights Barriers to HIV, TB and Malaria Services
12/2014 – Present	UNAIDS, Strategic and Technical Advisory Group
07/2008 – Present	UNAIDS, HIV and Human Rights Reference Group (co-chair Aug 2014 – present)
06/2012 – 6/2018	Global Institute for Health and Human Rights, University at Albany, International Advisory Board
02/2012 – 01/2016	Founding member, Coalition for the Protection of Health Workers in Armed Conflict
01/2014 – 01/2016	Founding member: Robert Carr Award for Research on HIV and Human Rights
07/2011 – 07/2012	XIX International AIDS Conference, Scientific Programme Committee
11/2009 – 09/2012	WHO/STOP TB Partnership, TB and Human Rights Task Force

FULL-TIME WORK EXPERIENCE

09/2018-Present **Drexel University, Dornsife School of Public Health,** *Philadelphia, PA.*
- Director, Global Health
- Clinical Professor, Dept of Community Health and Prevention

02/2016–08/2018 **Helen Keller International,** *New York, NY.*
- Vice President, Neglected Tropical Diseases

Provided strategic, technical and overall management for >$125m portfolio of work on NTDs. Led development of proposals resulting in >$80m in new projects.

08/2005–01/2016 **Human Rights Watch,** *New York, NY.*
- Director, Health Division (Sept 2008 – Jan 2016)
- Founded Disability Rights Division (2013); Environment Division (2015)
- Director, HIV/AIDS Program (August 2005 – August 2008)

Led research and advocacy division focused on human rights and health. Founded programs on disability rights and environment. Responsible for financial and personnel management, fundraising and communications.

07/2003–06/2005 **Centers for Disease Control and Prevention,** *Atlanta, GA.*
- Epidemiologist, EIS Officer

Led hepatitis outbreak investigations in US and overseas. Collaborated with U.S. and international academic and government researchers. Analyzed trends in hepatitis prevalence and vaccination rates in diverse populations.

07/2000–09/2002 **Walter Reed Army Institute of Research,** *Silver Spring, MD.*
- Research Fellow

Conducted molecular epidemiologic and immunologic research on malaria, examining host-parasite interaction, vaccine efficacy, and correlates of disease severity.

07/1995–06/1998 **Family Health International,** *Arlington, VA.*
- Technical Officer (Jan – June 1998)
- Evaluation Officer (Aug 1996 – Dec 1997)
- Associate Evaluation Officer (July 1995 – July 1996)

Designed and analyzed HIV behavioral research and program evaluation studies. Supervised field-based research and evaluation staff in U.S., Brazil, Jamaica, Dominican Republic, Kenya, Ghana, and Haiti.

09/1992–11/1994 **U.S. Peace Corps,** *Lomé, Togo.*
- Volunteer

Designed and implemented process monitoring system for national Guinea Worm eradication program. Conducted health education training. Supervised village health workers.

SHORT-TERM AND CONSULTING EXPERIENCE

Human Rights Watch, *New York, NY.*	Provide technical review for research design, analysis and documents related to health and environment and human rights.	Sept 2018 – Present
The Futures Group International, *REACH Project, Washington DC.*	Co-investigator for HIV/AIDS operations research related to orphans and vulnerable children and adolescent-oriented HIV volunteer counseling and testing.	Mar 2002 – June 2003
Walter Reed Army Institute of Research, *Silver Spring, MD.*	Developed database and provided statistical support to malaria vaccine clinical trial project.	Apr 2002 – June 2003
John Snow, Inc., *Arlington, VA.*	Developed curriculum and provided training on HIV/AIDS monitoring and evaluation to Ministry of Health staff from 8 countries.	Dec. 2002 – June 2003
TvT Associates, *SYNERGY Project, Washington, DC.*	Designed $20+ million comprehensive HIV/AIDS strategy for USAID Ukraine and USAID Russia.	Dec. 2001 – April 2003
PACT, *Washington, DC.*	Designed outcome and impact evaluation of HIV behavioral intervention project.	June 2002
Encompass LLC, *Bethesda, MD.*	Designed evaluation of World Bank health sector reform training.	January – May 2002
U of Washington, *Center for Health Education and Research.*	Developed guidelines and training materials for monitoring and evaluating HIV/AIDS programs.	April – May 2002
Family Health International, *Arlington, VA.*	Analyzed HIV-related behavioral surveillance results from studies in Honduras, Nigeria, Ghana, and Senegal.	Sept 1998 – Mar 2002
Datex Inc., *Falls Church, VA.*	Provided expert review for USAID-funded HIV/AIDS behavioral intervention grants competition.	May– Jun 2001 Jan – Feb 2000
PLAN International *Bamako, Mali and Arlington, VA.*	Designed and implemented quantitative and qualitative evaluation of HIV/AIDS program and developed $6 million follow-on program.	May – Dec 2000
***Ministry of Health**, Kingston, Jamaica.*	Analyzed behavioral surveillance results and facilitated workshop examining HIV trends.	Oct 1998
Eli Lilly Foundation, *Diabetes Control Program, Accra, Ghana.*	Designed and implemented outcome and impact evaluation of diabetes prevention and care program.	Sept 1996
Carter Center, *Niger Guinea Worm Eradication Program, Zinder, Niger.*	Designed and implemented outcome and impact evaluation of guinea worm eradication program.	Mar – May 1995

PEER REVIEW JOURNAL PUBLICATIONS

1 Kotellos KA, **Amon JJ**, Githens Benazerga W. *Field Experiences: measuring capacity building efforts in HIV/AIDS prevention programmes.* AIDS 1998; 12 (supl 2):109-17.

2 Figueroa JP, Brathwaite AR, Wedderburn M, Ward E, Lewis-Bell K, **Amon JJ**, Williams Y, Williams E. *Is HIV/STD control in Jamaica making a difference?* AIDS 1998; 12 (supl 2):S89-S98.

3 Hayman JR, Hayes SF, **Amon J**, Nash TE. *Developmental expression of two spore wall proteins during maturation of the microsporidian Encephalitozoon intestinalis*. Infect Immun 2001; 69(11):7057-66.

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6 Wheeler C, Vogt T, Armstrong GL, Vaughan G, Weltman A, Nainan OV, Dato V, Xia G, Waller K, **Amon J**, Lee TM, Highbaugh-Battle A, Hembree C, Evenson S, Ruta MA, Williams IT, Fiore AE, Bell BP. *A Foodborne Outbreak of Hepatitis A in Pennsylvania Associated with Green Onions*. New England Journal of Medicine 2005, 353(9):890-7.

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2 **Amon JJ**, Kotellos KA, Githens Benazerga W. *Evaluating Capacity Building*. HIV/AIDS Prevention and Control Synopsis Series. Family Health International, Arlington, VA: 1997.

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11 **Amon JJ** and Kasambala T. Structural barriers and human rights related to HIV prevention and treatment in Zimbabwe. In: M. Seglid and T. Pogge (eds) Health Rights. London: Ashgate. Oct 2010.

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When a Problem Comes Along, You Must Whip It. *Huffington Post*. June 26, 2010

Action not Rhetoric on HIV and Human Rights. *Huffington Post.* July 2, 2010

The Truth About China's Response to HIV/AIDS. *Los Angeles Times*. July 11, 2010

HIV Behind Bars. *The Post* (Lusaka). July 11, 2010

HIV and Human Rights: Here and Now? *Huffington Post*. July 19, 2010

The HIV and TB Prison Crisis in Southern Africa. *Huffington Post*. July 23, 2010

Jailing TB patients not remedy for the disease. *The Star* (Nairobi). Sept 17, 2010

Rights and Health, Right Now, for Migrants. *Africa Now (Tokyo).* October 2010 (with Kanae Doi)

Why Democracies Don't Get Cholera. *Foreign Policy.* October 25, 2010.

The Beginning of the End for the War on Drugs? *San Francisco Chronicle.* November 21, 2010

Rights Abuses Belie Success in AIDS Fight. *South China Morning Post.* December 1, 2010

World AIDS Day: Prevention, Treatment for Prisoners. *Zambia Post.* December 1, 2010

Lead poisoning in Nigeria: unprecedented. *Global Post.* December 2, 2010

China is hurting its future by not acting on lead. *South China Morning Post.* June 20, 2011

Hard life in Ugandan prisons. *The Independent (Uganda).* July 8. 2011

'Utterly Irresponsible': Donor Funding in Drug 'Treatment' Centers. *Huff. Post.* Sept 14, 2011

National Cashew Day: More Than Nuts. *Global Post.* October 3, 2011

A centre for abuse and beating. *The Nation* (Bangkok). October 11, 2011

Laos' Murky War on Drugs. *The Diplomat.* October 12, 2011

One AIDS march that should end. *Washington Blade.* October 28, 2011

Seoul's Broken Promises on HIV Testing. *The Diplomat.* June 29, 2013

Drug treatment centres give more abuse than therapy. *Bangkok Post*. December 18, 2013

Enlightened drug policies emerge globally, Cambodia remains rigid**.** *Global Post.* Jan 9, 2014

Health Under Attack. HRW Dispatch. May 19, 2014 (with Jennifer Pierre)

Canada's prostitution bill a step in the wrong direction. *Ottawa Citizen.* June 18, 2014

In The HIV Response, Who is 'Hard to Reach'? HRW Dispatch. July 23, 2014

Defeating AIDS. HRW Dispatch. June 30, 2015

How not to handle Ebola. CNN. September 12, 2014

58 Taking Care of the Caregivers. HRW Dispatch. December 17, 2014

59 Alert in a Time of Cholera. HRW Dispatch. March 26, 2015

60 Stop Using Hospitals as Debtor Prisons. HRW Dispatch. April 14, 2015

61 COP21: The Impact of Climate Change on the World's Marginalized Populations: Turkana County, Kenya. Health and Human Rights Journal Blog. October 27, 2015. (with Katharina Rall)

62 An Important, but Imperfect, Agreement by an Unprecedented Coalition. *US News and World Report.* December 18, 2015

63 Health workers are under attack around the world. Here's how bad it's getting. *Philadelphia Inquirer.* May 28, 2019. (with Jennifer Taylor)

INVITED PRESENTATIONS (SELECT)

1 *Surveillance design and evaluation approach of the Togo Guinea Worm Eradication Program.* III West African Guinea Worm Eradication Conference, Abidjan, Cote d'Ivoire, November 1993.

2 *Knowledge, attitudes and behaviors related to Guinea Worm Eradication, Togo.* IV West African Guinea Worm Eradication Conference, Ouagadougou, Burkina Faso, October 1994.

3 *Synthesis of evaluation results from the AIDSCAP project: 1992-1996.* HIV/STD/AIDS National Forum, Port-au-Prince, Haiti, June 3-5, 1996. Research and Evaluation Panel Chair.

4 *International Trends in HIV-Risk Related Behavior Change.* National Conference on HIV/AIDS, Kingston, Jamaica, November 25-26, 1996.

5 *HIV/AIDS and Adolescents in Ukraine.* Ukrainian-American Medical Society Annual Meeting. Philadelphia, PA, May 2003.

6 *Expanding HIV testing and respecting rights.* International conference on HIV/AIDS and Human Rights. Smolny College. St Petersburg, Russia. October 2005.

7 *HIV in Conflict Settings*. Joint Congressional Human Rights Caucus meeting. Washington DC. March 2006.

8 *Reflections and recollections.* Masters Internationalist - US Peace Corps Symposium. Washington DC. April 2006. (Keynote)

9 *Civil Society Participation in the Response to HIV/AIDS and Accountability.* Presented in panel 1: Breaking the cycle of infection for sustainable AIDS responses. United Nations General Assembly Special Session on HIV/AIDS. New York. June 2006.

10 *HIV testing and human rights.* Public Health Agency of Canada Meeting on HIV Testing. Toronto. August 2006.

11 *Hot Topics in Human Rights*. XVI International AIDS Conference. Toronto. August 2006.

12 *Burma, HIV and Human Rights.* Asia Society. New York. September 2007.

13 *HIV and Youth*. 12th Annual Herbert Rubin and Justice Rose Luttan Rubin International Law Symposium. New York University. New York. October 2007.

14 *HIV testing: human rights considerations*. Funders Network on Population, Reproductive Health and Rights. Annual Meeting, San Antonio, TX. October 2007.

15 *Human Rights and Epidemic Disease: TB control and constraints on rights.* Human Rights Funders Group. Annual Meeting. New York, NY. July 2008.

16 *Promoting Public Health and Human Rights in MDR-TB Care.* International Union against Lung and Tuberculosis Disease. Paris, France. October 2008.

17 *Public Health and Human Rights: Challenges around the World.* New York Academy of Sciences and Johns Hopkins School of Public Health Conference on Public Health and Human Rights. New York, NY. Dec 2008.

18 *Human Rights and Anti-Narcotics Policy.* UN General Assembly, Special Session on Drugs. Vienna, Austria. March 2009.

19 *Rights-based approaches to health.* Interaction Annual Meeting. Arlington, VA. July 2009. (panel moderator)

20 *Health and Human Rights: New orthodoxies and on-going conflicts in repressive states.* Stanford University, Palo Alto, CA. October 2010.

21 *HIV in Asia.* Asia Society. December 1, 2010.

22 *HIV Rights and Wrongs.* GlobeMed National Conference. Northwestern University, Chicago, IL. April 2011. (Keynote)

23 *Human Rights Perspective.* International Workshop on Treatment as Prevention. Vancouver, Canada. May 2011.

24 *Sustaining Environmental, Occupational and Public Health and Community Security: Lead Poisoning in China and Nigeria.* 12th National Conference on Science, Policy and the Environment. Washington, DC. January 2012.

25 *Health and Human Rights in Prisons.* European Infectious Disease meeting. Italy. September 2012. (Keynote)

26 *Measuring Violence against Children and the Effectiveness of Violence Prevention and Reduction Initiatives.* Columbia University. October 2013. (Panel Discussion Moderator)

27 *Political Epidemiology of HIV.* HIV 2014: Science, Community and Policy for Key Vulnerable Populations. New York Academy of Sciences. May 2014.

28 *On the Radar: Police Brutality, Politics & Public Health.* Princeton University. March 2015.

29 *Global Inequalities of Wealth and Health.* Bernstein Institute for Human Rights Annual Conference. New York University School of Law. April 2015.

30 *Environmental and occupational health and human rights.* Health and Human Rights Principles and Pedagogy. Florence, Italy. June 2015.

31 *Interviewing Victims of Human Rights Abuses.* Buzzfeed. New York. June 2015.

32 *Global Health and Governance.* Brookings Institution. May 2016.

33 *Access to pain medicine and human rights.* O'Neill Institute Health Rights Litigation. June 2016

33 *The Morbidity Management and Disability Prevention Project.* Global Alliance for Elimination of Trachoma 2020. Geneva, Switzerland. April 2017.

34 *Human Rights and Phylogenetic Analysis.* Ethics of Phylogenetics. Gates Foundation, UNAIDS, National Institutes for Health. London, UK. May 2017.

35 *Judicialization and access to medicines in Brazil.* O'Neill Institute Health Rights Litigation. Washington DC. June 2016.

36 *Implementing health related SDGs through a human rights perspective.* United Nations Social Forum. Geneva. October 2017.

37 *Indicators, Equity, Rights*. Making the end of AIDS real: Consensus building around what we mean by "epidemic control". Glion, Switzerland. October 2017.

CONFERENCE PRESENTATIONS

1 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among male STD clinic attendees in Jamaica.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

2 **Amon J**, Bolanos L, Gonzales MT, Zelaya A, Lopez C, Rodriguez J. *Knowledge of, availability, and use of condoms among commercial sex workers in four cities in Honduras.* XI Latin American Congress on STIs/V Panamerican Conference on AIDS**,** Lima, Peru, December 3-7, 1997.

3 Wedderburn M, **Amon J**, Samiel S, Brathwaite A, Figueroa P. *Knowledge, attitudes, beliefs and practices (KABP) about HIV/AIDS among youth aged 12-14 in Jamaica.* XII Int Conf AIDS. 1998; 12:191 (abstract no. 13527).

4 Wedderburn M, **Amon J,** Samiel S, Brathwaite A, Figueroa P. *Behavioral explanations for elevated prevalence of HIV in St. James Parish, Jamaica.* XII Int Conf AIDS. 1998; 12:216-7 (abstract no. 14171).

5 D'Angelo LA, **Amon J,** Lemos ME, Rebeiro MA, Gitchens W, Kotellos K. *Evaluating capacity building of implementing agencies in the AIDSCAP Brazil project*. XII Int Conf AIDS. 1998;12:945 (abstract no. 43503).

6 Saidel T, Mills S, **Amon J,** Rehle T. *Behavioral Surveillance Surveys (BSS) on specific target groups: a valuable complement to standardized general population surveys*. XII Int Conf AIDS. 1998;12:233 (abstract no.14256).

7 Essah KAS, Jackson D, Attafuah JD, **Amon J**, Yeboah KG. *Findings from the 2000 behavioral surveillance survey in Ghana*. XIV International AIDS Conference: Abstract no. C11062

8 Chatterji M, Murray N, Dougherty L, Alkenbrack S, Winfrey B, **Amon J**, Ventimiglia T, Mukaneza A. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* XV Int Conf on AIDS, 2004 (Abstract WePeD6602).

9 Murray NJ, Chatterji M, Dougherty L, Winfrey B, Buek K, **Amon J**, Mulenga Y, Jones A. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* XV Int Conf on AIDS, 2004 (Abstract TuOrD1218).

10 **Amon J**, Devasia R, Xia G, *et al. Molecular Epidemiologic Investigation of Hepatitis A Outbreaks, 2003*. 4th International Conference on Emerging Infectious Disease, Atlanta, GA, March 2004.

11 **Amon J**, Devasia R, Xia G, *et al. Multiple Hepatitis A Outbreaks Associated with Green Onions among Restaurant Patrons – Tennessee, Georgia, and North Carolina, 2003.* 53rd EIS Conference, Atlanta, GA, April 2004. (Winner, Mackel Award)

12 Chatterji M, Murray N, Dougherty L, Ventimiglia T, Mukaneza A, Buek K, Winfrey B, **Amon J**. *Examining the impact of orphanhood on schoolleaving among children aged 6-19 in Rwanda, Zambia, and Cambodia.* International Union for the Scientific Study of Population XXV International Population Conference Tours, France, July, 2005.

13 Murray NJ, Chatterji M, Dougherty L, Mulenga Y, Jones A, Buek K, Winfrey B, **Amon J**.. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* International Union for the Scientific Study of Population. International Population Conference France, July, 2005.

14 Cohen J, Schleifer R, Richardson J, Kaplan K, Suwannawong P, Nagle J, **Amon J.** *Documenting Human Rights Violations Against Injection Drug Users: Advocacy for Health*. 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver.

15 Schleifer R, Cohen J, Nagle J, **Amon J.** *Injection Drug Users, Harm Reduction, and Human Rights in Ukraine.* 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver, Canada.

16 Bencomo C, **Amon J,** Iordache R, Schleifer R, Asandi S, Bohiltea A, Bucata C, Terragni C, Velica L. *How gaps in Romania's social support undermine HIV/AIDS prevention and treatment for children and youth.* XVI International AIDS Conference: Abstract no. MOPE0922. August 2006.

17 Tate T, Bencomo C, Lisumbu J, Mafu Sasa R, Schleifer R, **Amon J**. *Local and cultural beliefs about HIV transmission fuel childrenīs rights abuses in the Democratic Republic of Congo (DRC).* XVI International AIDS Conference: Abstract no. CDE0086. August 2006.

18 Cohen J, Epstein H, **Amon J**. *Human rights implications of AIDS-affected children's unequal access to education.* XVI International AIDS Conference: Abstract no. TUAE0202. August 2006.

19 Schleifer R, Skala P, Lezhentsev K, **Amon J**. *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS.* XVI International AIDS Conference: Abstract no. THAE0302. August 2006.

20 **Amon, J**. *Using a Human Rights Framework to Examine HIV/AIDS Programs and Policies.* Abstract #139834. American Public Health Association Annual Meeting. November 2006. Boston, MA.

21 Ngonyama L, Lohman D, Clayton M, **Amon J**. *The Role of Lay Counselors in Expanding HIV Testing: Lesotho's Know Your Status Campaign.* Abstract 1631. 2008 HIV/AIDS Implementers Meeting. Kampala, Uganda. June 2008.

22 Lohman D, Ovchinnikova M, **Amon J**. *The role of Russia's drug dependence treatment system in fighting HIV.* XVII International AIDS Conference: Abstract no. TUAX0102. August 2008.

23 **Amon J**. *HIV-specific travel restrictions: human rights, legal and ethical considerations.* XVII International AIDS Conference: Abstract no. TUSS0406. August 2008.

24 Lohman D, Ngonyama L, Clayton M, **Amon J**. *Expanding HIV testing and human rights: Lesotho's Know Your Status Campaign.* XVII International AIDS Conference: Abstract no. TUPE0469. August 2008.

25 Cohen JE, **Amon J.** *Human Rights abuses and threats to health: recent experiences of Chinese drug users in detoxification and re-education through labor centers in Guangxi Province*. XVII International AIDS Conference: Abstract no. THPE1085. August 2008.

26 **Amon J**. Protecting the human rights of people at risk of and affected by TB. 3rd Stop TB Partners Forum, Rio March 2009

27 **Amon J.** *Undocumented Migrants and Drug Users in Asia: Tuberculosis Care and Human Rights.* 3rd Stop TB Partners Forum, Rio March 2009

28 **Amon J.** *Protecting the rights of drug users in China.* 20th International Conference of the International Harm Reduction Association meeting. April, 2009.

29 Lohman D, **Amon J.** *Pain and Policy: The Battle with Needless Suffering.* Unite for Sight, Yale University. April, 2009.

30 **Amon J.** *HIV testing for hard-to-reach populations.* In: New Strategies and Controversies in HIV Testing and Surveillance, International AIDS Society Conference. Cape Town, South Africa. July 2009.

31 **Amon J**. *Human Rights context of routine testing.* In: Maximizing the benefits of treatment for individuals and communities. International AIDS Society Conference. Cape Town, South Africa. July 2009.

32 **Amon J.** *Scaling up HIV testing through scaling up human rights protections.* In: Scaling up

Biomedical Prevention and Treatment Interventions - The Critical Role of Social Science, Law and Human Rights. International AIDS Society Conference. Cape Town, South Africa. July 2009.

33 **Amon J.** *HIV testing and human rights: competing claims and conflicting views.* American Anthropological Association. Philadelphia, PA. December 2009.

34 Pearshouse R, **Amon JJ**. *Engagement with compulsory drug detention centers: a legal and ethical framework.* 21st International Conference of the International Harm Reduction Association meeting. April, 2010.

35 Lohman D, Tymoshevska V, Rokhanski A, Kotenko G, Druzhinina A, Schleifer R, **Amon J**. *Availability and accessibility of opioid medications in Ukraine.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0202

36 Jones L, Akugizibwe P, **Amon J**, et al. *Human rights costing of ART for prevention.* XVIII International AIDS Conference. July 2010. Abstract no. TUPE1033

37 Lemmen K, Wiessner P, Haerry DHU, Todrys K, **Amon J**. *Deportation of HIV-positive migrants in 29 countries: impact on health and human rights.* XVIII International AIDS Conference. July 2010. Abstract no. TUAF0101

38 McLemore M, Winter M, **Amon J**. *Sentenced to stigma: segregation of HIV-positive prisoners.* XVIII International AIDS Conference. July 2010. Abstract no. THPE0942

39 Todrys K, Malembeka G, Clayton M, McLemore M, Shaeffer R, **Amon J**. *HIV and TB management in 6 Zambian prisons demonstrate improved but ongoing prevention, testing and treatment gaps.* XVIII International AIDS Conference. July 2010. Abstract no. THPDX105 (Awarded prize for best abstract on HIV/TB integration)

40 Pearshouse R, Cohen JE, **Amon J**. *Drug detention centers and HIV in China and Cambodia.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0203

41 Lohman D, Palat G, Nair S, **Amon J**, Schleifer R. *Palliative care: needs of and availability for people living with HIV in India.* XVIII International AIDS Conference. July 2010.

42 Kippenberg J, Thomas L, Lohman D, **Amon J**. *Children's access to HIV testing, treatment and palliative care in Kenya.* XVIII International AIDS Conference. July 2010.

43 Lohman D, Thomas L, **Amon J.** *Access to pain treatment and palliative care as a human right.* XVIII International AIDS Conference. July 2010. Abstract no. WEPE0982.

44 **Amon J.** *HIV and human rights.* XVIII International AIDS Conference. July 2010.

45 **Amon J.** *HIV treatment as prevention: human rights issues.* HIV10 Conference. Glasgow, Scotland. November 2010.

46 **Amon J.** *TB and human rights in Zambian prisons.* IULTB. Berlin, Germany. Nov 2010.

47 **Amon J.** *TB and Human Rights.* IULTB. Berlin, Germany. November 2010. (panel chair)

48 Todrys K, Kwon S-R, Burnett M, Lamia M, **Amon J.** *HIV and TB Prevention, Testing, and Treatment in 16 Ugandan Prisons.* 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, July, 2011.

49 Pearshouse R, **Amon J.** *Drug Detention Centers and HIV In Vietnam.* 10th International Congress on AIDS in Asia. August, 2011.

50 **Amon J.** *Reforms to protect health and rights in East African prisons.* IULTB. Lille, France. Oct. 2011.

51 **Amon J.** *Ethics and Human Rights in Publishing.* (Meet the Editors session). XIX International AIDS Conference. July 2012.

52 **Amon J.** *Balance Between Justice System and Provision of Services.* XIX International AIDS Conference. Washington, DC. July 2012. (co-moderator)

53 **Amon J.** *Advancing global health through human rights accountability.* IV Consortium of

Universities for Global Health. Washington, DC. March 2013.

54 **Amon J.** *Enhanced HIV testing in the context of human rights*. 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

55 Beletsky L, Vera A, Gaines T, Arredondo J, Werb D, Bañuelos A, Rocha T, Rolon ML, Abramovitz D, **Amon J**, Brower K, Strathdee SA. *Utilization of Google Earth to Georeference Survey Data among People who Inject Drugs: Strategic Application for HIV Research.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

56 **Amon J.** *The impact of climate change and population mobility on neglected tropical disease elimination*. International Meeting on Emerging Diseases and Surveillance (IMED). Vienna, Nov 2016.

57 **Amon J.** *Getting to Zero: Lessons for NTD Elimination from Successful STH Control Programs.* Neglected Tropical Disease NGO Network Annual Meeting. Dakar, Senegal, Sept 2017. (moderator)

58 Hoppe A, Coltart C, Parker M, Dawson L, **Amon JJ,** et al. *Ethical Considerations in HIV Phylogenetic Research.* 2018 International AIDS Conference. Amsterdam, Netherlands.

59 **Amon J.** Epidemic transition: How will we achieve it while ensuring equity and quality? 2018 International AIDS Conference. Amsterdam, Netherlands.

INVITED LECTURES

1 University of North Carolina School of Public Health (March 2006)

2 Duke University School of Public Policy (October 2006)

3 University of Chicago (October 2006)

4 University of Toronto Law School (November 2006)

5 Columbia University Law School (Dec 2006, 2007, 2009)

6 University of Denver School of International Affairs (March 2007)

7 Georgetown University Law School (April 2007)

8 Columbia University School of International and Public Affairs (Feb and Oct 2007)

9 University of Connecticut School of Law (April 2009)

10 New York University (January 2011, November 2014)

11 University of Zurich (September 2011)

12 Columbia University Mailman School of Public Health (Feb, Nov 2009; Dec 2013; Nov 2014,-15)

13 Yale University Law School (March 2013)

14 Johns Hopkins University Bloomberg School of Public Health (annually: May 2008-2019)

15 UCLA Law School (January 2014)

16 Stanford University Law & Medical Schools (January 2014)

17 University of Melbourne, Nossal Institute for Global Health (July 2014)

18 Fordham Law School (October 2014)

19 Northwestern University (November 2014; Nov 2015)

20 Dornsife School of Public Health, Drexel University (February 2018)

21 University of California San Diego (March 2018)

AWARDS

Centers for Disease Control and Prevention, Epidemic Intelligence Service, Mackel Award (Apr 2004)
Department of Health and Human Services, Public Health Service, Unit Commendation (Oct 2004)
Department of Health and Human Services, Secretary's Award for Distinguished Service (Aug 2005)

AD HOC REVIEWER

Journals:

New England Journal of Medicine, Lancet, International Journal of Epidemiology, STI, Global Public Health, Addiction, Hepatology, Health and Human Rights, Bulletin of the World Health Organization, Journal of the International AIDS Society, PLoS One, PLoS Medicine, Journal of the American Public Health Association, Anthropological Quarterly, Drug and Alcohol Dependence, Conflict and Health, BMC Public Health, Harm Reduction Journal, Law & Social Inquiry, Social Science and Medicine, Health and Human Rights Journal, International Journal of Drug Policy.

Grants:

Open Society Foundations, Public Health Program

EXHIBIT C

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. I am also a member of the Physicians for Human Rights. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is an infection caused by a novel zoonotic coronavirus SARS-COV-2 that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of March 21, 2020, there are over 260,000 confirmed cases of COVID-19 worldwide. COVID-19 has caused over 11,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States.

3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.

4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound

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

5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

6. The incubation period (between infection and the development of symptoms) for COVID-19 is typically 5 days, but can vary from as short as two days to an infected individual never developing symptoms. There is evidence that transmission can occur before the development of infection and from infected individuals who never develop symptoms. Thus, only with aggressive testing for SARS-COV-2 can a lack of positive tests establish a lack of risk for COVID-19.

7. A lack of proven cases of COVID-19 in the context of a lack of testing is functionally meaningless for determining if there is a risk for COVID-19 transmission in a community or institution.

8. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.

9. COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called mycocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

10. There is no vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

11. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.

12. COVID-19 strains have specifically traced infection between residents and staff members of a skilled nursing facility in the Seattle area. This evidence suggests that COVID-19 is capable of spreading rapidly in institutionalized settings. The highest known person-to-person transmission rates for COVID-19 are in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California.

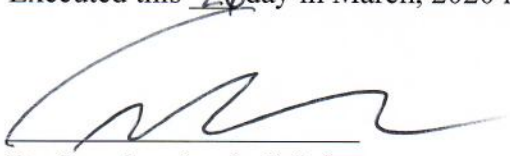
13. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers such as prisons and jails, particularly when residents cannot engage in social distancing measures, cannot practice proper hygiene, and cannot isolate themselves from infected residents or staff. With new individuals and staff coming into the detention centers who may be asymptomatic or not yet presenting symptoms, the risk of infection rises even with symptom screening measures.

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting, such as a prison, or jail, or an immigration detention center, with limited access to adequate hygiene facilities, limited ability to physically distance themselves from others,

and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 26 day in March, 2020 in Ann Arbor, Michigan.



Dr. Jonathan Louis Golob

EXHIBIT D

Jonathan Louis Golob, M.D. Ph.D.
Assistant Professor
206 992-0428 (c) 734-647-3870 (o)
golobj@med.umich.edu jonathan@golob.org

Education and Training

6/1997 – 6/2001	**Bachelor of Science**, Johns Hopkins University, Baltimore, MD Dual degree in Biomedical Engineering and Computer Science conferred June 2001.
7/2001 – 6/2011	**MSTP MD/PhD Combined Degree**, University of Washington, Seattle, WA. Ph.D. on the basic science of embryonic stem cells, specifically epigenetic regulation of differentiation Ph.D. conferred in June 2009. MD conferred in June 2011.
6/2011 – 6/2013	**Internal Medicine Residency**, University of Washington, Seattle, WA
6/2013 – 6/2017	**Infectious Diseases Fellowship**, University of Washington, Seattle, WA

Certifications and Licensure

Board Certifications

2014	Diplomate in Internal Medicine**,** American Board of Internal Medicine.
2016	Diplomate in Infectious Disease**,** American Board of Internal Medicine.

Current Medical Licenses to Practice

2013	Washington State Medical License, Physician, MD60394350
2018	Michigan State Medical License, Physician, 4301114297

Academic, Administrative, and Clinical Appointments

Academic

6/2014 – 6/2018	**Senior Fellow, Vaccine and Infectious Disease Division**, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2016 – 6/2018	**Joel Meyers Endowment Fellow**, Vaccine and Infectious Disease Division, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2017 – 6/2018	**Research Associate, Vaccine and Infectious Disease Division**, Fred Hutchinson Cancer Research Center, Seattle, WA
8/2017 – 6/2018	**Acting Instructor**, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington, Seattle, WA
8/2018 – Present	**Assistant Professor, Division of Infectious Diseases,** Department of Medicine, University of Michigan, Ann Arbor, MI

Clinical

12/2015 – 12/2016	**Infectious Disease Locums Physician**, Virginia Mason Medical Center, Seattle, WA
7/2017 – 6/2018	**Hospitalist Internal Medicine Physician**, Virginia Mason Medical Center, Seattle, WA
8/2017 – 6/2018	**Attending Physician**, Seattle Cancer Care Alliance, Seattle, WA
8/2017 – 6/2018	**Attending Physician**, Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington, Seattle, WA
8/2018 – Present	**Attending Physician,** Division of Infectious Diseases, Department of Medicine, University of Michigan, Ann Arbor, MI

Research Interests

1. I am primarily interested in understanding how the human gut microbiome *mechanistically* affects how patients respond to treatments. I have a particular focus on patients undergoing hematopoietic cell transplant, who are at risk for recurrence of their underlying disease, treatment-related colitis (from both conditioning and graft versus host disease), and infection. In human observational trials the human gut microbiome correlates with each of these aspects. My research program uses advanced stem-cell based *in-vitro* models of the human colonic mucosa to verify if the correlations in observational trials can cause similar effects *in vitro*, and then determine by which pathways (e.g. receptors) and broad mechanisms (e.g. epigenetics) the microbes affect the host.

2. Host-microbiome interactions are contextual. A beneficial interaction in health can turn pathologic. For example, my ongoing work focused on the microbial metabolite butyrate. Butyrate enhances the health of heathy and intact colonic epithelium, acting as a substrate for cellular respiration and through receptor-mediate processes reduces cellular inflammation. However, butyrate also blocks the ability of colonic stem cells to differentiate into mature epithelium. Thus, in colitis that results in a loss of colonic crypts, an intact and butyrogenic gut microbiome results in colonic stem cells being exposed to butyrate and inhibits recovery. My ongoing work uses a primary stem-cell based model of the human colonic mucusa to establish how butyrate blocks the differentiation of colonic stem cell with a hope of generating new treatments for patients with steroid-refractory colitis.

3. I am interested in validating and improving computational tools for biological research. I have a computer science and biomedical engineering background that combined with my clinical and molecular biology training positions me optimally to understand both major aspects of computational biology: what are the needs to make biological inferences from big data, and how can tools specifically be improved to achieve such inferences.

Grants

Present and Active

ASBMT New Investigator Award J. Golob (PI) 7/2018 – 7/2020
Hematopoietic Cell Transplant Outcomes and Microbial Metabolism
Role: PI
$30,000/yr for up to two years

NIH / NIAID R01 D. Fredricks (PI) 11/2017 – 11/2021
The Gut Microbiota and Graft versus Host Disease (GVHD), AI-134808
Role: Senior / key personnel
$823,701

NIH P01 T. Schmidt (PI) Pending / Reviewed
ENGINEERING MICROBIOMES AND THEIR MOLECULAR DETERMINANTS FOR PRODUCTION OF BUTYRATE AND SECONDARY BILE ACIDS FROM RESISTANT STARCH
Role: Key Personnel

NIH / NCI R21 J. Golob (PI) Pending / Submitted
Establishing a physiologic human colonic stem/progenitor cells model of regimen-related colitis
Role: PI

NIH R21 J. Golob (PI) Pending / Submitted
Manipulating Butyrate Production by the Gut Microbiome during Chronic HIV Infection
Role: PI

Completed

Joel Meyers Endowment Fellowship 6/2016 – 6/2018
Role: Research Fellow
$63,180

DCDR Grant R. Harrington (PI) 6/2014 – 6/2018
Support for data queries into the Deidentified Clinical Data Repository
Role: PI
$1000

NIH T32 Institutional Training Grant M. Boeckh (PI) 8/2016 – 8/2017
1T32AI118690-01A1
Role: Post-Doc Trainee
$315,972

NIH T32 Institutional Training Grant W. van Voorhis (PI) 7/1/14 – 6/30/16
5T32AI007044
Role: Post-Doc Trainee
$1,527,801

Honors and Awards

2001 Tau Beta Pi Engineering Honor Society
2001 Alpha Eta Mu Beta Biomedical Engineering Honor Society

2005 ARCS Fellowship
2015 Consultant of the Month Award. University of Washington Housestaff.
2016 Joel Meyer Endowment Fellow

Membership in Professional Societies

2013 Member, Infectious Diseases Society of America
2011 Member, American Board of Internal Medicine

Bibliography

Peer-Reviewed Journals and Publications

1. Gao Z, **Golob J,** Tanavde VM, Civin CI, Hawley RG, Cheng L. High levels of transgene expression following transduction of long-term NOD/SCID-repopulating human cells with a modified lentiviral vector. *Stem Cells* 19(3): 247-59, 2001.
2. Cui Y, **Golob J**, Kelleher E, Ye Z, Pardoll D, Cheng L. Targeting transgene expression to antigen-presenting cells derived from lentivirus-transduced engrafting human hematopoietic stem/progenitor cells. *Blood* 99(2): 399-408, 2002.
3. Boursalian TE, **Golob J**, Soper DM, Cooper CJ, Fink PJ. Continued maturation of thymic emigrants in the periphery. *Nature Immunology* 5(4): 418-25, 2004.
4. Osugi T, Kohn AD, **Golob JL**, Pabon L, Reinecke H, Moon RT, Murry CE. Biphasic role for Wnt/beta-catenin signaling in cardiac specification in zebrafish and embryonic stem cells. *PNAS* 104(23): 9685-9690, 2007.
5. **Golob JL**, Paige SL, Muskheli V, Pabon L, Murry CE: Chromatin Remodeling During Mouse and Human Embryonic Stem Cell Differentiation. *Developmental Dynamics* 237(5): 1389-1398, 2008.
6. **Golob JL**, Kumar RM, Guenther MG, Laurent LC, Pabon LM, Loring JF, Young RA, Murry CE: Evidence That Gene Activation and Silencing during Stem Cell Differentiation Requires a Transcriptionally Paused Intermediate State. *PLoS ONE* 6(8): e22416, 2011.
7. **Golob JL**, Margolis E, Hoffman NG, Fredricks DN. Evaluating the accuracy of amplicon-based microbiome computational pipelines on simulated human gut microbial communities. *BMC Bioinformatics* 18(1):283, 2017.
8. MacAllister TJ, Stednick Z, **Golob JL**, Huang, ML, Pergam SA. Under-utilization of norovirus testing in hematopoietic cell transplant recipients at a large cancer center. *Am J Infect Control* pii: S0196-6553(17)30783-6. doi: 10.1016/j.ajic.2017.06.010. [Epub ahead of print], 2017.
9. **Golob JL**, Pergam SA, Srinivasan S, Fiedler TL, Liu C, Garcia K, Mielcarek M, Ko D, Aker S, Marquis S, Loeffelholz T, Plantinga A, Wu MC, Celustka K, Morrison A, Woodfield M, Fredricks DN. The Stool Microbiota at Neutrophil Recovery is Predictive for Severe Acute Graft versus Host Disease after Hematopoietic Cell Transplantation. *Clin Infect Dis* doi: 10.1093/cid/cix699. [Epub ahead of print], 2017.
10. Bhattacharyya A, Hanafi LA, Sheih A, **Golob JL**, Srinivasan S, Boeckh MJ, Pergam SA, Mahmood S, Baker KK, Gooley TA, Milano F, Fredricks DN, Riddell SR, Turtle CJ. Graft-Derived Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Cell Transplantation. *Biol Blood Marrow Transplant* pii: S1083-8791(17)30758-9. doi: 10.1016/j.bbmt.2017.10.003. Epub 2017 Oct 9.
11. Ogimi C, Krantz EM, **Golob JL**, Waghmare A, Liu C, Leisenring WM, Woodard CR, Marquis S, Kuypers JM, Jerome KR, Pergam SA, Fredricks DN, Sorror ML, Englund JA, Boeckh M. Antibiotic Exposure Prior to Respiratory Viral Infection Is Associated with Progression to Lower Respiratory Tract Disease in Allogeneic Hematopoietic Cell

Transplant Recipients. Biol Blood Marrow Transplant. 2018 May 16. pii: S1083-8791(18)30268-4. doi: 10.1016/j.bbmt.2018.05.016. [Epub ahead of print]

12. **Golob JL**, Stern J, Holte S, Kitahata MM, Crane HM, Coombs RW, Goecker E, Woolfrey AE, Harrington RD. HIV DNA levels and decay in a cohort of 111 long-term virally suppressed patients. AIDS. 2018 Sep 24;32(15):2113-2118. doi: 10.1097/QAD.0000000000001948.
13. **Golob JL**, DeMeules MM, Loeffelholz T, Quinn ZZ, Dame MK, Silvestri SS, Wu MC, Schmidt TM, Fiedler TL, Hoostal MJ, Mielcarek M, Spence J, Pergam SA, Fredricks DN. Butyrogenic bacteria after acute graft-versus-host disease (GVHD) are associated with the development of steroid-refractory GVHD. Blood Adv. 2019 Oct 8;3(19):2866–2869.

Preprint publications

1. **Golob JL** and Minot SS. Functional Analysis of Metagenomes by Likelihood Inference (FAMLI) Successfully Compensates for Multi-Mapping Short Reads from Metagenomic Samples. Preprint. doi: https://doi.org/10.1101/295352

Other Publications

1. Science Columnist and Writer for *The Stranger*, Seattle, WA, 2004 – Present
2. Freelance contributor, Ars Technica, 2016 – Present.

Abstracts (presenter underlined)

1. **Golob JL,** Srinivasan S, Pergam SA, Liu C, Ko D, Aker S, Fredricks DN. Gut Microbiome Changes in Response to Protocolized Antibiotic Administration During Hematopoietic Cell Transplantation. ID Week, Infectious Diseases Society of America, October 2015 (Oral)
2. **Golob JL**, Stern J, Holte S, Kitahata M, Crane H, Coombs R, Goecker E, Woolfrey AE, Harrington RD. HIV reservoir size and decay in 114 individuals with suppressed plasma virus for at least seven years: correlation with age and not ARV regimen. IDWeek 2016, October 26-30, 2016, New Orleans. Abstract 953 (Oral).
3. **Golob JL** , Stohs E, Sweet A, Pergam SA, Boeckh M, Fredricks DN, and Liu C. Vancomycin is Frequently Administered to Hematopoietic Cell Transplant Recipients Without a Provider Documented Indication and Correlates with Microbiome Disruption and Adverse Events. ID Week, Infectious Diseases Society of America, October 2018 (# 72504).
4. Impact of Intestinal Microbiota on Reconstitution of Mucosal-Associated Invariant T Cells after Allogeneic Hematopoietic Stem Cell Transplantation. ASH 2018 (#3393).

Invited Lectures

1. Keynote Speaker, ARCS Foundation Annual Dinner. Seattle, WA Nov 3, 2008
2. Primary Care Conference: Direct to Consumer Genetic Testing, Seattle, WA, Mar 14, 2013
3. "IRIS and TB", Harborview Medical Center Housestaff Lunchtime Conference, Seattle, WA, Jun 9, 2014
4. "Complicated Enterococcal Endocarditis", University of Washington Medical Center (UWMC) Chief of Medicine Conference, Seattle, WA, Jul 14, 2014
5. "Coccidiomycosis", UWMC Chief of Medicine Conference, Seattle, WA, Oct 7, 2014
6. "HIV and CMV encephalitis", UWMC Chief of Medicine Conference, Seattle, WA, Apr 14, 2015
7. Research Presentation for GVHD Group Meeting, Seattle, WA, Nov 2015

8. “CMV Ventriculitis”, Clinical Case Presentation to the Virology Working Group, Fred Hutchinson Cancer Research Center (Fred Hutch), Seattle, WA, Nov 2015
9. “Microbiome and HCT Outcomes”. 1st Infectious Disease in the Immunocompromised Host Symposium – Tribute to Joel Meyers. Fred Hutch, Seattle, WA, Jun 13 2016.
10. “Microbiome and GVHD”. Infectious Disease Sciences / Virology Symposium, Fred Hutch / UW, Seattle, WA, Jan 17 2017
11. “Microbiome and GVHD”. 2nd Symposium on Infectious Disease in the Immunocompromised Host. June 19 2017
12. “The Gut Microbiome Predicts GVHD. Can It Be Engineered to Protect?”. St Jude. February 18th 2019

EXHIBIT E

Declaration of Brian McHale

I, Brian McHale, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand that the statements herein are subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. I am 44 years old.
2. I have been in custody on a probation detainer at the Montgomery County Correctional Facility (MCCF) since January 8, 2020.
3. I am currently on probation for several retail thefts and my alleged probations violations are technical.
4. A few years ago, I was diagnosed with hemochromatosis, an inherited blood disorder, which causes my body to absorb too much iron. This condition has damaged my internal organs and joints. I use crutches to walk and need a double hip replacement.
5. In order to control the damage, I have weekly "therapeutic phlebotomy," where one pint of my blood is removed. MCCF was taking me to a local hospital each week for my treatment but stopped doing so about three weeks ago. Not getting this treatment causes fatigue and places stress on my heart.
6. I have been a smoker for over thirty years. I also have hepatitis C.
7. In December of last year, I was hospitalized with pneumonia and on a respirator for a couple of days.
8. At MCCF, I share a cell with two other men. We share a toilet and sink in our cell. There is not six feet of free space in the cell and it is impossible for me to stay six feet away from the other two men.
9. I eat my meals with my unit – about sixteen men – in the dayroom.

10. I do not have access to hand sanitizer.
11. I have not been given any information by jail officials about how I can protect myself from COVID-19.
12. On March 18, 2020, my attorney filed an emergency habeas petition with the Court of Common Pleas of Montgomery County asking that I be released because my health conditions make me very vulnerable if I catch COVID-19.
13. On March 20, 2020, the Court of Common Pleas denied the habeas petition – the order says it was "not an emergency."
14. My attorney appealed that order to the Pennsylvania Superior Court.
15. On March 23, 2020, the Court of Common Pleas issued another order – that order says it is "correcting a formal error" and fixing its earlier order to state, "No further action will be taken during the pendency of Judicial Emergency Orders . . . Counsel for Defendant may request further process upon said Judicial Emergency Orders being vacated."
16. The same day, the Superior Court denied my appeal "without prejudice to the Montgomery County Court of Common Pleas to rule on Petitioner's emergency petition, filed in the Court of Common Pleas, upon the expiration of the judicial emergency period declared by the Court of Common Pleas."

Brian McHale

Hayden Nelson-Major

Date: 3/27/2020

Hayden Nelson-Major
Id. No. 320024

EXHIBIT F

Declaration of Jeremy Hunsicker

I, Jeremy Hunsicker, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand that the statements herein are subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. I am thirty-eight years old.
2. I am currently incarcerated at the Community Correction Center (CCC) in Lehigh County.
3. I was on parole for driving under the influence when I was arrested for driving with a suspended license. My parole was revoked and I was resentenced to six to twelve months. I was also sentenced to six to twelve months for driving with a suspended license.
4. I was sentenced in November of last year and have been at CCC ever since.
5. I am a union sheet metal worker. Although I am eligible for work release, I have not been able to work because there is some issue with getting my paperwork processed.
6. The work release program at CCC is still going on and about thirty-eight other people are continuing to work and return to CCC after finishing their shifts.
7. Prior to COVID-19, I was allowed to leave CCC three times a week to see a counselor. They stopped letting me out of CCC last Tuesday.
8. There are four pods at CCC. I am currently housed with about twenty other people on a pod for night shift workers.
9. My pod shares one bathroom with three urinals, three toilets, and six showers.

10. Two pods are called to the cafeteria at a time for meals and there can be almost seventy people eating together. All meals come refrigerated and we takes turns heating up our meals in one of the six microwaves in the cafeteria.
11. CCC recently started doing temperature checks. Each pod is called down to the medical office on Monday, Wednesday, and Friday. The pod lines up together outside the medical office and we are called into the medical office two at a time.
12. There is no hand sanitizer available.
13. CCC permits people to have certain items shipped to CCC but they denied my request to order antibacterial wipes.

Jeremy Hunsicker

Hayden Nelson-Major

Date: 3/27/2020

Hayden Nelson-Major
Id. No. 320024

EXHIBIT G

Declaration of Christopher Aubry

I, Christopher Aubry, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand that the statements herein are subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. I am fifty-five years old.
2. I am currently incarcerated at the Montgomery County Correctional Facility ("MCCF").
3. I am serving a sentence of one to twenty-three months for simple assault and related charges.
4. I install and repair data and voice wiring. My company is working during the pandemic.
5. Although I am work release eligible, MCCF stopped the program because of COVID-19 before I was reported to MCCF on March 20, 2020.
6. At MCCF, I am housed in a pod with approximately fifty other people. We sleep in bunk beds and share a bathroom.
7. It is impossible for me to stay six feet away from other people at MCCF.
8. I do not have access to hand sanitizer.

Christopher Aubry

Hayden Nelson-Major

Date: 3/27/2020

Hayden Nelson-Major
Id. No. 320024

EXHIBIT H

Declaration of Michael Foundos

I, Michael Foundos, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand that the statements herein are subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. Michael Foundos is thirty-nine years old.
2. I am currently incarcerated at the George W. Hill Correctional Facility in Delaware County.
3. I am a second year apprentice in a roofing union.
4. While on probation for simple possession of a controlled substance, I was charged with retail theft in Delaware County and Montgomery County.
5. I was given an unsecured bond on my Montgomery County case and a $50,000 monetary bond on my Delaware County case.
6. I cannot afford to pay the bail that was set in my Delaware County retail theft case.
7. Probation lodged a detainer on me because of the retail theft charges.
8. I have been at George W. Hill Correctional Facility since September 1, 2019.
9. There are thirty cells per block and, for the most part, two people per cell. Each cell has a toilet and a sink.
10. Jail officials recently started passing out extra bars of soap but we do not have access to hand sanitizer.
11. My block eats meals together and there is about a foot between us when we sit at the tables to eat.
12. On March 25, 2020, the jail officials started doing “tiered” exercise – they send the bottom and top tiers out for exercise at different times.

Michael Foundos

Date: 3/27/2020

Hayden Nelson-Major
Id. No. 320024

EXHIBIT I

Declaration of Frederick Leonard

I, Frederick Leonard, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand that the statements herein are subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. I am twenty-nine years old.
2. I am currently incarcerated at the Pike County Correctional Facility (PCCF).
3. I was sentenced to six to twenty-four months, less one day, for driving under the influence, driving with a suspended license, and fleeing.
4. I have been a smoker since I was twelve and have had bronchitis a bunch of times. I have allergies and a family history of lung disease.
5. I am in an eight by twelve foot cell with two other men. The cell contains a bunk bed and single bed, which means that we are sleeping less than two feet apart. We share a toilet and sink in the cell.
6. PCCF has started passing out three bars of soap per cell every other day but the bars do not last a full day and we end up sharing soap.
7. We eat six to a table and are within arm's reach of each other.
8. One of the correctional officers tested positive for COVID-19 four days ago. I believe that the correctional officer was at PCCF the day before she tested positive.
9. Five female inmates were also recently tested for COVID-19.
10. After the correctional officer tested positive, the air ducts at PCCF began spitting out dust – I think that the jail changed the air filters. Many inmates have been coughing and complaining about sore throats since then.

11. PCCF recently started taking our temperature each day. A nurse visits each unit and uses a forehead thermometer. Some of the nurses do not wear gloves or wipe the thermometer.
12. PCCF is now wiping down doors with antibacterial spray once a day.

Frederick Leonard

Hayden Nelson-Major

Date: 3/27/2020

Hayden Nelson-Major
Id. No. 320024

EXHIBIT J

Declaration of Malik Neal

I, Malik Neal, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand the statements herein are made subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. My name is Malik Neal. I am a resident of Philadelphia County, PA.
2. I am a volunteer with the Pennsylvania Prison Society ("PPS"). I have been a volunteer with PPS since 2015, and led the Philadelphia chapter from 2016 to 2019. In 2017, I also joined the Board of Directors of PPS.
3. Through my volunteering role with PPS, I have gained firsthand knowledge of county detention facilities in Philadelphia, including the Curran-Fromhold Correctional Facility ("CFCF"), Riverside Correctional Facility ("RCF"), and the Detention Center ("DC").
4. I visit Philadelphia detention facilities about twice a month; previously, I went as often as once a week. The frequency with which I visit these facilities depends on the requests that PPS receives from incarcerated people, or if I am planning to conduct wellness visits with previously visited incarcerated people.
5. I have also formally toured both CFCF and RCF and have walked through parts of DC on multiple occasions to conduct visits.
6. My most recent visit to CFCF and DC was in early March 2020. My most recent visit to RCF was in February 2020.
7. To my knowledge, there have not been any major changes at the facility since my last visit that would impact my below observations.

8. Social distancing, as recommended by the CDC, would be difficult, if not impossible to achieve in CFCF, RCF, and DC.
9. At CFCF, the largest correctional facility in Philadelphia, a housing unit has two levels of cells. In the center, there is a common area with tables. The cells surround this common space.
10. The majority of cells in CFCF, DC, and RCF contain two people. Individuals housed in those cells sleep on bunk beds, and share a single toilet and sink. There is running water in the cell, but often, as has been reported to me, the hot water does not work, resulting in people only receiving cold water. The toilet is in close proximity to the sleeping area, and is unhygienic. When individuals are in these cells, it is impossible to stay the CDC-recommended six feet apart when one shares a cell.
11. At CFCF, there are also several "multipurpose" rooms, which have been converted from offices and hold four people. I have received reports that these rooms were being used to house individuals at CFCF as recently as March 23, 2020. These rooms contain two sets of bunk beds. In these rooms, it is impossible to stay six feet from one's cellmates.
12. When individuals arrive to CFCF, they are initially placed in a single holding cell prior to being processed. Depending on the how many people are being processed, this cell can have eight to ten people in it at one time. These facilities say it takes about eight to twelve hours to process a new intake. The holding cell prior to intake is a sparse room with benches. On one occasion, I saw to twelve or thirteen people there, with some of them forced to sit on the floor. I received a report that this intake-holding cell held eight people at once as recent as March 17, 2020.

13. Each block shares only several communal showers; showers are not regularly or sufficiently cleaned or otherwise sanitized between each use.
14. Similarly, each block only shares several phones for many individuals to use. These phones are not regularly or sufficiently sanitized between uses.
15. Individuals at CFCF and RCF can access the common areas in their block during the day. Typically, individuals are supposed to get eight hours of out-of-cell time per day. Individuals go in groups for out-of-cell time.
16. However, lockdowns are frequent, especially at RCF, which results in individuals remaining locked in their cells for 24 hours at a time, where they cannot socially distance from one another. I spoke to someone who was released from CFCF on March 24, 2020, who reported being locked down every other day. Sometimes, lockdowns result from security issues inside the facility, but other times, out-of-cell time is denied because there is a shortage of staff to supervise or because of retribution by individual officers.
17. If someone is housed in solitary confinement at CFCF or RCF, they are supposed to receive an hour of out-of-cell time per day, but this does not always happen. These individuals must also be shackled every time they leave their cell, except for showers. To be shackled, an individual must come into very close contact with a correctional officer.
18. It is my belief that individuals eat meals in the tables in the common areas on the block, but I have not personally observed mealtimes in the facilities. However, I have seen the common areas: these tables are not six feet across, and it would be impossible to remain six feet from others while sitting at these tables.

19. The Detention Center is an older building, which consists of two floors full of cells, with stairs in the middle. In DC, incarcerated people typically eat in large cafeteria. During a recent visit in early March, I observed a group of thirty to forty individuals walking together for mealtime.
20. The ability to properly isolate and quarantine ill inmates in Philadelphia County facilities is lacking. I am not aware of sufficient free space in CFCF, RCF, or DC that would enable this to occur.
21. Currently, newly admitted individuals at CFCF are placed in "quarantine." These individuals are to be temporarily housed in this separate block for 14 days before being transferred to general population. Within that unit, people are placed in a cell with another person, and adequate social distancing remains impossible.
22. The majority of complaints received by the organization when I led the Philadelphia chapter were related to health concerns. This includes for conditions prior to arrival at the facility, or for conditions that developed while incarcerated. We have received numerous reports from incarcerated people that their sick call slips were not responded to at all. Sick call slips are submitted physically, and I am uncertain of how individuals will be able to communicate their healthcare needs if the facilities are locked down to a degree where physical papers cannot be given to guards.
23. If this level of lockdown were implemented, I anticipate this would also impact individuals' ability to file grievances. The organization regularly receives reports from incarcerated people who have not received responses to grievances. Without the intervention of my organization and its volunteers, I am concerned that problems in the facilities will go unaddressed.

24. Sanitation is also a consistent problem at CFCF, RCF, and the Detention Center. To my knowledge, inmate workers are responsible for custodial tasks in the facilities. Incarcerated people do not have regular access to cleaning supplies, so cannot adequately clean and sanitize their cells.

Pursuant to 18 Pa.C.S. § 4904, I, Malik Neal, declare under penalty of perjury that the foregoing is true and correct.

Dated: 3/27/20

Malik Neal

EXHIBIT K

Declaration of Bret Grote

I, Bret Grote, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand the statements herein are made subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. My name is Bret Grote. I am a resident of Allegheny County, PA and am admitted to practice law in the Commonwealth of Pennsylvania.
2. I am the Co-Founder and Legal Director of the Abolitionist Law Center ("ALC"). I have been in this role since 2013.
3. I am also a Professor of Practice at the University of Pittsburgh School of Law where I teach Prison Litigation and supervise students in practicum work.
4. Through my role with ALC, I have extensive knowledge about the Allegheny County Jail ("ACJ"). I visit one to three times a week, and supervise staff and law students who have gone on approximately 200 visits over the past 8 months. My last visit to ACJ was on March 5, 2020.
5. To my knowledge, there have not been any major changes at the facility since my last visit that would impact my below observations.
6. Social distancing, as recommended by the CDC, would be very difficult to achieve at ACJ without a significant reduction in jail population.
7. ACJ is an eight-story building with multiple housing units, or "pods," per floor. The number of pods varies by floor. There are approximately 1,725 individuals housed in ACJ at this time.
8. Individuals are held for extended periods of time in the Intake area of ACJ. Intake consists of a single room that is about 2.5 to 3 times the size of a regular cell, and each

cell is approximately 12 x 7 feet. This room contains some benches, and individuals cannot have access to any personal property. There are separate Intake rooms for male and female individuals entering ACJ. There are regularly 10 or more people housed in each Intake area, sharing a single toilet and sink. There are no actual beds in the Intake area, so people sleep on the benches or on the floor. There are not enough benches for each person to sleep on a bench. Individuals housed in the Intake area must eat their meals on the floor or sitting on a bench, in close proximity to others. It is not possible to remain six feet apart from other people in the Intake area. During Intake, a cursory medical screening is conducted. After several days in Intake, individuals are moved onto a pod, where they will come into contact with a new set of incarcerated people and staff.

9. Once an individual is assigned to a pod, they may or may not have a cellmate, depending on administrative policies in place at ACJ. A significant number of people housed at ACJ on the pods will be double-celled. An individual who must share a cell will not be able to stay six feet away from their cellmate, because of their square footage of each cell.
10. Even if an individual is housed in a cell alone, they will regularly come into contact with members of staff and other incarcerated people because of the spatial layout of the pod.
11. Each cell has a sink and a toilet, as well as running water, unless water has been turned off in the individual cell or across the facility. Access to soap is a constant problem in ACJ: an individual will not receive it frequently and will not receive it upon request. Typically, they will receive soap once a week, although a recently released client I spoke on March 26th told me that their entire pod went nearly two weeks without soap this month. For individuals housed in some pods, such as the acute mental health pod, there is a serious lack of access to personal hygiene supplies, as well as cleaning supplies and

toilet paper. If an individual is placed on suicide watch, all property, including personal hygiene items, is removed from their cell. The lack of personal hygiene items for all leads many people to share deodorant, toothbrushes, and hairbrushes.

12. There are only a few showers per pod, with many people sharing the same shower area, without any sanitation between individual uses.
13. Access to common areas varies by pod, as does the layout of the common space available. Individuals at ACJ typically spend at least one-third of their day, or eight hours, confined to a cell. An individual may get six hours of out-of-cell time daily. The rest of their time will be spent in their cell; if their cell is shared, they will spend that portion of their daily unable to adequately distance themselves from others.
14. Most individuals will eat their meals at communal tables on their pods. The tables are small and can reasonably fit four people, with one person on each side. A table is only four feet by four feet, at most, so no one can social distance from others during meal times.
15. Individuals on restricted housing unit status are held in solitary confinement and must eat their meals in their cell, where they also use the restroom.
16. It is not possible for an incarcerated person to move throughout ACJ without coming into contact with many other people. They are typically escorted by an officer through crowded hallways, where they will pass block workers, ACJ staff, and others in narrow hallways. Because the building is eight stories, elevator use in the facility is frequent; it is impossible to practice proper social distancing in the confined space of an elevator.
17. If someone is housed in a special unit or restrictive housing, they must be closely escorted everywhere in the facility by a member of ACJ staff. Before they can be

escorted anywhere, these individuals must be placed into cuffs, which require very close contact with a correctional officer. They also remain in very close proximity to the officer while being escorted. When they are returned to their cell, they will again come into very close contact with a correctional officer, so that officer can remove the cuffs.

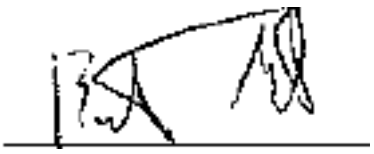
18. Use of force within ACJ is also a frequent occurrence, which can put an incarcerated person into close contact with several staff members. ACJ staff regularly place people into a restraint chair; to do so, approximately six ACJ staff members must come into close contact to restrain an individual. That individual must then sit in the chair for hours, restrained, without any opportunity to wash their body until they are released.
19. ACJ is very unsanitary. Dirt, grime, and dust are visible on many surfaces, which shows that they have not been adequately cleaned or sanitized. I do not think the elevator has been cleaned in a long period of time. I have received regular reports of roaches, usually crawling on or around food trays that are being distributed from a dolly that is wheeled through the institution.
20. To my knowledge, individuals in ACJ cannot access cleaning supplies to clean their individual cells. It would be impossible to sanitize a cell on a daily basis.
21. There are many "high contact" areas that an individual would come into contact with every day, including the communal showers and communal tables. Likewise, there are items in ACJ that are touched by many without adequate sanitization, including food trays, and recreational equipment. Entire pods of individuals share a limited number of phones, which are likewise not sanitized between use.
22. It is unclear whether ACJ can properly isolate and quarantine people within the facility. While there are entire sections of the jail that are currently not in use, these sections have

not been used in a while, which means there may be safety or sanitary reasons they should not be utilized, such as the reported presence of mold.

23. Access to medical care is inadequate at ACJ. At present, there are approximately 45 vacancies for healthcare staff. There are extreme delays in individuals' ability to access care, as well as huge staffing shortages.
24. A woman housed at ACJ can only have an appointment with medical on Thursdays. If a woman is seeking medical care she must submit a "sick call" slip, but these slips regularly take a week or more to be answered and only on Thursdays will she be seen.
25. Individuals at ACJ have not received any information about how to practice proper social distancing, if this were even possible inside of ACJ. Staff have not given informational sessions, and operations have continued as normal. Just today I heard that a person who had been coughing and feeling unwell was told she was paranoid and has been ignored for days.
26. To my knowledge, the facility plans to open up space to house ill inmates, but it will be difficult to achieve any meaningful isolation of inmates if they contract COVID-19.

Pursuant to 18 Pa.C.S. § 4904, I, Bret Grote, declare under penalty of perjury that the foregoing is true and correct.

Dated: March 26, 2020



Bret Grote

EXHIBIT L

Declaration of Ernest Fuller

I, Ernest Fuller, hereby state that the facts set forth below are true and correct to the best of my knowledge, information, and belief. Further, I understand the statements herein are made subject to the penalties of 18 Pa.C.S.A. § 4904 (relating to unsworn falsification to authorities).

1. My name is Ernest Fuller. I am a resident of Bedford County, PA.
2. I am a volunteer with the Pennsylvania Prison Society ("PPS"). I have been a volunteer with PPS since 1991.
3. Through my volunteering role with PPS, I have gained firsthand knowledge of the Blair County Prison.
4. My last visit to Blair County Prison was on January 20, 2020. I visit the Blair County Prison on a regular basis. I tour the blocks of the Blair County Prison at least every three months.
5. To my knowledge, there have not been any major changes at the facility since my last visit that would impact my below observations.
6. Social distancing, as recommended by the CDC, would be very difficult to achieve in the Blair County Prison without a significant population reduction because of the physical structure of the facility.
7. There are two primary parts of the prison. The original section was built in 1869, and contains some blocks with individual cells, and some dormitory style rooms. The original section holds approximately one-third of the inmates. The new section was built in 1983, contains a mix of individual cell and dormitory rooms. The new section is primarily separate cells. There are 11 blocks in total, which vary in size from ten inmates up to seventy-five inmates.

8. Because of the way in which the prison is constructed, it is very difficult to move an inmate without close contact with other inmates and/or staff.
9. The facility also uses a single heating and cooling system for the entire facility. There is a filter, but I do not believe it is medical grade. The same air is circulated throughout the entire prison by this system.
10. Some cells contain two people. Individuals housed in those cells sleep on bunk beds, and share a single toilet and sink. There is running water in the cell, but individuals have no control over what temperature the water is.
11. Other individual cells in the prison house eight to ten people. In these cells, there are several bunk beds. In these more populated cells, inmates still only share one toilet and one sink. In these cells, it is more difficult to stay six feet apart because of the square footage occupied by bunk beds, the toilet, and the sink.
12. Sometimes, there are more people in a cell than there are beds. When this occurs, some individuals must sleep on cots that are low to the ground, inside of the cell. Typically in the prison, there are at least a few inmates on these cots at any one time. Sometimes, an individual must sleep in the cot because they cannot physically access an upper bunk. This makes staying at least six feet apart inside a cell close to impossible.
13. The dormitory-style rooms vary in size. The former chapel has been refurbished into a dormitory style room with approximately twelve inmates in a room that is approximately 15-20 feet by 30 feet. Another dormitory-style room holds about twenty people. A larger dormitory-style room in the new section of the jail holds between twenty-five and thirty people.

14. In at least some of the dormitory-style areas, the beds are placed only three to four feet apart. Appropriate social distancing would be difficult even in these larger dormitory-style areas.
15. Most blocks have access to showers on the block, but these showers are not always in operation, so sometimes individuals must go to another block to use a shower. Some of the smaller blocks do not have their own showers. In larger blocks, up to seventy-five people may be sharing a few showers.
16. Most blocks have daily access to showers, but those in the Restrictive Housing Unit do not.
17. To get access to soap, inmates must purchase soap from the commissary. If an inmate is indigent, they receive a block of soap that is approximately 1" by 1.5" to use for the entire week. This soap must be used to wash their hands and to clean their bodies.
18. Each block has common space, except the RHU. The common spaces vary in size depending on the block.
19. The largest common space is approximately 12 feet wide by the 100 feet long, which is the length of the block. It abuts all of the cells in which people are housed.
20. In more modern parts of the facility, they have common spaces that are approximately fifty feet by forty feet and contain some metal picnic tables.
21. Individuals either eat meals in these common areas at tables, or may be served their meals inside of their cells. When individuals are eating at common tables, they frequently are sitting shoulder-to-shoulder with one another. The tables are only 2.5 to 3 feet wide across.
22. The ability to properly isolate and quarantine ill inmates at the facility is lacking.

23. There are a few fully-enclosed cells for observation, that are typically used to observe those on "suicide watch."

24. There also are four to five cells to quarantine all new arrivals to the jail. Typically, individuals are held in these cells for 48 hours, but that time may be increasing in light of COVID-19. These quarantine cells house four people.

25. To my knowledge, doctors are infrequently present in the jail, and much of the medical care requiring a physician is conducted via video technology. Nurses are available on site.

26. To my knowledge, the facility plans to open up space to house ill inmates, but it will be difficult to achieve any meaningful isolation of inmates if they contract COVID-19.

Pursuant to 18 Pa.C.S. § 4904, I, Ernest Fuller, declare under penalty of perjury that the foregoing is true and correct.

Dated: 3/26/20

Ernest Fuller