EXHIBIT

1

Affidavit of Robert B. Greifinger, MD

I, Robert B. Greifinger, certify as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities,* a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.[1]

2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am very familiar with correctional facilities, having toured and evaluated the medical care in several hundred correctional facilities across the nation. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of today, according to the World Health Organization, more than 465,915 people have been diagnosed with COVID-19 around the world and 21,031 have died.[2] In the United States, at least 85,724 people have been diagnosed and at least 1,275 people have died thus far.[3] These numbers are likely a severe underestimate, due to the lack of availability of testing.

4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19 and there is unlikely to be a vaccine for at least a year. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 transmission is to use scrupulous hand hygiene and social distancing.

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

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

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

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

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

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

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

8. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, and neurological and neurologic and neurodevelopmental conditions.

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

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

11. Recognizing the urgency and severity of the pandemic, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of a risk mitigation strategy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24. Risk mitigation is the only viable public health strategy available to limit transmission of infection, morbidity and mortality in prisons, and to decrease the likely public health impact outside of the prisons. Even with the best-laid plans to address the spread of COVID-19 in prisons, the release of individuals, prioritizing the most medically vulnerable individuals, is a key part of a risk mitigation strategy. In my opinion, the most urgent public health need is to release people from prison, prioritizing those who are most vulnerable, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

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

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

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

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

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

29. Isolation, e.g., segregation or solitary confinement, is not an acceptable mitigation strategy. People who are isolated are monitored less frequently, due to decreased visualization. If they develop COVID-19 symptoms, or their symptoms escalate, they may not be able to get the medical attention they desperately need in a timely fashion. It also makes it more likely that there will be increases in suicide attempts or self-harm, giving rise to more medical problems in the midst of a pandemic. Isolation also increases the amount of physical contact between staff and prisoners—in the form of increased handcuffing, escorting to and from the showers, and increased use of force due to the increased psychological stress of isolation. My expert opinion is that the use of isolation or lockdown is not a medically appropriate method for abating the substantial risks of COVID-19.

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

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

Robert B. Greifinger, M.D.

EXHIBIT

2

Declaration of Dr. Jaimie Meyer

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

I. Background and Qualifications

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

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

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

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

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

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

II. Heightened Risk of Epidemics in Jails and Prisons

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.

[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Conclusion and Recommendations

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

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

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

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

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

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

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

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

March 15, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

EXHIBIT

3

DECLARATION OF DR. CRAIG W. HANEY, PHD

I, Craig W. Haney, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Craig W. Haney Ph.D.

DR. CRAIG W. HANEY, PHD

EXHIBIT

4

Declaration for Persons in Detention and Detention Staff
COVID-19

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

I, Chris Beyrer, declare as follows:

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

The nature of COVID-19

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

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

8. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 160 countries and all populated continents, heavily affected countries include Italy, Spain, Iran, South Korea, and the US, now the world's most affected country. As of today, March 29th, 2020, there have been 713,171 confirmed human cases globally, 33,597 known deaths, and some 149,000 persons have recovered from the infection. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.

9. SARS-nCoV-2 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

10. The U.S. CDC estimates that the reproduction rate of the virus, the R_0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again, is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

The risks of COVID-19 in detention facilities

11. COVID-19 poses a serious risk to inmates and workers in detention facilities. Detention Facilities, including jails, prisons, and other closed settings, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.

12. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities from which inmates derive.

13. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as 6-foot distancing and proper decontamination of surfaces is virtually impossible. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May, 2019.

14. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilet, shower, and eating environments and limits on hygiene and personal protective equipment such as masks and gloves in some facilities. Limits on soap (copays are common) and hand sanitizer, since it can contain alcohol, are also risks for spread.

15. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in

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

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

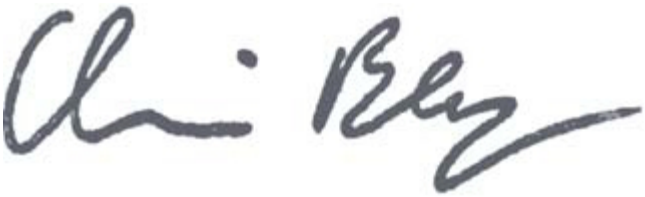
17. While every effort should be made to reduce exposure in detention facilities, this may be extremely difficult to achieve and sustain. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.

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

19. Given the experience in China as well as the literature on infectious diseases in jail, additional outbreaks of COVID-19 among the U.S. jail and prison populations are highly likely. Releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole.

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

Executed this 16th day of March, 2020.



Professor Chris Beyrer

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EXHIBIT

5

I, Dan Pacholke, declare as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

Dan Pacholke

April 1, 2020

Attachment 1

DAN PACHOLKE

PROFILE

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

EMPLOYMENT HISTORY

Principal, Dan Pacholke Consulting, LLC. 2018 to Present

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

New York University, Litmus at Marron Institute of Urban Management

Associate Director 2016-2017

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

Washington State Department of Corrections

Secretary 2015-2016

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

Deputy Secretary 2014-2015

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

Director, Prisons Division 2011-2014

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

Attachment 1

Deputy Director, Prisons Division 2008-2011

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

Monroe Correctional Complex
Interim Superintendent 2008

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

Stafford Creek Corrections Center
Superintendent 2007-2008

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

Cedar Creek Corrections Center
Superintendent 2003-2007

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

Monroe Correctional Complex
Special Assignment Deputy Superintendent 2002

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

Headquarters
Performance System Administrator 1999-2002

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

Headquarters
Emergency Response Manager 1995-1999

Developed and implemented statewide emergency response system. Directed the

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

Clallam Bay Corrections Center
Correctional Captain 1989-1995

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

Clallam Bay Corrections Center
Correctional Lieutenant 1986 -1989

Washington Corrections Center
Correctional Sergeant 1985-1986

McNeil Island Corrections Center
Correctional Officer 1982-1985

PUBLICATIONS

Useem, Bert, Dan Pacholke, and Sandy Felkey Mullins. "Case Study–The Making of an Institutional Crisis: The Mass Release of Inmates by a Correctional Agency." *Journal of Contingencies and Crisis Management* (2016)
Pacholke, Dan (2016, July 27). Change is relative to where you begin. Vera Institute of Justice. Think Justice Blog. https://www.vera.org/blog/addressing-the-overuse-of-segregation-in-u-s-prisons-and-jails/change-is-relative-to-where-you-begin

Pacholke, Dan and Sandy Felkey Mullins. *More Than Emptying Beds: A Systems Approach to Segregation Reform*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, 2016. NCJ 249858.

Pacholke, D. (2014, March). Dan Pacholke: How prisons can help inmates lead meaningful lives [Video file]. Retrieved from https://www.ted.com/talks/dan_pacholke_how_prisons_can_help_inmates_live_meaningful_lives?language=en

Young, C., Dan Pacholke, Devon Schrum, and Philip Young. *Keeping Prisons Safe: Transforming the Corrections Workplace*. 2014.

Aubrey, D., LeRoy, C. J., Nadkarni, N., Pacholke, D. J., & Bush, K. Rearing endangered butterflies in prison: Incarcerated women as collaborating conservation partners. 2012.

AWARDS

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

Attachment 1

Governor's Sustaining Leadership Award, 2003

CONSULTING

Sustainability in Prisons Project, Co-Director
2004-2015

Nebraska Department of Correctional Services
2015

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

National Institute of Corrections
1998 to 2002

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

Defensive Technology Corporation
Senior Instructor
1995 to 1998

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

Security Auditing & Critical Incident Reviews
Lead Auditor

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

EDUCATION:

The Evergreen State College, BA, Olympia, Washington

Attachment 3

Career Highlights

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

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

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

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

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

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

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

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

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

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

Attachment 3

- Implemented Dog retraining programs in all Washington State Prisons.

EXHIBIT

6

UPLC
UPTOWN PEOPLE'S LAW CENTER

4413 North Sheridan | Chicago, Illinois 60640
Phone: 773.769.1411 | Fax: 773.769.2224
www.uplcchicago.org

March 17, 2020

The Honorable J. B. Pritzker
207 State House
Springfield, IL 62706

Re: Coronavirus in Illinois Prisons

Dear Governor Pritzker:

The COVID-19 pandemic represents an unprecedented threat to men and women who are incarcerated in IDOC custody. These individuals are held in close quarters—several feet closer than the six-foot distance that you and the CDC have recommended for individuals not held in custody. They are simply not able to engage in the "social distancing" that public health officials have stressed is mandatory to combat the rate of illness. As a result, if any one of these individuals becomes infected with COVID-19, nearly everyone within the prison will face a dangerously high risk of becoming infected.

If and when (as is likely, given reports from countries like Italy who are experiencing our rate of infection just weeks ahead of the United States) IDOC prisons experience an outbreak, the prison's health system will be overwhelmed. That, in turn, is likely to overwhelm local outside hospital systems where sick prisoners are referred, which will render them unable to provide lifesaving treatment to the population—both incarcerated and free—that need it.

We are thankful that at this point IDOC does not have any positive cases. To avoid contamination, in addition to the steps already announced by IDOC, it is imperative that you take action to ensure that every individual in IDOC custody today who can be released in a way that is consistent with public safety, is released.

This administration has taken the lead across the country in ensuring that the threat faced by the COVID-19 pandemic is taken seriously. In keeping with this administration's initiative, we implore you to take the following immediate steps to protect the vulnerable individuals in IDOC custody, as well as the individuals who work there:

1. **Immediately order the release of individuals whose release dates are within 120 days.** These individuals have already worked with prison staff and those outside to confirm that they will be returning to a confirmed home site, and have release plans.

2. **Release all individuals in custody awaiting parole revocation hearings.** People previously on supervised release who are in IDOC custody because of non-violent parole violations and new charges that are bail eligible, and especially people in custody because of technical violations, should be released immediately.

3. **Prioritize release for any individuals whose release plans are pending host site approval.** These individuals have a place to return, but are simply waiting for IDOC to approve. These people should be prioritized, and once approved, immediately released.

4. **Order IDOC to stop taking people into custody for parole violations unless they present a clear and present danger of imminent physical harm, and rescind all parole warrants.** As we know from the information set out by your administration and the CDC, introducing new people into the prison population will only exacerbate the likelihood of an outbreak within the prison. IDOC should immediately stop taking any individuals into custody for parole or MSR violations unless their actions present a clear and present danger of imminent physical harm, and should withdraw all parole-related warrants.

5. **Release individuals with viable clemency petitions.** Several individuals have viable clemency petitions that are awaiting decision by this administration; anyone whose petitions are viable should be released immediately.

6. **Take all actions necessary to maximize good time credits.** Under Illinois law, 730 ILCS 5/3-6-3, the IDOC Director "may award up to 180 days of earned sentence credit for good conduct in specific instances as the Director deems proper." This provision should be used proactively to reduce the population in IDOC facilities.

7. **Evaluate individuals who are pregnant, postpartum, or living with their infants in IDOC programs.** Pregnant and postpartum women, as well as the babies in the Moms and Babies nursery, are particularly vulnerable to illness. People who are pregnant often have suppressed immune systems and can also have decreased lung capacity, complicating respiratory illnesses. High fevers can also lead to birth defects and miscarriage. The majority of pregnant people and participants in the Moms and Babies program have release dates within the next twelve months. Their release should be prioritized through all available means.

8. **Evaluate individuals with HCU living assignments and chronic care needs for consideration of early release.** These are vulnerable populations who require significant staff time and resources. If these individuals have sentences that allow

for consideration of any form of early release, and home placement options, steps should be taken to get them released as soon as possible.

9. **Take steps to limit intake into IDOC facilities.** As we are quickly learning from public health experts, the safest way to protect against outbreaks of COVID-19 is to limit the number of social interactions. We urge you to take action to decrease the number of individuals being taken into IDOC custody, including by placing any limits allowable on receiving, by asking courts and prosecutors to adjust sentencing priorities to avoid incarceration to the fullest extent possible.

10. **Ensure that the IDOC has the resources necessary to combat a possible COVID-19 outbreak in one or more IDOC facilities.** It is imperative that IDOC have the resources that it needs to provide supplies to both prisoners and staff. This must include unfettered access to soap and cleaning supplies for prisoners, and thermometers and protective gear for staff.

These actions are a necessary first step to minimize the likelihood of an outbreak in IDOC facilities, and to contain the virus within the state. Many of the individuals in IDOC custody are among the most vulnerable for catastrophe should an outbreak occur. We hope that you will approach their health as seriously as you have approached the health of the rest of the state.

The organizations below would welcome an opportunity to speak with you or members of your administration about how to effectively respond to this public health emergency and protect the health and safety of individuals and IDOC custody and the Illinois community.

Signed,

ACLU of Illinois
Chicago Community Bond Fund
Chicago Urban League
Children and Family Justice Center, Bluhm Legal Clinic,
Northwestern Pritzker School of Law
Community Justice and Civil Rights Clinic, Bluhm Legal Clinic,
Northwestern Pritzker School of Law
Equip for Equality
John Howard Association
Legal Council for Health Justice
Loevy & Loevy
Roderick and Solange MacArthur Justice Center
Shriver Center on Poverty Law
Uptown People's Law Center
Women's Justice Institute

cc: Lt. Governor Juliana Stratton
Director Rob Jeffreys
Chief of Staff Camile Lindsay
Gary Caplan, Office of the Governor
Christian Mitchell, Deputy Governor for Public Safety, Infrastructure, Energy & Environment

EXHIBIT

7

PURPOSE:

The State of Illinois must act with increased urgency to release individuals from incarceration who are at significant risk of harm from COVID-19, as well as those who require substantial medical and staff resources that should be preserved for the COVID-19 response.

The purpose of this document is to assist in identifying prisoners who are medically vulnerable, elderly, or resource-intensive (in terms of medical equipment, space and staff time) due to disability or medical condition. We also set forth steps that the Governor's Office and the IDOC must take to release or, where release is unavailable, to transfer individuals to other settings better able to care for their needs to the furthest extent possible.

I. Facility Identification of the High-Risk/Resource-Intensive Population

If IDOC has not done so already, IDOC must identify all prisoners (a) who are medically vulnerable with regard to COVID-19, (b) who are elderly, and (c) who require medical resources and staff time that should be devoted to COVID-19. As we understand it, IDOC may have already created a list that meets some of or all of these criteria. If this has not been done in any part, or if the current list was not prepared with facility-level medical input, IDOC should direct each facility, through its Medical Directors (MDs) and Health Care Unit Administrators (HCUAs), to create a list, or supplement its existing list, to include the following:

- People over age 55.

- People housed in Health Care Units (HCUs) who could reside at home with supports or services. While many of IDOC's sickest residents are housed in prison HCUs, not everyone who resides in a HCU would need inpatient care in the community. (We understand there is reluctance to release those who would need to be discharged to a community hospital.) For example, some people reside in HCUs because they need certain equipment (such as oxygen tanks) that could be dangerous inside the general prison population. People with paralysis are frequently housed in HCUs because they need assistance with activities of daily living. Others reside in HCUs

because they frequently see outside medical specialists for treatment of chronic conditions. Still others are receiving palliative or hospice care.

- People who are immunocompromised.

- People who are seen at chronic clinics.

- People who are pregnant, nursing, or in "moms and babies" programs. It should be easy for administrators at Logan or Decatur to determine who falls into this category.

Due to the urgency of this situation, the Governor should give IDOC facilities a strict deadline by which to identify these individuals, such as 24 hours.

II. Release High- Risk and Resource-Intensive Prisoners

All the individuals on this list are people who are either at risk of severe harm from COVID-19 and/or require regular medical resources that should be preserved to prepare for an outbreak within the system.

IDOC should utilize its authority and discretion, under existing law, to release as many individuals as possible. Maintaining custody of people in these categories presents a significant threat to public safety and health because of the devastating impact that an outbreak will have inside the prison, as well as on staff, local hospitals, and surrounding communities. Releases should be completed as quickly as possible. If COVID-19 becomes widespread in the prisons before vulnerable people are released, the influx of incarcerated people who become sick into community-based hospitals will without any doubt overwhelm their capacity, and cause avoidable deaths.

The Governor's Office needs to act decisively to insure that IDOC is fully exercising its authority to release as many people as possible from custody to the furthest extent possible, including by ordering IDOC to immediately:

- Issue administrative directives allowing for the transfer to home detention and/or electronic monitoring all individuals identified pursuant to Section I above who qualify under 730 ILCS 5/5-8A-3(d) and (e).

- Release to home detention and electronic monitoring all individuals within its authority to do so, including all people serving sentences for Class 2-4

felonies pursuant to 730 ILCS 5/5-8A-3(e), and all eligible people over the age of 55 who have less than 12 months left to serve on their sentence pursuant to 730 ILCS 5/5-8A-3(d). This reduction is necessary to allow for social distancing and to preserve IDOC's resources and medical staff for COVID-19 preparedness.

- In coordination with PRB, expeditiously return all IDOC-requested good time credit pursuant to 20 Ill. Adm. Code 107.160. IDOC should direct counselors at each institution to submit requests for good time restoration for all offenses other than for violations under Offense 102a.

- Award discretionary good time credit pursuant to 20 Ill. Adm. Code 107.210 to the furthest extent possible to all eligible individuals to facilitate immediate and continuing releases.

- Immediately lift all outstanding parole holds for people who are in custody (in both IDOC and local jails) awaiting preliminary and final revocation hearings. Communicate the release of parole holds to local Sheriffs, Public Defenders, States Attorneys and Judges.

Due to the state of emergency and significant threat to public safety, the Governor's Office must also expand the number of people eligible for release, including by:

- Immediately act to expand eligibility for release to home detention to all individuals identified pursuant to Section I above.

- Increase staffing of parole and field services, to the extent necessary, to facilitate IDOC's preparedness for a COVID-19 outbreak. Work in collaboration with social workers and other staff from nonprofit organizations to identify appropriate placements for people eligible for release, to expedite the pace of release.

- Direct State's Attorneys, Courts, and County Sheriffs to take immediate steps to release anyone who is either identified as elderly or medically vulnerable.
    - To expedite the timely release of medically vulnerable people, State's Attorneys should agree to resentence anyone identified by IDOC as medically vulnerable to time served.

  - Courts should act quickly on joint motions to release defendants who are being held pretrial, on motions to resentence defendants who are serving incarcerative sentences. Courts should grant motions on the paper submissions whenever possible, and should schedule any hearings expeditiously and telephonically. Courts should waive the presence of the defendant whenever possible.
  - Sheriffs should use their discretion broadly to reduce pre-trial detention to the furthest extent possible. Sheriffs should coordinate with other entities to reduce detention in all manners possible, including by communicating with IDOC to release parole warrant holds. Sheriffs should decline to arrest or cite low-level and misdemeanor conduct ,and should use cite-and-release authority whenever possible.

- The Governor's Office should use its broad clemency powers to initiate the commutation of sentences to time served for all people in the target categories listed in Section I who are not otherwise eligible for release pursuant to existing statutes and who (i) in addition to being identified in the categories laid out in Section I, have release dates within the next five years, and/or (ii) due to being over the age of 70 and/or due to severe medical condition (such as cancer), are in the highest category of risk of death as a result of COVID-19 infection, regardless of release date.

- The Governor's Office should direct the PRB to restore good time credit revocations to the furthest extent possible.

- The Governor's Office should conduct an expedited review of all pending commutation petitions, regardless of whether a hearing by the PRB has been scheduled or completed. This review should begin with any medical emergency commutation petitions that have been filed and then any petitions filed by individuals over the age of 55. Many clemency petitions include a reentry plan that can be immediately enacted.

- The Governor's Office should direct IDOC to immediately release all people who are awaiting parole revocation hearings on technical violations.

- The Governor's Office should direct IDOC to stop taking people into custody on technical parole violations. These people do not need to be in IDOC custody. With each new person processed into reception facilities, the risk of

COVID-19 outbreak grows. Additionally, the medical clearance process diversts valuable medical resources away from COVID-19 management.

- The Governor's Office should direct the PRB to convene telephonically to immediately review every C-number prisoner still in custody for immediate parole. These individuals, by definition, are all over the age of 60 (the majority are in their 70s), and therefore at extremely high risk of serious illness and death from COVID-19.

- The Governor's Office should take steps to expand 730 ILCS 5/3-6-3 to allow IDOC to award up to 360 days (from 180) of earned sentence credit for good conduct in specific instances as the Director deems proper.

III. Prioritize Resources to Facilitate Safe Releases Immediately

Steps must be taken to facilitate the immediate release of these individuals in the safest manner possible, including the following steps:

Expansion of Field Services: Field services should immediately execute release/transfer planning for all people identified pursuant to Sect. I above to determine all viable placement options. To the extent needed, Field Services could utilize other clinical staff resources to assist in identifying home placement options. Facilities should be directed to make this effort a priority. Facilities should also be given the discretion to identify other individuals in their custody who staff believe should be candidates for release.

Evaluate public host site requirements and remove barriers to host site approval that are not related to public safety. The requirements should be reviewed and any that are not essential to ensure re-entry should be abandoned. For example, host sites are often denied for lack of a landline phone despite the availability of other forms of communication. Another example is that some host sites have been denied because they are located in "high crime" neighborhoods. Given the statewide order to shelter in place, this should not be a barrier to placement at this time. Additionally, the Governor's Office should assist in expanding housing options connecting with community partners, universities, and grant providers for social services to explore new housing options.

Provision of State-Issued Identification: The Governor's Office should take immediate action to facilitate an interagency agreement or memorandum of

understanding between the IDOC and the Secretary of State's Office to immediately provide state identification to individuals who are, or are about to be, released. Many of these individuals will need identification in order to provide for themselves, including to obtain prescribed medications, but state offices that issue IDs are currently closed. This could be done in a number of ways, including by IDOC providing the photos and personal information needed directly to the Secretary of State to reduce the amount of in-person involvement needed by the individual.

Medicaid Expansion of Eligibility, Benefits and Enrollment: The state has flexibility to adapt its Medicaid programs to address COVID-19 and should take steps to expand eligibility and benefits and to make enrollment easier. The state may do this (without federal involvement) through state plan amendments (SPAs) or changes in policies and processes.

The Governor should bridge the necessary state agencies and IDOC to prioritize and require changes in the Medicaid program to specifically expedite the enrollment and benefits for all individuals identified in Sect. I above who are being released. While the state's Medicaid program may already be reviewing eligibility requirements more broadly, the Governor's Office must ensure that specific steps are taken to expedite the enrollment and benefits for those being released from IDOC, including by considering expanding a category of presumptive eligibility for those identified pursuant to Sect. I above. For more information, see: https://d28lcup14p4e72.cloudfront.net/245981/5087590/Medicaid%20flexibilities%20to%20address%20COVID19.pdf

Medical Documentation: Many of the individuals subject to Sect. I above will require immediate and ongoing medical care. The State or its vendor should therefore provide them a copy of their medical records without charge to facilitate their care.

For those released who are presumptively qualified for SSI benefits, we have attached a draft form that physicians can use to easily provide the needed documentation. This form should be provided to all facilities for immediate use.

Continuity of Care: To the furthest extent feasible, the State and the IDOC should take steps to:

- Provide at least a one month supply of prescription medications upon release. This is an increase from the current two-week supply issued in light of the

difficulty many may encounter with obtaining identification and finances to obtain their own medications.

- Schedule appointments for continuing care with any outside treaters currently utilized for the patient's care where the release is to the same community, or assist in identifying treaters as needed in the home community.

- Assist in providing resources and referrals for home services and health care. We will provide a list of resources.

- Provide the Social Security pamphlet to individuals identified in Sect. 1 above. https://www.ssa.gov/pubs/EN-05-10133.pdf

- Provide Medicaid/Medicare applications and the relevant phone numbers.

Amanda Antholt, Equip for Equality
Sheila Bedi, Community Justice Clinic at Northwestern Pritzker School of Law
Camille Bennett, ACLU of Illinois,
Jobi Cates, Restore Justice Illinois,
Thomas F Geraghty & Northwestern Pritzker School of Law, Bluhm Legal Clinic
Sarah Grady, Loevy & Loevy
Harold C. Hirshman, Dentons
Alan Mills, Uptown People's Law Center
Jennifer Soble, Illinois Prison Project
Sarah Staudt Chicago Appleseed
Vanessa del Valle, MacArthur Justice Center

EXHIBIT

8

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

Report of the 2nd Court Appointed Expert

Lippert v. Godinez

October 2018

Prepared by the Medical Investigation Team

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

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other state prison systems nationwide.[21] IDOC Spending in 2017 is still below the average 2015 spending of prisons nationwide.

Ten Lowest Per Capita Expenditures for Health Care in US State Prison Systems in 2015	
State	**Per Capita Annual**
Louisiana	$2,173
Alabama	$3,234
Indiana	$3,246
Nevada	$3,246
South Carolina	$3,478
Arizona	$3,529
Georgia	$3,610
Illinois	$3,619
Kentucky	$3,763
Mississippi	$3,770

For most state systems, the number of employees, age, and percent of female population were the largest drivers of cost of prison health programs. The Federal Bureau of Prisons assessed that institutions with the highest percentages of aging inmates spent five times more per inmate on medical care and 14 times more per inmate on medication than institutions with the lowest percentage of aging inmates. The National Institute of Corrections estimates that inmates over age 55 cost, on average, two to three times more than the expense for all other inmates.[22] Based on this same 2017 report, Illinois has the seventh *lowest* rate of persons over age 55 (8.5%). As well, in 2015 IDOC had a female population of 5.8%, the ninth *lowest* rate of females incarcerated in state prison systems. These two factors should lower the costs of care somewhat, but are not so great as to account for the difference in IDOC cost from the mean health expenditure of state prison systems.[23]

Staffing appears to be the biggest contributor to the low IDOC spending on health care. In fiscal year 2015, Illinois has the second lowest number of full-time equivalent (FTE) health care workers (19.3 per 1,000 inmates) of all 50 state prison systems. The range of FTEs per 1,000 in the 50 state systems range from 18.6 FTEs per 1,000 inmates to 86.8 FTEs per 1,000 inmates.[24]

[21] In his deposition, Mr. Brunk the Chief Financial Officer for the IDOC stated on pages 12-13 that the total expenditures on health care in the IDOC were approximately $203 million. Using a population of approximately 42,000 the expenditures per inmate per year would be approximately $4,800.

[22] Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

[23] Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

[24] Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

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

Key Findings

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

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

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

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

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

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

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

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

list of major responsibilities or tasks, except for addressing questions of the physician staff. Because neither IDOC nor Wexford performs effective review of clinical care of physicians, poorly performing physicians continue to perform poorly without apparent oversight. We noted this on multiple chart reviews and mortality reviews.

Wexford Regional Medical Directors are also responsible for ensuring patient care is consistent with community standards.[43] Yet we found many examples of physicians providing care inconsistent with current standards of care that appear to be systemic practices. For example, IDOC does not provide colorectal cancer screening based on current standards of care and does not appear to routinely screen patients with cirrhosis for varices or hepatocellular carcinoma. Persons with chronic obstructive lung disease (COPD) are not provided pulmonary function testing, which is a cornerstone of management of COPD. The current management of lipid disorders is not in line with current standards or with the Office of Health Services treatment guideline. We will discuss these later in the Chronic Disease section of this report. These deficiencies need to be corrected because these deficiencies have caused morbidity and mortality. There is no evidence of participation of the Wexford Regional Medical Team in identifying these deficiencies to the IDOC or ensuring that their physicians are practicing based on contemporary standards of care.

With respect to facility leadership, administrative supervision by HCUAs at individual facilities has improved since the First Court Expert's visit. The IDOC HCUAs are responsible for administrative operational supervision of each facility. Of the 26 HCUA positions, all but one is now filled. However, two of the HCUAs also serve as acting Regional Coordinators, making them much less effective as HCUAs. Effectively, only 23 of 26 HCUA positions are filled. HCUAs were all competent and were engaged in solving administrative problems, even though some problems appeared unrecognized. This is one of the most significant and positive advances since the First Court Expert's report and is a strength that the program can build on.

Medical Directors are all Wexford positions. Of the 26 Medical Directors statewide, 8.5 (33%) are vacant.[44] This is an enormous vacancy rate for this key leadership position. Approximately only half of physicians have training in primary care, which will be discussed later in this report. This is a very small percentage of physicians trained in primary care. When a Medical Director is not trained in primary care it is very difficult to be responsible for monitoring performance of medical staff rendering direct patient care. An untrained physician is not likely to know how that care is supposed to be provided. We found that onsite monitoring of clinical care was very poor to nonexistent.

Director of Nursing (DON) positions can be either Wexford or IDOC. Fifteen (58%) of the DON positions are staffed by Wexford. Eleven (42%) are staffed by the IDOC. Seven (27%) of DON positions are vacant; four DON vacancies are Wexford positions and three DON vacancies are

[43] Regional Medical Director's Responsibilities as provided by Wexford Health Sources.
[44] Illinois Medical Vacancy Report with ASRs as of 6/18/18 provided by the Attorney General's Office from Wexford Health Sources. This report gives staffing at all facilities as of 6/18/18.

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

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

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

IDOC Policy

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

Wexford Provider Staffing and Physician Credentialing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician Staffing

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

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

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

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

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

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

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

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

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

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

Non-Physician Staffing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the Warden. This appears to have resulted in procedures that accommodate custody needs even when it results in medication administration practices that violate nursing practice standards.

Further, we observed nurses floating medication well in advance of administration, which alters the medication's properties, and crushing medication that was put in the reused envelopes, which contaminates other medications put into the envelope. These practices put inmates at risk of receiving ineffective treatment and adverse drug reaction.

Medication Continuity

Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed. Chronic disease medications are provided to patients either as "Keep on Person" (KOP) or each dose is administered by a nurse. We found many examples of patients whose ordered medications were never provided, were delayed starting, and were stopped because the patient had not been seen by a provider to renew medication. Record reviews indicated that appointments for chronic care are not scheduled to take place prior to expiration of chronic disease medication orders. As a result, providers often reorder medications without seeing the patient to conduct a clinical evaluation to determine whether the treatment plan should be continued or changed, based upon the how well the patient's chronic disease is controlled.

Facility policy and procedures[162] direct that the MAR be available with the medical record at the time of a chronic care provider visit. However, we saw no evidence that current MARs were available at the time a patient saw a provider. We also saw no evidence that providers review the MAR and discuss the patient's adherence as part of chronic care appointments. Facility policy and procedures[163] also instruct nurses to refer patients to a provider for evaluation and possible change in treatment if they refuse to take prescribed medication. In the records we reviewed, there were multiple examples of patients not taking medication as prescribed who were not referred for provider evaluation.

Monitoring Performance

Pharmacy audits and inspections, which are done routinely, document the problems described above. These reports are reviewed and included in the institution CQI meetings. They document ongoing problems system wide with medication, including: use of the envelope rather than MAR to prepare medication; failure to document medication given on the MAR; failure to transcribe orders onto the MAR; administering medication for which there was no order, or when the inmate was not present at the facility; administering medications that differ from the order; documenting in advance that medication was administered; and the presence of open, undated, multi-use containers of medication. There has been some coaching and

[162] LCC, SCC, and DCC Operations Policy and Procedure P. 107 Management of Chronic Disease and MCC Policy and Procedure V3-12 Medical management of offenders with a chronic condition. No policies and procedures were provided for NRC.
[163] LCC, SCC, and DCC Operations Policy and Procedure P. 128 Medication Services and MCC Policy and Procedure V 4-1 Pharmacy Services. No policies and procedures were provided for NRC.

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

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

Infection Control

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

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

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

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

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

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

First Court Expert Findings

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

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

Current Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[175] Dixon Infection Control Patient #3.

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

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

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

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[176] Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and it is performed only upon patient consent. The IDOC has large rates of refusal of HIV testing, unlike other similar correctional centers that offer opt-out testing. Opt-out testing generally raises the rates of screening.

[177] Administrative Directive 04.03.11 Section5 II. F. 5. d.

[178] Mortality Review Patient #22.

[179] Smith, S. (2013) Infectious Diseases. In L. Schoenly and C. Knox (Eds.) *Essentials of Correctional Nursing*. New York: Springer. P. 189.

[180] MCC Infection Control Patient #7.

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

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

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

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

EXHIBIT

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

Prepared by:
John M. Raba, MD
Monitor

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I. Overview

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

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

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

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

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

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

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

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

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

EXHIBIT

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ILLINOIS DEPARTMENT OF CORRECTIONS
DIRECTOR'S OFFICE
SPRINGFIELD 62702

COVID-19 RESPONSE

JB PRITZKER
Governor

ROB JEFFREYS
Director

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

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

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

Alyssa Williams
Chief of Programs and Support Services

[redacted]

[redacted]

ILLINOIS DEPARTMENT OF CORRECTIONS

DIRECTOR'S OFFICE
SPRINGFIELD 62702

COVID-19 RESPONSE

JB PRITZKER
Governor

ROB JEFFREYS
Director

Memorandum

To: Men and Women in Custody

From: Alyssa Williams, Chief of Programs and Support Services

Date: March 20, 2020

Subject: Administrative Quarantine

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

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

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

The Department will continue offering the following services:

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

ILND 44 (Rev. 09/07/18)

CIVIL COVER SHEET

The ILND 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. ***(See instructions on next page of this form.)***

I. (a) PLAINTIFFS

James Money et. al.

(b) County of Residence of First Listed Plaintiff Cook
(Except in U.S. plaintiff cases)

(c) Attorneys *(firm name, address, and telephone number)*

DEFENDANTS

Rob Jeffreys, in his official capacities as Director of the Illinois Department of Corrections

County of Residence of First Listed Defendant
(In U.S. plaintiff cases only)

Note: In land condemnation cases, use the location of the tract of land involved.

Attorneys *(if known)*

II. BASIS OF JURISDICTION *(Check **one** box, only.)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 2 U.S. Government Defendant
- ☒ 3 Federal Question *(U.S. Government not a party)*
- ☐ 4 Diversity *(Indicate citizenship of parties in Item III.)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(For Diversity Cases Only.)*

*(Check **one** box, only for plaintiff and **one** box for defendant.)*

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

IV. NATURE OF SUIT *(Check **one** box, only.)*

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

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 463 Habeas Corpus - Alien Detainee (Prisoner Petition)
- ☐ 465 Other Immigration Actions

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

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

FEDERAL TAXES
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

V. ORIGIN *(Check **one** box, only.)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation ☐ 8 Multidistrict Litigation Direct File

VI. CAUSE OF ACTION (Enter U.S. Civil Statute under which you are filing and write a brief statement of cause.)

Pursuant to 28 U.S.C 2254

VII. PREVIOUS BANKRUPTCY MATTERS (For nature of suit 422 and 423, enter the case number and judge for any associated bankruptcy matter previously adjudicated by a judge of this Court. Use a separate attachment if necessary.)

VIII. REQUESTED IN COMPLAINT:

☐ Check if this is a **class action** Under rule 23, F.R.C.V.P. **Demand $**

Check Yes only if demanded in complaint.
Jury Demand: ☐ Yes ☒ No

IX. RELATED CASE(S) IF ANY *(See instructions)*

Judge Case Number

X. Is this a previously dismissed or remanded case? ☐ **Yes** ☒ **No** **If yes, Case #** **Name of Judge**

Date 4/2/2020

Signature of attorney of record /s/ Vanessa del Valle

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority for Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I. (a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.

United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.

United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.

Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.

Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; NOTE: federal question actions take precedence over diversity cases.)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If the nature of suit cannot be determined, be sure the cause of action, in Section VI below, is sufficient to enable the deputy clerk or the statistical clerk(s) in the Administrative Office to determine the nature of suit. If the cause fits more than one nature of suit, select the most definitive.

V. Origin. Place an "X" in one of the six boxes.

Original Proceedings. (1) Cases which originate in the United States district courts.

Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.

Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.

Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.

Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.

Multidistrict Litigation. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407. When this box is checked, do not check (5) above.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. Do not cite jurisdictional statutes unless diversity. Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. Previous Bankruptcy Matters For nature of suit 422 and 423 enter the case number and judge for any associated bankruptcy matter previously adjudicated by a judge of this court. Use a separate attachment if necessary.

VIII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P. Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

IX. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

X. Refiling Information. Place an "X" in the Yes box if the case is being refiled or if it is a remanded case, and indicate the case number and name of judge. If this case is not being refiled or has not been remanded, place an “X” in the No box.

Date and Attorney Signature. Date and sign the civil cover sheet.