IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

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

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

EXPEDITED CONSIDERATION REQUESTED

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INTRODUCTION

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

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

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

FACTUAL BACKGROUND

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

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

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

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

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

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

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[2] Dr. Beyrer, Professor of Epidemiology, International Health, and Medicine at Johns Hopkins Bloomberg School of Public Health, regularly teaches courses on the epidemiology of infectious diseases. This semester he is teaching a course on emerging infections. He is a member of the National Academy of Medicine, a former president of the International AIDS Society, and a past winner of the Lowell E. Bellin Award for Excellence in Preventive Medicine and Community Health. Beyrer Decl., ¶ 1.

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

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

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

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

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

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

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

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

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

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

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

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[7] *Id.* at 1.

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

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

For these reasons, Dr. Beyrer concludes that "additional outbreaks of COVID-19 are extremely likely," so that "releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole." *Id.* ¶ 34.

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

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

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

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

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

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

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

The Hopkins Faculty Letter makes the following recommendations:

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

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

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

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

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

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

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

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

Fathi Decl. Ex. D at 2-3.

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

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

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

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

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

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

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

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

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

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

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

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

ARGUMENT

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

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

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

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

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

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

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

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

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

deliberate indifference standard applies. *See, e.g.*, *Hill v. Nicodemus*, 979 F.2d 987, 991 (4th Cir. 1992) ("[P]rison officials violate [a] detainee's rights to due process when they are deliberately indifferent to serious medical needs."); *see also Young v. City of Mount Rainier*, 238 F.3d 567, 575 (4th Cir. 2001) ("[D]eliberate indifference to the serious medical needs of a pretrial detainee violates the due process clause.").[11]

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

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

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

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

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

[11] In *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015), the Supreme Court held that, unlike the standard applied to convicted prisoners' excessive force claims under the Eighth Amendment, the standard for pretrial detainees' excessive force claims under the Fourteenth Amendment includes no subjective component. *Id.* at 2472-73. While some courts have extended *Kingsley* to medical care claims brought by pretrial detainees (*see, e.g.*, *Gordon v. County. of Orange*, 888 F.3d 1118, 1124-25 (9th Cir. 2018)), the Fourth Circuit has not yet decided this issue.

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

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

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

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

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

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

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

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

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

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

Fathi Decl, Ex. A at 1.

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

CONCLUSION

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

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

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

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

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

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

Respectfully submitted this 9th day of April, 2020.

/s/
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