IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No.: 20-cv-977-PAB

THOMAS CARRANZA, *et al.*,

Plaintiffs, on their own and on behalf of a class of similarly situated persons,

v.

STEVEN REAMS, Sheriff of Weld County, Colorado, in his official capacity,

Defendant.

PLAINTIFFS' REPLY TO DEFENDANT'S RESPONSE [DOC. #26]
AND SUPPLEMENTAL RESPONSE [DOC. #41]

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1. **Defendant's actions have not been sufficient to moot[1] any of Plaintiffs' requested relief.**

Due process requires that detainees in a jail be protected from conditions that "pose an unreasonable risk of serious damage to . . . future health." *Helling v. McKinney*, 509 U.S. 25, 35 (1993). Plaintiffs all face a heightened risk of serious illness or death if they contract COVID-19, which is the very definition of a "substantial" risk of "serious harm."

> [Defendant's] arguments fail to address the stark reality of this particular global public health crisis. In the face of a deadly pandemic with no vaccine, no cure, limited testing capacity, and the ability to spread quickly through asymptomatic human vectors, a "generalized risk" *is* a "substantial risk" of catching the COVID-19 virus for any group of human beings in highly confined conditions[.]

Malam v. Adducci, No. 20-10829, 2020 U.S. Dist. LEXIS 59407, at *26-28 (E.D. Mich. Apr. 5, 2020). It is indisputable "that the most effective way of preventing [COVID-19] infection is

[1] Unlike plaintiffs in *Nellson v. Barnhart*, Plaintiffs' requested relief would add "additional measures beyond defendants' current screening, testing, and isolation procedures." No. 20-cv-00756-PAB, 2020 U.S. Dist. LEXIS 66971, at *15 (D. Colo. Apr. 16, 2020). Further, as discussed below, there is a demonstrably wide gulf between Defendant's purported policies and Defendant's actual practices related to mitigation of the spread of COVID-19 in the jails.

avoiding interaction with those who are infected—more specifically, not touching them or the things they touch, and not breathing the air they breathe." *Essien v. Barr*, Civil Action No. 20-cv-1034-WJM, 2020 U.S. Dist. LEXIS 72422, at *14-15 (D. Colo. Apr. 24, 2020).[2] As such, it cannot pass constitutional muster that Plaintiffs, who are medically vulnerable, continue to be forced to share facilities with others who may be infected with a deadly virus, and particularly be forced to do so without putting in place basic, evidence-based measures to keep them safe. *Gates v. Collier*, 501 F.2d 1291, 1300-1303 (5th Cir. 1994) (cited with approval in *Helling*, 509 U.S. at 34).[3] Defendants' failure to take the below-outlined basic measures, all of which Plaintiffs' expert says are necessary to protect high risk inmates, unreasonably risks Plaintiffs' lives.

First, Defendant has failed to take the single most important measure to stop the spread of COVID-19: physical distancing[4] of all inmates from one another (and staff when not necessitated by facility security) within the Weld County Jail.[5] Defendant has failed to take the following reasonable steps (relating to physical distancing) to protect Plaintiffs from COVID-19:

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[2] The conditions in the Weld County Jail are worse than those described by the court in *Essien*, where the court held that detainees had demonstrated that it was likely that they would catch the virus where they spent "sixteen hours a day in a 7 x 9 foot cell—usually two to a cell"; shared "a toilet and a sink"; shared cells that were part of a "pod that currently houses 49 total detainees" where those in the pod shared space that is "only one half [the size] of a basketball court"; shared "seven shower stalls, which are cleaned once per day" with the other members of their pod; and received only one "paper facemask" with no certainty as to when it would "be replaced" they. 2020 U.S. Dist. LEXIS 72422, at *14-15.

[3] *See also Forbes v. Edgar*, 112 F.3d 262, 266 (7th Cir. 1997); *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996).

[4] The key feature of physical distancing is that individuals be able to keep at least 6 feet apart from other individuals. **Exhibit 1**, *Expert Declaration Of Carlos Franco-Paredes*, p. 10-11.

[5] Again, Plaintiffs request that, should Defendant not be able to ensure that Plaintiffs are protected from COVID-19 exposure through physical distancing, this Court order the transfer of a sufficient number inmates to electronic home monitoring to allow for appropriate physical distancing within the Weld County Jail. This Court, sitting as a single judge, may order that Defendant transfer prisoners to a safe facility or form of custody of his choosing. An order that prisoners be transferred to receive adequate medical care or to be removed from areas where they would be exposed to deadly diseases is not a "prisoner release order" within the meaning of the PLRA and,

(1) Plaintiffs (individuals that are considered high-risk by accepted medical guidelines) have not been meaningfully physically distanced from other inmates, some of whom are likely to be infected with COVID-19. **Ex. 1**, pp. 1-3, 9-11.[6] Currently, in different units, and particularly in the B and C units and in one of the transition units, individuals with high-risk comorbidities are housed in cells with one to three other cellmates. *Id.*, p. 8.
(2) High-risk individuals are not being identified, prioritized for single-celled housing, or provided additional protective measure to increase physical distancing. *Id.* Instead, the high-risk individuals are housed and treated like the other inmates. *Id.*[7] This was "confusing" to Dr. Franco-Paredes given that, in most of the units, there are many empty cells that remained unused, while other cells hold two to four people. *Id.*

Second, Defendant has failed to implement appropriate policies and protocols to identify inmates who are possibly carrying COVID-19 and quarantine those inmates from other individuals. Defendant's isolation practices are focused singularly on highly symptomatic inmates, which is a patently unreasonable response in the face of research reflecting that at least 40% of viral spread is caused by asymptomatic people. This phenomenon is playing out in Colorado's prisons right now.[8] And, as Plaintiffs' expert explains, it is likely playing out in the Weld County Jail, where asymptomatic and mildly symptomatic inmates in general population are likely contagious and spreading the virus. Plaintiffs' expert observed no practices that

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therefore, may be issued by a single-judge court. Under the PLRA, a "prison" is a "Federal, State, or local facility that incarcerates or detains." 18 U.S.C. § 3626(g)(5). Plaintiffs are not asking that they be sent anywhere other than a safe facility that incarcerates them—that is a place that "confin[es]" them, *see* Black's Law Dictionary, *Incarceration* (11th ed. 2019) —and, therefore, they do not seek a "prisoner release order" under the PLRA. *See Gray v. Cnty. of Riverside*, No. 13 C 0444, Dkt. 191, at pp. 4-5 (C.D. Cal. Apr. 14, 2020) (recognizing that an order directing a sheriff to transfer detainees to a safer location is not a "prisoner release order").

[6] *Coronel v. Decker*, 2020 U.S. Dist. LEXIS 53954, 2020 WL 1487274, at *5 (S.D.N.Y. Mar. 27, 2020) (finding that containment efforts were inadequate where it took no "specific action to prevent the spread of COVID-19 to high-risk individuals," such as isolation or "special safety or hygiene protocols").

[7] Defendant's response admits that Plaintiffs (who are clearly vulnerable individuals) have not been identified by Defendant's supposed protocol for identifying medical vulnerable individuals. [Doc. #41], p. 11.

[8] This is no more evident than in the Sterling Correctional Facility where "the Department of Corrections performed prevalence testing after only a few confirmed cases of COVID-19 and a minimal number of symptomatic inmates" and the result was that "138 out of 255 inmates tested positive for the virus." **Ex. 1**, p. 9.

addressed the likelihood of asymptomatic inmates or ensured immediate isolation and testing of individuals who had one or more mild symptoms of COVID-19. **Ex. 1**, p. 8. Inmates who report fever and cough in the Weld County Jail still are provided with Tylenol, rather than COVID-19 screening, preventative isolation, and testing. *Id.* Moreover, it is clear that some individuals who were admitted to the medical isolation unit (Unit 11) of the Weld County Jail were released from medical isolation in around a week's time (less than the CDC-recommended quarantine period) and were placed in cells with other inmates who had not been in quarantine. *Id.*

Third, Defendant continues to fail to implement daily thorough and professional disinfecting and sanitizing of the Weld County Jail. Defendant implicitly admits that he is not having the Jail professionally cleaned (and not on an adequately regular basis). [Doc. #34], p. 34. Plaintiffs' expert learned as much during his visit to the Jail. **Ex. 1**, p. 9; *Cristian A.R. v. Decker*, Civil Action No. 20-3600, 2020 U.S. Dist. LEXIS 66658, at *34-35 (D.N.J. Apr. 12, 2020) (noting failure to clean posed unreasonable risk to inmates of contracting COVID-19).[9]

Finally, while there has been incremental progress on some measures that Plaintiffs requested when they filed this lawsuit, "as prisons and courts around the country are beginning to

[9] The Court in *Cristian A.R.* found unconstitutional conditions that are markedly better than those in the Weld County Jail: "Petitioners spend 23.5 hours a day in cramped cells that they have to share with another person and the remaining thirty minutes out of their cells in common areas. It is during those thirty minutes that the detainees are at high risk for COVID-19 exposure and transmission. That brief period is the only time they have each day to take showers, make telephone calls to family members and attorneys, visit the commissary, and use recreation areas. Coming into close contact with frequently used items and shared spaces is unavoidable. Respondents do not state the Facilities clean and sanitize the common areas and frequently-touched common items in-between each period during which new detainees and inmates leave their cells. Instead, they provide that cleaning occurs at least three or four times per day. Accordingly, even crediting the Facilities' increased efforts to clean and disinfect shared spaces, Respondents cannot dispute that many, if not all, detainees use the common areas and objects in-between cleanings and are being exposed to potentially contaminated surfaces. Detainees also report that corrections officers' and medical staff's use of gloves and masks is inconsistent and certainly not in line with the CDC's recommendations, further compounding their risk of exposure."

recognize, such measures are insufficient to stem deadly prison outbreaks." *Malam*, 2020 U.S. Dist. LEXIS 59407, at *26-28. The requested relief that has been partially implemented includes:

(1) Providing hygiene supplies, including supplies to wash hands and disinfect common areas, to inmates at all times and free of charge,
    a. While hygiene products have been provided to inmates, cleaning is left entirely to inmates and is voluntary; shared toilets and sinks are often not cleaned between uses; staff do not clean nor do they mandate that inmates clean between uses, **Ex. 1**, p. 9;
(2) Providing personal protection equipment, including but not limited to masks, to all staff members and inmates,
    a. While surgical masks have been provided to inmates, they have been forced to wear the same mask for approximately 10-12 days, in contravention of public health guidelines **Ex. 1**, pp.. 9, 11;
(3) Taking particularly heightened precautions with respect to food handling and delivery,
    a. There is no evidence that the inmates who are handling food are exempt from the above-outlined problems within the Weld County Jail, including lengthy use of the same personal protective equipment and failure to appropriately socially distance within food preparation areas;
(4) Providing accurate, up-to-date educational and informational materials regarding sanitation and prevention of COVID-19, the status of how COVID-19 is affecting the facility including the number of infected inmates and staff, and daily access to news reports regarding COVID-19,
    a. While Defendant has provided a video with educational materials, it has not informed inmates about the status of how COVID-19 is affecting the facility.

2. **The constitutionally inadequate COVID-19 response at the Weld County Jail is fully attributable to the final policymaker for the Jail: Defendant Reams.**[10]

2.1 **Defendant Reams is a final policymaker.**

Defendant "is a final policymaker with regard to [the Weld County] jail, such that his actions 'may fairly be said to be those of the municipality.'" *Lopez v. LeMaster*, 172 F.3d 756, 763 (10th Cir. 1999) (quoting *Bd. of the Cty. Comm'rs v. Brown*, 520 U.S. 397, 404 (1997)); *see*

[10] Contrary to Defendant's arguments, Plaintiffs need not plead a separate claim to implicate Defendant under *Monell*. In fact, doing so is improper. Municipal liability is simply another theory of liability for a particular constitutional claim, not a stand-alone legal claim. *See, e.g.*, *Whiting v. City of Cathedral City*, No. EDCV 13-250-BRO(CW), 2014 U.S. Dist. LEXIS 64002, at *12 n.2 (C.D. Cal. Apr. 23, 2014) ("Supervisor liability or municipal liability is not a separate claim for relief or cause of action, but a theory on why a supervisor or municipal defendant is liable on a claim or cause of action."); *Romero v. Bd. of Cty. Comm'rs*, 202 F. Supp. 3d 1223, 1267 (D.N.M. 2016) (Browning, J.).

also Layton v. Bd. of Cty. Comm'rs, 512 F. App'x 861, 870-72 (10th Cir. 2013). A decision by municipal policymakers on a single occasion could satisfy the "official policy" requirement of *Monell. Pembaur v. City of Cincinnati*, 475 U.S. 469 (1986). Where action is directed by a "final policymaker," the municipality is equally responsible whether that action is taken only once or repeatedly. *Id*. at 484-85.[11]

Here, Defendant possesses final policymaking authority in the operation of the Weld County Jail and his decisions regarding the Jail's response to COVID-19, in and of themselves, are the decisions of Weld County. "[F]inal policymaking authority is a legal issue to be determined by the court based on local and state law." *Randle v. City of Aurora*, 69 F.3d 441, 447 (10th Cir. 1995) Colorado law explicitly grants that Defendant, as the elected Sheriff of Weld County, "shall have charge and custody of the jails of the county, and of the prisoners in the jails, and shall supervise them himself or herself or through a deputy or jailer." C.R.S. § 30-10-511. Defendant's authority as to the operation of the Weld County Jail is unlimited and unchecked.[12] In accordance with the undeniable fact that Sheriffs have complete authority over the operation of their county jail, courts have consistently found that Colorado sheriffs are final policymakers when it comes to the operation of jails. *E.g. Cortese v. Black*, 838 F. Supp. 485, 495-96 (D. Colo. 1993) (holding that Larimer County Sheriff was a "final policymaker"); *Carrillo v. Suthers*, 2014 U.S. Dist. LEXIS 184359, *32 (D. Colo. December 29, 2014) (noting that "a sheriff is typically the final policymaker for matters concerning the operations of a county jail").

The circumstances of Defendant's authority make clear that he is a final policymaker for the Weld County Jail's response to COVID-19. Defendant is in charge of the day to day decisions

[11] *See Jett v. Dallas Indep. Sch. Dist.*, 491 U.S. 701, 736-38 (1989); *City of St. Louis v. Praprotnik*, 485 U.S. 112 (1988).
[12] *See, e.g.*, C.R.S. §§ 30-10-503, 504, 506 and 522.

at Weld County Jail -- i.e., Defendant is not "meaningfully constrained by policies not of that official's own making," Defendant's decisions are "final -- i.e., are [not] subject to any meaningful review," and the decision in how to respond to COVID-19 is "within the realm of [his] grant of authority" at state law. *Randle*, 69 F.3d at 448. Defendant makes no argument that he answers to anyone, let alone another governing body within Weld County, for his decisions within the Weld County Jail. In fact, Defendant voluminously outlines the unilateral actions he has taken within the Jail within the last two months. *See* [Doc. #26]; [Doc. #41]. This is quintessential final policymaker behavior.

2.2 **Defendant Reams has been, and continues to be, deliberately indifferent.**

The deliberate indifference exhibited by Defendant prior to the filing of this lawsuit is outlined extensively in Plaintiffs' Motion for Temporary Restraining Order. [Doc. #1], pp. 40-45. Then, Plaintiffs filed this lawsuit. If Defendant had any argument before that he was unaware of the deficiencies in his response to COVID-19, the Complaint itself served to put him on notice. And, Defendant has received further notice from the supplemental filings (including declarations). Yet, in the ensuing weeks, Defendant has abjectly failed in a number of regards (as outlined, *supra*, **Section 1**). The failure to remedy ongoing constitutional violations is "evidence of deliberate indifference on the part of a municipality." *Layton*, 512 F. App'x at 870-72.[13] Defendant's deliberate indifference has been clear. And, as a final policymaker, Defendant's conscious disregard, alone, of the risks presented by COVID-19 is enough to support municipal liability. *Id.* at 872.

2.3 **Defendant's inaction continues to unreasonably risk the spread of COVID-19.**

[13] *See also Brown*, 520 U.S. at 407 ("[A finalpolicymaker's] continued adherence to an approach that they know or should know has failed to prevent tortious conduct by employees may establish the conscious disregard for the consequences of their action—the 'deliberate indifference'—necessary to trigger municipal liability." (quoting *City of Canton*, 489 U.S. at 390 n.10)).

Defendant Reams' inaction, in the face of mounting evidence that a serious outbreak was likely to transmit COVID-19 to Plaintiffs, is the "moving force" behind the violation of Plaintiffs' constitutional rights. *Brown*, 520 U.S. at 404. Defendant's continuing failure to take the above-outlined appropriate action demonstrates a "direct causal link," *see Brown*, 520 U.S. at 404, between Defendant's (in)action and Plaintiffs' risk of catching COVID-19 and suffering serious illness or death. *Layton*, 512 F. App'x at 870-72 (finding deliberate indifference where sheriff knew of problems with the jail's medical care, could have "taken any number of possible remedial actions", but chose not to act). Therefore, if this Court finds that Plaintiffs have demonstrated that they are exposed to an unreasonable and unconstitutional risk of harm from COVID-19 by the Weld County Jail's lack of response to the COVID-19 pandemic, Defendant is liable as the final policymaker for the Jail.[14]

3. **Plaintiffs' requested relief complies with the PLRA's requirements.**

Contrary to Defendant's assertions, an injunction ordering Plaintiffs' requested relief meets the criteria required by the PLRA. The PLRA's guidance "must be undertaken in light of both the magnitude of existing constitutional violations and the available alternative remedies." *Morales Feliciano v. Rullan*, 378 F.3d 42, 54 (1st Cir. 2004). Plaintiffs ask that this Court "do no more than to order [correctional] officials to [comply with the constitution] in general terms and to verify that the plan they submit satisfies the relevant constitutional standards[.]" *Westefer v. Neal*, 682 F.3d 679, 686 (7th Cir. 2012). It is not this Court's duty to micromanage Defendant's implementation of Plaintiffs' requested relief (and, Defendant himself asks this Court not to do so in accordance with principles of federalism and comity, [Doc. #26]. p. 39). Plaintiffs have not

[14] *See Layton*, 512 F. App'x at 870-72 (holding that a sheriff's "willingness—demonstrated by inaction—to permit seriously ill inmates to remain unmonitored in their cells evinces deliberate indifference for purposes of establishing municipal liability").

outlined hyper-specific relief but rather have asked the Court to order "defendant to draft and promulgate a plan, which leaves to the defendant discretion to determine the details of how to deliver the relief ordered." *Pierce v. County of Orange*, 761 F. Supp. 2d 915, 947-48 (C.D. Cal. 2011).

Further, with respect to the weight this Court must give to any adverse impact on public safety or the operation of a criminal justice system, 18 U.S.C. § 3626(a)(1), public safety is served by the requested relief because "[c]learly the public has an interest in preventing the further spread of COVID-19." *Rafael L.O.*, 2020 U.S. Dist. LEXIS 62389, 2020 WL 1808843, at *9.[15] And, as noted above, Plaintiffs requested relief provides Defendant with flexibility to ensure efficiency.

4. **Irreparable Harm,[16] Balance of Equities, and the Public Interest.[17]**

[15] *See also Bent v. Barr*, No. 19-cv-06123-DMR, 2020 U.S. Dist. LEXIS 62792, at *22-24 (N.D. Cal. Apr. 9, 2020) ("Given that additional burdens on the health system in this crisis may lead to a greater number of deaths among the public, public health considerations cannot be ignored in assessing… risk to the community.").

[16] As the Supreme Court observed in *Helling*, "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." 509 U.S. at 33.Plaintiffs "who all suffer from underlying medical conditions, may have a 20% chance of death if they contract COVID-19 (according to preliminary data from China), and they are detained in facilities where the virus is still spreading." *Cristian A.R. v. Decker*, Civil Action No. 20-3600, 2020 U.S. Dist. LEXIS 66658, at *38-39 (D.N.J. Apr. 12, 2020). They "cannot practically adhere to social distancing guidelines or the adequate level of personal hygiene, that have been touted as the most effective means to thwart the spread of the virus." *See Rafael L.O.*, 2020 U.S. Dist. LEXIS 62389, 2020 WL 1808843, at *8. Certainly the threat of death qualifies as irreparable harm.

[17] Defendant spends a majority of his briefing on these subjects, leading the court on a wild goose chase. (Plaintiff does not request the release of inmates but, as a last resort, Plaintiff asks this Court to transfer inmates to home confinement, which is dramatically different than release). With that being said, Plaintiffs acknowledge that Defendant and the public have an interest in ensuring Plaintiffs' appearance at future court proceedings as well as preventing danger to the community should they be transferred to home confinement. However, numerous courts "have recognized the shifting nature of these interests in light of the COVID-19 pandemic" and held that even release serves the public interest. *Bent*, 2020 U.S. Dist. LEXIS 62792, at *22-24 (collecting cases).

Plaintiffs acknowledge that Defendant and the public have an interest in institutional security, community safety, and the efficient use of government resources. However, Plaintiffs requests will not affect these interests because Defendant has full authority as to how to implement them. And, a chorus of courts now recognized that a risk to public safety "requires considering all factors," including the "substantial medical and security challenges [that] would almost certainly arise" in the event of a COVID-19 outbreak in a prison or detention facility. *Bent*, 2020 U.S. Dist. LEXIS 62792, at *22-24 (collecting cases). Simply put, preventing the spread of COVID-19 in the Weld County Jail is in line with the interests that Defendant raises: it will benefit public safety, reduce use of government resources (preventative medicine is always cheaper than more intensive procedures), and increase institutional security (should the outbreak escalate a shortage of healthy deputies will almost certainly occur).

5. **This Court should not require bond in this case.**[18]

Defendant cites to no authority in his request for $1,000,000 bond. There is precedent, however, supporting Plaintiffs request that no bond be required in this case. 11A Charles Alan Wright et al., *Federal Practice & Procedure* § 2954 n.29 (3d ed., Apr. 2016 update) (citing civil rights cases where the bond was excused or significantly reduced).

6. **Conclusion and Requested Relief.**

Plaintiffs have attached an amended order, outlining only the relief that is *essential* (and narrowly tailored) to ensuring that Plaintiffs are not exposed to an unreasonable risk of contracting COVID-19. *See* **Exhibit 2**.

Dated: April 28, 2020

Respectfully submitted,

[18] Plaintiffs are inmates who are being held in jail because they cannot afford bond, and they do not seek damages in this lawsuit.

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CERTIFICATE OF SERVICE

I hereby certify that on April 28, 2020, I electronically filed the foregoing **PLAINTIFFS' REPLY TO DEFENDANT'S RESPONSE [DOC. #26] AND SUPPLEMENTAL RESPONSE [DOC. #41]** with the Clerk of the Court using the CM/ECF system which will send notification to the following counsel.

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EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No.: 20-cv-00977-PAB-MEH

THOMAS CARRANZA, et al.

Plaintiffs, on their own and on behalf of a class of similarly situated persons,

v.

STEVEN REAMS, Sheriff of Weld County, Colorado, in his official capacity,

Defendant.

EXPERT DECLARATION OF CARLOS FRANCO-PAREDES

A) The impact of the COVID-19 pandemic

The catastrophic consequences of the current COVID-19 pandemic in terms of human and social disruption costs obeys to two major factors: (a) the transmissibility of this infection and (b) the severity of the disease in human populations. Globally, as of today, there are 2,790,936 confirmed cases and 195,920 deaths. In the U.S., there are an increasing number of COVID-19 cases and deaths. Since March 16, 2020, the epidemiologic curve demonstrates a logarithmic increase in the number of cases with many major epicenters of transmission as it has occurred in the Pacific Northwest, New York, New Jersey, Florida, California, and Louisiana. Every U.S. state is dealing with COVID-19 cases and the number of deaths continue to pile up. As of today, there are approximately 890,524 cases and 51,017 deaths demonstrating that community-based transmission clearly continues to occur.

B) Medically vulnerable populations

There is growing number of confirmed cases in the U.S., increasing number of hospitalizations and admissions to intensive care units, and many deaths. In this wave of the pandemic or in subsequent ones, it is likely the number of infected individuals may continue to occur.

According to the CDC, there are groups of individuals deemed at high risk to developing severe disease and dying from this infection including those above 50 years of age and those with underlying medical conditions (regardless of their age) **(See Table).** These cases are also amplifiers or hyper-spreaders of the infection since they tend to have high viral concentrations in their respiratory secretions.

The clinical experience in China, South Korea, Italy, France, and Spain has shown that 80% of confirmed cases tend to occur in persons 30-69 years of age regardless of having any underlying medical conditions. Of these, 20% develop severe clinical manifestations or become critically ill. Among those with severe clinical manifestations regardless of their age or underlying medical conditions, progress to respiratory failure, septic shock, and multiorgan dysfunction requiring intensive care support including the use of mechanical ventilator support. The overall case fatality rate is 10-14% of those who develop severe disease. In China, 80% of deaths occurred among adults $\geq$ 60 years.

As of March 16, 2020, cases of COVID-19 in the U.S. reported by the CDC shows that 31% of COVID-19 cases, 45% of hospitalizations, and 80% of deaths occurred among adults aged > 65 years of age. Case-fatality in persons aged >85 ranging from 10-27%, followed by 3-11% among persons aged 65-84 years, 1% among persons aged 55-64 and <1% among persons aged 20-54 years of age.

Table 1. Risk factors for developing severe disease and death

Age groups at high risk of developing severe disease and dying without underlying medical conditions	$\geq$50 years (1% CFR)* 60-69 years (3.6% CFR) 70-79 years (8% CFR)
High risk groups of dying with underlying medical conditions regardless of their age	-Cardiovascular disease (congestive heart failure, history of myocardial infarction, history of cardiac surgery) -Systemic Arterial Hypertension (High Blood Pressure) Chronic respiratory disease (asthma, chronic obstructive pulmonary disease including chronic bronchitis or emphysema, or other pulmonary diseases) -Diabetes mellitus -Cancer

	-Chronic Liver Disease -Chronic Kidney Disease -Autoimmune Diseases -Severe Psychiatric Illness ** -History of transplantation -Immune suppression (HIV/AIDS, glucocorticoids, other immunosuppressant drugs, history of smoking) -Pregnancy

*CFR= Case Fatality Rate is an indicator used during outbreaks to identify the number of individuals who succumb out of those who become infected ** In South Korea, 20% of deaths occurred in what they defined as Psychiatric Illness (J Korean Med Sci 2020; 35(10): e112).

Preliminary data has shown that 20 percent of people in high-risk categories who have contracted COVID-19 have died

Reports by the Chinese CDC, demonstrates that the case fatality rate is highest among critical cases in the high-risk categories with COVID at 49%. case fatality was higher for patients with comorbidities: 10.5% for those with cardiovascular disease, 7% for diabetes, and 6% each for chronic respiratory disease, hypertension, and cancer. Case fatality for patients who developed respiratory failure, septic shock, or multiple organ dysfunction was 49%.

For people with these risk factors, COVID-19 can severely damage lung tissue, which requires an extensive period of rehabilitation, and in some cases, can cause a permanent loss of respiratory capacity.

There is preliminary evidence that persons with COVID-19 and recovering from severe disease and progress to extensive pulmonary disease including Acute Respiratory Distress Syndrome (ARDS). Long term sequelae of those with sepsis, ARDS and respiratory failure identified in the literature include long-term cognitive impairment, psychological morbidities, neuromuscular weakness, pulmonary dysfunction, and ongoing healthcare utilization with reduced quality of life and need for rehabilitation services.

COVID-19 may also target the heart muscle, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work.

The full description of the pathogenesis of COVID-19 requires to be completely elucidated. However, there is clinical evidence that in addition to the severe lung injury associated to this viral infection, some persons may also develop myocardial involvement that appears to be the result of either direct viral infection or micro-thrombosis of the myocardial vasculature. From the published case reports, myocarditis caused by this viral pathogen is associated with congestive heart failure, cardiac arrhythmias and death[j]. Similar to other viral myocarditis, most patients may develop long-term myocardial damage[k].

Among persons infected with SARS-CoV-2 and developing COVID-19 severe disease systemic inflammation is associated with adverse outcomes. However, there is evidence that the use of corticosteroids have not shown benefit and they might be more likely to harm when administered in persons with ARDS caused by COVID-19. Similar to influenza infection, acute lung injury and acute respiratory distress syndrome caused by the respiratory epithelial membrane dysfunction leading to acute respiratory distress syndrome. Preliminary evidence from case reports and small cases series from China and South Korea confirm that there is minimal inflammation and evidence of cell necrosis in the form of apoptosis of the respiratory epithelium. The resultant tissue hypoxia is responsible and potential concomitant bacterial sepsis contribute to multiorgan dysfunction and death. If a patient with COVID-19 develops myocarditis, cardiogenic shock caused by fulminant myocarditis may also contribute to the overall occurrence of multiple organ failure.

Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner

There is evidence of substantial undocumented infection facilitating the rapid dissemination of novel coronavirus SARS-CoV-2 which is responsible for 79% of documented cases of CoVID-19 in China. Once an individual is exposed to this virus from either a symptomatic individual (21% of cases) or from asymptomatic individuals (79% of cases), the shortest incubation period is 3 days with a median incubation period of 5.1 (95% CI 4.5 to 5.8 days). Overall, 97.5% of persons who develop symptoms, do so within 11.5 days of the initial exposure.

Most persons with COVID-19 who develop severe disease do so immediately after admission or within 3-5 days from their initial presentation and representing 53% of those requiring intensive care unit admissions and advanced supportive care.

There is sufficient evidence that the SARS-CoV-2 pandemic has an overwhelming impact in healthcare utilization in all settings (China, South Korea, Italy, France, Germany, and others). In the U.S., current evidence demonstrates that COVID-19 can result in severe disease, including hospitalization (31%) and admission to an intensive care unit (53% of ICU admissions). To respond to this overwhelming demand in ICU admissions, there is a need for a multidisciplinary approach that is time-consuming and requires highly-trained personnel including pulmonary and critical care physicians, nurses, respiratory therapists, phlebotomists, social workers, case managers. The care of this group of patients also requires subspecialists including nephrologists, infectious disease physicians, hematologists, hospitalists, and others. Patients on mechanical ventilation or requiring extracorporeal membrane oxygenation require additional staff including perfusionists and 1:1 dedicated nursing care. Currently, many medical centers in urban and rural settings in the U.S. are functioning at full capacity. It is therefore important to note that in the potential outbreak occurring within an immigration detention center, the number of detainees that will require transfer outside the facility for specialized care may exceed the capacity of local

healthcare systems. This is particularly important in rural and semirural settings where many immigration detention centers are located, and where they may have contact with a limited number of local medical centers.

Numerous organizations and research studies have used the age of 55 to define the lower limit of older detainees at risk of developing severe COVID-19 disease. This consensus is based on the fact that detained people have consistently been identified as having higher levels of health problems that reflect 10-15 years more progressed than chronological age.

C) Jails and prisons in the U.S. are increasingly becoming epicenters of COVID-19 transmission

Over my 20 years of experience as an infectious disease clinician, I have provided care at outpatient clinics and during inpatient consultation services in infectious diseases to a large number of patients residing in jail and prison populations. A copy of my CV is presented in Exhibit A.

As an infectious disease clinician with a public health degree in the dynamics of infectious disease epidemics and pandemics, I am concerned about the inevitable spread of COVID-19 in jails, prisons, community corrections facilities, and juvenile detention centers. The conditions in these facilities do not allow for appropriate infection control protocols and will make the current COVID-19 pandemic worse. Incarcerated populations have higher rates of underlying illness and, by extension, will have a higher case fatality rate. It is now clear that asymptomatic individuals can spread this infection. With staff traveling between their homes and the facilities, and newly arrested individuals brought in as others are released, containment of the virus is not possible. Prisons and jails are becoming the epicenter of COVID-19 transmission in the U.S. I can also certify that incarcerated individuals have a higher prevalence of chronic medical conditions that place them at high risk of developing severe coronavirus disease and potentially dying from this infection. Some of these medical conditions include HIV/AIDS, uncontrolled diabetes mellitus, chronic obstructive pulmonary disease, and other conditions**.**

Like other viral pathogens, SARS-CoV-2 is closely dependent on the complexity of human behavior and human interactions. There are many documented outbreaks of respiratory pathogens in jails and prisons in many countries. Custodial institutions have been the epicenter of outbreaks of infections amongst prisoners amplifying infections at rates far exceeding those in non-incarcerated communities. Highly transmissible viral infections such as measles, mumps, and the novel coronavirus disseminates rapidly among inmates and staff and potentially into the larger community. Overcrowding, insufficient sanitation, poor ventilation, and inadequate healthcare in prisons contribute to enabling these institutions as breeding grounds of infectious disease outbreaks. Detention and incarceration involves large groups of people living in cohorts in confined spaces creating many challenges for curbing the spread of COVID-19. The number of single rooms in jails or prisons are insufficient to adhere to the recommended isolation and quarantine guidelines and limits the ability to implement stringent infection prevention practices.

The SARS-CoV-2 ability to survive for prolonged periods on highly prevalent materials in custodial settings including non-porous surfaces and metallic surfaces complicates disinfection

practices. It is exceedingly difficult to comply with established infection prevention protocols recommending repeated disinfection and decontamination of all surfaces in jails and prisons resulting from the large number of inmates and complex human patterns of interactions between inmates and with the staff. A recent natural experiment inside a cruise ship demonstrated the rapid spread of the SARS-CoV-2 among large crowds inside a closed environment. A total of 696 cumulative cases of COVID-19 and 9 deaths occurred among the 3711 passengers inside the Princess Diamond Cruise berthed at the port of Yokohama, Japan from February 03 to March 1, 2020. The most recent estimates demonstrate that the basic reproduction number of the SARS-CoV-2 is higher than previously estimated (R_0= 5.6) and higher than the influenza virus A/H_1N_1 that caused the 1918-1919 pandemic. In contrast to influenza viruses, transmission of this coronavirus occurs by those with undetected infection having mild symptoms or asymptomatic infection in up to 20% of cases. Thus, transmission of this viral pathogen in closed spaces with a large presence of individuals increases the frequency of exposure and infection. Without complete social distancing in imprisonment settings, our ability to reduce the transmission dynamics to achieve a R_0 less than one is limited.

The current outbreak of the novel coronavirus (SARS-Co-2) in different county jails and prisons in the U.S. highlights the ease of transmission of COVID-19 behind walls of jails and prisons. There is sufficient experience with this pandemic demonstrating that congested living conditions facilitate the spread of this infection. Jails and prisons are epicenters for infectious diseases because of the unavoidable close contact in often overcrowded, poorly ventilated, and unsanitary conditions. On April 14 the Bureau of Federal Prisons reported 446 cases among inmates and 248 cases among employees in 42 facilities and 11 Residential Reentry Centers (RRCs). However, by April 19, there were 495 cases among inmates, 309 cases among staff, and 22 deaths distributed in 45 facilities and 19 RRCs. There are at least 1,300 confirmed cases of COVID-19 tied to prisons and jails with at least 34 deaths when combining prisons and jails nationwide as per different reports. The revolving door of jails have fueled an increasing number of documented outbreaks in custodial institutions.

It is a major challenge for security staff to practice hospital-level infection control measures to protect them from becoming infected with the novel coronavirus. In a hospital or nursing home, staff may move up and down a single hallway over their shift, and they may interact with one patient at a time. In detention settings, officers move great distances, are asked to shout or yell commands to large numbers of people, routinely apply handcuffs and operate heavy doors/gates, operate large correctional keys and are trained in the use of force. These basic duties cause the personal protective equipment they are given to quickly break and become useless, and even when in good working order, may impede their ability talk and be understood, in the case of masks. For officers working in or around patients at risk or with symptoms, there may be an effort to have them wear protective gowns, as one would in any other setting with similar clinical risks. These gowns cover their radios, cut down tools and other equipment located on their belts and in my experience working with correctional staff, are basically impossible to use as a correctional officer.

An additional concern for transmission in carceral settings is the fact that COVID-19 may be potentially transmitted through aerosolized fecal contact or contact with infected feces when using an infected toilet. This is relevant because the plume of aerosolized fecal material that occurs when a toilet is flushed is not addressable by closing the lid of ICE detainee toilets, which

lack a lid. This mode of transmission would pose a threat to anyone sharing a cell with a person who has COVID-19 and could occur before a person becomes symptomatic. This mode of transmission could also extend beyond cellmates, especially in circumstances where common bathrooms exist or where open communication between cells exists.

D) Situational analysis of the State of Colorado and Weld County

The State of Colorado has 10,447 confirmed cases of COVID-19 with 486 deaths. After Denver County and Arapahoe County, Weld County is the third county with the highest number of cases (1353) and the third with the highest number of deaths (84).

E) Weld County Jail

Informational Sources related to the Weld County Jail.

In preparing the portion of this declaration related to conditions of the Weld County Jail, I have reviewed all of Plaintiffs' declarations in this case, as well as Sheriff Reams' declaration and the declarations attached to Defendant's Supplemental Response [ECF 39]. I also performed two jail inspections that lasted approximately three hours each, once on April 10 and once on April 24. Between those two inspections, I spoke with 13 incarcerated persons about conditions in the jail and I spoke with several correctional staff and medical staff. I found the Weld County correctional staff to be forthright and welcoming, and they were open to questions and gave me ample opportunity to speak openly with inmates who chose to converse with me. Likewise, I found the inmates with whom I spoke to be open and forthright, and their accounts were largely consistent with one another of the relevant conditions in the jail related to COVID-19.

April 10 Inspection

I had the opportunity to tour the Weld County Jail and interview some members of the medical staff and inmates on April 10.

As of April 10, Weld County staff reported to me that Weld County Jail had 14 COVID-19 cases, including 6 with positive tests and 8 presumptive cases. On April 10, they had isolated these 13 people in Unit 11 (Medical Isolation Unit). At least one of the inmates with COVID housed in the jail was receiving supplemental oxygen. A fifteenth person was COVID-19 positive at the jail, but so sick as to need hospital transfer. I learned from staff and through an in-person interview that, in mid-March, that Mr. Anthony Griego was the 14th case that was transferred to a local hospital due to the severity of his illness. He then returned to the jail but was then transferred back to the hospital on April 23 or 24 because of worsening symptoms.

Since the April 10 tour, I have learned that another Weld County inmate, Charles Peterson, was reportedly released from the Weld County Jail very sick Monday March 30. According to his death certificate, Mr. Peterson was 78 years old and, thus, high risk for serious illness or death under CDC guidelines. His death certificate also indicates congestive heart failure and diabetes mellitus as underlying conditions, both of which would put Mr. Peterson in a high risk category even absent his advanced age. He had reportedly been in the jail since March 11. Upon his release, he was reportedly taken almost immediately to the hospital. He died there two days later on April 1, 2020. His death certificate lists "COVID-19 infection" as a cause of death, along with acute respiratory failure and viral pneumonia, which are commonly caused by COVID-19 infection.

Based on my conversations with staff and inmates on April 10, as well as inmate accounts conveyed in declarations filed in this case, it appears that before April 7 or April 8, Weld County Jail was not adhering to CDC guidance recommendations in a meaningful manner.

Mr. Peterson and Mr. Griego were likely what has been defined as 'superpreaders' of the infection. Theywere reportedly sick and kept in general population without social distancing, and they likely acted as the epicenter of the outbreak in the Weld County Jail. Because of age and underlying illness, they both developed severe disease.

There were two jail units under quarantine.

During my inspection, I observed and received information from correctional officers and inmates that Weld County Jail was implementing some mitigating interventions according to CDC guidelines including reducing the jail population and spreading inmates out to decrease the numbers within cells; staggering pod time and limiting the number of people on the pod at any given time; providing inmates with masks, isolating sick inmates; performing limited testing of sick inmates; making cleaning supplies more readily available, and providing some education regarding COVID-19 to inmates. I saw evidence of these changes, but noted several substantial deficiencies which remained in the April 24 inspection, and which I describe further below.

April 24 Inspection

During the first inspection, there were 13 inmates in the medical unit with a combination of probable and confirmed COVID-19 cases. After today's inspection, there were only 7 COVID-19 cases in the male medical unit. I observed that four of them were receiving supplemental oxygen and several of them were bunked two to a cell. There are currently no units on quarantine.

In different units, particularly in the B unit and in one of the transition units, I observed that individuals with high-risk comorbidities were housed in cells with between one and three other cellmates where social distancing is not possible. I did not see evidence that high risk individuals were being identified for single-celled housing or increased social distancing. The high risk individuals I interviewed were housed and treated like the other inmates.

This was a bit confusing given that in most of the units I visited, there were many empty cells that remained unused, while the occupied cells held 2 to 4 people.

I learned that some individuals that were admitted to the medical isolation unit (Unit 11) stayed less than the recommended quarantine period as per CDC guidelines, and were released from medical isolation in around a week's time. They were then placed in cells with other inmates who had not been in quarantine.

I also spoke to several inmates who had experienced symptoms consistent with COVID-19, including cough or fever. These inmates had not been tested for COVID-19 and remained housed with other cell mates with whom they could not practice social distancing.

I saw no practices to address the likelihood of asymptomatic inmates. I saw no practices that reflected immediate isolation and testing of individuals who had one or more mild symptoms of COVID-19. Inmates consistently reported that fever and cough resulted in the provision of Tylenol, rather than COVID-19 screening, preventative isolation, and testing.

All inmates, except those in medical isolation, reported that they rarely if ever have their temperature checked and they are not asked by staff about symptoms of COVID-19.

Most inmates reported that cleaning is left entirely to inmates and is voluntary; that shared toilets and sinks are often not cleaned between uses, that staff do not clean nor do they mandate that inmates clean between uses.

Most inmates are housed in dry cells, locked down 22 ½ hours a day without access to supplies to clean their hands unless they are let out of their cell to use the common bathroom.

While all inmates had a disposable mask, they also all reported that they had only had two masks in the last 14 days. As a result, they had the to wear one disposable mask for between 10-12 days before they got a new one.

One major concern observed today is that Unit A, which during the initial inspection was a quarantined unit - where it is likely the place where COVID-19 outbreak initiated - is now used as an intake unit. Inmates that were housed in unit A were transferred a few days ago to units B and C. Without testing those inmates in unit A prior to their transfer for the presence of asymptomatic coronavirus infection, they could introduce the infection to these two other units. In fact, this is likely given the fact that asymptomatic infection may be responsible for 44% of coronavirus transmission.

OPINION

The leadership and the staff at the Weld County Jail have instituted a substantial number of interventions to mitigate the impact of COVID-19 and improve the safety of the inmate population. Additionally, I would like to note that the Deputy Officers and other staff who participated during these two inspections were extremely collaborative during the two inspections conducted at Weld County Jail (April 10 and April 24). It is also my opinion that there is the willingness and the openness to listen to potential recommendations that may strengthen existing efforts to improve the safety of the inmates and the staff.

As recent evidence indicates from other jails in other States and more recently from Sterling prison in Colorado, the presence of even a small outbreak of cases of COVID-19 only indicates the tip of the iceberg of a larger number of undetected cases in those with no symptoms or mild symptoms, which constitutes approximately 80% of cases. In Sterling Correctional Facility, where the Department of Corrections performed prevalence testing after only a few confirmed cases of COVID-19 and a minimal number of symptomatic inmates, 138 out of 255 inmates tested positive for the virus. There is evidence that during an outbreak 20% or more persons have no symptoms and temperature screens are not helpful. This 20% may be responsible for 44% of the transmission of the novel coronavirus. As Mr. Dean Williams, Director of the Colorado Department of Corrections stated today in a new release: *"Given the insidious nature of this virus we had suspected that despite seeing a relatively low number of inmates with symptoms, the number of positives was potentially much higher"*

It is my opinion that when reviewing Weld County Jail data received April 24, it is unclear why despite having only 9 individuals in isolation with 8 COVID-19 positive tests, there are no inmates in quarantine. Since Weld County Jail had 14 COVID-19 cases combining confirmed and probable cases only two weeks ago, at a time when some meaningful social distancing had only just begun, it is likely that if testing to

confirm evidence of infection is done, it may probably reveal many asymptomatically infected inmates potentially spreading the infection. This scenario is what is currently seen at Sterling Prison in Colorado and in Ohio. It is my opinion that without substantial testing of previously quarantined individuals and increased single-celling, that the virus is likely to continue to spread in the jail, putting high risk inmates at a substantial risk of serious illness or death.

After conducting these two inspections of the Weld County Jail, where I had the opportunity to speak with inmates and staff and observed the dynamics of the different units, it is my opinion that additional interventions are necessary to protect inmate, staff and ultimately community safety. Herein, is a summary of these recommendations:

- **This unprecedented pandemic calls for unprecedented measures in every setting but particularly in congregate settings.**
    - No one inside Weld County Jail or outside living in the larger community is safe until there is interruption of coronavirus transmission.

- **Implementing CDC protocols to mitigate Covid-19 transmission in Weld County Jail is not sufficient unless social distancing is meaningfully implemented.**
    - Reducing the inmate population to allow for social distancing is the cornerstone of reducing the impact of this highly transmissible viral pathogen.
    - Social distancing requires inmates maintaining a distance of at least six feet from each other, disinfection of key areas (telephones and toilets), mask use, and regular handwashing must be meticulously followed. These protocols are necessary to prevent spread of COVID-19 among otherwise healthy people. However, these protocols are imperative for high-risk individuals. Without these protocols, high-risk individuals face a substantial risk of serios illness or death from the virus.
    - Reduction of population should occur to allow the maximum amount of social distancing possible, with a guarantee of social distancing for high risk inmates, discussed further below.

- **Prevention of exposure to the novel coronavirus**
    - Institute directives for all inmates in all units to use disinfectant and clean telephones after each use.
    - Institute directives for all inmates in all units to use disinfectant prior to the use and after using toilettes.
    - Enforce guidance on bed positions:
        - For single beds positioned next to each other (side-to side): At least 6 feet apart and inmate's laying position is head to toe
        - For bunkbeds that are positioned next to each other or across from one another: Position beds at least 6 feet apart. Ensure the inmate's laying position is head to toe on each separate bunk bed, so positioning allows for the least transmission risk as possible. This includes laying position that is head to toe with adjacent bunks.
    - Enforce social distancing practices of all inmates in all units during med-line or meal-line
    - Sick inmates should not be required to clean their own cell and no inmate should clean up after other inmates.

- Professional janitorial services should be brought in to disinfect the male medical isolation unit or any unit, which may become quarantined in the near future.
- Professional janitorial services or trained staff should thoroughly clean each unit every night.

- **Inmates at high-risk of severe disease and dying from COVID-19 infection need to be identified, and then either released or provided 24-7 social distancing.**
  - Medically vulnerable inmates are at a substantial risk of contracting, spreading and becoming seriously ill or dying from COVID-19 in any carceral setting, particularly in a place like Weld County Jail that is experiencing an outbreak. To the greatest extent possible, medically vulnerable inmates should be released.
  - To the extent that inmates at risk of severe disease or death cannot be released, medically vulnerable individuals should be housed in single-person cells to mitigate the risk of serious illness or death to this population. For example, from today's inspection, I would consider that Mr. Richard Barnum and Mr. Jesus Martinez should not be placed in a cell other 3 inmates. Mr. Barnum has chronic kidney disease and chronic liver disease (see above table for medically vulnerable populations). Mr. Jesus Martinez has a history of asthma and hypertension, which places him at-risk of severe disease and should therefore be housed preferentially in a solo cell.
  - During the intake, it is imperative to enhance efforts to identify inmates at high-risk of COVID-19 complications to guide enforcement of social distancing interventions such as placement in a single cell.
  - All current inmates should be immediately screened to determine if they meet the criteria for high risk noted in Table 1.

- **Personal Protective Equipment**
  - There is a need to replace with more regularity disposable surgical masks that inmates are currently wearing. While there are no specific guidelines stating how long a surgical mask should be replaced in carceral settings, I do recommend to exchange masks at least every third day but definitely no longer than five days since it will lose its barrier function. The initial set of masks were only replaced approximately 14 days after.
  - The use of washable cloth masks may be an alternative and a cost-effective alternative.

- **Expanding testing capabilities for COVID-19 at Weld County Jail to ensure interruption of transmission and to guide isolation and quarantine interventions.**
  - There is increasing evidence and recent publications to suggest that expanding testing capabilities will improve isolation and quarantine strategies in congregate settings.
  - Given the rapid spread of COVID-19 across the U.S. and the globe based on the clear evidence of the novel coronavirus SARS-CoV-2 transmission from asymptomatic persons broadened SARS-CoV-2 testing to include asymptomatic persons in prioritized settings such as jails.

- There is evidence from jails and prisons in other settings that despite having excellent infection control practices, suggested social distancing interventions, keeping the door open for new introductions may only flatten the epidemiologic curve of cases. However, it will not definitively halt the occurrence of new cases in settings where there is ongoing sustained community transmission as it has occurred in the larger community in Weld County.
- As shown in custodial settings in Ohio, the rate of asymptomatic and symptomatic infection in an enclosed jail environment could reach up to 70% (with more than 20% asymptomatic infection).A similar ration of symptomatic to asymptomatic ratio was identified and reported today at Sterling Prison in Colorado.
- Priorities for testing:
  - Test newly admitted for novel coronavirus infection even if asymptomatic to reduce the risk of new introductions into Weld County Jail. There is no other way to effective screen asymptomatic people at intake.
  - Any inmate at Weld County Jail with one or more symptoms consistent with COVID-19 should undergo a clinical assessment including testing for the presence of the novel coronavirus SARS-CoV-2 in nasopharynx.
  - All inmates recently released from Unit A should be tested. For those who are positive, any of their new cellmates should be tested. During an outbreak, testing asymptomatic exposed will reduce the chances of spread to other units. For example, there may be individuals that were transferred from Unit A where the outbreak may have initiated and who completed an appropriate quarantine period in the A unit. However, they may have asymptomatic infection despite having normal temperature and normal screening for symptoms and now that they were transferred to unit B may actually be silent spreaders. Within unit B, it his individual with asymptomatic infection is housed in a cell with an at-risk individual, this practice may cause this cellmate to become severely ill and in turn, disseminate the infection to others. Those with severe symptoms have high concentrations of coronavirus in their respiratory secretions.
  - Ideally, all Weld County inmates and staff should be tested, but prevalence testing is a reasonable alternative.

- Intake Unit. At intake, there is no way to protect high risk individuals from potential exposure other than a single-cell environment. Under no circumstances should high-risk individuals be placed in a cell with any other person prior to the 14 day quarantine.

- **Adhering to CDC quarantine and isolation guidelines.**
  - A14-day quarantine should be used for: a) asymptomatic individuals exposed to a case; and, b) new arrestees and bookings (unless specific testing for coronavirus is performed as suggested above).
  - Medical isolation practices should be implemented for those with symptoms consistent with COVID-19 regardless of having any underlying comorbidity to develop severe disease.

- Inmate with a positive COVID-19 test should be placed in isolation (as should persons with symptoms consistent with COVID-19 pending test results). Those with a negative test should be placed in quarantine with close clinical monitoring and if indicated repeat testing.
- Transferring those exposed to a case may spread further this infection, if testing for COVID-19 is not conducted among asymptomatic individuals, even if the quarantine period was completed according to guidelines. Screening for symptoms and temperature is insufficient to stop the spread of this highly transmissible virus given the high risk of transmitting the infection by asymptomatic individuals.

I declare under penalty of perjury that the statements above are true and correct to the best of my knowledge.

Date: April 24, 2020

Carlos Franco-Paredes, MD, MPH, DTMH (Gorgas)

Associate Professor of Medicine

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33. Gransky M, Keller A, Venters H. Death rates among detained immigrants in the United States. In J Environ Res Public health 2015; 12, 14414-14419.
34. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. PLoS Med 2006; 3(10); e449.
35. Hotez PJ. Neglected infections of poverty in the United States of America. PLoS Negl Trop Dis 2008; 2(6): e256.
36. Franco-Paredes C, Santos-Preciado JI. Freedom, justice, and the Neglected Tropical Diseases. PLoS Negl Trop Dis 2011; 8: e1235.
37. The Guardian. Data form US south shows African Americans hit hardest by COVID-19. https://www.theguardian.com/world/2020/apr/08/black-americans-coronavirus-us-south-data. Accessed: April 12, 2020.
38. MMWR. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020; March 27, 2020: 69(12): 339-342.
39. The United States Department of Justice. Aging in Prison. National Institute of Corrections. Available at: https://nicic.gov/aging-prison. Accessed: April 24, 2020.

40. Williams BA, Stern MF, Mellow j, Safer M, Greifinger RB. Aging in correctional custoy: setting a policy agenda for older prisoner health care. Am J Public Health 2012; 102(8): 1475-1481.
41. Ghandi RT, Lynch JB, Del Rio C. Mild or moderate Covid-19. N Engl J Med 2020; April 24. DOI: 10.1056/NEJMcp2009249.
42. Gandhi M, Yokoe DS, Havlir DV. Asymptomatic transmission, the Achilles' Heel of current strategies to control Covid-19. N Engl J Med 2020. April 24. DOI: 10.1056/NEJMe2009758.
43. Arons MM, Hatfield KM, Reddy SC, et al. Presymptomatic SARS-CoV-2 infections and transmission in a skilled nursing facility. N Engl J Med 2020. DOI: 10.1056/NEJMoa2008457.
44. Sharsftein JM, Becker SJ, Mello MM. Diagnostic testing for the novel coronavirus. JAMA 2020; 323(15): 1437-38.
45. He X, Lau EHY, Wu P, et al. Temporal dynamics in viral shedding and transmissibility of COVID-19. Nature Med 2020; DOI: 10.1038/s41591-020-0869-5.
46. Chen Y, Chen L, Deng Q, et al. The presence of SARS-CoV-2 RNA in feces of COVID-19 patients. J Med Virol. 2020 Apr 3. doi: 10.1002/jmv.25825.
47. Colorado Official State Web Portal. Available at: https://covid19.colorado.gov/outbreak-data. Accessed: April 24, 2020.

1

EXHIBIT A.

PERSONAL INFORMATION
Carlos Franco-Paredes, M.D., M.P.H.

CURRENT PROFESSIONAL POSITION AND ACTIVITIES:

- Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus and Infectious Diseases (July

2018 - ongoing).

- Fellowship Program Director, Division of Infectious Diseases, University of Colorado Denver School of Medicine, Anschutz Medical Campus (March 2019- ongoing).

EDUCATION

1989 -1995	M.D. - La Salle University School of Medicine, Mexico City, Mexico
1996-1999	Internship and Residency in Internal Medicine, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002	Fellowship in Infectious Diseases, Emory University School of Medicine Affiliated Hospitals, Atlanta, GA
1999-2002	Fellow in AIDS International Training and Research Program, NIH Fogarty Institute, Rollins School of Public Health, Emory University, Atlanta, GA
1999 - 2002	Masters Degree in Public Health (M.P.H.) Rollins School of Public Health, Emory University, Atlanta, GA, Global Health Track
2001-2002	Chief Medical Resident, Grady Memorial Hospital, Emory University School of Medicine, Atlanta, GA
2006	Diploma Course in Tropical Medicine, Gorgas. University of Alabama, Birmingham and Universidad Cayetano Heredia, Lima Peru

CERTIFICATIONS

1999-Present	Diplomat in Internal Medicine American Board of Internal Medicine (Recertification 11/2010-11/2020)
2001-present	Diplomat in Infectious Diseases, American Board of Internal Medicine, Infectious Diseases Subspecialty (Recertification 04/2011-04/2021)
2005-present	Travel Medicine Certification by the International Society of Travel Medicine
2007-present	Tropical Medicine Certification by the American Society of Tropical Medicine – Diploma in Tropical Medicine and Hygiene (DTMH - Gorgas)

EMPLOYMENT HISTORY:

- 2002 - 2004 - Advisor to the Director of the National Center for Child and Adolescent Health and of the National Immunization Council (NIP), Ministry of Health Mexico; my activities included critical review of current national health plans on vaccination, infectious diseases, soil-transmitted helminthic control programs; meningococcal disease outbreaks in the jail system, an outbreak of imported measles in 2003-2004 and bioterrorism and influenza pandemic preparedness. I represented the NIP at meetings of the Global Health Security Action Group preparation of National preparedness and response plans for Mexico

- 2005 – 2011- Co-Director Travel Well Clinic, Emory University

Emory Midtown Hospital

- 2004- 8/2009 -Assistant Professor of Medicine
  Department of Medicine, Division of Infectious Diseases
  Emory University School of Medicine, Atlanta GA
- 3/2008-10/2009 Consultant WHO, HQ, Geneva, Influenza Vaccine
- 9/2009- 3/2011 Associate Professor of Medicine
  Department of Medicine, Division of Infectious Diseases
  Emory University School of Medicine, Atlanta GA
- 1/2007 – 3/2011 Assistant Professor of Public Health
  Hubert Department of Global Health
  Rollins School of Public Health, Emory University, Atlanta GA
- 4/2011 –5/2013 - Associate Professor of Public Health in Global Health
  Hubert Department of Global Health
  Rollins School of Public Health, Emory University, Atlanta GA
- 2010 - WHO HQ Consultant for a 4-month-period on the Deployment of H1N1 influenza vaccine in the African Region, Jan to March 2010, Switzerland Geneva, WHO HQ 2010 sponsored by John Snow Inc. USAID, Washington, D.C.
- 2014-2015 - Consultant International Association of Immunization Managers, Regional Meeting of the Middle Eastern and North African Countries and Sub Saharan Africa, held in Durban South Africa, Sept 2014; and as rapporteur of the Inaugural Conference, 3-4 March 2015, Istanbul, Turkey.
- 3/2011- 5/2017 - Phoebe Physician Group –Infectious Diseases Clinician Phoebe Putney Memorial Hospital, Albany, GA.
- 5/2015 - 9/2015 - Consultant Surveillance of Enteric Fever in Asia (Pakistan, Indonesia, Bangladesh, Nepal, India) March 2015-October 2015.
- June 19, 2017-June 31, 2018–Visiting Associate Professor of Medicine, Division of Infectious Diseases, University of Colorado Denver, Anschutz Medical Campus
- June 2004- present - Adjunct Professor of Pediatrics, Division of Clinical Research, Hospital Infantil de México, Federico Gómez, México City, México. Investigador Nacional Nivel II, Sistema Nacional de Investigadores (12/2019); SNI III Sistema Nacional de Investigadores (1/2020-); Investigador Clínico Nivel E, Sistema Nacional de Hospitales

HONORS AND AWARDS

1995 Top Graduating Student, La Salle School of Medicine
1997 Award for Academic Excellence in Internal Medicine, EUSM

1999 Alpha Omega Alpha (AOA) House staff Officer, EUSM

2002 Pillar of Excellence Award. Fulton County Department of Health and Wellness Communicable Disease Prevention Branch, Atlanta GA

2002 Emory University Humanitarian Award for extraordinary service in Leadership Betterment of the Human Condition the Emory University Rollins School of Public Health

2002 Winner of the Essay Contest on the Health of Developing Countries:

Causes and Effects in Relation to Economics or Law, sponsored by the Center for International Development at Harvard University and the World Health Organization Commission on Macroeconomics Health with the essay "*Infectious Diseases, Non-zero Sum Thinking and the Developing World"*

2002 *"James W. Alley"* Award for Outstanding Service to Disadvantaged Populations, Rollins School of Public Health of Emory University May 2002. Received during Commencement Ceremony Graduation to obtain the Degree of Masters in Public Health

2006 Golden Apple Award for Excellence in Teaching, Emory University, SOM

2006 Best Conference Award Conference, "*Juha Kokko*" Best Conference Department of Medicine, EUSM

2007 "*Jack Shulman*" Award Infectious Disease fellowship, Excellence in Teaching Award, Division of Infectious Diseases, EUSM

2007 Emerging Threats in Public Health: Pandemic Influenza CD-ROM, APHA's Public Health Education and Health Promotion Section, Annual Public Health Materials Contest award

2009 National Center for Preparedness, Detection, and Control of Infectious Diseases. Honor Award Certificate for an exemplary partnership in clinical and epidemiologic monitoring of illness related to international travel. NCPDCID Recognition Awards Ceremony, April 2009. CDC, Atlanta, GA

2012 The ISTM Awards Committee, directed by Prof. Herbert DuPont, selected the article "Rethinking typhoid fever vaccines" in the Journal of Travel Medicine (Best Review Article)

2012 Best Clinical Teacher. Albany Family Medicine Residency Program

2018 Outstanding Educator Award – Infectious Diseases Fellowship, Division of Infectious Diseases, University of Colorado, Anschutz Medical Center, Aurora Colorado

EDITORSHIP AND EDITORIAL BOARDS

2007-Present Deputy/Associate Editor PLoS Neglected Tropical Disease

Public Library of Science

2017-2018 Deputy Editor, Annals of Clinical Microbiology and Antimicrobials

BMC

2007-2019 Core Faculty International AIDS Society-USA -Travel and Tropical Medicine/HIV/AIDS

INTERNATIONAL COMMITTEES

2018- Member of the Examination Committee of the International Society of Travel Medicine. Developing Examination Questions and Proctoring the Certificate in Traveler's Health Examination
Proctor Certificate of Traveler's Health Examination (CTH) as part of the International Society of Travel Medicine– 12th Asia-Pacific Travel Health Conference, Thailand 21-24 March 2019
Proctor Certificate of Traveler's Health Examination (CTH), Atlanta, GA, September, 2019

PUBLICATIONS

BOOKS

Franco-Paredes C, Santos-Preciado JI. Neglected Tropical Diseases in Latin America and the Caribbean, Springer-Verlag, 2015. ISBN-13: 978-3709114216 ISBN-10: 3709114217

Franco-Paredes C. Core Concepts in Clinical Infectious Diseases, Academic Press, Elsevier, March 2016. ISBN: 978-0-12-804423-0

RESEARCH ORIGINAL ARTICLES (clinical, basic science, other) in refereed journals:

1. Del Rio C, **Franco-Paredes C**, Duffus W, Barragan M, Hicks G. Routinely Recommending HIV Testing at a Large Urban Urgent-Care Clinic – Atlanta, GA. *MMWR Morbid Mortal Wkly Rep* 2001; 50:538-541.

2. Del Rio C, Barragán M, **Franco-Paredes C**. *Pneumocystis carinii* Pneumonia. *N Engl J Med* 2004; 351:1262-1263.

3. Barragan M, Hicks G, Williams M, **Franco-Paredes C**, Duffus W, Del Rio C. Health Literacy is Associated with HIV Test Acceptance. *J Gen Intern Med* 2005; 20:422-425.

4. Rodriguez-Morales A, Arria M, Rojas-Mirabal J, Borges E, Benitez J, Herrera M, Villalobos C, Maldonado A, Rubio N, **Franco-Paredes C**. Lepidopterism Due to the Exposure of the Moth *Hylesia metabus* in Northeastern Venezuela. *Am J Trop Med Hyg* 2005; 73:991-993.

5. Rodriguez-Morales A, Sánchez E, Arria M, Vargas M, Piccolo C, Colina R, **Franco-Paredes C**. White Blood Cell Counts in *Plasmodium vivax*. *J Infect Dis* 2005; 192:1675-1676.

6. Franco-Paredes C, Nicolls D, Dismukes R, Kozarsky P. Persistent Tropical Infectious Diseases among Sudanese Refugees Living in the US. *Am J Trop Med Hyg* 2005; 73: 1.

7. Osorio-Pinzon J, Moncada L, **Franco-Paredes C**. Role of Ivermectin in the Treatment of Severe Orbital **Myiasis Due to *Cochliomyia hominivorax*. *Clin Infect Dis* 2006; 3: e57-9.**

8. Rodriguez-Morales A, **Franco-Paredes C**. Impact of *Plasmodium vivax* Malaria during Pregnancy in Northeastern Venezuela. *Am J Trop Med Hyg* 2006; 74:273-277.

9. Rodriguez-Morales A, Nestor P, Arria M, **Franco-Paredes C**. Impact of Imported Malaria on the Burden of Malaria in Northeastern Venezuela. *J Travel Med* 2006; 13:15-20.

10. Rodríguez-Morales A, Sánchez E, Vargas M, Piccolo C, Colina R, Arria M, **Franco-Paredes C.** Is anemia in *Plasmodium vivax* More Severe and More Frequent than in *Plasmodium falciparum? Am J Med* 2006; 119:e9-10.
11. Hicks G, Barragan M, **Franco-Paredes C**, Williams MV, del Rio C. Health Literacy is a Predictor of HIV Knowledge. *Fam Med J* 2006; 10:717-723.
12. Cardenas R, Sandoval C, Rodriguez-Morales A, **Franco-Paredes C**. Impact of Climate Variability in the Occurrence of Leishmaniasis in Northeastern Colombia. *Am J Trop Med Hyg* 2006; 75:273-7.
13. Franco-Paredes C, Nicolls D, Dismukes R, Wilson M, Jones D, Workowski K, Kozarsky P. Persistent and Untreated Tropical Infectious Diseases among Sudanese Refugees in the US. *Am J Trop Med Hyg* 2007; 77:633-635.
14. Rodríguez-Morales AJ, Sanchez E, Arria M, Vargas M, Piccolo C, Colina R, **Franco-Paredes C**. Hemoglobin and haematocrit: The Threefold Conversion is also Non Valid for Assessing Anaemia in *Plasmodium vivax* Malaria-endemic Settings. *Malaria J* 2007; 6:166.
15. Franco-Paredes C, Jones D, Rodriguez-Morales AJ, Santos-Preciado JI. Improving the Health of Neglected Populations in Latin America. *BMC Public Health* 2007; 7.
16. Kelly C, Hernández I, **Franco-Paredes C**, Del Rio C. The Clinical and Epidemiologic Characteristics of Foreign-born Latinos with HIV/AIDS at an Urban HIV Clinic. *AIDS Reader* 2007; 17:73-88.
17. Hotez PJ, Bottazzi ME, **Franco-Paredes C**, Ault SK, Roses-Periago M. The Neglected Tropical Diseases of Latin America and the Caribbean: Estimated Disease Burden and Distribution and a Roadmap for Control and Elimination. *PLoS Negl Trop Dis* 2008; 2:e300.
18. Tellez I, Barragan M, Nelson K, Del Rio C, **Franco-Paredes C**. *Pneumocystis jiroveci* (PCP) in the Inner City: A Persistent and Deadly Pathogen. *Am J Med Sci* 2008; 335:192-197.
19. Rodriguez-Morales AJ, Olinda, **Franco-Paredes C**. Cutaneous Leishmaniasis Imported from Colombia to Northcentral Venezuela: Implications for Travel Advice. *Trav Med Infect Dis* 2008; 6(6): 376-9.
20. Jacob J, Kozarsky P, Dismukes R, Bynoe V, Margoles L, Leonard M, Tellez I, **Franco-Paredes C**. Five-Year Experience with Type 1 and Type 2 Reactions in Hansen's Disease at a US Travel Clinic. *Am J Trop Med Hygiene* 2008; 79:452-454.
21. Delgado O, Silva S, Coraspe V, Ribas MA, Rodriguez-Morales AJ, Navarro P, **Franco-Paredes C**. Epidemiology of Cutaneous Leishmaniasis in Children and Adolescents in Venezuela. *Trop Biomed.* 2008; 25(3):178-83.
22. Franco-Paredes C, Lammoglia L, Hernandez I, Santos-Preciado JI. Epidemiology and Outcomes of Bacterial Meningitis in Mexican Children: 10-Years' Experience (1993-2003). *Int J Infect Dis* 2008; 12:380-386.
23. Pedroza A, Huerta GJ, Garcia ML, Rojas A, Lopez I, Peñagos M, **Franco-Paredes C**, Deroche C, Mascareñas C. The Safety and Immunogenicity of Influenza Vaccine in Children with Asthma in Mexico. *Int J Infect Dis* 2009; 13(4): 469-75.
24. Museru O, **Franco-Paredes C**. Epidemiology and Outcomes of Hepatitis B Virus Infection among Refugees Seen at U.S. Travel Medicine Clinic: 2005-2008. *Travel Med Infect Dis* 2009; 7: 171-179.
25. Rodriguez-Morales AJ, Olinda M, **Franco-Paredes C**. Imported Cases of Malaria Admitted to Two Hospitals of Margarita Island, Venezuela: 1998-2005. *Travel Med Infect Dis* 2009: (1): 48-45.

26. Kelley CF, Checkley W, Mannino DM, **Franco-Paredes C**, Del Rio C, Holguin F. Trends in Hospitalizations for AIDS-associated *Pneumocystis jiroveci* Pneumonia in the United States (1986-2005). *Chest* 2009; 136(1): 190-7.
27. Carranza M, Newton O, **Franco-Paredes C**, Villasenor A. Clinical Outcomes of Mexican Children with Febrile Acute Upper Respiratory Infection: No Impact of Antibiotic Therapy. *Int J Infect Dis* 2010; 14(9): e759-63.
28. Museru O, Vargas M, Kinyua M, Alexander KT, **Franco-Paredes C,** Oladele A. Hepatitis B Virus Infection among Refugees Resettled in the U.S.: High Prevalence and Challenges in Access to Health Care. ***J Immigrant Minor Health* 2010;**
29. Moro P, Thompson B, Santos-Preciado JI, Weniger B, Chen R, **Franco-Paredes C.** Needlestick injuries in Mexico City sanitation workers. *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* 2010; 27 (6): 467-8.
30. Barragan M, Holtz M, **Franco-Paredes C**, Leonard M. The Untimely Misfortune of Tuberculosis Diagnosis at time of Death. *Infect Dis Clin Pract* 2010; 18(6):1-7.
31. Hochberg N, Armstrong W, Wang W, Sheth A, Moro R, Montgomery S, Steuer F, Lennox J, **Franco-Paredes C**. High Prevalence of Persistent Parasitic Infections in Foreign-born HIV-infected Persons in the United States. *PLoS Neglect Dis* 2011; 5(4): e1034.
32. Larocque RC, Rao SR, Lee J, Ansdell V, Yates JA, Schwartz BS, Knouse M, Cahill J, Hagmann S, Vinetz J, Connor BA, Goad JA, Oladele A, Alvarez S, Stauffer W, Walker P, Kozarsky P, **Franco-Paredes C**, Dismukes R, Rosen J, Hynes NA, Jacquerioz F, McLellan S, Hale D, Sofarelli T, Schoenfeld D, Marano N, Brunette G, Jentes ES, Yanni E, Sotir MJ, Ryan ET; the Global TravEpiNet Consortium. Global TravEpiNet: A National Consortium of Clinics Providing Care to International Travelers--Analysis of Demographic Characteristics, Travel Destinations, and Pretravel Healthcare of High-Risk US International Travelers, 2009-2011. *Clin Infect Dis*. 2012; 54(4):455-462.
33. Espinosa-Padilla SE, Murata C, Estrada-Parra S, Santos-Argumendo L, Mascarenas C, **Franco-Paredes C**, Espinosa-Rosales FJ. Immunogenicity of a 23-valent pneumococcal polysaccharide vaccine among Mexican children. *Arch Med Res* 2012;
34. Harris JR, Lockhart SR, Sondermeyer G, Vugia DJ, Crist MB, D'Angelo MT, Sellers B, **Franco-Paredes C**, Makvandi M, Smelser C, Greene J, Stanek D, Signs K, Nett RJ, Chiller T, Park BJ. *Cryptococcus gattii* infections in multiple states outside the US Pacific Northwest. *Emerg Infect Dis*. 2013; 19 (10):1620-6.
35. Franco-Paredes C. Aerobic actinomycetes that masquerade as pulmonary tuberculosis. Bol Med Hosp Infant Mex 2014; 71(1): 36-40.
36. Chastain DB, Ngando I, Bland CM, **Franco-Paredes C**, and Hawkins WA. Effect of the 2014 Clinical and Laboratory Standard Institute urine-specific breakpoints on cefazolin susceptibility rates at a community teaching hospital. *Ann Clin Microbiol Antimicrob* 2017; 16(1): 43.
37. Kashef Hamadani BH, **Franco-Paredes C**, MCollister B, Shapiro L, Beckham JD, Henao-Martinez AF. Cryptococcosis and cryptococcal meningitis- new predictors and clinical outcomes at a United States Academic Medical Center. *Mycoses* 2017; doi: 10.1111/myc.12742.
38. Chastain DB, **Franco-Paredes C**, Wheeler SE, Olubajo B, Hawkins A. Evaluating Guideline Adherence regarding Empirical Vancomycin use in patients with neutropenic fever. *Int J Infect Dis* 2018; Feb 22. pii: S1201-9712(18)30052-3. doi: 10.1016/j.ijid.2018.02.016. PMID: 29477362

39. Parra-Henao G, Amioka E, **Franco-Paredes C**, Colborn KL, Henao-Martinez AF. Heart failure symptoms and ecological factors as predictors of Chagas disease among indigenous communities in the Sierra Nevada de Santa Marta, Colombia. *J Card Fail* 2018; Mar 26. pii: S1071-9164(18)30119-2. doi: 10.1016/j.cardfail.2018.03.007.
40. Vela Duarte D, Henao-Martinez AF, Nyberg E, Castellanos P, **Franco-Paredes C**, Chastain DB, Lacunar Stroke in Cryptococcal Meningitis: Clinical and Radiographic Features. *J Stroke and Cerebrovascular Disease* 2019;
41. Chastain DB, Henao-Martinez AF, **Franco-Paredes C**. A clinical pharmacist survey of prophylactic strategies used to prevent adverse events of lipid-associated formulations of amphotericin B. *Infect Dis* 2019;
42. Henao-Martínez AF, Chadalawada S, Villamil-Gomez WE, DeSanto K, Rassi A Jr, **Franco-Paredes C**. Duration and determinants of Chagas latency: an etiology and risk systematic review protocol. *JBI Database System Rev Implement Rep*. 2019 Jul 22. doi: 10.11124/JBISRIR-D-18-00018.

CONSENSUS STATEMENTS

Pritchett MA, Oberg CL, Belanger A, De Cardenas J, Cheng G, Cumbo Nacheli G, **Franco-Paredes C,** Singh J, Toth J, Zgoda M, Folch E. Society for Advanced Bronchoscopy Consensus Statement and Guidelines for bronchoscopy and airway management amid the COVID-19 pandemic. *J Thorac Dis* 2020; http:/dx.doi.org/10.21037/jtd.2020.04.32

RESEARCH ORIGINAL ARTICLES AS COLLABORATOR (clinical, basic science, other) in refereed journals:
43. Benator D, Bhattacharya M, Bozeman L, Burman W, Cantazaro A, Chaisson R, Gordin F, Horsburgh CR, Horton J, Khan A, Lahart C, Metchock B, Pachucki C, Stanton L, Vernon A, Villarino ME, Wang YC, Weiner M, Weis S; **Tuberculosis Trials Consortium**. Rifapentine and Isoniazid Once a Week versus Rifampicin and Isoniazid twice a week for Treatment of Drug-susceptible Pulmonary Tuberculosis in HIV-Negative Patients: a Randomised Clinical Trial. *Lancet* 2002; 360:528-34.
44. Weiner M, Burman W, Vernon A, Benator D, Peloquin CA, Khan A, Weis S, King B, Shah N, Hodge T; **Tuberculosis Trials Consortium**. Low INH Concentrations and Outcome of Tuberculosis Treatment with Once-weekly INH and Rifapentine. *Am J Rev Crit Care Med* 2003; 167:1341-1347.
45. Jasmer RM, Bozeman L, Schwartzman K, Cave MD, Saukkonen JJ, Metchock B, Khan A, Burman WJ; **Tuberculosis Trials Consortium**. **Recurrent Tuberculosis in the United States and Canada: Relapse or Reinfection?** *Am J Respir Crit Care Med* 2004; **170:1360**-1366.
Mendelson M, Davis XM, Jensenius M, Keystone JS, von Sonnenburg F, Hale DC, Burchard GD, Field V, Vincent P, Freedman DO; **GeoSentinel Surveillance Network**. Health risks in travelers to South Africa: the GeoSentinel experience and implications for the 2010 FIFA World Cup. *Am J Trop Med Hyg*. 2010; 82(6): 991-5.
46. Hagmann S, Neugebauer R, Schwartz E, Perret C, Castelli F, Barnett ED, Stauffer WM; GeoSentinel Surveillance Network. Illness in children after international travel: analysis from the **GeoSentinel Surveillance Network**. *Pediatrics.* 2010; 1 25(5): e1072-80.
47. Schlagenhauf P, Chen LH, Wilson ME, Freedman DO, Tcheng D, Schwartz E, Pandey P, Weber R, Nadal D, Berger C, von Sonnenburg F, Keystone J, Leder K; **GeoSentinel**

Surveillance Network. Sex and gender differences in travel-associated disease. *Clin Infect Dis*. 2010; 50 (6): 826-32.
48. Jensenius M, Davis X, von Sonnenburg F, Schwartz E, Keystone JS, Leder K, Lopéz-Véléz R, Caumes E, Cramer JP, Chen L, Parola P; **GeoSentinel Surveillance Network**. Multicener GeoSentinel analysis of rickettsial diseases in international travelers, 1996-2008. *Emerg Infect Dis*. 2009; 15(11):1791-8.
49. Chen LH, Wilson ME, Davis X, Loutan L, Schwartz E, Keystone J, Hale D, Lim PL, McCarthy A, Gkrania-Klotsas E, Schlagenhauf P; **GeoSentinel Surveillance Network**. *Emerg Infect Dis*. 2009; 15(11): 1773-82.
50. Nicolls DJ, Weld LH, Schwartz E, Reed C, von Sonnenburg F, Freedman DO, Kozarsky PE; **GeoSentinel Surveillance Network**. Characteristics of schistosomiasis in travelers reported to the GeoSentinel Surveillance Network 1997-2008. *Am J Trop Med Hyg 2008*; 79(5): 729-34.
51. Greenwood Z, Black J, Weld L, O'Brien D, Leder K, Von Sonnenburg F, Pandey P, Schwartz E, Connor BA, Brown G, Freedman DO, Torresi J; **GeoSentinel Surveillance Network.** Gastrointestinal infection among international travelers globally. *J Travel Med* 2008; 1 5(4):221-8.
52. Davis XM, MacDonald S, Borwein S, Freedman DO, Kozarsky PE, von Sonnenburg F, Keystone JS, Lim PL, Marano N; **GeoSentinel Surveillance Network**. Health risks in travelers to China: the GeoSentinel experience and implications for the 2008 Beijing Olympics. *Am J Trop Med Hyg* 2008; 79(1): 4-8.
53. Boggild AK, Castelli F, Gautret P, Torresi J, von Sonnenburg F, Barnett ED, Greenaway CA, Lim PL, Schwartz E, Wilder-Smith A, Wilson ME; **GeoSentinel Surveillance Network**. Vaccine preventable diseases in returned international travelers: results from the GeoSentinel Surveillance Network. *Vaccine* 2010; 28(46):7389-95.
54. Esposito DH, Han PV, Kozarsky PE, Walker PF, Gkrania-Klotsas E, Barnett ED, Libman M, McCarthy AE, Field V, Connor BA, Schwartz E, MacDonald S, Sotir MJ; **GeoSentinel Surveillance Network**. Characteristics and spectrum of disease among ill returned travelers from pre- and post-earthquake Haiti: The GeoSentinel experience. *Am J Trop Med Hyg* 2012 Jan; 86(1):23-8.
55. Boggild AK, Castelli F, Gautret P, Torresi J, von Sonnenburg F, Barnett ED, Greenaway CA, Lim PL, Schwartz E, Wilder-Smith A, Wilson ME; **GeoSentinel Surveillance Network**. Latitudinal patterns of travel among returned travelers with influenza: results from the GeoSentinel Surveillance Network, 1997-2007. *J Travel Med* 2012; 19(1):4-8. doi: 10.1111/j.1708-8305.2011.00579.x.

REVIEW, EDITORIALS, CASE SERIES, CASE REPORT ARTICLES:

56. Franco-Paredes C, Jurado R. Ankylosing Spondylitis Fibrocavitary Lung Disease. *Clin Infect Dis* 2001; 32:1062.

57. Franco-Paredes C, Evans J, Jurado R. Diabetes Insipidus due to *Streptococcus pneumoniae* Meningitis. *Arch Intern Med* 2001; 161; 1114-15.

58. Franco-Paredes C, Blumberg H. Tuberculosis Psoas Abscess caused by *Mycobacterium tuberculosis* and *Staphylococcus aureus*: Case Report and Review. *Am J Med Sci* 2001; 321:415-17.

59. Jurado R, **Franco-Paredes C**. Aspiration Pneumonia: A Misnomer. *Clin Infect Dis* 2001;33:1612-3.

60. Del Rio Carlos, **Franco-Paredes C**. Bioterrorism: A New Public Health Problem. *Sal Publ Mex* 2001; 43:585-88.

61. Franco-Paredes C, Blumberg H. New Concepts in the Diagnosis of Latent Tuberculosis Infection. *Consultant* 2001; 41:1105-1121.

62. Franco-Paredes C, Bellehemeur T, Sanghi P, et al. Aseptic Meningitis and Retrobulbar Optic Neuritis Caused By VZV Preceding the Onset of PORN in a Patient with AIDS. *AIDS* 2002; 16:1045-1049.

63. Franco-Paredes C, Mehrabi D, Calle J, Jurado R. Night Sweats Revisited. *Infect Dis Clin Pract* 2002; 11:291-293.

64. Franco-Paredes C, Jurado R, Del Rio C. The Clinical Utility of the Urine Gram Stain. *Infect Dis Clin Pract* 2002; 11:561-563.

65. Franco-Paredes C, Agudelo C. Editorial Response: The Ever Expanding Clinical Spectrum of Tuberculosis. *J Clin Rheumatol* 2002;8:1-2.

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FORMAL TEACHING

Medical Student Teaching

2001 - 2002 Clinical Methods, Emory University School of Medicine

I. 2001 - 2002 Clinical Instructor Harvey Cardiology Course, Emory University School of Medicine

2001 - 2002 Problem-Based Learning for Second year Medical Students, EUSM

2005-2011 Clinical Methods Preceptor, ECLH

2006-2008 Medical Spanish - Instructor for M2, EUSM

2006-2007 Directed Study on Social Determinants of Infectious Diseases for M2 students (Lindsay Margolis and Jean Bendik), EUSM

2007-2011 Instructor - Global Health for M2 Students, EUSM

2007-2008 Presentation-Case Discussion – Social Determinants of Diseases – Coordinated by Dr. Bill Eley – Emory School of Medicine New Curriculum.

2018- Small Group: Parasitic Diseases, Microbiology Course for First Year Medical Students, University of Colorado, Anschutz Medical Center.

2019- MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite

2019- Class Global Health and Underserved Populations of the New SOM CU Curriculum. Course Co-Director. Pilot Class (Jan 6-Jan 17, 2020).

2020- MS-2 Small group discussion Microbiology, University of Colorado, Anschutz Medical Center: Parasitic Diseases, CNS Infections, Septic Arthritis-Cat Bite

Graduate Program

Training programs

2006-2011 Professor - GH511 (Global Health 511) International Infectious Diseases Prevention and Control, Rollins School of Public Health

2009-2011 Professor – GH500 D – Key Issues in Global Health, Career MPH Program

2006-2011 Thesis Advisor to students Global Health Track – Hubert Department of Global Health, Rollins School of Public Health of Emory University

2008-2011 Coordinator International Exchange between Rollins School of Public Health and National Institute of Public Health, Cuernavaca, Mexico – Supported by the Global Health Institute of Emory University

Residency and Fellowship Program:

2004-2011 Resident Report – Noon Conferences Emory Crawford Long Hospital and Grady Memorial Hospital

2004-2011	Didactic Lectures on Parasitic Diseases and Non-tuberculous mycobacterial diseases for Internal Medicine Residents and Infectious Disease Fellows
2005-2008	Coordinator Journal Club Infectious Disease Division
2005-2011	Travel Medicine Elective, Internal Medicine Residents (2 internal residents per month)
2005	Grand Rounds – EUH - Department of Medicine: "Travel Medicine"
2006	Grand Rounds – ECLH – Department of Medicine: "Malaria"
2008	Grand Rounds - ECLH – Department of Medicine: "Leprosy"
2008-2011	Journal Club Coordinator, Internal Medicine Residency Program – ECLH
2009	Grand Rounds - EUH – Department of Medicine: "Leprosy a Modern Perspective of an Ancient Disease"
2009	Grand Rounds – Pulmonary and Critical Care Division – Neglected Tropical Diseases of the Respiratory Tract, June 16, 2009
2017	Grand Rounds – Leprosy, University of Colorado, Anschutz Medical Center, Division of Infectious Diseases, December 2017
2017	Grand Rounds – Infections associated with Secondary Antiphospholid Syndrome, University of Colorado, Anschutz Medical Center, Division of Rheumatology,
2018	Didactic Session – Travel Medicine (Pretravel and Postravel) Infectious Diseases Fellowship Anschutz Medical Center, Division of Infectious Diseases
2017-	Infectious Diseases Fellows Clinic, University of Colorado, Anschutz Medical Center, IDPG.
2019	Invited Speaker: Travel Medicine, Pretravel/Postravel Care, Physician Assistant Program, September 12, 2019, University of Colorado, Anschutz Medical Center

Other categories:

2000-2002	Physician Assistant Supervision during Fellowship/Junior Faculty, Emory University
2004-2007	Mentoring of four College Students to enter into Medical School (Emory, Southern University, and Dartmouth):
	Lindsay Margolis 2004-Emory University
	Michael Woodworth 2005 – Emory University
	Peter Manyang 2007 – Southern University
	Padraic Chisholm 2007 – Southern University/Emory University

2009-2011	Project Leader. Partnership – Emory Global Health Institute – University-wide - Emory Travel Well Clinic and is titled Hansen's disease in the state of Georgia: A Modern Reassessment of an Ancient Disease". http://www.globalhealth.emory.edu/fundingOpportunities/projectideas.php. Students: 5 MPH students (RN/MPH, MD/MPH)
2017-	Infectious Diseases Fellowship Program, University of Colorado, Anschutz Medical Center. Teaching activities Inpatient and outpatient (ID Fellows Weekly Clinic)
2019-	Infectious Diseases Fellowship Program Director University of Colorado, Aurora Colorado

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No.: 20-cv-977-PAB

THOMAS CARRANZA;
JESUS MARTINEZ;
RICHARD BARNUM;
THOMAS LEWIS;
MICHAEL WARD;
COLBY PROPES; and
CHAD HUNTER,

Plaintiffs, on their own and on behalf of a class of similarly situated persons,

v.

STEVEN REAMS, Sheriff of Weld County, Colorado, in his official capacity,

Defendant.

[AMENDED PROPOSED] ORDER

Having considered the evidence and authority submitted by the parties in this matter, and in accordance with Fed.R.Civ.P. 65, the Court finds that entry of interim injunctive relief is appropriate in this case because: Plaintiffs are likely to succeed on the merits; there is a real threat of irreparable harm absent injunctive relief; the balance of harms favors entry of an injunction; and the issuance of injunctive relief is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Plaintiffs have demonstrated that they are being held under unconstitutional conditions of confinement at the Weld County Jail in violation of their Eighth and Fourteenth Amendment rights. *See Helling v. McKinney*, 509 U.S. 25 (1993). The conditions of confinement Plaintiffs are currently being held under are likely to cause them to suffer irreparable harm absent interim injunctive relief. *Prairie Band of Potawatomi Indians v. Pierce*, 253 F.3d 1234,

1250 (10th Cir. 2001). The balance of harms weighs in favor of granting interim injunctive relief because Plaintiffs' situation is life and death. *Edmisten v. Werholtz*, 287 F. App'x 728, 732-35 (10th Cir. 2008); *see also Thakker, et al. v. Doll, et al.*, No. 20 C 0480, Dkt. 47, at 24 (M.D. Pa. Mar. 31, 2020). Finally, the public interest favors stopping the spread of COVID-19, *Bent v. Barr*, No. 19-cv-06123-DMR, 2020 U.S. Dist. LEXIS 62792, at *22-24 (N.D. Cal. Apr. 9, 2020) (collecting cases), and protecting Plaintiffs' constitutional rights. *Kikumura v. Hurley*, 242 F.3d 950, 963 (10th Cir. 2001).

Accordingly, this Court issues the following injunctive relief requiring that Defendant:

1. Physically distance all inmates from one another and staff within the Weld County Jail, which necessitates at least six feet of distance between individuals at all times;
2. Identify inmates at high-risk of severe disease and dying from COVID-19, in accordance with guidelines from the CDC and CDPHE, and physically distance these individuals particularly (including, but not limited to, housing these individuals in single-cells);
3. On a daily basis, thoroughly and professionally disinfect and sanitize the Weld County Jail;
4. Provide hygiene supplies, including supplies to wash hands and disinfect common areas, to inmates at all times and free of charge and implement policies and procedures requiring that common areas be disinfected between uses by inmates;
5. Provide adequate personal protection equipment, including but not limited to masks, to all staff members and inmates (and ensure that these materials are replaced at least every third day);

6. Implement a testing procedure to identify inmates who are possibly carrying COVID-19, including testing to identify asymptomatic carriers and those with one or more symptom of COVID-19;
7. Implement a quarantine and isolation procedure that is in line with CDC guidelines for all individuals exposed to COVID-19 and new intakes to the Weld County Jail;
8. Take particularly heightened precautions with respect to food handling and delivery, such as ensuring that people who come into contact with food are not displaying any potential symptoms of COVID-19, have not recently been in contact with people displaying potential symptoms of COVID-19, and people who come into contact with food wear appropriate personal protective equipment at all times when in contact with food (including but not limited to appropriate masks and gloves); and
9. Provide accurate, up-to-date educational and informational materials regarding the status of how COVID-19 is affecting the facility, including the number of infected inmates and staff.

Further, this Court holds that, in accordance with Fed.R.Civ.P. 65(c), bond is waived in this matter because the above-outlined interim relief is in the public interest. *See Davis v. Mineta*, 302 F.3d 1104, 1126 (10th Cir. 2002).

SO ORDERED, this ___ day of _____ 2020, at Denver, Colorado

_____
United States District Judge