UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

JOSEPH A. DENBOW and SEAN R. RAGSDALE, *on their own and on behalf of a class of similarly situated persons*, *Petitioners*, v. MAINE DEPARTMENT OF CORRECTIONS and RANDALL A. LIBERTY, Commissioner of Maine Department of Corrections *in his official capacity*, *Respondents.*	Case No. _____ **Petition for Writ of Habeas Corpus and Complaint for Injunctive and Declaratory Relief** **Class Action Complaint** **IMMEDIATE RELIEF SOUGHT**

INTRODUCTION

1. COVID-19 is a deadly virus that disproportionately sickens and kills medically vulnerable people housed in closed congregate settings like cruise ships, nursing homes, and prisons.[1] As Maine's Governor's Chief Legal Counsel recently explained to this Court, "indoor settings where a large number of people sit stagnant, remain in close proximity to one another, breathe the same air, touch common personal and fixed property, and remain there for an extended period of time present an especially dangerous environment for community spread, particularly for persons who are elderly or who have certain compromising medical

[1] John M. Barry, *The Single Most Important Lesson from the 1918 Influenza*, New York Times (March 17, 2020), https://cutt.ly/PtQ5uAZ (Opinion piece by author of "The Great Influenza: The Story of the Deadliest Pandemic in History," noting comparison between current COVID-19 outbreak and the 1918 influenza outbreak widely considered one of the worst pandemics in history).

conditions."[2] Although this statement was originally made in support of the government's restriction on in-person religious gatherings, it applies with even greater force to Maine's prisons, where people (including many who are medically vulnerable) spend much of the day in close contact with approximately 50 to 80 other prisoners and prison staff who circulate to and from the community each day.

2. With no vaccine or known cure for the virus, physical distancing is critical and, for those most vulnerable to the virus, it can be a matter of life or death. As explained by the Director of the Maine Center for Disease Control and Prevention, "[p]hysical distancing is the best vaccine that we have."[3] For people who are particularly medically vulnerable to serious illness or death from COVID-19—including those with underlying medical conditions such as diabetes, heart disease, and lung disease—physical distancing is also a form of necessary preventative medical care.[4] Other mitigation measures like frequent hand-washing, use of alcohol-based hand-sanitizer, and widespread testing, are additional important preventative measure for everyone—and especially those at highest risk.[5]

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[2] Langhauser Decl., *Calvary Chapel of Bangor v. Mills*, Docket No. 20-cv-156-NT, ECF No. 21 (May 8, 2020).

[3] Maine CDC briefing: April 1, 2020, https://www.youtube.com/watch?v=nX4ljxGU4VI (quote from Maine CDC Director Dr. Nirav Shah).

[4] Social Distancing, U.S. Centers for Disease Control and Prevention (last accessed Apr. 6, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html; *see also* Parrish Decl. ¶ 35 ("To protect medically vulnerable individuals—as well as other individuals and staff—it is necessary to be able to engage in adequate physical distancing *at all times*").

[5] Parrish Decl. ¶¶ 25–28, 30; *see also Hand Hygiene in COVID-19*, U.S. Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html (last visited May 9, 2020); Emily Mosites, *Assessment of SARS-CoV-2 Infection Prevalence in Homeless Shelters – Four U.S. Cities, March 27-April 15, 2020*, U.S. Centers for Disease Control and Prevention (May 1, 2020), https://bit.ly/3dKZHmY (acknowledging widespread

3. There can be no dispute that, if there was a vaccine or a pharmaceutical treatment for COVID-19, the prison would be obliged to provide it to prisoners—even if providing the treatment would be costly or inconvenient.[6] But no vaccine or treatment is available. Instead, for medically vulnerable people who are mostly likely to face serious illness and death from the virus, prevention is the most important type of care. Indeed, there is consensus among medical experts that physical distancing is critical for individuals at high risk of serious illness or death from COVID-19, like the Petitioners and proposed Class Members.[7]

4. Yet, despite encouraging and even requiring these mitigation measures for the vast majority of people,[8] the State of Maine fails to ensure that such preventative treatment is available to prisoners, and, to the contrary, prevents most prisoners from social distancing. Indeed,

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positive yet asymptomatic cases of COVID-19 and concluding that "[t]esting *all* persons can facilitate isolation of those who are infected to minimize ongoing transmission in" homeless shelters, another closed congregate setting like prisons*); Consideration for Use if Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes*, U.S. Centers for Disease Control and Prevention (last visited May 9, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html (recommending widespread testing and retesting in nursing homes, another closed congregate setting with many medically vulnerable individuals). The Maine CDC states that people at higher risk of serious illness should "limit close contact with others," "avoid crowds," and "practice social distancing." *Coronavirus (COVID-19) Frequently Asked Questions*, Maine CDC (May 6, 2020), https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/documents/Public-COVID19-FAQ-6May2020.pdf

[6] *See, e.g.*, *Estelle v. Gamble*, 429 U.S. 97, 106 (1976); *Abu-Jamal v. Wetzel*, No. 3:16-CV-2000, 2017 WL 34700, at *18 (M.D. Pa. Jan. 3, 2017) (prisons cannot "deliberately den[y] providing treatment to inmates with a serious medical condition and chosen a course of monitoring instead").

[7] Parrish Decl. ¶¶ 34-36.

[8] *Cavalry Chapel of Bangor v. Mills*, No. 1:20-CV-00156-NT, 2020 WL 2310913, at *3-*4 (D. Me. May 9, 2020) (listing state-imposed restrictions and stay-at-home mandates).

the prison setting makes social distancing all but impossible, prohibits access to alcohol-based hand-sanitizer, and limits necessary medical care to manage underlying medical conditions.[9]

5. Maine's Department of Correction ("DOC") also refuses to provide medical furlough or rehabilitative services to Petitioners and Class Members, even when necessary to enable them to physically distance and protect themselves from infection. For example, although DOC provides medical furlough for other types of care that is available only outside the prison setting,[10] DOC has refused to grant *any* medical furloughs to enable medically vulnerable prisoners to physically distance during COVID-19.[11]

6. Similarly, DOC has applied stricter-than-usual criteria for community confinement—adding many new technical requirements on top of the statutory criteria. Under these criteria, DOC has refused to grant community confinement to medically vulnerable prisoners who have an imminent release date, who are classified as "minimum" or "community" security, and who (absent COVID-19 restrictions) would be allowed to work in the community.[12] As one prison case worker recently candidly and bluntly told

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[9] *See, e.g.*, Am. Compl., *Loisel v. Clinton*, Docket No. 19-cv-00081-NT, ECF No. 26 (June 26, 2019) (alleging violation of the Eighth Amendment and Americans with Disabilities Act on behalf of a proposed class for failure to provide treatment for Hepatitis C); *see also id.* at ¶ 46 (alleging that medication for Hepatitis C that is withheld from many prisoners is available to MaineCare beneficiaries diagnosed with chronic HCV).

[10] 34-A M.R.S. § 3035(C)(2); DOC Policy 27.04 (available at https://www.maine.gov/corrections/PublicInterest/policies.shtml, click on Policy 27.04).

[11] Sideris Decl., Att. B (email from DOC Classification Director stating that "[t]he department is not utilizing the medical furlough to release clients during the COVID19 pandemic").

[12] *See, e.g.*, Debow Decl. ¶¶ 9-14; Ragsdale Decl. ¶¶ 8-11.

one of the Petitioners, , "there's nobody being released because of medical conditions, so you can get that idea right out of your head."[13]

7. Petitioners Joseph Denbow and Sean Ragsdale are medically vulnerable prisoners forced to live in crowded settings where they are exposed to close contact with dozens of other prisoners and staff every day—any of whom could be carriers of the COVID-19 infection. Not only does DOC require Petitioners to live in crowded settings—in which physical distancing is impossible—but it also denies them access to alcohol-based hand sanitizer and provides for hand-washing only in a communal bathroom shared with approximately fifty other prisoners. Despite the heightened risks posed by such settings, DOC has tested only two prisoners (out of 340) in the Mountain View Correctional Facility, where Petitioners are housed.[14]

8. The combination of crowded settings, poor hygiene, and the absence of adequate testing in DOC facilities means that the virus could be rapidly spreading undetected throughout the prisons at this very moment. This is not just a hypothetical risk. The outbreaks in correctional facilities around the country,[15] illustrate that the risk of harm posed to prisoners, prison staff, and the entire community is real, concrete and imminent.[16]

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[13] Denbow Decl. ¶ 13.

[14] Maine DOC Daily Dashboard (May 11, 2020), https://www.maine.gov/corrections/home/MDOC%20COVID19%20Web%20Dashboard%205-11-2020.pdf.

[15] Sam Kelly, *134 inmates at Cook County Jail confirmed positive for COVID-19*, CHICAGO SUN-TIMES (Mar. 30, 2020). https://cutt.ly/6tYTqi5.

[16] The State recently emphasized the risks of "community spread" from in-person religious gatherings of more than 10 people, stating that holding such gatherings in violation of the statewide order "subjects all persons attending such gatherings to an avoidable risk of community spread; and that this risk in turn threatens unnecessarily the health and lives of Maine

9. To protect against this imminent risk of serious illness and death, Petitioners bring this action on behalf of themselves and all similarly situated medically vulnerable prisoners incarcerated by the Maine Department of Corrections. Medically vulnerable prisoners include prisoners over 55 or those with underlying health conditions, such as asthma, diabetes, and heart disease.[17] Petitioners also seek to represent the following three subclasses of similarly situated persons: **(1)** medically vulnerable prisoners with an earliest release date within one year (the earliest date by which a vaccine may be expected)[18], **(2)** medically vulnerable prisoners classified as minimum risk or community custody, and **(3)** prisoners who are medically vulnerable because of conditions that are protected under federal disability rights laws. This lawsuit seeks emergency class relief to protect vulnerable class members before it is too late. If the Court does not immediately grant requested relief—including ordering the Department to provide necessary information and a safe release plan—Petitioners request an expedited hearing. Given the rapid spread of this highly contagious virus, time is of the essence.[19]

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citizens and, if not contained, the stability of the State's first-responder and health care systems." Langhauser Decl., *Cavalry Chapel of Bangor v. Mills*, Docket No. 20-156-NT, ECF No. 21 (May 8, 2020). The same risks are even more present in prisons, in which people are in closed and crowded settings—not just for a couple of hours once a week—but all day, every day, and in which prison staff travel to and from the facility each day, as potential vectors of the disease.

[17] Goldenson Decl. ¶ 39.

[18] Declaration of Dr. Nirav Shah, *Cavalry Chapel of Bangor v. Mills*, Docket No. 20-cv-156-NT, ECF No. 20 (May 8, 2020).

[19] *See, e.g.*, COVID-19 Dashboard by the Center for Systems Science and Engineering at Johns Hopkins University, Coronavirus Resource Center, *available at* https://coronavirus.jhu.edu/map.html; Kevin Miller, *Three more deaths, 50 new COVID-19 cases reported in Maine*, Portland Press Herald (May 14, 2020), https://www.pressherald.com/2020/05/14/three-more-deaths-50-new-covid-19-cases-reported-in-

I. JURISDICTION AND VENUE

10. Petitioners bring this putative class action pursuant to 22 U.S.C. § 2241 for relief from incarceration that violates their Eighth Amendment rights under the U.S. Constitution, and that violates the Americans with Disabilities Act, 42 U.S.C. § 12131 *et seq*., and the Rehabilitation Act, 29 U.S.C. § 794.

11. This Court has subject matter jurisdiction over these claims pursuant to 28 U.S.C. § 2241 (habeas corpus), 28 U.S.C. § 1651 (All Writs Act), and Article I, § 9, cl. 2 of the U.S. Constitution (Suspension Clause) / 28 U.S.C. § 1331 (federal question jurisdiction).

12. Venue is proper in this judicial district pursuant to 28 U.S.C. § 2241(d) because the Petitioners and all other class members are in custody in this judicial district and venue. Venue is proper pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events or omissions giving rise to Petitioners' claims occurred in this district.

II. PARTIES

13. Petitioner Sean R. Ragsdale is incarcerated in Mountain View Correctional Facility. He is 56 years old. He is at high risk for serious illness or death from COVID-19 because he has a long-term chest infection, diabetes, and Hepatitis C, which has caused him liver damage. Mr. Ragsdale uses an inhaler in order to breathe normally, takes insulin twice a day, and as a result of his disabilities has been given work restrictions by doctors to not stand on his feet for prolonged periods of time or do strenuous activity. Medication for Hepatitis C is medically indicated to treat Mr. Ragsdale's condition and prevent further liver disease, but

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maine/ (referencing Maine's "rising cases numbers" which Maine's CDC director called "concerning").

DOC has not provided that medication. Although payments have been suspended while he is in prison, he receives Social Security income (SSI) for his disabilities. He was convicted of two counts of aggravated trafficking of drugs and has completed most of his sentence of imprisonment, with a planned release date in approximately two months, on July 17, 2020. He is currently classified as "community" custody, meaning that, but for the current COVID-19 restrictions, he would be approved to work in the community during the day. Mr. Ragsdale is an individual with a disability for purposes of the ADA and the Rehabilitation Act.

14. Petitioner Joseph A. Denbow is incarcerated in Mountain View Correctional Facility. He is 54 years old. He is at high risk for serious illness or death from COVID-19 because he suffers from asthma, chronic obstructive pulmonary disease (COPD) and is in remission from colorectal cancer. He is incarcerated for driving without a license and aggravated forgery, for initially giving the traffic officer his brother's name instead of his own. He has completed most of his two-year prison sentence, with an earliest release date of August 30, 2020. He is currently classified as "minimum" security and, before the current COVID-19 restrictions, worked in the community doing odd-jobs like sheet rocking and painting, and would return to the facility at night. Mr. Denbow is an individual with a disability for purposes of the ADA and the Rehabilitation Act.

15. Respondent Randall A. Liberty is the Commissioner of the Maine Department of Corrections. In that role, he has "general supervision, management and control of the research and planning, grounds, buildings, property, officers, employees and clients of any correctional facility, detention facility or correctional program." 34-A M.R.S. § 1402(1). Commissioner Liberty is sued in his official capacity.

16. Respondent Maine DOC is "responsible for the direction and general administrative supervision, guidance and planning of adult and juvenile correctional facilities and programs within the State." 34-M.R.S. §1202.

III. FACTUAL ALLEGATIONS

A. COVID-19 Poses a Significant Risk of Illness, Injury, or Death

17. The novel coronavirus that causes COVID-19 has led to a global pandemic.[20] As of May 15, 2020, at 8 AM, there were 4,444,670 reported COVID-19 cases throughout the world[21] In the United States alone, the Centers for Disease Control and Prevention ("CDC") reports 1,384,930 cases and 83,947 deaths as of May 14, 2020.[22] As of May 14, 2020, Maine has had 1,405 coronavirus cases and seen 207 hospitalizations and 69 deaths as a result of the virus.[23] All these numbers are likely underestimates because of limited availability of testing.[24]

18. Projections indicate that as many as 240,000 people in the U.S. will die from COVID-19, accounting for existing interventions.[25]

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[20] Betsy McKay et al., *Coronavirus Declared Pandemic by World Health Organization*, WALL ST. J. (Mar. 11, 2020, 11:59 PM), https://cutt.ly/UtEuSLC.

[21] Johns Hopkins University COVID-19 Case Tracker, available at https://coronavirus.jhu.edu/, last accessed May 15, 2020; John Hopkins University COVID-19 Dashboard, available at https://coronavirus.jhu.edu/map.html, last accessed May 8, 2020.

[22] COVID-19 Tracker, U.S. Centers for Disease Control and Prevention, https://www.cdc.gov/covid-data-tracker/index.html (last accessed May 14, 2020)

[23] https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml (last accessed May 14, 2020)

[24] Goldenson Decl. ¶ 13.

[25] Rick Noack, et al., *White House Task Force Projects 100,000 to 240,000 Deaths in U.S., Even With Mitigation Efforts*, Wash. Post. (April 1, 2020, 12:02 a.m.), https://cutt.ly/5tYT7uo.

19. The virus is known to spread from person to person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.[26] There is no vaccine against COVID-19, and there is no known medication that is effective to prevent or treat it.[27] Social distancing—deliberately keeping at least six feet of space between persons to avoid spreading illness[28]—and a vigilant hygiene regimen, including hand hygiene, are critical for protecting against transmission of COVID-19.[29]

20. These measures are particularly important because the coronavirus spreads aggressively, and people can spread it even if they do not feel sick or exhibit any symptoms.[30] The only assured way to curb the pandemic is through dramatically reducing contact for all.[31] Every American institution—from schools[32] to places of worship,[33] from businesses[34] to

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[26] Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations for Patience with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, https://cutt.ly/ztRAo0X.

[27] Parrish Decl. ¶ 16; Goldenson Decl. ¶ 19.

[28] Johns Hopkins University, *Coronavirus, Social Distancing and Self-Quarantine*, https://cutt.ly/VtYYiDG.

[29] Goldenson Decl. ¶ 19; Parrish Decl. ¶ 16.

[30] Goldenson Decl. ¶ 18; Parrish Decl. ¶¶ 20-23.

[31] Harry Stevens, *Why Outbreaks Like Coronavirus Spread Exponentially, and how to "Flatten the Curve,"* Wash. Post. (March 14, 2020), https://cutt.ly/etYRnkz.

[32] Centers for Disease Control, *Interim Guidance for Administrators of US K-12 Schools and Child Care Programs*, https://cutt.ly/ItRPq5n.

[33] Centers for Disease Control, *Interim Guidance for Administrators and Leaders of Community- and Faith-Based Organizations to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)*, https://cutt.ly/KtRPk1k.

[34] Centers for Disease Control, *Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19)*, https://cutt.ly/stRPvg4.

legislatures[35]—has been exhorted to reduce the number of people in close quarters, if not empty entirely.[36] They have also been told to undertake aggressive sanitation measures, such as cleaning and disinfecting all surfaces for exacting periods of time with products with particular alcohol contents, and closing off any areas used by a sick person.[37]

21. Once contracted, COVID-19 can cause severe damage to lung tissue, including a permanent loss of respiratory capacity, and it can damage tissues in other vital organs, such as the heart and liver.[38]

22. People over the age of 50 face a greater risk of serious illness or death from COVID-19.[39] In a February 29, 2020 preliminary report, individuals age 50-59 had an overall mortality rate of 1.3%; 60-69-year-olds had an overall 3.6% mortality rate, and those 70-79 years old had an 8% mortality rate.[40]

23. People of any age who suffer from certain underlying medical conditions, including lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from

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[35] Nat'l Conf. of State Legislatures, *Coronavirus and State Legislatures in the News*, https://cutt.ly/4tRPQne.a.

[36] *Cavalry Chapel of Bangor v. Mills*, No. 1:20-CV-00156-NT, 2020 WL 2310913, at *3-*4 (D. Me. May 9, 2020) (listing state-imposed restrictions and stay-at-home mandates in Maine).

[37] Centers for Disease Control, *Cleaning and Disinfecting Your Facility*, https://cutt.ly/atYE7F9.

[38] Parrish Decl. ¶¶ 4-5; *see also* Centers for Disease Control, *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*, https://cutt.ly/etRPVRl

[39] Xianxian Zhao, et al., *Incidence, clinical characteristics and prognostic factor of patients with COVID-19: a systematic review and meta-analysis* (March 20, 2020), https://cutt.ly/etRAkmt.

[40] *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths* Chart, https://cutt.ly/ytEimUQ (data analysis based on WHO China Joint Mission Report).

cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, and asthma, also have an elevated risk.[41] Early reports estimate that the mortality rate was 13.2% for those with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.[42]

24. In many people, COVID-19 causes fever, cough, and shortness of breath. However, many people in higher risk categories who develop serious illness will need advanced support.[43] This requires highly specialized equipment like ventilators that are in limited supply, and an entire team of care providers, respiratory therapists, and intensive care physicians.[44]

25. In serious cases, COVID-19 causes acute respiratory disease syndrome, which is life-threatening: even those who receive ideal medical care with ARDS have a 30% mortality rate.[45] Even in non-ARDS cases, COVID-19 can severely damage lung tissue, which

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[41] *Coronavirus disease (COVID-19) advice for the public: Myth buster*s, World Health Organization, https://cutt.ly/dtEiCyc ("Older people, and people with pre-existing medical conditions (such as asthma, diabetes, heart disease) appear to be more vulnerable to becoming severely ill with the virus.").

[42] *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization (Feb. 28, 2020), at 12, https://cutt.ly/xtEokCt (finding fatality rates for patients with COVID-19 and co-morbid conditions to be: "13.2% for those with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer").

[43] Goldenson Decl. ¶ 17; Parrish Decl. ¶ 29.

[44] Parrish Decl. ¶ 29; *see also* Novel Coronavirus 2019 (COVID-19), https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml#situation (listing the number of available ventilators and intensive care hospital beds in Maine).

[45] Letter from Faculty at Johns Hopkins School of Medicine, School of Nursing, and Bloomberg School of Public Health to Hon. Larry Hogan, Gov. of Maryland, March 25, 2020, https://cutt.ly/stERiXk; *see also* Goldenson Decl. ¶ 11.

requires an extensive period of rehabilitation, and in some cases, cause permanent loss of breathing capacity.[46] COVID-19 may target the heart, causing cardiac complications up to and including heart failure.[47] COVID-19 can also trigger an over-response of the immune system and result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury.[48]

26. These complications can manifest at an alarming pace. 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.[49]

27. According to recent estimates, the fatality rate of people infected with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems.[50] Patients who do not die from serious cases of COVID-19 may still face prolonged recovery periods, including extensive rehabilitation from neurologic damage, loss of digits, and loss of respiratory capacity.[51]

28. As of May 14, 2020, the United States leads the world in confirmed cases of COVID-19.[52] As of May 14, 2020, Maine has had 1,565 confirmed coronavirus cases and seen 207

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[46] Parrish Decl. ¶ 5.

[47] Parrish Decl. ¶ 5.

[48] *Id.*

[49] CDC, *Interim Clinical Guidance*, *supra* note 38.

[50] Betsy McKay, *Coronavirus vs. Flu Which Virus is Deadlier*, WALL ST. J. (Mar. 10, 2020, 12:49 PM), https://cutt.ly/itEmi8j.

[51] *Id.*

[52] Donald G. McNeil, Jr., *The U.S. Now Leads the World in Confirmed Coronavirus Cases*, New York Times (March 26, 2020), https://cutt.ly/QtQ7zz6.

hospitalizations 69 deaths as a result of the virus.[53] Many of the deaths attributed to the coronavirus happened in congregate care nursing facilities.[54] There is no way to know when the number of daily cases will abate—on May 14, the State CDC Director acknowledged a "concerning" "increase of cases . . . over the past days."[55]

B. **The Dangers of COVID-19 Are Heightened in Prisons**

29. The imperatives of social distancing and hygiene apply with special force to prisons, where the government controls almost entirely a person's ability to avoid others and to maintain adequate sanitation. Persons who live or work in prisons face a particularly acute threat of illness, permanent injury, and death, beyond that faced by the general public.[56]

30. As another court has explained, "Prisons are tinderboxes for infectious disease. The question whether the government can protect inmates from COVID-19 is being answered every day, as outbreaks appear in new facilities."[57] For example, dramatic outbreaks have occurred in the Cook County Jail, Rikers Island in New York City, and multiple prisons in Ohio.[58] In one Ohio prison, more than 80% of the approximately 2,500 prisoners tested

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[53] Novel Coronavirus 2019 (COVID-19), Maine CDC, https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml (last visited May 15, 2020).

[54] Maine DHHS Press Release (Apr. 28, 2020), https://www.maine.gov/dhhs/press-release.shtml?id=2460746 (last visited May 15, 2020).

[55] Kevin Miller, *Three more deaths, 50 new COVID-19 cases reported in Maine*, Portland Press Herald (May 14, 2020), https://www.pressherald.com/2020/05/14/three-more-deaths-50-new-covid-19-cases-reported-in-maine/.

[56] Goldenson Decl. ¶¶ 39-40.

[57] *United States v. Rodriguez*, No. 2:03-cr-0271, 2020 WL 1627331, (E.D. Pa., Apr. 1, 2020).

[58] Goldenson Decl. ¶ 37 (citing sources).

positive.[59] Eight of the ten largest-known infections sources in the U.S. are associated with jails or prisons.[60]

31. People in congregate environments, which are places where people live, eat, and sleep in close proximity, face increased danger of contracting COVID-19, as evidenced by the rapid spread of the virus in cruise ships[61] and nursing homes.[62] It is virtually impossible for people in prisons to engage in the necessary social distancing and hygiene required to mitigate the risk of transmission. High numbers of shared contact surfaces, limited access to medical care, and high numbers of people with chronic, often untreated, illnesses living in close proximity with each other exacerbate the dangers in correctional settings.

32. Correctional facilities house large groups of people together, and move people in groups to eat, recreate, and obtain medical care.[63] They frequently have insufficient medical care for the population even outside times of crisis.[64] Incarcerated people, rather than

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[59] Goldenson Decl. ¶ 37 (citing sources).

[60] Goldenson Decl. ¶ 37.

[61] *See* Parrish Decl. ¶¶ 10-12. The CDC is currently recommending that travelers defer cruise ship travel worldwide. "Cruise ship passengers are at increased risk of person-to-person spread of infectious diseases, including COVID-19." *COVID-19 and Cruise Ship Travel*, Centers for Disease Control and Prevention, https://cutt.ly/7tEEQvT.

[62] The CDC notes that long-term care facilities and nursing homes pose a particular risk because of "their congregate nature" and the residents served. *Preparing for COVID-19: Long-term Care Facilities, Nursing Homes*, Centers for Disease Control and Prevention, https://cutt.ly/7tEEITH.

[63] *See, e.g*, Nathalie Baptiste, *Correctional Facilities are the Perfect Incubators for the Coronavirus*, (March 6, 2020), https://cutt.ly/GtRSi3e; Goldenson Decl. ¶¶ 26-28.

[64] *See, e.g.*, Steve Coll, *the Jail Health-Care Crisis*, The New Yorker (Feb. 25, 2019), https://cutt.ly/ftERHNg; *see also* Am. Compl., *Loisel v. Clinton*, Docket No. 1:19-cv-00081-NT, ECF No. 26 (June 26, 2019) (alleging inadequate medical care in the Maine Department of Corrections for prisoners with another infectious disease, Hepatitis C); Dan Neumann, *Four fired nurses raise the alarm about Maine's for-profit prison contractor*, Beacon (Dec. 13, 2018),

professional cleaners, are responsible for cleaning the facilities, with minimal supervision.[65]

33. Outbreaks of the flu regularly occur in jails and prisons, including an influenza outbreak in two prison facilities in Maine in 2011.[66] During the H1N1 epidemic in 2009, jails and prisons dealt with a disproportionately high number of cases,[67] including in the Cumberland County Jail, in Portland Maine.[68]

34. In addition to Dr. Parrish and Dr. Goldenson, whose declarations are attached to this petition, numerous public health experts, including Dr. Gregg Gonsalves,[69] Ross

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https://mainebeacon.com/four-fired-nurses-raise-the-alarm-about-maines-for-profit-prison-contractor/.

[65] *See, e.g.,* Ragsdale Decl. ¶ 16; Denbow Decl. ¶ 19. Wendy Sawyer, *How much do incarcerated people earn in each state?*, Prison Policy Initiative, (April 10, 2017); https://cutt.ly/qtER2bh (noting that "custodial, maintenance, laundry" and "grounds keeping" are among the most common jobs for incarcerated people).

[66] Influenza Outbreaks at Two Correctional Facilities – Maine, March 2011, Centers for Disease Control and Prevention (Apr. 6, 2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

[67] *See, e.g.,* Meyer Decl. at ¶ 19, Docket No. 20-cv-1803-AKH, ECF No. 42 (Mar. 16, 2020), https://drive.google.com/file/d/1rVxt85J-LCDLQLBMFDaNu49PczCdnLvs/view. This H1N1 "swine flu" pandemic outbreak spread dramatically in jails and prisons in 2010, but that strain of virus had a low fatality rate because of the characteristics of the virus—COVID-19's fatality rate is far higher. David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few* (Feb. 15, 2010), https://cutt.ly/ytRSkuX.

[68] *Swine Flu Spreads in Jail*, Ellsworth American (June 9, 2009), https://www.ellsworthamerican.com/maine-news/health-news/swine-flu-spreads-in-jail/.

[69] Kelan Lyons, *Elderly Prison Population Vulnerable to Potential Coronavirus Outbreak*, Connecticut Mirror (March 11, 2020), https://cutt.ly/BtRSxCF.

MacDonald,[70] Dr. Marc Stern,[71] Dr. Oluwadamilola T. Oladeru and Adam Beckman,[72] Dr. Anne Spaulding,[73] Homer Venters,[74] Jaimie Meyer,[75] the faculty at Johns Hopkins schools of nursing, medicine, and public health,[76] and Josiah Rich[77] have all strongly cautioned that people booked into and held in correctional settings are likely to face serious, even grave, harm due to the outbreak of COVID-19.

35. Prisons are not hermetically sealed. By their nature, the people who go in—especially correctional and medical staff—typically come out in very short order. Failing to prevent and mitigate the spread of COVID-19 endangers not only those within the institution, but the entire community. Hence, immediate and aggressive action is the only mitigation effort

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[70]Craig McCarthy and Natalie Musumeci, *Top Rikers Doctor: Coronavirus 'Storm is Coming,'* New York Post (March 19, 2020), https://cutt.ly/ptRSnVo.

[71] Marc F. Stern, MD, MPH, *Washington State Jails Coronavirus Management Suggestions in 3 "Buckets,"* Washington Assoc. of Sheriffs & Police Chiefs (March 5, 2020), https://cutt.ly/EtRSm4R.

[72] Oluwadamilola T. Oladeru, et al., *What COVID-19 Means for America's Incarcerated Population – and How to Ensure It's Not Left Behind*, (March 10, 2020), https://cutt.ly/QtRSYNA.

[73] Anne C. Spaulding, MD MPDH, *Coronavirus COVID-19 and the Correctional Jail,* Emory Center for the Health of Incarcerated Persons (March 9, 2020).

[74] Madison Pauly, *To Arrest the Spread of Coronavirus, Arrest Fewer People*, Mother Jones (March 12, 2020), https://cutt.ly/jtRSPnk.

[75] Meyer Decl., Docket No. 20-cv-1803-AKH, ECF No. 42 (Mar. 16, 2020), https://drive.google.com/file/d/1rVxt85J-LCDLQLBMFDaNu49PczCdnLvs/view.

[76] Letter from Faculty at Johns Hopkins School of Medicine, School of Nursing, and Bloomberg School of Public Health to Hon. Larry Hogan, Gov. of Maryland, March 25, 2020, https://cutt.ly/stERiXk.

[77] Amanda Holpuch, *Calls Mount to Free Low-risk US Inmates to Curb Coronavirus Impact on Prisons*, The Guardian (March 13, 2020 3:00 p.m.), https://cutt.ly/itRSDNH.

that Respondents can undertake to comport with public health guidance and to prevent a catastrophic outbreak at the facility.

C. Persons Incarcerated in Maine's Prisons Face Grave and Immediate Danger Due to COVID-19

36. Beyond the general public health presented by the COVID-19 pandemic, persons incarcerated in Maine's prisons face a particularly acute threat of illness, permanent injury, and death.

37. As of May 14, 2020, Maine has had 1,405 coronavirus cases and seen 207 hospitalizations and 69 deaths as a result of the virus.[78] No part of Maine has been spared, and the virus has shown up in every county in the state. Penobscot County, where Mountain View Correctional Facility is located, had 91 confirmed cases as of May 14, 2020[79] and has experienced spreading of coronavirus through community transmission.[80] Cumberland County, where Maine Correctional Center and Southern Maine Women's Reentry Center

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[78] COVID-19 Situation Reports, Maine CDC, available at https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml#situation (last accessed May 15, 2020).

[79] COVID-19 Situation Reports, Maine CDC, available at https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml#situation (last accessed May 15, 2020).

[80] Charles Eichacker, *Coronavirus is spreading in Penobscot County through community transmission*, Bangor Daily News, April 10, 2020, available at https://bangordailynews.com/2020/04/10/news/penobscot/coronavirus-is-spreading-in-penobscot-county-through-community-transmission/, last accessed May 8, 2020.

are located, had 778 cases as of May 14, 2020[81] and also has confirmed community transmission of the virus.[82]

38. Despite the need to maintain 6 feet of distance and not congregate in gatherings larger than 10 people,[83] prisoners in Maine Department of Corrections facilities cannot perform basic physical distancing. Petitioners, for example, live in dorms with approximately fifty other people, with whom they share common rooms, sinks, showers, and toilets. They sleep in small rooms with three other people.[84]

39. Despite the need for masks in areas where physical distancing is difficult, DOC does not enforce the requirement to wear masks in the common rooms or dorms. Nor do corrections officers wear masks while standing within six feet from their colleagues. Although incarcerated people have been given two cloth masks (made from the same material as the prison-issue boxer briefs), prisoners are sometimes unable to sanitize them between uses, and, when they are able to wash them, they quickly break down.

40. In any event, when others around them are not wearing them, masks offer only limited benefit for a wearer who is trying to protect themselves from catching the infection.[85] The

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[81] COVID-19 Situation Reports, Maine CDC, available at https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml#situation (last accessed May 15, 2020).

[82] Eichacker, *Coronavirus is spreading in Penobscot County through community transmission*, note 80, supra.

[83] Frequently Asked Questions, Me. Dep't of Health and Human Servs., https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/documents/Public-COVID19-FAQ-8May2020.pdf (last visited May 15, 2020).

[84] Denbow Decl. ¶¶ 15-26; Ragsdale Decl. ¶¶ 13-24.

[85] Parrish Decl. ¶ 14.

Maine CDC has made clear that "[e]ven if you wear a facemask, you should also use other prevention methods," and that wearing facemasks should "not take the place of other prevention measures,"[86] like physical distancing and proper hygiene.

41. Yet the only hand hygiene to which Petitioners have access is the bathroom sink used by approximately fifty other prisoners. The DOC-provided hand sanitizer is not effective against COVID-19. The Maine CDC states that people should "[u]se an alcohol-based hand sanitizer that contains 60 percent to 95 percent alcohol."[87] The hand sanitizer that DOC provides to prisoners is alcohol free.[88]

D. Existing Procedures and Protocols Will Not Be Sufficient to Ensure the Safety of Class Members or the General Public

42. Because of the severity of the threat posed by COVID-19, and its potential to rapidly spread throughout a correctional setting, public health experts recommend the rapid release from custody of people most vulnerable to COVID-19.[89] Release is necessary to protect the

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[86] Frequently Asked Questions, Maine Dep't of Health and Human Servs., https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/documents/Public-COVID19-FAQ-6May2020.pdf.

[87] Frequently Asked Questions, Maine Dep't of Health and Human Servs., https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/documents/Public-COVID19-FAQ-6May2020.pdf

[88] Denbow Decl. ¶ 17; Ragsdale Decl. ¶ 20.

[89] *See* Goldenson Decl. ¶¶ 43-44; Parrish Decl. ¶ 35 ("When physical distancing is not possible in one setting, people should be moved out of that setting to the greatest extent possible"); Meyer Dec., *supra* note 75 at ¶¶ 37–38 (noting that population reduction in jails will be "crucially important to reducing the level of risk both for those within [jail] facilities and for the community at large," and that stemming the flow of intakes is a part of the necessary intervention); Stern Decl. at ¶¶ 9–10, *Dawson v. Asher*, 20-cv-409 (W.D. Wash.), ECF No. 6, (noting that release is "a critically important way to meaningfully mitigate" the risks of harm to persons who are at high risk of serious illness or death, as well as to support the broader community health infrastructure).

people with the greatest vulnerability to COVID-19 from transmission of the virus, and also facilitate greater risk mitigation for prisoners, staff, and the broader community. Release of the most vulnerable people from custody would also reduce the burden on the region's health care infrastructure by reducing the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.

43. Jail administrators in Cuyahoga County, Ohio[90]; San Francisco, California[91]; Jefferson County, Colorado[92]; Montgomery, Alabama[93]; and the State of New Jersey,[94] among others, have concluded that widespread jail release is a necessary and appropriate public health intervention. Similarly, as of May 8, 2020, jails in Maine had reduced their populations by more than 40 percent since January 2020.[95]

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[90] Scott Noll, *Cuyahoga County Jail Releases Hundreds of Low-Level Offenders to Prepare for Coronavirus Pandemic*, (March 20 2020 6:04 p.m.), https://cutt.ly/CtRSHkZ.

[91] Megan Cassidy, *Alameda County Releases 250 Jail Inmates Amid Coronavirus Concerns, SF to Release 26*, San Francisco Chronicle (March 20, 2020), https://cutt.ly/0tRSVmG.

[92] Jenna Carroll, *Inmates Being Released Early From JeffCo Detention Facility Amid Coronavirus Concerns*, KDVR Colorado (March 19, 2020 2:29 pm.), https://cutt.ly/UtRS8LE.

[93] *See In Re: Covid-19 Pandemic Emergency Response*, Administrative Order No. 4, Montgomery County Circuit Court (March 17, 2020).

[94] Erin Vogt, *Here's NJ's Plan for Releasing Up to 1,000 Inmates as COVID-19 Spreads* (March 23, 2020), https://cutt.ly/QtRS53w.

[95] Daily Dashboard, Dep't of Corrections, https://www.maine.gov/corrections/home/MDOC%20COVID19%20Web%20Dashboard%205-14-2020.pdf (last visited May 15, 2020).

44. DOC has taken some precautions in an attempt to limit the risk of an outbreak of COVID-19, including adopting a phased approach to the COVID-19 response.[96] Due to "concerns of community transmissions," DOC is in "Phase Two," which includes the following:

    a. suspending visitation, work release and other community-related activities,[97]
    b. implementing screening measures for staff,[98]
    c. providing for increased cleaning and provision of cleaning supplies,
    d. posting signage about hand washing and general fact sheets about COVID-19
    e. using Personal Protective Equipment (PPE) for med-line and MAT staff,
    f. providing the flu vaccine those who want it but have not received it,
    g. providing daily briefings at all facilities,
    h. suspending self-serve dining,
    i. pre-planning with local hospitals, and
    j. designating isolation areas at each facility, and limiting staff working among multiple facilities.[99]

45. Although not mentioned in Phase Two precautions, DOC has also provided two cloth masks per incarcerated individual, and, in some facilities, created alternative systems for providing meals. DOC has stated that it "will enter phase three [precautions] when there is

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[96] Statement of Commissioner Liberty, Maine Dep't of Corrections (Mar. 27, 2020), https://www.maine.gov/corrections/home/3.27.20%20Statement%20from%20Commisioner%20Liberty.pdf.

[97] Statement of Commissioner Liberty, Maine Dep't of Corrections (Mar. 20, 2020), https://www.maine.gov/corrections/home/Response%20from.%20Randall%20Liberty.pdf.

[98] Statement of Commissioner Liberty, Maine Dep't of Corrections (Mar. 20, 2020), https://www.maine.gov/corrections/home/Response%20from.%20Randall%20Liberty.pdf.

[99] *Id.*; *see also* Statement of Commissioner Liberty, Maine Dep't of Corrections (Mar. 27, 2020), https://www.maine.gov/corrections/home/3.27.20%20Statement%20from%20Commisioner%20Liberty.pdf.

a suspected or confirmed case within a DOC facility."[100] Yet DOC did not enter Phase three after a confirmed positive case of a corrections worker at the Bolduc facility.[101]

46. DOC's plan, should there be an outbreak in the facility, is limited to: notifying state agencies and the medical community according to state protocol, increasing the use of PPE, suspending programming "as necessary," isolating intakes in cohorts, instituting "alternative method for medical distribution" and "alternative method for food services, as necessary" and triaging sick calls.[102]

47. Notwithstanding the efforts that DOC has taken, physical distancing in the facility remains impossible, testing is limited, and rapid transmission of the disease in the facility remains all but assured:

    a. **Physical distancing:** Prisoners typically sleep two or four to a cell, share showers with 30 to 80 other inmates, and spend much of the day in small and crowded dayrooms where physical distancing is impossible. When traveling throughout the facility to go to the meal hall or elsewhere, prisoners are bunched together and cannot physically distance because there is no enough space.

    b. **Testing:** Despite concerns with asymptomatic and pre-symptomatic transmission of the virus, DOC has performed only limited testing of prisoners with symptoms of COVID-19. As of May 14, 2020, DOC has tested only 26 inmates, or 1.3 percent of incarcerated adults.[103] DOC does not test prisoners or staff who are

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[100] Statement of Commissioner Liberty, Maine Dep't of Corrections (Mar. 27, 2020), https://www.maine.gov/corrections/home/3.27.20%20Statement%20from%20Commisioner%20Liberty.pdf.

[101] Statement of Commissioner Liberty, Maine Dep't of Corrections (Mar. 31, 2020), https://www.maine.gov/corrections/home/3.31.20%20Statement%20from%20Commissioner%20Liberty.pdf.

[102] Statement from Randall A. Liberty, Commissioner Department of Corrections, March 27, 2020, https://www.maine.gov/corrections/home/3.27.20%20Statement%20from%20Commisioner%20Liberty.pdf.

[103] Daily Dashboard, https://bit.ly/2Z1Ay3r (last visited May 14, 2020).

exposed to someone who tests positive unless they have symptoms themselves. For example, DOC did not test prisoners or staff who were exposed to the Bolduc employee who tested positive because "no clients or staff became symptomatic as a result of exposure."[104] A symptom-based approach to testing is particularly concerning in prison because some prisoners are so afraid of being forced into segregation or isolation that they have expressed they will not self-report any symptoms of COVID-19.[105] Numerous prisoners have said that, even if they start to feel symptoms, they will try to hide them.[106]

c. **Hygiene:** Hand sanitizer has been provided but it contains no alcohol, contrary to CDC guidelines.[107] Although DOC provides prisoners with gloves and spray bottles of cleaning solution to clean the dormitories, bathrooms, there is minimal supervision to ensure consistent or thorough cleaning. No bleach or bleach-based products are provided for cleaning.

d. **Masks**: Prisoners and staff are not required to wear masks at all times, and often do not wear them.

48. At current populations and staffing levels, it is impossible for DOC to ensure that all medically vulnerable inmates can perform physical distancing as described in CDC[108] and other public health guidelines, namely, providing all incarcerated persons a six-foot radius (113 ft^2) or more of distance between any other persons at all times, including during meals, transportation, provision of medication, recreation, counts, and all other activities.

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[104] Megan Gray, *Maine prisons pressured to release more inmates, and information, during pandemic*, Portland Press Herald (May 3, 2020), https://www.pressherald.com/2020/05/03/maine-prisons-pressured-to-release-more-inmates-and-more-information-during-pandemic/.

[105] Denbow Decl. ¶ 23; Ragsdale Decl. ¶ 21.

[106] *Id.*

[107] *See, e.g.*, https://www.fda.gov/drugs/information-drug-class/qa-consumers-hand-sanitizers-and-covid-19

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

E. DOC Has Categorically Refused Access to Medical Furlough and Severely Limited Home Confinement to Medically Vulnerable Prisoners

49. In light of these serious risks, immediate release of medically vulnerable Petitioners remains a necessary public health intervention.[109] Release is needed to prevent irreparable harm to the medically vulnerable Class Members, and to reduce the incarcerated population in DOC facilities to enable adequate social distancing for all prisoners and staff.[110]

50. Yet unlike other correctional facilities in Maine,[111] DOC has not engaged in widespread or systematic release of people who are medically vulnerable, near the end of their sentence, or otherwise eligible for home confinement.[112]

51. DOC has the authority to release prisoners on medical furlough when "medically necessary" and on supervised community confinement (SCCP) when certain statutory

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[109] *See supra* ¶ 33.

[110] *Id.* Further, in the prison context, the ABA urges that "Governmental authorities in all branches in a jurisdiction should take necessary steps to avoid crowding that… adversely affects the … protection of prisoners from harm, including the spread of disease." ABA Standard on Treatment of Prisoners 23-3.1(b).

[111] Randy Billings, *Increase in arrests of Portland's homeless worries civil liberties group*, Portland Press Herald (Apr. 7, 2020), https://www.pressherald.com/2020/05/07/uptick-in-homeless-arrests-worries-civil-liberties-group/ (quoting Cumberland County Sheriff as stating that "the jail has reduced its population by about 31 percent by releasing people with 90 days or fewer left on their sentences, and other nonviolent offenders eligible for home confinement").

[112] Although DOC's incarcerated population has decreased by approximately 11% since January 2020, this is because DOC has temporarily halted most new admissions and many prisoners are being released on their planned release date. The average sentence for prisoners in DOC custody is only 1.6 years. However, according to the DOC website, there are only 64 prisoners currently on SCCP, out of a total of 1934 prisoners. Daily Dashboard (May 14, 2020), https://bit.ly/3fRsJmQ.

criteria are satisfied. *See* 34-A M.R.S. § 3035(2)(C)[113]; 34-A M.R.S. § 3036-A.[114] In each of these circumstances, DOC retains custody and oversight over prisoners in the community.

52. Advocates have been urging DOC for months to protect all prisoners—especially those who are medically vulnerable—by granting home confinement or other measures to enable physical distancing in the community. In a letter sent on March 19, 2020, the ACLU of Maine urged that prisons and jails "do not needlessly keep people incarcerated who are especially vulnerable to COVID-19."[115] In another letter sent on April 20, 2020, a coalition of organizations urged the Department of Corrections to exercise its authority—including under medical furlough and SCCP—"to release enough people so that those left inside can adhere to CDC guidelines for safe physical distancing."[116] In outreach on behalf of individual prisoners, moreover, the ACLU of Maine and other attorneys have requested

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[113] By statute, the Commissioner "may grant to a client under sentence to the department . . . furlough from the facility in which the client is confined under the following conditions," including granting furlough "for the obtaining of medical services for a period longer than 10 days if medically required." 34-A M.R.S. § 3035(2)(C).

[114] By statute, the Commissioner "may transfer any prisoner committed to the department to be transferred from a correctional facility to supervised community confinement," so long as (A) the prisoner has served 2/3 of a more-than-five-year sentence or ½ of a five-years-or-less sentence, (B) the prison has 18 months or less remaining on the term of imprisonment (incorporating any good time credits), (C) is classified as minimum or community security. 34-A M.R.S. § 3036-A. Conditions for SSCP include completing a work, education, or treatment program; living in an approved residence; submitting to a curfew, travel restrictions, drug tests, and searches; and abstaining from alcohol and drugs. *Id.*

[115] March 18, 2020 Letter, available at https://www.aclumaine.org/sites/default/files/aclu_coronavirus_criminal_justice_maine_letterhead_03182020.pdf.

[116] April 20, 2020 Coalition Letter, available at https://www.aclumaine.org/sites/default/files/coalition_letter_to_mills_admin_04.20.20.pdf.

SCCP, medical furlough, or and other accommodations to protect specific medically vulnerable prisoners.[117] These requests have been rejected.

53. Despite its broad authority, DOC has "not expanded eligibility for home confinement to additional groups of inmates" since the pandemic erupted and instead is "using an even stricter set of criteria than usual."[118] In addition to the statutory criteria and typical guidelines, DOC has applied additional "parameters" to limit the number and type of people who are eligible for home confinement. The new and stricter guidelines include the following:

    a. Client's current release date must be less than one year (*even though the statute allows for a default of 18 months*),
    b. Client is not currently serving a sentence for a crime committed against a person (*even though this is not a typical statutory or policy requirement*),
    c. Client may not have a criminal history that includes a crime against a person, fugitive from justice, or several prior revocations of probation (*even though these are not typical statutory or policy requirements*),
    d. Client must be approved as community custody by the Department's classification instrument (*even though the statute allows for minimum as well as community custody*),
    e. Client's placement plan must include stable housing, medical services (as needed), and treatment / programming services (as appropriate) (*even though*

[117] *See, e.g.*, Sideris Decl. & Att. A, B.

[118] Megan Gray, *Maine prisons pressured to release more inmates, and information, during pandemic*, Portland Press Herald, May 3, 2020, available at https://www.pressherald.com/2020/05/03/maine-prisons-pressured-to-release-more-inmates-and-more-information-during-pandemic/ (last accessed May 4, 2020); *see also* Daily Dashboard, Maine Dep't of Corrections (May 6, 2020), https://www.maine.gov/corrections/home/MDOC%20COVID19%20Web%20Dashboard%205-6-2020.pdf.

many prisoners get medical care through MaineCare, which is suspended during periods of incarceration).[119]

54. DOC also provides several nonspecific factors, including the client's medical history and current medical conditions, the client's history on probation and/or SCCP, and the client's treatment and programming progress and compliance while incarcerated.[120]

55. Although one would assume that "medical conditions" would *support* release, the experience of Petitioners suggests that DOC treats the presence of underlying medical conditions as a reason not to release otherwise eligible prisoners. Indeed, Petitioner Denbow's case worker told him that "there's nobody being released because of medical conditions, so you can get that idea right out of your head."[121]

56. Similarly, in refusing timely accommodation for Petitioner Ragsdale, the Attorney General's office explained that "[a]t present, he receives medication and medical treatment on site," whereas "[i]n the community, he would have to visit pharmacies and medical providers to obtain treatment."[122] The AG's office made the same point in opposing Petitioner Denbow's release as requested in state court, stating that "multiple prescription medications . . . are presently provided to him in prison by the prison's private medical contractor, but in the community, he would have to find access to medications through a

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[119] Daily Dashboard, Maine Dep't of Corrections, https://www.maine.gov/corrections/home/MDOC%20COVID19%20Web%20Dashboard%205-8-2020.pdf.

[120] Daily Dashboard, Maine Dep't of Corrections, https://www.maine.gov/corrections/home/MDOC%20COVID19%20Web%20Dashboard%205-8-2020.pdf.

[121] Denbow Decl. ¶ 13.

[122] State Resp. to Demand Letter (May 7, 2020).

doctor's office or pharmacy."[123] Upon information and belief, to the extent any medically vulnerable individuals are currently released on SCCP, it is in spite of their medical risk and not because of it. Many medically vulnerable inmates who would be safe on SCCP are not being meaningfully considered.

57. DOC has also refused to grant expedited review or processing for people who are medically vulnerable. Petitioner Ragsdale, for example, applied for home confinement more than one month ago, but did not get any response until his lawyer sent a demand letter. Even after that, all he received was more paperwork to complete, and a notice that "[t]here is no guarantee that your application will be processed immediately" and that "[a]t this time very limited home investigations are being done. If it is not done now, it will be done when normal operations resume."

58. The Department has also applied a categorical prohibition against using medical furlough to enable medically vulnerable prisoners to physically distance during the state of emergency—regardless of medical necessity. DOC has stated that the medical furlough program is typically used to transition clients into medical programs when current medical conditions are not able to be attained while they are incarcerated. Yet even though physical distancing is necessary for at-risk prisoners, DOC has refused to use medical furlough to enable medically vulnerable prisoners to physically distance during the state of emergency and facilitate greater physical distancing for those who remain inside. Instead, the Director

[123] State Resp., *Denbow v. State* (Apr. 27, 2020) (Appendix of State Filings at 40).

of Classification has represented that "the department is not utilizing the medical furlough to release clients during the COVID-19 pandemic."[124]

59. In short, DOC has refused to use medical furlough and has applied community release so narrowly as to effectively be unavailable for the people who need it most. In normal times, such an approach may be merely unwise. In this pandemic, it is unconstitutional and unlawful because it unnecessarily and deliberately exposes medically vulnerable prisoners to an unacceptable risk of serious illness or death.

60. The imminent reopening of Maine's economy only makes the plight of prisoners more dangerous. Outbreaks in other crowded settings have continued to increase even as Maine contemplates reopening.[125] Prisons are inextricably linked to the wider community, and a rise in community cases increases the risk COVID-19 will infiltrate the prisons. Once the virus infiltrates the prisons (if it has not already done so), it will likely spread rapidly—increasing risk for prisoners, prison staff and their families, the medical works who are responsible for treating them, and the community as a whole.

IV. CLASS ACTION ALLEGATIONS

61. Petitioners bring this action pursuant to Rule 23 of the Federal Rules of Civil Procedures on behalf of themselves and a class of similarly situated individuals.

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[124] Sideris Decl., Att. B (email from DOC Classification Director).

[125] Kevin Miller, Virus outbreaks reported at Portland meat plant, Bangor homeless shelter, Portland Press Herald (Apr. 29, 2020), https://www.pressherald.com/2020/04/29/maine-cdc-reports-16-new-coronavirus-cases-one-additional-death/ (recording outbreaks in a Tyson Foods meat-processing plant Bangor's Hope House Health and Living Center, which includes a homeless shelter). Charles Eichacker, *Westbrook nursing home becomes 7th in Maine with a coronavirus outbreak*, Bangor Daily News (May 6, 2020) https://bangordailynews.com/2020/05/06/news/portland/westbrook-nursing-home-becomes-7th-in-maine-with-a-coronavirus-outbreak/.

62. Petitioners Sean R. Ragsdale and Joseph A. Denbow seek to represent a class of all current and future inmates who, by reason of age or medical condition, are particularly vulnerable to injury or death if they were to contract COVID-19.

63. The "Medically-Vulnerable" subclasses are defined as all current and future persons held by DOC who qualify as high-risk under the CDC guidelines, including individuals over the age of 55, as well as all current and future persons incarcerated by DOC of any age who experience (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as congenital heart disease, congestive heart failure and coronary artery disease; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; and/or (l) a current or recent (last two weeks) pregnancy.

64. This action has been brought and may properly be maintained as a class action under Federal law. It satisfies the requirements for class certification under Rule 23 of the Federal Rules of Civil Procedure, including the numerosity, commonality, typicality, and adequacy requirements for maintaining a class action under Fed. R. Civ. P. 23(a).

65. Joinder is impracticable because (1) the classes are numerous; (2) the classes include future members, and (3) the class members are incarcerated, rendering their ability to institute

individual lawsuits limited, particularly in light of cancelation of all legal visitation and court closures.

66. On information and belief, there more than 900 people in the proposed Class. A significant portion of prisoners in DOC custody are medically vulnerable. According to DOC's own estimates, approximately 925 prisoners in DOC custody have underlying medical conditions that could place them at heightened risk for serious illness or death from COVID-19.[126] On top of this number are the additional prisoners who are medically vulnerable solely because of their age.

67. Petitioners also seek to represent three subclasses of individuals, **(A)** those who are set to be released within one year (the "Imminent Release Subclass"), **(B)** those who are classified by DOC as minimum or community security (the "Minimum Security Subclass"), and **(C)** those who are medically vulnerable because of disabilities protected by federal disability rights law (the "Disabilities Subclass").

    a. **Imminent Release Subclass**: Many Class Members are set to be released within one year, with the average sentence in the Maine Department of Corrections only 1.6 years. Members of this Subclass will soon be released to the community, and keeping them in prison simply makes it more like that they will become infected in the closed, congregate setting of prison, and carry the infection with them upon release to the community.

[126] Sideris Decl. Att. B (DOC Classification Director stating that there are approximately 925 prisoners with preexisting conditions).

b. **Minimum Security Subclass:** With many dorms filled with prisoners who are minimum security or community security, the second subclass is also sizeable. Members of this Subclass have been identified by DOC has presenting extremely low risk to security. Continued incarceration exposes them to a high risk of serious illness or death.

c. **Disabilities Subclass:** Persons who are medically vulnerable to COVID-19 because of underlying medical conditions are protected, not only by the Eighth Amendment to the United States Constitution, but also be federal disability rights laws like the ADA and the Rehabilitation Act.

68. Common questions of law and fact exist as to all members of the proposed class. All have a right to receive adequate COVID-19 prevention, testing, and treatment. All are deprived of the ability to physically distance in DOC facilities, all are harmed by DOC's insufficient testing, and all are deprived of necessary hand hygiene such as alcohol-based hand sanitizer. Further, all members of the Class are harmed by the DOC's categorical refusal to consider medical furlough, or to expedite and facilitate home confinement for medically vulnerable individuals.

69. Named Petitioners have the requisite personal interest in the outcome of this action and will fairly and adequately protect the interests of the class. Petitioners have no interests adverse to the interests of the proposed class. Petitioners retained *pro bono* counsel with experience and success in the prosecution of civil rights litigation. Counsel for Petitioners know of no conflicts among proposed class members or between counsel and proposed class members.

70. Respondents have acted on grounds generally applicable to all proposed class members, and this action seeks declaratory and injunctive relief. Petitioners therefore seek class certification under Rule 23(b)(2).

71. In the alternative, the requirements of Rule 23(b)(1) are satisfied, because prosecuting separate actions would create a risk of inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of contact for the party opposing the proposed classes.

A. THE COURT SHOULD GRANT PETITIONERS THE RELIEF THEY SEEK

Petitioners' Incarceration Amidst the Likely COVID-19 Outbreak in DOC Facilities Violates their Right to Constitutional Conditions of Confinement

72. Corrections officials have a constitutional obligation to provide for detainees' reasonable safety and to address their serious medical needs. *See DeShaney v. Winnebago County Dept. of Soc. Services*, 489 U.S. 189, 200 (1989) ("[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause."); *Youngberg v. Romeo*, 457 U.S. 307, 315–16, 324 (1982) (the state has an "unquestioned duty to provide adequate . . . medical care" for incarcerated persons); *Wilson v. Seiter*, 501 U.S. 294, 300 (1991); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *Brown v. Plata*, 563 U.S. 493, 531-32 (2011); *Farmer v. Brennan*, 511 U.S. 825, 834 (remanding for determination whether correctional officer violated Eighth Amendment by failing to prevent "a substantial risk of serious harm").

73. An inmate's entitlement to medical treatment "reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards" is undisputed. *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987).

74. This obligation requires corrections officials to protect detainees from infectious diseases like COVID-19; officials may not wait until someone tests positive for the virus, and an outbreak begins. *Helling v. McKinney*, 509 U.S. 25, 33-34 (1993) ("That the Eighth Amendment protects against future harm to inmates is not a novel proposition. . . . 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"); *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996) ("[C]orrectional officials have an affirmative obligation to protect [forcibly confined] inmates from infectious disease"); *see also Farmer v. Brennan*, 511 U.S. 825, 833 (1994) ("[H]aving stripped [prisoners] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course.").

75. "[T]o prove an Eighth Amendment violation, a prisoner must satisfy both of two prongs: (1) an objective prong that requires proof of a serious medical need, and (2) a subjective prong that mandates a showing of prison administrators' deliberate indifference to that need." *Kosilek v. Spencer*, 774 F.3d 63, 82 (1st Cir. 2014).

76. Under the objective prong, the risk of infection with COVID-19 represents a serious medical need for Petitioners and medically vulnerable Class Members. As another court recently explained, "[f]or infected inmates, the virus can lead to pneumonia," and "[i]n the worse pneumonia cases, COVID-19 victims suffer diminishing oxygen absorption, with resulting organ failure," and victims "chok[ing] to death." *Wilson v. Williams*, No. 4:20-

CV-00794, 2020 WL 1940882, at *8 (N.D. Ohio Apr. 22, 2020). "While not every inmate who contracts the virus will die, [medically vulnerable prisoners] are at a much greater risk of doing so." *Id.* "They have a very serious medical need to be protected from the virus." *Id.*

77. Under the subjective prong, with respect to an impending infectious disease like COVID-19, deliberate indifference is satisfied when corrections officials "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year," even when "the complaining inmate shows no serious current symptoms." *Helling*, 509 U.S. at 33 (holding that a prisoner "states a cause of action . . . by alleging that [corrections officials] have, with deliberate indifference, exposed him to conditions that pose an unreasonable risk of serious damage to future health"); *see also Hope v. Pelzer*, 536 U.S. 730, 738 (2002) (citing *Farmer*, 511 U.S. at 842) (court "may infer the existence of [deliberate indifference] from the fact that the risk of harm is obvious").

78. DOC's refusal to enable physical distancing in its facilities, or to provide meaningful access to medical furlough or home confinement for the medically vulnerable class—ensuring they will be unable to physically distance and protect themselves from the virus—qualifies as deliberate indifference. *See, e.g.*, *Hare v. City of Corinth, Miss.*, 74 F.3d 633, 644 (5th Cir. 1996) ("even where a State may not want to subject a detainee to inhumane conditions of confinement or abusive jail practices, its intent to do so is nevertheless

presumed when it incarcerates the detainee in the face of such known conditions and practices."). [127]

79. Even if DOC's current spacing of detainees and provision of healthcare would serve the legitimate purpose of prison health and safety in normal times, those procedures are now endangering health and safety in the wake of COVID-19. *See Plata*, 563 U.S. 493 (ordering release of inmates to correct overcrowding that violated Eighth Amendment); Memorandum and Order, *Thakker v. Doll*, No. 20-CV-0480 (M.D. Pa. Mar. 31, 2020) (categorically releasing petitioners who "suffer[] from chronic medical conditions and face[] an imminent risk of death or serious injury if exposed to COVID-19).

B. DOC'S, Practices, and Procedures in the Face of COVID-19 Violate the ADA and the Rehabilitation Act

80. The Disability Subclass includes everyone in the medically vulnerable class who is vulnerable because of a disability as defined under federal law. This includes everyone in the medically vulnerable subclass except those vulnerable solely because of age or pregnancy status. All other conditions that increase risk for COVID-19 complications or death—including lung conditions, asthma, heart conditions, diabetes, kidney disease, livery disease, HIV, immune dysfunction, autoimmune disorders, cancer treatment, and history of organ or bone marrow transplantation—are disabilities under federal disability rights laws. By categorically refusing medical furloughs and severely limiting home confinement for medically vulnerable prisoners, DOC's policies and practices violate the ADA and the Rehabilitation Act.

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[127] *See also*, Public Health Experts' Declarations, *supra* note 89.

81. Title II of the ADA requires that public entities refrain from discriminating against qualified individuals on the basis of a disability. 42 U.S.C. § 12132. Section 504 of the Rehabilitation Act imposes parallel requirements on public entities that receive federal funds, as does the Maine DOC. *See Duvall v. Cty. of Kitsap*, 260 F.3d 1124, 1135 (9th Cir. 2001). In order to avoid disability discrimination in the Maine DOC in this public health emergency, release is a reasonable and nondiscriminatory method to ensure that the members of the Disability Subclass are able to receive necessary preventative care—the ability to physically distance.

1. The ADA and Section 504 Apply to the Respondents and Members of the Disability Subclass

82. Petitioners and Class Members in the Disability Subclasses are protected people with disabilities under the ADA and Section 504. They are all medically vulnerable to COVID-19 complications or death due to their disabilities. "Disability" is defined broadly, to include, inter alia, a "physical or mental impairment that substantially limits one or more major life activities." 42 U.S.C. § 12102(1)(A). "Major life activity" is itself broadly defined, and includes "the operation of a major bodily function," such as "functions of the immune system, normal cell growth . . . neurological, brain, respiratory, circulatory, [or] endocrine" systems. 42 U.S.C. § 12102(2)(B). Petitioners and Members of the Disability Subclasses have disabilities that substantially limit a major life activity or major bodily function.[128]

[128] Several conditions within the disability subclasses are expressly identified in regulations as presumptively covered disabilities. 28 C.F.R. § 35.108(d)(2)(iii) ("it should easily be concluded" that "[c]ancer substantially limits normal cell growth . . . diabetes substantially limits endocrine

83. Petitioners and Class Members are "qualified" for Defendants' programs, services, and activities, including provision of necessary medical treatment, including medical furlough when necessary; home confinement under 34-A M.R.S. § 3036-A; and safe, constitutional living conditions during confinement; and medical care and rehabilitative services to prepare for reentry after release. 42 U.S.C. § 12131(2); 28 C.F.R. § 35.104; 28 C.F.R. § Pt. 35, App. B ("[T]itle II applies to anything a public entity does").

84. The Maine Department of Corrections is a "public entity" for purposes of the ADA, and is bound to comply with Title II. 42 U.S.C. § 12131(B) ("public entity" includes "any department, agency, special purpose district, or other instrumentality of a State or States or local government"); *see also Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998). The Maine DOC also receives federal funds for purposes of the Rehabilitation Act.

2. Under the ADA and Section 504, DOC has an Affirmative Obligation to Ensure Equal and Equally Safe Access to Programs, Services, and Activities and to Avoid Disability Discrimination Against Disabled Class Members.

85. In order to avoid disability discrimination, public entities have an affirmative obligation to ensure that people with disabilities can participate in all of the entity's programs, benefits, and services on an equal and equally safe basis as people without disabilities. 28 C.F.R. §§ 35.102(a), 35.130(a)-(b); *Pierce v. D.C.*, 128 F. Supp. 3d 250, 266 (D.D.C. 2015) ("[B]ecause Congress was concerned that '[d]iscrimination against [people with disabilities] was . . . most often the product, not of invidious animus, but rather of thoughtlessness and indifference – of benign neglect[,]' the express prohibitions against

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function . . . epilepsy . . . substantially limits neurological function . . . HIV infection substantially limits immune function."

disability-based discrimination in Section 504 and Title II include *an affirmative obligation* to make benefits, services, and programs accessible to disabled people"); *id.* at 269 ("[N]othing in the disability discrimination statutes even remotely suggests that covered entities have the option of being passive in their approach to disabled individuals as far as the provision of accommodations is concerned."). Public entities must avoid policies, practices, criteria, or methods of administration that have the purpose or effect of excluding or discriminating against persons with disabilities. 28 C.F.R. § 35.130(b)(3), (8).

86. These affirmative obligations include a requirement that public entities make reasonable modifications to their policies, practices, or procedures where necessary to avoid disability discrimination. 28 C.F.R. § 35.130(b)(7)(i). The ADA also prohibits public entities from "utiliz[ing] criteria or methods of administration . . . [t]hat have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability" or "[t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities." 28 C.F.R. § 35.130(b)(3)(i)-(ii).

3. **Reasonable modifications, including release of the Disability Subclass, are required under the ADA and Section 504.**

87. DOC discriminates against the Disability Subclass by refusing to "affirmatively accommodate" their disabilities as necessary to provide "meaningful access to a public service." *Nunes v. Mass. Dep't of Correction*, 766 F.3d 136, 145 (1st Cir. 2014) (citation omitted). The Disability Subclasses are entitled to full constitutional protections, as well as reasonable modifications under disability rights laws to ensure they can participate equally and with equal safety in Defendants' programs, services, and activities. Defendants' programs, services, and activities include provision of necessary medical treatment,

including medical furlough when necessary, 34-A M.R.S. § 3035(C)(2); rehabilitative programs such as home confinement under 34-A M.R.S. § 3036-A; and safe, constitutional living conditions during confinement to prepare the person for a safe return to society at the end of their sentence. Disability Subclass members cannot access these services equally if they are severely ill, unconscious, or dead. Because of their high risk of these catastrophic outcomes—which will inevitably result in exclusion from the jail's programs—the jail must release them as a reasonable modification, and to avoid unlawful discriminatory methods of administration.

88. DOC has also excluded members of the Disability Subclass from available medical services and rehabilitative programs—namely, medical furlough and home confinement. Release to the community is a reasonable and necessary accommodation for many members of the Disability Subclass, who require space to physically distance and protect themselves from the virus. By categorically making medical furlough unavailable during the pandemic, DOC discriminates against members of the Disability Subclass who require life-saving preventive care (physical distancing) that is only available outside of the prison. And by applying stricter-than-usual standards for home confinement during the pandemic and by failing to process applications in a reasonable timeframe, DOC discriminates against Subclass Members with disabilities who are at heightened risk from the pandemic. In short, by categorically refusing to provide access to medical furlough and by denying reasonable access to home confinement, DOC has denied access to necessary treatments and programs in violation of disability rights laws.

89. Release of the Disability Subclasses is a reasonable modification and is not a fundamental alteration. *Cf. Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 1003 (E.D. Cal. 2009);

Inmates of Allegheny Cnty. Jail v. Peirce, 487 F. Supp. 638, 644 (W.D. Pa. 1980); *cf. Henrietta D. v. Bloomberg*, 331 F.3d 261, 281 (2d Cir. 2003) ("[t]he reasonableness of the modifications that plaintiffs seek . . . is evidenced by the fact that virtually all are modifications that defendants have long purported … to provide") (quoting *Henrietta D. v. Giuliani*, 119 F. Supp. 2d 181, 208 n.17 (E.D.N.Y. 2000)). Release on medical furlough, home confinement, or another accommodation is the most effective and reasonable modification to ensure Disability Subclass members are not subject to disability discrimination.

C. 28 U.S.C. § 2241 is an Appropriate Vehicle to Remedy these Violations

90. Section 2241(c)(3) allows this court to order the release of inmates like Petitioners who are held "in violation of the Constitution or laws . . . of the United States." 28 U.S.C. 2241(c)(3); *Peyton v. Rowe*, 391 U.S. 54, 67 (1968) (Section 2241(c)(3) can afford immediate release for claims other than those challenging the sentence itself). This circuit has confirmed that Section 2241 is available for so-called "conditions of confinement" challenges. *Miller v. U.S.*, 564 F.2d 103, 105 (1st Cir. 1977) ("Section 2241 provides a remedy for a federal prisoner who contests the conditions of his confinement.").[129]

[129] *See Miller v. U.S.*, 564 F.2d 103, 105 (1st Cir. 1977) ("Section 2241 provides a remedy for a federal prisoner who contests the conditions of his confinement."); *see also Thompson v. Choinski*, 525 F.3d 205, 209 (2d Cir. 2008) ("This court has long interpreted § 2241 as applying to challenges to the execution of a federal sentence, 'including such matters as the administration of parole, . . . prison disciplinary actions, prison transfers, type of detention and prison conditions.'"); *Aamer v. Obama*, 742 F.3d 1023, 1032 (D.C. Cir. 2014) ("Our precedent establishes that one in custody may challenge the conditions of his confinement in a petition for habeas corpus.").

91. Habeas corpus is the appropriate remedy when a petitioner challenges "the fact or duration of his confinement" or seeks a "quantum change" to a less restrictive form of custody. *Gonzalez-Fuentes v. Molina*, 607 F.3d 864, 873 (1st Cir. 2010) (citing, *e.g.*, *Wilkinson v. Dotson*, 544 U.S. 74, 78 (2005)); *Dickerson v. Walsh*, 750 F.2d 150, 152 (1st Cir. 1984). In this case, Petitioners and Class Members challenge the fact of their confinement, which, they allege, has "become unconstitutional because of the COVID-19 pandemic risk." *McPherson v. Lamont*, No. 3:20CV534, 2020 WL 2198279, at *4 (D. Conn. May 6, 2020) (exercising jurisdiction over a section 2241 habeas petition challenging unlawful confinement during the COVID-19 pandemic) (citing cases).

D. Exhaustion of State Remedies in the Face of COVID-19 Spread Would Be Futile

92. Federal courts apply a judge-made exhaustion doctrine in § 2241 cases. *See Braden v. 30th Judicial Circuit Court of Kentucky*, 410 U.S. 484, 490 (1973).[130] Unlike the statutory exhaustion requirement in § 2254, the judge-made exhaustion requirement for § 2241 petitions is prudential, flexible, and non-jurisdictional. *See, e.g. Santiago-Lugo v. Warden*, 785 F.3d 467, 474 (11th Cir. 2015). The Supreme Court has described the exhaustion doctrine in § 2241 cases as a "judicially crafted instrument which reflects a careful balance between important interests of federalism and the need to preserve the writ of habeas corpus as a 'swift and imperative remedy in all cases of illegal restraint or

[130] *Cf. Deere v. Superior Court of Cal.*, No. 07-56109, 2009 WL 2386677, at *1 (9th Cir. Aug. 5, 2009) (declining to decide the question of whether a § 2241 petitioner must first exhaust his state remedies "to the extent this question has not been decided."); *U.S. v. Castor*, 937 F.2d 293, 296-297 (7th Cir. 1991) ("While these applicants [defendants awaiting trial] are not subject to the statutory requirement of exhaustion remedies, 28 U.S.C. § 2254(b)(1988) … federal courts nevertheless may require, as a matter of comity, that such detainees exhaust all avenues….").

confinement.'" *Braden*, 410 U.S. at 490 (citation omitted). Courts, accordingly, apply it with those dual purposes in mind. *See, e.g.*, *Park v. Thompson*, 356 F. Supp. 783, 788 (D. Haw. 1973) ("It is the legal issues that are to be exhausted, not the petitioner.").

93. Courts have also recognized that exhaustion is excused where it would be futile. "Although the exhaustion rule is important, it is not immutable: exhaustion of remedies is not a jurisdictional prerequisite to a habeas petition, but, rather, a gatekeeping provision rooted in concepts of federalism and comity." *Allen v. Attorney Gen. of State of Me.*, 80 F.3d 569, 573 (1st Cir. 1996); *Schandelmeier v. Cunningham*, 819 F.2d 52, 53 (3d Cir. 1986) (applying futility doctrine to state prisoner seeking Section 2241 habeas relief). *McPherson v. Lamont*, No. 3:20CV534 (JBA), 2020 WL 2198279, at *4 (D. Conn. May 6, 2020)2012) (quoting *Beharry v. Aschcroft*, 329 F.3d 51, 62 (2d Cir. 2003). A state corrective process may be futile when it "is so clearly deficient as to render futile any effort to obtain relief." *Duckworth v. Serrano*, 454 U.S. 1, 3 (1981).

94. Efforts to obtain relief for Petitioners demonstrate that it would be not only futile, but dangerous to force Petitioners and Class Members to exhaust state remedies when their risk of COVID-19 contraction is increasing by the minute. "[U]ndue delay, if it in fact results in catastrophic health consequences, could make exhaustion futile." *McPherson v. Lamont*, No. 3:20CV534 (JBA), 2020 WL 2198279, at *6 (D. Conn. May 6, 2020) (citing *Washington v. Barr*, 925 F.3d 109, 118 (2d Cir. 2019)). It would be futile to seek such relief in state court, where Mr. Denbow's individual petition for post-conviction review has languished without a hearing for nearly five weeks (since April 13, 2020), Denbow

Decl., ¶ 27, and where Maine criminal procedure requires singular treatment of post-conviction review, and does not authorize class treatment. *See* M.R. Crim. P. 67(b).[131]

95. In light of the unprecedented crisis presented by the COVID-19 pandemic, class relief is essential to promote efficiency, consistency, and fairness, and to improve access to legal and expert assistance by parties with limited resources.[132] Class relief is essential because proceeding on a case-by-case basis is too cumbersome in the face of the unprecedented COVID-19 pandemic—as illustrated by outbreaks across the country.[133] As such, exhaustion is futile for proposed Class Members, because requiring each member to individually petition the state court would burden the limited judicial resources during this

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[131] *See also* M. R. Crim. P. 67(b) (requiring that a single petition may attack only a single proceeding); M.R. Civ. P. 23 (applying only in civil actions, not criminal actions like post-conviction reviews).

[132] *Monk v. Shulkin*, 855 F.3d 1312, 1320–21 (Fed. Cir. 2017) (referencing inherent authority to aggregate cases when it "promot[es] efficiency, consistency, and fairness, and improving access to legal and expert assistance by parties with limited resources"); Stephen C. Robin, *Healing Medicare*, 95 N.C. L. Rev. 1293, 1303 (2017) (citing *Barr*, 930 F.2d at 74; *Air Line Pilots Ass'n, Int'l v. Civil Aeronautics Bd.*, 750 F.2d 81 (D.C. Cir. 1984)) (suggesting a preference for suits brought on behalf of a class or association, where the court can "shift[ ] its focus from one claimant to the whole system" and "simply address[ ] the unreasonable delays felt by all of the potential parties with claims under the Act in question"); *Harshaw v. Farrell*, 55 Ohio App. 2d 246, 247, 380 N.E.2d 749, 750–51 (Ohio Ct. App. 1977) (holding that "a class action in habeas corpus may be the swiftest, fairest, and most effective way to obtain common relief for a large group of persons who are confined unlawfully under similar or identical circumstances").

[133] Recent news includes outbreaks in jails and prisons in Tennessee, Massachusetts, and Michigan. *See, e.g.*, COVID-19 outbreak infecting over 500 prisoners may have come from staff: Medical director (Apr. 28, 2020), https://abcnews.go.com/US/covid-19-outbreak-infecting-500-prisoners-staff-medical/story?id=70382322; Mass. Prisons And Jails Among Hardest Hit By Coronavirus In U.S. (Apr. 28, 2020), https://www.wbur.org/investigations/2020/04/28/coronavirus-prisons-jails-massachusetts-deaths-cases; Lakeland has the most positive COVID-19 cases of all M.D.O.C facilities (87 percent of tested prisoners were positive for the coronavirus) (Apr. 22, 2020), https://wtvbam.com/news/articles/2020/apr/22/lakeland-has-the-most-positive-covid-19-cases-of-all-mdoc-facilities/1009979/.

emergency and cause further delay. The risk of irreparable harm to Petitioners and Class Members is simply too high to require exhaustion in this circumstance.

V. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

Unconstitutional Punishment in Violation of the Eighth Amendment to the U.S. Constitution
28 U.S.C. § 2241

96. Under the Eighth Amendment, persons in carceral custody have a right to be free from cruel and unusual punishment. As part of the right, the government must provide incarcerated persons with reasonable safety and address serious medical needs that arise in jail. *See, e.g., Estelle*, 429 U.S. at 104; *DeShaney*, 489 U.S. at 200. Deliberate indifference to the serious risk COVID-19 poses to Class Members infringes on the protection from cruel and unusual punishment. Respondents violate this right by subjecting Class Members to conditions of confinement that do not ensure their safety and health.

97. The Prison has neither the capacity nor the ability to comply with public health guidelines to prevent an outbreak of COVID-19 and cannot provide for the safety of the Post-Conviction Class.

98. Respondents' actions and inactions result in the confinement of members of the Post-Conviction Class in a jail where they do not have the capacity to test for, treat, or prevent COVID-19 outbreaks, which violates Petitioners's rights to treatment and adequate medical care.

99. By operating prison without the capacity to test for, treat, or prevent a COVID-19 outbreak, Respondents, as supervisors, direct participants, and policy makers for the Maine Department of Corrections have violated the rights of Class Members under the Eighth Amendment.

SECOND CLAIM FOR RELIEF

Discrimination on the Basis of Disability in Violation of Title II of the ADA

42 U.S.C. § 12131 *et seq.* / 28 U.S.C. § 2241

Disability Subclass versus all Respondents

100. Petitioners incorporate by reference each of the preceding paragraphs and allegations as if fully set forth herein.

101. Title II of the ADA requires that public entities refrain from discriminating against qualified individuals on the basis of disability. 42 U.S.C. § 12132. The regulations implementing Title II of the ADA require that public entities avoid unnecessary policies, practices, criteria or methods of administration that have the effect of excluding or discriminating against persons with disabilities in the entity's programs, services, or activities. 28 C.F.R. § 35.130(a), (b)(3), (b)(8). Further, a public entity must "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7)(i).

102. Petitioners Ragsdale and Denbow are individuals with disabilities for purposes of the ADA. 42 U.S.C. § 12102. As people held in the Maine Department of Corrections, they are "qualified" for the programs, services, and activities being challenged herein. 42 U.S.C. § 12131(2).

103. Defendants are violating Title II of the ADA by failing to make the reasonable modifications necessary to ensure equal access to adjudication, jail services, and release for people with disabilities who face high risk of complications or death in the event of

COVID-19 infection. Defendants are further violating the ADA by employing methods of administration (including a policy of non-release even in the face of COVID-19) that tend to discriminate against people with disabilities by placing them at heightened risk of severe illness and death.

THIRD CLAIM FOR RELIEF

Discrimination on the Basis of Disability in Violation of Section 504 of the Rehabilitation Act

29 U.S.C. § 794 *et seq.* / 28 U.S.C. § 2241

Disability Subclass versus all Respondents

104. Section 504 of the Rehabilitation Act states that "no otherwise qualified individual with disability in the United States . . . shall, solely by reason of [] disability, be excluded from the participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a). The regulations implementing Section 504 of the Rehabilitation Act require that entities receiving federal financial assistance avoid unnecessary policies, practices criteria or methods of administration that have the effect of discriminating against persons with disabilities. 28 C.F.R. § 41.51(b)(3)(i).

105. 134. Defendants receive "Federal financial assistance" within the meaning of 28 U.S.C. § 794(a).

106. Petitioners Ragsdale and Denbow are individuals with disabilities for purposes of the Rehabilitation Act, 42 U.S.C. § 12012, 29 U.S.C. § 705(20)(B). As people held in the Maine Department of Corrections, they are "qualified" for the programs, services, and activities being challenged herein.

107. Defendants are violating section 504 of the Rehabilitation Act by failing to make the reasonable modifications necessary to ensure equal access to adjudication, jail services, and release for people with disabilities who face high risk of complications or death in the event of COVID-19 infection. Defendants are further violating the ADA by employing methods of administration (including a policy of non-release even in the face of COVID-19) that tend to discriminate against people with disabilities by placing them at heightened risk of severe illness and death.

VI. REQUEST FOR RELIEF

108. Petitioners and Class Members respectfully request that the Court order the following:

1. Certification of this Petition as a Class Action;
2. A temporary restraining order, preliminary injunction, permanent injunction, order of enlargement, and/or writ of habeas corpus
    a. declaring that it is unconstitutional and unlawful for DOC to categorically deny access to medical furlough during the pandemic;
    b. ordering DOC to identify members of the medically vulnerable class, the imminent release subclass, the minimum-or-community custody subclass, and the disability subclass, within two days;
    c. order DOC to evaluate, under standards that comply with the Eighth Amendment and federal disability laws, each class member's eligibility for medical furlough, home confinement, or another accommodation to enable social distancing, or, in the alternative, appoint a Rule 706 expert to complete such evaluation; and

d. order enlargement for Class Members to safely physically distance in the community or another appropriate setting;

3. A declaration that DOC's policies and practices violate the Eighth Amendment right against cruel and unusual punishment;
4. A declaration that DOC's policies and practices violate the ADA and Rehabilitation Act's prohibition of discrimination on the basis of disability;
5. All further action required to release Class and Subclass Members to ensure that all remaining persons are incarcerated in DOC facilities under conditions consistent with CDC guidance to prevent the spread of COVID-19, including requiring that all persons be able to maintain six feet or more of space between them;
6. Any further relief this Court deems appropriate.

Dated: May 15, 2020

Respectfully Submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

JOSEPH A. DENBOW and SEAN R. RAGSDALE, *on their own and on behalf of a class of similarly situated persons,* *Petitioners,* v. RANDALL A. LIBERTY, Commissioner of Maine Department of Corrections *in his official capacity*, MAINE DEPARTMENT OF CORRECTIONS, *Respondents*	Case No. _____

DECLARATION OF JOSEPH DENBOW

I, Joseph Denbow, am over the age of 18 and fully competent to make the following declaration:

1. I am currently incarcerated in the Maine Department of Corrections (DOC), Mountain View Correctional Facility. My DOC number is 33030. I am 54 years old and suffer from numerous chronic health conditions that I understand place me at higher risk for severe illness or death from COVID-19. I receive Social Security income because of my disabilities.
2. I have already served the majority of a two-year prison sentence. My earliest release date is August 30, 2020. I am incarcerated for driving without a license and for initially giving the traffic officer my brother's name instead of my own (resulting in a conviction of aggravated forgery). I have been unable to pay off fines associated with decades-old driving offenses and this is my second time serving a sentence in prison for driving on a revoked license. Even once I am released, I will remain supervised by the DOC during 2 years of probation.
3. I am terrified of dying in prison from this respiratory disease. Many years ago, my three-month-old daughter died from a respiratory virus after my girlfriend and I unsuccessfully sought care at a local hospital. I understand all too well that respiratory viruses can be deadly. I do not want to become the next prisoner who dies from COVID-19 in prison without being able to see my family again.

Medical Conditions and History

4. I am 54 years old and suffer from asthma and chronic obstructive pulmonary disease. I am in remission from a recent bout with colorectal cancer, which required chemotherapy, radiation, and pain medication. I am prescribed two different inhalers to manage my asthma, plus nebulizer treatment as needed. I use my inhaler 3-4 times a week. My parents both died of lung cancer, and my brother and sister-in-law recently passed away from lung disease.

5. As a result of the opioid medication prescribed for chronic post-operative pain during and after my cancer treatment, I developed an addiction to opioids and am now in treatment with medication for addiction treatment (MAT).

6. I believe my cancer is in remission, but in November 2019, the medical provider reviewed a CT scan and found a lesion on my kidney, and stated that the lesion would require further evaluation. It can be hard to access medical care in the Maine Department of Corrections. I have not received additional care or evaluation for the potential kidney lesion, despite discussing it with another medical provider at a January 2020 appointment. Apparently in response to this concern, a doctor recently notified me that I am in remission, but he did not say that they would provide any follow-up evaluation or treatment for any lesion on my kidney.

7. None of the medical providers are able to assure me that I will be protected from the virus in this facility, or that I will be able to get necessary care if I get sick. On March 23, I put in a sick call slip explaining that I was "overwhelmed with worry / stress over this coronavirus and not being scanned in 8 months to see where my cancer situation [is] at[.]" At the medical appointment, I told the provider that I need someone to protect me from the virus and said "I didn't come to prison to die." In medical notes, the provider noted she was "unable to provide much reassurance." I have talked with another medical provider who said that DOC does not know what they will do when the virus comes to the facility.

8. I am also diagnosed with several psychiatric conditions in addition to substance use disorder, including anxiety, depression, and post-traumatic stress disorder.

Home Confinement or Medical Furlough

9. I am classified as "minimum" level supervision, and I am allowed to go off of prison grounds to work in the community. Before the COVID-19-related restrictions, I was trusted to work in the community during the day at various locations and return to the prison at night. My jobs in the community included projects like sheet rocking and painting, as well as setting up tables and chairs for town meetings.

10. Yet DOC has refused to allow me to physically distance in community custody during the COVID-19 pandemic.

11. The staff reviewing my application for community custody found that my work attendance, performance, and other issues were satisfactory, and noted that I had "been a great worker and ha[d] shown good attitudes toward others." However, they denied my application, stating that I had a "previous SCCP failure" almost seven years ago.

    a. Specifically, when I was incarcerated in 2012 to 2014 for an earlier instance of driving on a revoked license, I was temporarily released on SCCP in 2013 to attend college classes in the community.

    b. DOC revoked my SCCP based on alleged violations of the SCCP conditions, including dropping out of school. I tried to explain to the DOC that I had a doctor's note for stopping my classes (including for symptoms that would later be diagnosed as cancer). I was not charged with any new criminal conduct or probation violation, and never posed a risk to anyone in the community.

c. This "previous SCCP failure" is the sole reason provided for keeping me in prison, where I am afraid I could get sick and die from COVID-19.

12. I want to be able to safely socially distance in the community with my fiancé. My fiancé and I both receive Social Security income payments for our disabilities and, once we got settled, could use those funds to pay for necessities like rent and food. But my fiancé is currently living with her daughter and cannot plan for housing for us until she knows whether I will be allowed to get out.

13. Other people who have jobs in the community have been released on SCCP. Most people who I talk to in my minimum-security dorm who have medical conditions are nowhere close to getting approved for SCCP. When I was talking with my case worker about the possibility of being released because of my medical conditions, she responded that nobody with medical conditions was getting out, saying "there's nobody being released because of medical conditions, so you can get that idea right out of your head."

14. I do not know anybody who has been released on medical furlough because of COVID-19.

Conditions in the Prison

15. DOC policies make social distancing impossible. I live in constant fear that the more-than-fifty people who I have close contact with each day could be carrying or spreading the virus.

16. I share a dorm, common rooms, sinks, showers, and toilets, with approximately fifty other inmates. Although there are upstairs and downstairs bathrooms in the dorm, my cell is on the lower floor, where the common rooms are, and many prisoners use the downstairs bathrooms while they are using the common rooms.

17. I sleep in an approximately 8 foot by 10 foot cell with three other prisoners. Another prisoner sleeps in the bunk right on top of me. Two other people are across the room. I have no way of knowing whether the other people in my cell have done a thorough job of washing their hands, or whether they may be carrying the virus.

18. I have no idea whether other prisoners or staff could have the virus, and, for most people, I do not think that DOC knows either.

    a. Nobody that I talk to has been tested.

    b. As to prison staff, DOC states that they do temperature checks and symptom-screening of staff when they arrive at the facility. But DOC does not provide us with information about testing for prison staff. Some guards have stayed home lately. I do not know whether the officers are staying home because they have symptoms of the disease. I saw news reports that an officer at Bolduc Facility tested positive, but I do not know whether any of the officers at Mountain View have tested positive.

19. I have read that COVID-19 can live on surfaces for days and I am afraid that the virus could be living on surfaces throughout the dorm (including in the shared bathrooms). We are assigned to clean the dorms several times a day, but there is no supervision to make sure people do a good job. I am not assigned to clean the dorms or bathrooms, but I do it anyway when I can tell that people have not been cleaning as necessary. When I do the

cleaning, I am thorough because I know that I am at high risk for serious illness or death from COVID-19. But other prisoners are not as careful as I am, if they even remember to clean at all. I am worried that door knobs, surfaces, bathroom sinks and showers, and the phone area, are not thoroughly cleaned (if they are cleaned at all), and that the virus could spread on surfaces in those locations.

a. We do not have any bleach or bleach-based materials to clean. Instead, the cleaning materials that DOC provides are: Correct Pac Glass Cleaner, Eco Lab High Performance Floor Cleaner, and Eco Lab Neutral Bathroom Cleaner. There has not been any change in the cleaning materials since we learned about COVID-19.

20. We have access to soap and hand sanitizer to clean our hands. For weeks, I have been using the hand sanitizer to help protect me from COVID-19, because I was told that hand sanitizer can kill the virus.

    a. But I recently learned that the hand sanitizer that DOC provides does not have any alcohol in it, and is not the type of hand sanitizer that the CDC has said would be effective against the virus. The type of hand sanitizer that we have access to is Deb Instant Foam Pure – no alcohol. I feel upset that DOC was giving me wrong information about how to protect myself against COVID-19.

    b. The only place to wash my hands is in the bathroom that is shared among approximately 50 people.

21. All prison staff and prisoners now have access to masks, but most people do not wear masks most of the time, including in the dorm surrounded by 50+ people.

    a. There is no enforcement of any requirements for prisoners to wear masks in the dorm, which has approximately fifty prisoners, plus officers.

    b. The masks that are provided to prisoners look like they are made of the same material as our boxer shorts, with elastics on both sides. After a couple times being washed, they are already falling apart.

22. Even though I try to stay away from other people as much as possible, there are many times each day when I cannot avoid close contact with other people.

    a. I wake up each morning in my cell with three other inmates close by, including in the top bunk right over my bottom bunk, and another bunk bed nearby.

    b. When traveling throughout the facility, whether going to meals or to get medication, we are bunched up together and keeping distance is impossible.

    c. We go to the meal hall every other day. During meal times, we are supposed to eat six feet apart from each other in the meal hall, but in traveling to the meal hall, we are bunched up together, heel-to-heel, because there is not enough space. We aren't supposed to be around other dorms, but another dorm usually comes into the meal hall before we're finished eating. That's even more people that I'm exposed to many days of the week.

    d. I receive medication for addiction treatment (MAT). To get that medication, I go to another building and sit in a small room with seven other prisoners, none of us

wearing masks. The officers get really close to all of us to look in our mouths and to make sure that we are following the rules.

e. During the day, approximately fifty inmates share common areas in the dorm. One common room is about 16 by 18 feet, and the second room is about 10 by 15 feet. People hang out in there playing cards or watching TV. People are usually right on top of each other. Sometimes up to 9 people are in a day room and not wearing masks. It is impossible to physically distance in that space.

f. We are also crowded together when waiting to use the phones, which are basically our only way to communicate with our families, friends, or lawyers, now that visitation is cancelled. The phone area is especially crowded during the evenings and there is nobody cleaning the phones between uses. I try to protect myself by using antiseptic wipes on the phone before I use them, but I do not even know whether the wipes are effective to kill the virus.

23. I am afraid that even if other prisoners get sick, they will try to hide it (and infect the rest of us) because they're afraid of going to "seg." DOC has not told us their plan for people who are sick with COVID-19 and people assume that if they start showing signs of a fever or other symptoms, they will be put in isolation or in segregation. I have heard several people say that, if they start to feel symptoms, they will try to hide it so that they will not have to go to seg.

24. DOC continues to transfer people between dorms, including moving people between medium security and minimum security dorms. When people are moved between housing units, they are not quarantined or isolated for fourteen days. They are immediately part of the general population in the new dorm.

25. The staff here go through the motions for social distancing, but they do not take the risk of infection seriously. I have heard several officers say that they do not think the virus will get in here. Other staff say that the prison is the safest place that you can be. The other day, one of the officers told us that there were only supposed to be five people outside, but then said "what's the difference . . . you're all mingled together all day anyway." I heard another officer say "they're just going through the motions."

26. DOC tries to keep us limited to our dorm, but I am still worried that the staff could quickly spread the disease between the dorms. Officers from many different dorms congregate together and then travel to and from the dorms all around the facility. Not to mention that the staff travel to and from the community every day. I am afraid that, with the reopening, staff are more likely to get infected in the community and to bring the virus into the facility and spread it around all the dorms. If the virus got in, I am afraid it would spread like wildfire.

Case in State Court

27. On March 13, 2020, my lawyer filed a case in state court that I thought might protect me from COVID-19 and let me quarantine in the community. But now I've been waiting for more than four weeks without any word from the court or hearing scheduled.

28. Every day that something doesn't happen is another day COVID-19 could get here. I am afraid that every additional day I am in prison could be the day that I will become infected with COVID-19. I do not want to die in prison.

29. I have provided my attorney with authority to use my electronic signature.

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

Dated May 9, 2020

/s/ Joseph Denbow

Joseph Denbow

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

JOSEPH A. DENBOW and SEAN R. RAGSDALE, *on their own and on behalf of a class of similarly situated persons,* *Petitioners,* v. RANDALL A. LIBERTY, Commissioner of Maine Department of Corrections *in his official capacity,* MAINE DEPARTMENT OF CORRECTIONS, *Respondents*	Case No. _____

DECLARATION OF SEAN RAGSDALE

I, Sean Ragsdale, am over the age of 18 and fully competent to make the following declaration:

1. I am currently incarcerated in the Maine Department of Corrections (DOC), Mountain View Correctional Facility. My DOC number is 126457. I was convicted of drug trafficking and have served almost all of my four-year sentence. My earliest release date is July 17, 2020. Once I am released, I will remain supervised by the DOC during three years of probation.
2. I have seen news reports of outbreaks of COVID-19 in prisons across the country. I understand that COVID-19 can be transmitted by people who do not show symptoms of the disease and I am afraid that there may be a current, undetected outbreak in Mountain View facility, or an outbreak at some point before I am released from prison in July 2020.
3. I am scared that I will get infected with COVID-19 in the next two months, and could get sick and die before I am released. I just want to keep myself safe by physically distancing in the community.

Medical Conditions and History

4. I am 56 years old. I have a long-term chest infection, diabetes, Hepatitis C, and MRSA (a blood infection). I use an inhaler for my chest infection, to open up my lungs so I can breathe. I also inject insulin twice a day as treatment for my diabetes. I have liver damage as a result of Hepatitis C and am not provided medication by DOC to treat Hepatitis C.
5. I got the chest infection because DOC assigned me to work in the boiler room under dangerous conditions. The boiler room heats one side of the entire prison. The job was to take four-foot lengths of wood that weigh more than 100 pounds with ice and snow from

outside and throw it in the boiler. I was assigned to this job for about four months, from September 2019 to mid-February 2020. During that time, I developed a chest infection, but I wasn't allowed to stop doing that job until I got a medical work hold. Even then, DOC gave me a disciplinary write-up for stopping work.

6. I also have multiple diagnosed mental illnesses, including schizophrenia, bipolar, and post-traumatic stress disorder.

7. As a result of my physical and mental disabilities, I previously received Social Security income (SSI). This income was paused during my time in prison, but I have applied to have the income restarted upon my release and expect to receive a decision within the next few days.

Home Confinement and Medical Furlough

8. I am classified as "community" level supervision, which means that the DOC has approved me to work in the community. But for the COVID-19-related restrictions, I would be authorized to work in the community during the day and return to the prison at night.

9. I applied for Supervised Community Confinement, but did not receive any response for about a month. The person responsible for reviewing the SCCP requests was out sick for two weeks and nobody else was assigned to review the requests.

10. My lawyer sent a demand letter on May 4th, asking for release on SCCP or medical furlough, or for another accommodation under the Americans with Disabilities Act. The next day, I received a message from Diana Whyte, a secretary of classification at the Mountain View Facility that they had reviewed my request and provided another packet for me to fill out that will be transferred to Augusta for further review. I am still not approved for SCCP or medical furlough and the process could take a long time. The DOC said that "[t]here is no guarantee that your application will be processed immediately" and that "[a]t this time very limited home investigations are being done." "If it is not done now, it will be done when normal operations resume." I am afraid that "normal operations" means operations after the risk from COVID-19 has passed, which could be a very long time. I am afraid that "normal operations" will not return until after it is too late for me.

11. I am going to be released anyway in approximately two months and I will be safer if I am released (and allowed to physically distance) in the community before I am exposed and infected with COVID-19.

Conditions in the Prison

12. DOC policies and facilities make social distancing impossible. I am afraid that the more-than-fifty people who I have close contact with each day could be carrying or spreading the virus.

13. I share a dorm, common rooms, sinks, showers, and toilets, with approximately 50 other inmates. Although there are upstairs and downstairs bathrooms, my cell is on the lower

floor, where the common rooms are, and many prisoners use the downstairs bathrooms while they are using the common rooms.

14. I sleep in an approximately 10 foot by 10 foot cell with three other prisoners. Another prisoner sleeps in the bunk right on top of me. Two other people are across the room. I have no way of knowing whether the other people in my cell have done a thorough job of washing their hands, or whether they may be carrying the virus.

15. I have no idea whether other prisoners or staff could have the virus. As to prison staff, DOC states that they do temperature checks and symptom-screening of staff when they arrive at the facility. But DOC does not provide us with information about testing for prison staff. Some guards have been staying home lately. I do not know whether the officers are staying home because they have symptoms of the disease. I saw news reports that an officer at Bolduc tested positive, but I do not know whether any of the officers at Mountain View have tested positive.

16. I have read that COVID-19 can live on surfaces for days and I am afraid that the virus could be living on surfaces throughout the dorm (including in the shared bathrooms). Prisoners are assigned to clean the dorms several times a day, but there is no supervision to make sure people do a good job. When it is my turn to clean the dorms and bathrooms, I am thorough because I know that I am at high risk for serious illness or death from COVID-19. I clean the bathrooms and showers, which are often littered with used razors or other trash. I am worried that other prisoners are not as careful as I am, and I am worried that door knobs, surfaces, bathroom sinks and showers, and the phone area, are not thoroughly cleaned, and that the virus could spread on surfaces in those locations.

    a. We do not have any bleach or bleach-based materials to clean the dorm. Instead, the cleaning materials that DOC provides are: Correct Pack Glass Cleaner, Eco Lab High Performance Floor Cleaner, and Eco Lab Neutral Bathroom Cleaner. There has not been any change in the cleaning materials since we learned about COVID-19.

17. We have access to soap and hand sanitizer to wash our hands. But the hand sanitizer that DOC provides does not have any alcohol in it, and is not the type of hand sanitizer that the CDC has said would be effective against COVID-19. The type of hand sanitizer that we have access to is Deb instant foam pure – no alcohol. The only place to wash my hands is in the bathroom that is shared among approximately 50 people.

18. All prison staff and prisoners now have access to masks, but most people do not wear masks most of the time, including in the dorm surrounded by 50+ people.

    b. The masks that are provided to prisoners look like they are made of the same material as our boxer shorts, with elastics on both sides. After a couple times being washed, they already start to fall apart.

    c. Although these masks are supposed to be washed each night and returned to us, DOC has misplaced my replacement mask. Since then, I have been unable to have my mask washed because there is no replacement. As a result, my mask has not been machine-washed for more than a week. I have had to wash my mask in the bathroom sink.

d. DOC has also provided guards with masks, but many of them do not wear the masks when they are with each other or in their office, even though they travel to and from the facility each day and could be carrying the infection into the facility.

e. None of the guards or prisoners have N-95 masks.

19. Even though I try to stay away from other people as much as possible, there are many times each day when I cannot avoid close contact with other people.

f. I live in a dorm with about fifty other inmates. During the day, those fifty people share common areas. The common areas are approximately 10 by 15 feet in size and there are two in the dorm. Most prisoners do not wear masks in the dorms. It is impossible to physically distance.

g. I share a cell with three other prisoners. Nobody wears a mask when they sleep.

h. I have to get my insulin injection twice a day. To get my insulin, I have to walk to the other end of the building and get machine-searched and pat-searched by one or more correctional officer. I get a shot from the nurse, who wears a homemade mask or scarf. Nurses do not have N-95 masks. The nurses wear gloves but no other protective equipment. The nurses do not change gloves between patients.

a. If I was in my own apartment or room in the community, I could inject my insulin by myself at home.

i. There is a small outdoor space where people go to smoke and to be outside. It's about 10 by 10 feet. People are right on top of each other. The officers do not ask people to wear masks outside.

j. When traveling throughout the facility, we are bunched up together and keeping distance is impossible. For example, during meal times, we are supposed to eat six feet apart from each other, but in traveling to and from the meal hall, we are bunched up together, heel-to-heel, because there is not enough space. On the days when we are in the meal hall, prisoners from another dorm often comes in before we are finished eating, so we are exposed to dozens of other people.

k. To get our medication, we have to travel to the medication line, where we stand lined up, bunched up. People wear masks in the medication line but take them off when they get to the medication window, in order to swallow the pills in front of the officer and the nurse. The nurses do not wear gloves during the medication line.

l. We are also crowded together when waiting to use the phones, especially at night. Now that all visitation is cancelled, the phones are one of the only ways that we can communicate with friends and family in the community, or talk with a lawyer. The phone area is crowded and there is nobody cleaning the phones between uses. This area is visibly dirty and smell bad. But there is no other way that I can contact family members or my attorney.

m. About two weeks ago, there was a fire drill in which prison and staff—approximately 60 people in total—were crammed together outside of dorm 3. Maintaining physical distance was impossible.

20. DOC continues to transfer people between dorms, including moving people between medium security and minimum security dorms. When people are moved between housing units, they are not quarantined or isolated for fourteen days. They are immediately part of the general population in the new dorm.

21. I am afraid that even if other prisoners get sick, they will try to hide it (and infect the rest of us) because they're afraid of going to "seg." DOC has not told us their plan for when people get sick with COVID-19 and people assume that if they start showing signs of a fever or other symptoms, they will be put in isolation or in segregation. I have heard several people say that, if they start to feel symptoms, they will try to hide them so that they will not have to go to segregation or isolation.

22. DOC tries to keep us limited to our dorm, but I am still worried that the staff could quickly spread the disease between the dorms. Officers from many different dorms congregate together and then travel to and from the dorms all around the facility. Not to mention that the staff travel to and from the community every day. I am afraid that, with the reopening of the economy, staff are more likely to get infected in the community and to bring the virus into the facility and spread it around all the dorms. If the virus got in, I am afraid it would spread like wildfire.

23. I have provided my attorney with authority to use my electronic signature.

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

Date: May 13, 2020

/s/ Sean Ragsdale

Sean Ragsdale

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

JOSEPH A. DENBOW and SEAN R. RAGSDALE, *on their own and on behalf of a class of similarly situated persons,* *Petitioners,* v. RANDALL A. LIBERTY, Commissioner of Maine Department of Corrections *in his official capacity*, MAINE DEPARTMENT OF CORRECTIONS, *Respondents*	Case No. _____

DECLARATION OF ROY GIBSON PARRISH, MD

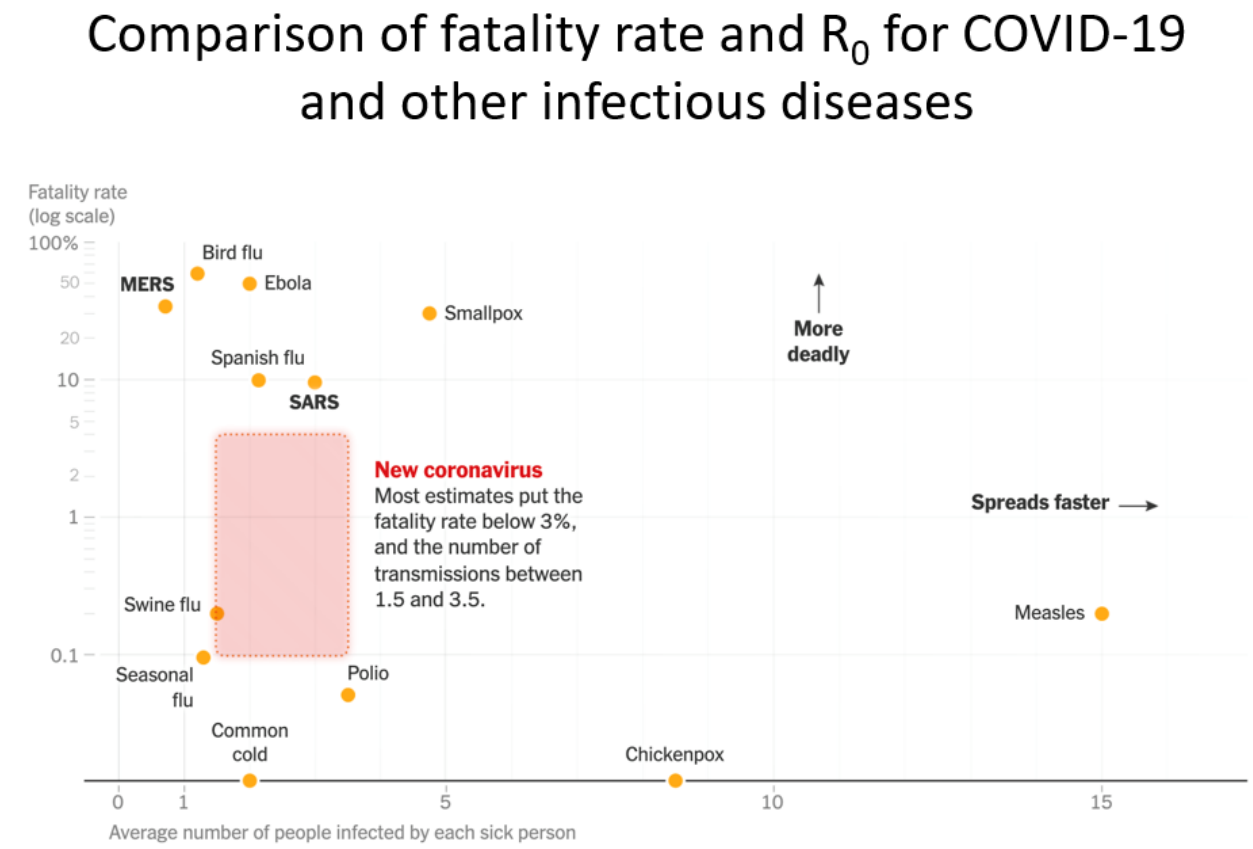
I, Roy Gibson Parrish, declare as follows:

1. I am a medical doctor with 35 years of experience as an epidemiologist. From 1982 through 2002, I served as a medical epidemiologist at the U.S. Centers for Disease Control and Prevention, including as the Acting Director of the Division of Public Health Surveillance and Informatics. Since leaving the CDC, I have worked as an independent consultant in population health and population health information systems, continuing to publish and make presentations around the country. From 2003 to 2011, I served as an Adjunct Associate Professor of Community and Family Medicine at Dartmouth Medical School, and from 2013 to the present, I have served on the Adjunct Faculty at the University of New Hampshire. I also currently teach classes at the Maine Medical Center. Attached as Exhibit A is a copy of my curriculum vitae.

COVID-19 Is a Highly Transmissible and Potentially Deadly Virus

2. COVID-19 is highly contagious and potentially deadly infection caused by the novel coronavirus SARS-COV-2. The following graph shows estimates of the virus's reproduction

number (*i.e.*, the average number of people who will contract a contagious disease from one person with that disease) and its fatality rate, based on existing knowledge about this novel virus. A higher contact rate between an infectious person and susceptible persons will contribute to a higher reproduction number—a factor that contributes to the rapid spread of the virus in closed, congregate settings like nursing homes, prisons, and jails.



Source: New York Times. How Bad Will the Coronavirus Outbreak Get? Here Are 6 Key Factors. By Knvul Sheikh, Derek Watkins, Jin Wu and Mika Gröndahl. Updated Feb. 7, 2020. https://www.nytimes.com/interactive/2020/world/asia/china-coronavirus-contain.html

3. According to the World Health Organization, as of May 12, 2020, there were more than four million confirmed cases worldwide, with more than 280,000 deaths.[1] The United

[1] Situation Report, World Health Organization (May 12, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200512-covid-19-sitrep-113.pdf?sfvrsn=feac3b6d_2.

States now has the highest number of reported cases in the world, with approximately 1,364,061 total cases, and 82,246 total deaths as of May 13, 2020.[2] In Maine, there were 1,515 confirmed cases and 66 deaths, as of May 13, 2020, though case numbers "are likely being undercounted."[3]

4. COVID-19 is a serious disease, which clinically can range from no or mild symptoms to respiratory failure and death. Symptoms can include cough, shortness of breath or difficulty breathing, fever, muscle pain, headache, sore throat, and new loss of taste or smell.[4]

5. Complications of the disease include pneumonia, respiratory failure, acute respiratory distress syndrome (ARDS), acute cardiac injury, multiple organ failure, and death.[5] Of the patients who experience pneumonia, some develop a dangerous condition known as ARDS, which causes damage to the walls of the air sacs in the lungs.[6] COVID-19 can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. Pneumonia is also associated with

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[2] Cases in the US, U.S. Centers for Disease Control and Prevention (May 12, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[3] Novel Coronavirus 2019 (COVID-19), Maine Center for Disease Control and Prevention, https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml; Steve Craig, Maine CDC reports 33 new coronavirus cases, 1 more death, Portland Press Herald (May 3, 2020), https://www.pressherald.com/2020/05/03/maine-cdc-reports-33-new-cases-one-death/.

[4] Symptoms of COVID-19, U.S. Centers for Disease Control and Prevention (last visited May 4, 2020), https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.

[5] Zhao, et al., *A comparative study on the clinical features of COVID-19 pneumonia to other pneumonias* (2020), https://bit.ly/3b5QhRp; Fei Zhou, et al., *Clinical Course and Risk Factors for Mortality of Adult Inpatients With COVID-19 in Wuhan, China: A Retrospective Cohort Study*, Lancet (Mar. 28, 2020), available at https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30566-3.pdf.

[6] https://health.clevelandclinic.org/heres-the-damage-coronavirus-covid-19-can-do-to-your-lungs/.

cardiac complications, "including new or worsening heart failure, new or worsening arrhythmia, or myocardial infarction."[7] There is also emerging evidence that the virus can trigger an over-response by the immune system in infected people, which can result in widespread damage to other organs,[8] including permanent injury to the kidneys (leading to dialysis dependence), liver, or neurologic injury.

6. COVID-19 is highly contagious and can spread "very easily and sustainably between people."[9] "The virus is thought to spread mainly from person-to-person" between people who are "in close contact with one another."[10] The virus can travel "[t]hrough respiratory droplets produced when an infected person coughs, sneezes or talks," even by people who are not showing symptoms.[11] It is also "possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes."[12] "COVID-19 can live for hours or days on a surface, depending on factors such as sun light and humidity."[13]

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[7] Riccardo Inciardi, Cardiac Involvement in a Patient with Coronavirus Disease 2019, JAMA Cardiology (Mar. 27, 2020), https://jamanetwork.com/journals/jamacardiology/fullarticle/2763843; Fei Zhou, Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study, The Lancet (Mar. 9, 2020) https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30566-3.pdf.

[8] John B. Moore and Carl H. June, *Cytokine release syndrome in severe COVID-19*, Science (May 1, 2020), https://science.sciencemag.org/content/368/6490/473.

[9] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

[10] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

[11] *Id.*

[12] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

[13] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

Older People and People with Underlying Medical Conditions Are At Particularly High Risk

7. As of March 11, 2020, the World Health Organization (WHO) identified individuals at highest risk to include "older people" and "those with underlying medical conditions."[14] "The risk of severe disease gradually increases with age starting from around 40 years."

8. According to the CDC, people at higher risk for severe illness from COVID-19 include older people and "[p]eople of all ages with underlying medical conditions, particularly if not well controlled," including:

    a. People with chronic lung disease (including chronic obstructive pulmonary disease) or moderate to severe asthma
    b. People who have serious heart conditions
    c. People who are immunocompromised
        i. Conditions that can cause a person to be immunocompromised include cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
    d. People with severe obesity (body mass index [BMI] of 40 or higher)
    e. People with diabetes
    f. People with chronic kidney disease undergoing dialysis
    g. People with liver disease.[15]

9. Early reports estimate that the mortality rate for those with cardiovascular disease was 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.[16]

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[14] *See* Situation Report, World Health Organization (March 11, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10 (accessed May 4, 2020).

[15] People Who Are At Higher Risk, Centers for Disease Control and Prevention (last visited May 13, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

[16] *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization (Feb. 28, 2020), page 12, at https://cutt.ly/KtD3ALr ("While patients who

COVID-19 Poses Extreme Risks in Closed Congregate Settings like Maine's Prisons

10. DOC facilities are closed congregate settings in which COVID-19 is likely to spread rapidly once it enters a facility, despite attempts at infection control within each facility.[17] By their very nature, prisons are at high risk for the spread of infectious disease.[18] As of April 21, 2020, "among 37 jurisdictions reporting, 32 (86%) reported at least one confirmed COVID-19 case among incarcerated or detained persons or staff members, across 420 correctional and detention facilities."[19] Even for those facilities that had not yet reported any confirmed cases of COVID-19, it is likely that at least some were already experiencing undetected asymptomatic or presymptomatic transmission.

11. It is well-documented that COVID-19 spreads rapidly in other closed congregate settings, like homeless shelters, nursing homes, and cruise ships, even with certain hygiene protections in place.[20] The chart below demonstrates the spread of the virus on the Diamond Princess cruise ship:

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reported no comorbid conditions had a CFR of 1.4%, patients with comorbid conditions had much higher rates: "13.2% for those with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer").

[17] Matthew J. Akiyama, et al., *Flattening the Curve for Incarcerated Populations — Covid-19 in Jails and Prisons* (Apr. 2, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2005687.

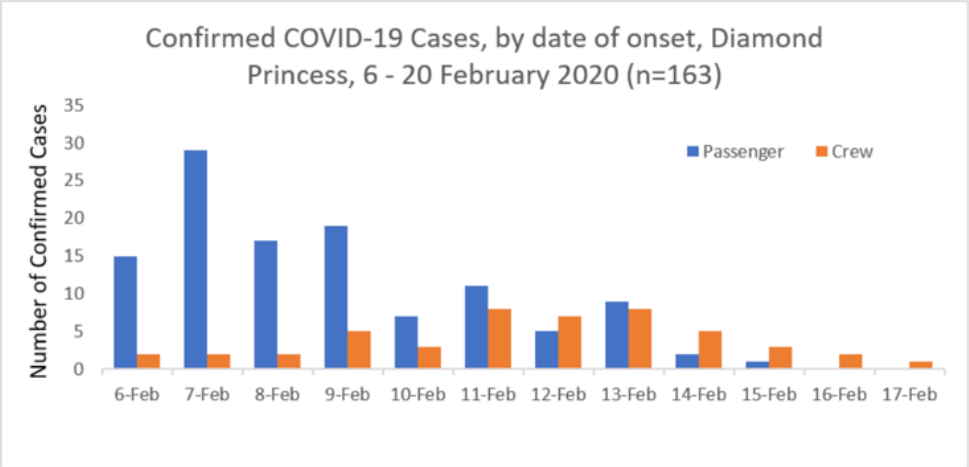
[18] Megan Wallace, *COVID-19 in Correctional and Detention Facilities – United States, February-April 2020*, U.S. Centers for Disease Control and Prevention (May 6, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm?s_cid=mm6919e1_w.

[19] *Id.*

[20] *See, e.g.*, Leah F. Moriarty, *et al.*, *Public Health Responses to COVID-19 Outbreaks on Cruise Ships – Worldwide, February-March 2020* (Mar. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e3.htm (discussing the outbreak of COVID-19 on the Diamond Princess cruise ship); Pengcheng Xu, et al., *Transmission routes of Covid-19 virus in the Diamond Princess Cruise ship* (Apr. 9, 2020), https://www.medrxiv.org/content/10.1101/2020.04.09.20059113v1; Temet M. McMichael, *et al. COVID-19 in a Long-Term Care Facility – King County Washington, Feb. 27-Mar. 9, 2020* (Mar. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm.

The Diamond Princess

Figure 1. Number of confirmed COVID-19 cases* with reported onset dates, by onset date, aboard Diamond Princess, 6 – 20 February 2020 (n=163)



* *The number of cases (n = 163) was based on the cases with available onset date reported.*

Field Briefing: Diamond Princess COVID-19 Cases, 20 Feb Update. Japan. National Institute of Infectious Diseases. PUBLISHED: 21 FEBRUARY 2020. Available at: https://www.niid.go.jp/niid/en/2019-ncov-e/9407-covid-dp-fe-01.html

12. As demonstrated by past outbreaks of infectious disease, the prison setting presents serious risks of the rapid spread of COVID-19 within facilities.[21] In the Maine Department of Corrections specifically, a seasonal flu epidemic sickened a large number of inmates and staff in 2011, even killing one prisoner.[22] The risk is that an outbreak of COVID-19 in the same facilities could be even deadlier.

[21] Akiyama, *supra* n. 36 (stating "Highly transmissible novel respiratory pathogens pose a new challenge for incarcerated populations because of the ease with which they spread in congregate settings. Perhaps most relevant to the Covid-19 pandemic, the 2009 H1N1 influenza pandemic exposed the failure to include jails in planning efforts.").

[22] *Influenza Outbreaks at Two Correctional Facilities – Maine, March 2011*, Centers for Disease Control and Prevention (Apr. 6, 2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

13. The high rates of chronic disease among prisoners means that any such outbreak could be particularly serious and potentially deadly. "Half of all incarcerated persons have at least one chronic disease, and according to the U.S. Department of Justice, 81,600 are over the age of 60, factors that increase the risk of poor outcomes of infection."[23] "Populations involved with the criminal justice system have an increased prevalence of infectious diseases such as HIV and hepatitis C virus (HCV) infections and tuberculosis."[24] "Disparities in social determinants of health affecting groups that are disproportionately likely to be incarcerated — racial minorities, persons who are unstably housed, persons with substance use disorders or mental illness — lead to greater concentrations of these illnesses in incarcerated populations."[25]

14. "Social distancing is extremely challenging" in prison settings.[26] The Maine Department of Corrections has acknowledges that "[a] correctional facility, by nature, is challenged by the practice of physical distancing." [27] Even considering some of the precautions to limit physical contact with members of the community, "infected persons — including staff members — will continue to enter correctional settings," and can introduce the disease in the prison setting.[28]

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[23] Akiyama, *supra* n. 36 (citing Maruschak LM, Berzofsky M, Unangst J. *Medical problems of state and federal prisoners and jail inmates*, 2011–12. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. February 2015 (https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf).

[24] Akiyama, *supra*, n. 36.

[25] *Id.*

[26] Akiyama, supra, n. 36.

[27] State of Maine Department of Corrections PRESS RELEASE, March 25, 2020, available at https://www.maine.gov/corrections/home/Press%20Release.%20DOC%20response%20to%20GOV%20EO%20(003).pdf (last accessed May 4, 2020).

[28] *Id.*

15. In light of these risks, a recent article explained that "three levels of preparedness need to be addressed: the virus should be delayed as much as possible from entering correctional settings; if it is already in circulation, it should be controlled; and jails and prisons should prepare to deal with a high burden of disease."[29] Public health experts have emphasized that a key part of this preparation must include "'decarcerating,' or releasing, as many people as possible, focusing on those who are least likely to commit additional crimes, but also on the elderly and infirm."[30]

Physical Distancing Is Crucial to Prevent Spread of the Virus

16. There is no vaccine to prevent COVID-19, nor is there any known cure. An initial multicenter clinical trial suggests that remdesivir may shorten the time to clinical improvement in severely ill COVID-19 patients, but this finding requires confirmation in larger studies.[31] The focus thus remains on mitigation and prevention. "The best way to prevent illness is to avoid being exposed to the virus."[32] To prevent new infections, the CDC strongly recommends thorough and frequent handwashing, cleaning surfaces with

[29] *Id.*

[30] *Id.*

[31] Wang Y, Zhang D, Du G, Du R, Zhao J, Jin Y, et al. Remdesivir in adults with severe COVID-19: a randomised, double-blind, placebo-controlled, multicentre trial. Lancet, Published:April 29, 2020 DOI:https://doi.org/10.1016/S0140-6736(20)31022-9. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31022-9/fulltext.

[32] Protect Yourself, Coronavirus Disease 2019 (COVID-19), U.S. Centers for Disease Control and Prevention (last visited May 4, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

EPA-approved disinfectants, keeping at least six feet of space between people, and avoiding group settings.[33]

17. "Limiting face-to-face contact with others is the best way to reduce the spread of coronavirus disease 2019 (COVID-19)."[34] "To practice social or physical distancing," the CDC instructs that people "[s]tay at least 6 feet . . . from other people, [d]o not gather in groups," and "[s]tay out of crowded places and avoid mass gatherings."[35] **"**Social distancing is recommended for all ages to slow the spread of the virus, protect the health care system, and help protect vulnerable older adults."[36]

18. To practice physical distancing, the CDC recommends (among other things) "avoid[ing] large and small gatherings in private places and public spaces, such a friend's house, parks, restaurants, shops, or any other place," as well as "avoid[ing] using any kind of public transportation, ridesharing, or taxis."[37]

19. "Social distancing is especially important for people who are at higher risk of getting very sick."[38]

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[33] Protect Yourself, Coronavirus Disease 2019 (COVID-19), U.S. Centers for Disease Control and Prevention (last visited May 4, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

[34] Social Distancing, U.S. Centers for Disease Control and Prevention (last visited May 11, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

[35] *Id.*

[36] CDC COVID-19 Response Team, *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) – United States, February 12-March 16, 2020*, U.S. Centers for Disease Control and Prevention (Mar. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm.

[37] Social Distancing, U.S. Centers for Disease Control and Prevention (last visited May 11, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

[38] Social Distancing, U.S. Centers for Disease Control and Prevention (last visited May 11, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

Testing and Asymptomatic Transmission

20. The need for physical distancing is particularly high because, in the absence of widespread testing, the virus could spread rapidly among asymptomatic carriers before any outbreak is detected. Symptoms of COVID-19 may appear "2-14 days after exposure to the virus."[39] As the CDC warns, "[s]ince people can spread the virus before they know they are sick, it is important to stay away from others when possible, even if you have no symptoms."[40] "Recent studies indicate that people who are infected but do not have symptoms likely also play a role in the spread of COVID-19."[41] Indeed, "[a] key factor in the transmissibility of Covid-19 is the high level of SARS-CoV-2 shedding in the upper respiratory tract, even among presymptomatic patients."[42]

21. For example, a study about COVID-19 in a skilled nursing facility in Washington State revealed "[r]apid and widespread transmission of SARS-CoV-2," with "[m]ore than half of residents with positive test results [being] asymptomatic at the time of testing and most likely contribut[ing] to transmission."[43] Only twenty-three days after the first resident of

[39] Symptoms, U.S. Centers for Disease Control and Prevention (last visited May 4, 2020), https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.

[40] Social Distancing, U.S. Centers for Disease Control and Prevention (May 12, 2020) https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html.

[41] *Id.*; *see also* Melissa Arons, et al., *Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility*, New England Journal of Medicine (Apr. 24, 2020), https://www.nejm.org/doi/full/10.1056/NEJMoa2008457.

[42] Monica Ghandi, et al., *Asymptomatic Transmission, the Achilles' Heel of Current Strategies to Control Covid-19* (Apr. 24, 2020), https://www.nejm.org/doi/full/10.1056/NEJMe2009758 (discussing *see also* Melissa Arons, et al., *Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility*, New England Journal of Medicine (Apr. 24, 2020), https://www.nejm.org/doi/full/10.1056/NEJMoa2008457).

[43] Melissa Arons, *Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility* (Apr. 24, 2020), https://www.nejm.org/doi/full/10.1056/NEJMoa2008457.

the nursing home tested positive, this facility "had a 64% prevalence of COVID-19 among residents . . . *despite early adoption of infection-control measures*."[44] Accordingly, the study concluded that "[i]nfection-control strategies focused solely on symptomatic residents were not sufficient to prevent transmission after SARS-CoV-2 introduction into this facility."[45]

22. Similarly, another study was conducted of a homeless shelter in Boston, in which "[t]he congregate nature and hygienic challenges of shelter life create the potential for rapid transmission of SARS-CoV-2 in this vulnerable population."[46] Widespread testing in this facility revealed 36% positive tests (147 out of 408 people tested), with the vast majority of people having few or no symptoms of COVID-19 at the time they tested positive.[47] This study likewise concluded that "COVID-19 can be widely transmitted in a homeless shelter setting, *even when infection control vigilance is high*."[48] Study findings suggest that universal testing may be better than "a symptom triggered approach . . . for identifying and mitigating COVID-19 among people experiencing homelessness."[49]

23. Widespread testing in prison facilities shows even higher rates of positive tests. For example, after widespread testing, 73% of inmates at an Ohio prison recently tested

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[44] *Id.* (emphasis added).

[45] *Id.*

[46] Travis P. Baggett, et al., *COVID-19 outbreak at a large homeless shelter in Boston: Implications for universal testing*, https://www.medrxiv.org/content/10.1101/2020.04.12.20059618v1.

[47] *Id.*

[48] *Id.* (emphasis added).

[49] *Id.*

positive for coronavirus.[50] As reported, "[n]o other state has reported as many cases of COVID-19 behind bars as Ohio, in large part because no other state has tested as many inmates as Ohio."[51]

Actions by Maine Department of Corrections

24. **Physical Distancing:** The CDC guidance on the COVID-19 response in prisons and jails is to "[i]mplement social distancing."[52] As the CDC explains, "[a]lthough social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19."[53] Especially for medically vulnerable people like those in the CDC high-risk group, it is medically necessary that they are able to physically distance, stay away from large groups, and remain six feet away from others at all times. Based on Petitioners' declarations provided to me, it appears that these measures are not possible under current conditions in Maine DOC facilities.

25. **Hygiene:** Based on Petitioners' declarations, DOC does not provide alcohol-based hand sanitizer, as the CDC recommends.[54] Unlike hand sanitizer with more than 60% alcohol, the CDC has not found that hand sanitizer with less alcohol (or no alcohol) is effective to

[50] Bill Chappell, 73% Of Inmates At An Ohio Prison Test Positive For Coronavirus, NPR (Apr. 20, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/04/20/838943211/73-of-inmates-at-an-ohio-prison-test-positive-for-coronavirus.

[51] *Id.*

[52]COVID-19 Guidance for Correctional & Detention Facilitie, U.S. Centers for Disease Control and Prevention (May 11, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[53] *Id.*

[54] Hand Hygiene, U.S. Centers for Disease Control and Prevention (last accessed May 11, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html.

reduce the number of pathogens (including the SARS-CoV-2 virus) that may be present on the hands.[55]

26. **Masks**: The most important fact to remember about masks is that, although they may offer *some* protection for the wearer, the primary benefit is to reduce the likelihood that a person already infected with COVID-19 will not unknowingly pass COVID-19 on to others.[56] Even for this benefit, "[m]ultiple layers of fabric are better than only one," because "[m]ore layers means less chance that viral particles will be able to pass through."[57] Masks are no substitute for necessary preventive measures like physical distancing.

27. **Testing:** Given the Department of Corrections' practice of testing only symptomatic prisoners, the fact that there are no current positive tests of COVID-19 of prisoners in the facilities does not mean that the facilities are safe. The prevalence of asymptomatic transmission of COVID-19 means that there may already be prisoners or prison staff in the various facilities who are asymptomatic carriers of COVID-19 and are spreading it, undetected, throughout the facilities. An approach to testing that does not account for

[55] The CDC has clarified that it "does not have a recommended alternative to hand rub products with greater than 60% ethanol or 70% isopropanol as active ingredients. Benzalkonium chloride, along with both ethanol and isopropanol, is deemed eligible by FDA external icon for use in the formulation of healthcare personnel hand rubs. However, available evidence indicates benzalkonium chloride has less reliable activity against certain bacteria and viruses than either of the alcohols." *Id.*

[56] Catherine Roberts, *How to Choose and Wear a Mask During the Coronavirus Pandemic*, Consumer Reports (Apr. 24, 2020), https://www.consumerreports.org/coronavirus/how-to-choose-and-wear-a-mask-during-the-coronavirus-pandemic/?EXTKEY=YSOCIAL_PAIDPROMO_FB.

[57] *Id.*

asymptomatic or pre-symptomatic spread of the virus cannot show the full picture of the outbreak.

28. The current plan for a phased reopening of the economy could present additional risks. A study from the 1918 influenza pandemic suggests that premature reopening could increase the spread of infection in the community into the prison as well.[58] If anything, the phased reopening of the economy places prisoners at greater risk of infection than before.

29. Department of Corrections has engaged in "pre-planning with local hospitals" to prepare for a potential outbreak.[59] The high proportion of medically vulnerable individuals in the prison means that, in the event of an outbreak in prison, a disproportionate number of these individuals could require hospital-level care, which would not only be expensive and consume scarce medical resources, but also could expose medical staff and the greater community to additional risk.

Improved Preventive Measures are Needed for At-Risk and Other Individuals

30. Preventive measures can have a protective effect on the population as a whole, as well as being clinically necessary for an individual patient. For example, "[v]accines work on both an individual basis, by preventing or attenuating clinical disease in a person exposed

[58] Howard Markel, MD, PhD., *Nonpharmaceutical Interventions Implemented by US Cities During the 1918-1919 Influenza Pandemic*, JAMA (Aug. 8, 2007), https://jamanetwork.com/journals/jama/fullarticle/208354.

[59] Statement from Randall A. Liberty, Commissioner Department of Corrections, March 25, 2020, available at https://www.maine.gov/corrections/home/3.27.20%20Statement%20from%20Commisioner%20Liberty.pdf (last accessed May 4, 2020).

to the pathogen, and also on a population basis, by affecting herd immunity."[60] When it comes to COVID-19, physical distancing is critical to protect the community as a whole from widespread transmission of the virus. Additionally, the same preventive measures are important for medically vulnerable individuals at particular risk of serious illness or death from COVID-19.

31. This interplay between public health and individual clinical need is the focus of clinical epidemiology. "Clinical epidemiology is the application of epidemiological principles and methods to the practice of clinical medicine."[61] "Because epidemiology deals with populations and clinical medicine deals with individuals, it has been suggested that clinical epidemiology is a contradiction in terms. However, clinical epidemiology is simply concerned with a defined patient population rather than the usual community-based population."[62]

32. Two of the central concerns in clinical epidemiology include (1) "effectiveness of treatment" and (2) "prevention in clinical practice."[63] As to the first, "[s]pecific treatments need be shown to do more good than harm among patients who actually use them: this is called efficacy."[64] However, as discussed above, there is no effective

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[60] R. Bonita, et al., BASIC EPIDEMIOLOGY at 119, World Health Organization (2d ed) (2006) available at https://apps.who.int/iris/bitstream/handle/10665/43541/9241547073_eng.pdf?sequence=1.

[61] R. Bonita, et al., BASIC EPIDEMIOLOGY at 133, World Health Organization (2d ed) (2006) available at https://apps.who.int/iris/bitstream/handle/10665/43541/9241547073_eng.pdf?sequence=1.

[62] *Id.*

[63] *Id.*

[64] R. Bonita, et al., BASIC EPIDEMIOLOGY at 139, World Health Organization (2d ed) (2006) available at https://apps.who.int/iris/bitstream/handle/10665/43541/9241547073_eng.pdf?sequence=1.

treatment for COVID-19. That makes the second element—prevention—all the more clinically important.

33. Prevention of disease is a cornerstone of clinical practice and public health. This is no less true in the midst of a deadly pandemic. There are different levels of prevention. Primary prevention is designed "to limit the incidence of disease by controlling specific causes and risk factors."[65] Secondary prevention aims to reduce the more serious consequences of disease through early diagnosis and treatment."[66] "Tertiary prevention is aimed at reducing the progress or complications of established disease," and often overlaps with treatment of chronic disease.[67]

34. In the case of COVID-19, primary prevention through adequate and continuous physical distancing, use of masks, and good hand hygiene, early diagnosis through testing of symptomatic and asymptomatic individuals, and isolation of infected persons with quarantine of their contacts are critical to containing COVID-19, especially in light of the risk of asymptomatic transmission of the virus. That said, the Department of Corrections has not been able to provide adequate physical distancing of inmates and staff (as described in Petitioners' declarations provided to me) and has tested only a small percentage of the total population (24 out of 1,938),[68] focusing only on symptomatic

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[65] R. Bonita, et al., BASIC EPIDEMIOLOGY at 103, World Health Organization (2d ed) (2006) available at https://apps.who.int/iris/bitstream/handle/10665/43541/9241547073_eng.pdf?sequence=1.

[66] R. Bonita, et al., BASIC EPIDEMIOLOGY at 109, World Health Organization (2d ed) (2006) available at https://apps.who.int/iris/bitstream/handle/10665/43541/9241547073_eng.pdf?sequence=1.

[67] *Id.*

[68] Daily Dashboard, Maine Dep't of Corrections (May 11, 2020), https://www.maine.gov/corrections/home/MDOC%20COVID19%20Web%20Dashboard%205-11-2020.pdf.

cases.[69] These measures are insufficient in light of what would likely be a high rate of COVID-19 transmission in a closed congregate prison setting—meaning that asymptomatic and pre-symptomatic cases could transmit disease widely and trigger an outbreak of COVID-19 even before the first positive case was detected.

35. The absence of adequate primary prevention and testing in DOC facilities, plus the absence of any treatment or vaccine for COVID-19, makes enhanced measures of primary prevention of paramount importance. To protect medically vulnerable individuals—as well as other individuals and staff—it is necessary to be able to engage in adequate physical distancing at all times. When physical distancing is not possible in one setting, people should be moved out of that setting to the greatest extent possible. For example, physical distancing is generally not possible in K-12 schools, so state and local governments across the country have reasonably decided to close schools and to provide education remotely. In other risky settings such as prisons, all available options should be considered for transferring people (especially those who are medically vulnerable to serious illness or death) to another setting in which they can safely perform adequate physical distancing.

36. To the extent the Department of Corrections is failing to ensure physical distancing (as described in Petitioners' declarations provided to me), they are failing to provide necessary measures to prevent COVID-19, especially for the most medically vulnerable prisoners. It is inappropriate to take a wait-and-see approach to COVID-19. There is no

[69] Megan Gray, *Maine prisons pressured to release more inmates, and information, during pandemic*, Portland Press Herald (May 3, 2020), https://www.pressherald.com/2020/05/03/maine-prisons-pressured-to-release-more-inmates-and-more-information-during-pandemic/ (stating that "[n]o tests were necessary for COVID-19 as no clients or staff became symptomatic as a result of exposure" to an employee who tested positive).

effective medical treatment for the virus itself and available interventions—including oxygen support and ventilators—are expensive and scarce. Medically vulnerable individuals are the most likely to need these types of intensive care. Failing to provide adequate preventive care for medically vulnerable prisoners could lead to serious illness and death, increased spread of the disease in the prison and the greater community, and greater burdens on scarce medical resources.

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

Executed this 14th of May, 2020

/s/ R. Gibson Parrish

R. Gibson Parrish, M.D.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

JOSEPH A. DENBOW and SEAN R. RAGSDALE, *on their own and on behalf of a class of similarly situated persons,* *Petitioners*, v. RANDALL A. LIBERTY, Commissioner of Maine Department of Corrections *in his official capacity*, MAINE DEPARTMENT OF CORRECTIONS, *Respondents*	Case No. _____

DECLARATION OF JOSEPH GOLDENSON, MD

I, Joseph Goldenson, MD, declare as follows:

Background

1. I am a medical physician with 33 years of experience in correctional health care. For 28 years, I worked for Jail Health Services of the San Francisco Department of Public Health. For 22 of those years, I served as the Director and Medical Director. In that role, I provided direct clinical services, managed public health activities in the San Francisco County jail, including the management of HIV, tuberculosis, Hepatitis C, and other infectious diseases in the facility and the planning and coordination of the jail's response to H1N1, and administered the correctional health enterprise, including its budget, human resources services, and medical, mental health, dental, and pharmacy services.
2. I served as a member of the Board of Directors of the National Commission on Correctional Health Care for eight years and am past President of the California chapter of the American Correctional Health Services Association. In 2014, I received the Armond Start Award of

Excellence from the Society of Correctional Physicians, which recognizes its recipient as a representative of the highest ideals in correctional medicine.

3. For 35 years, I held an academic appointment as an Assistant Clinical Professor at the University of California, San Francisco.

4. I have worked extensively as a correctional health medical expert and court monitor. I have served as a medical expert for the United States District Court for the Northern District of California for 25 years. I am currently retained by that Court as a medical expert in *Plata v. Newsom*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to inmate patients in the California Department of Correctional Rehabilitation. I have also served as a medical expert and monitor at Cook County Jail in Chicago; Los Angeles County Jail; at other jails in Washington state, Texas, and Florida; and at prisons in Illinois, Ohio, and Wisconsin.

5. My curriculum vitae is attached as exhibit A.

6. Within the preceding four (4) years, I have testified as an expert by deposition or trial in the following cases:

- *Charlotte Diana Winkler v. Madison County, Kentucky, et al.*, United States District Court, Eastern District of Kentucky, Central Division at Lexington, Case No. 5:15-CV-45-KKC, Deposition (June 2016)
- *Jane Doe #1, et al. v. Johnson, et al.*, United States District Court for the District of Arizona, No. CV-15-00250-TUC-DCB, Hearing for Preliminary Injunction (November 2016)
- *Eugene McCain v. St. Clair County, et al.*, United States District Court, Eastern District of Michigan, Southern Division, Case No. 2:16-cv-10112 (March 2017)
- *Jane Doe #1, et al. v. Johnson, et al.*, United States District Court for the District of Arizona, No. CV-15-00250-TUC-DCB, Deposition (December 2017)
- *The Estate of Rachel M. Hammers, Deceased, et al. v. Douglas County, Kansas Board of Commissioners, et al*, District Court of Douglas County, Kansas at Lawrence, Case No. 2:14-CV-02188-JTM-KMH, Trial (June 2018)
- *Jane Doe #1, et al. v. Johnson, et al.*, United States District Court for the District of Arizona, No. CV-15-00250-TUC-DCB, Trial (January 2020)

The Nature of COVID-19

7. The SARS-CoV-2 virus ("COVID-19"), and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the World Health Organization ("WHO"). Cases first began appearing between December 1 and December 31, 2019, in Hubei Province, China.

8. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus that caused the 2002–2003 SARS epidemic.

9. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.1 to 3.5%, which is up to 35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.

10. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardiovascular diseases, hypertension, respiratory diseases, like asthma and COPD, diabetes, and immune compromise.

11. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS), which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and in parts of China.

12. COVID-19 is widespread. Since it first appeared in China in late 2019, outbreaks have subsequently occurred in more than 160 countries and all populated continents; heavily affected countries include Italy, Spain, Iran, South Korea, and the U.S. The U.S. is now the world's most affected country. As of May 7, 2020, there have been 4,413,597 confirmed human cases globally and 300,798 known deaths.[1] It is not contained, and cases are growing exponentially.

13. In the United States alone, the Centers for Disease Control and Prevention ("CDC") reports 1,384,930 cases and 83,947 deaths as of May 14, 2020.[2] As of May 14, 2020, Maine has had 1,405 coronavirus cases and seen 207 hospitalizations and 69 deaths as a result of the virus.[3] All these numbers are likely underestimates because of limited availability of testing.

14. COVID-19 is now known to be fully adapted to human-to-human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

15. COVID-19 is a highly contagious respiratory illness. It is transmitted between persons in close proximity (within about six feet) by airborne droplets released by infected individuals when they cough or sneeze. The droplets can survive in the air for up to three hours. It may also be possible for an individual to become infected by touching a surface or object that has the virus on it and then touching his or her own mouth, nose, or possibly eyes. Infected

[1] https://coronavirus.jhu.edu/map.html (last accessed May 14, 2020).
[2] https://www.cdc.gov/covid-data-tracker/index.html (last accessed May 14, 2020)
[3] https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml (last accessed May 14, 2020)

droplets can survive on surfaces for variable lengths of time, ranging from up to four hours on copper, to 24 hours on cardboard, to two to three days on plastic or stainless steel.

16. The U.S. CDC estimates that the reproduction rate of the virus, the R0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20–30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2–14 days, which is why isolation is generally limited to 14 days.

17. CDC has recently added to the list of possible signs and symptoms of COVID-19 to include fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.[4] In severe cases, infection can result in respiratory failure or death. The care of people infected with COVID-19 depends on the seriousness of their illness. People with moderate symptoms may require hospitalization for supportive treatment, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics.

18. A significant number of infected individuals do not exhibit symptoms, however, and asymptomatic individuals—either before the onset of symptoms or because no symptoms will ever manifest—can nevertheless transmit the disease to others. According to the CDC,

[4] Centers for Disease Control and Prevention, Symptoms of Coronavirus, https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (last accessed May 14, 2020).

up to 25 percent of people infected with COVID-19 will remain asymptomatic.[5] Similarly, infected individuals may experience only mild symptoms. These asymptomatic and mildly symptomatic individuals can, and do, transmit the virus, contributing to its rapid spread. Because of the high risk of transmission by asymptomatic individuals, CDC recently recommended everyone wear a mask when they leave their homes.[6]

19. There is currently no vaccine for COVID-19, and no cure. The only known ways to prevent the spread of COVID-19 involve measures such as thorough handwashing, frequent decontamination of surfaces, and maintaining six feet of physical distance between individuals ("social distancing").

The Risks of COVID-19 in Correctional Facilities

20. COVID-19 poses a serious risk to prisoners, workers, and anyone else in correctional facilities. Correctional facilities, including facilities like Maine's prisons, have long been associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis. For example, in 2011, the Maine Department of Corrections experienced a seasonal flu epidemic that sickened a large number of inmates and staff in 2011, even killing one prisoner.[7] The Hepatitis C virus is also common among prisoners

[5] Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html (last accessed May 14, 2020).
[6] U.S. Centers for Disease Control and Prevention, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("Interim Guidance"), at 8-12, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last accessed May 14, 2020).
[7] *Influenza Outbreaks at Two Correctional Facilities – Maine, March 2011*, Centers for Disease Control and Prevention (Apr. 6, 2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm (last accessed May 14, 2020).

in Department of Corrections custody. Department of Corrections records indicate that, as of October 2017, there were 580 inmates in Department of Corrections custody infected with Hepatitis C.[8]

21. The severe epidemic of tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities surrounding a prison.

22. Infections that are transmitted through droplets, like influenza and COVID-19, are particularly difficult to control in detention and correctional facilities, as social distancing and proper decontamination of surfaces are virtually impossible.

23. For example, several deaths were reported in the U.S. in immigration detention facilities associated with ARDS following influenza A, including a 16-year old immigrant child who died of untreated ARDS in custody in May 2019.

24. It is estimated that during the Spanish influenza of 1918 half of the 1900 inmates at San Quentin Prison in California contracted the disease during the first wave of the epidemic. Sick calls increased from 150 to 700 daily. Most of the ill were kept in the general prison population because the hospital ward was full.[9]

25. Current recommendations for social distancing and frequent cleansing of surfaces to prevent infection and the spread of the virus are extremely difficult, if not impossible, to

[8] Amended Compl., Ex. 1, *Loisel v. Clinton*, Docket No. 19-cv-81-NT, ECF No. 26-1 (June 26, 2019) (stating that as of October 31, 2017, there are 580 [Hepatitis C Virus positive] prisoners housed in the Maine Department of Corrections").

[9] L.L. Stanely, MD., 43 Public Health Reports (1896-1970), *Influenza at San Quentin Prison, California* (May 9, 1919), https://www.jstor.org/stable/4575142?seq=1#metadata_info_tab_contents.

implement in the correctional setting. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as population density in close confinement; insufficient ventilation; and shared toilet, shower, and eating environments. Shared spaces and equipment (such as telephones) are commonly not adequately disinfected, especially during the current pandemic when more frequent cleaning and disinfecting are required. Limits on alcohol-based hand sanitizer are also risks for spread. The nationwide shortage of personal protective equipment (PPE), as well as ancillary products (such as cleaning supplies and thermometer probes) further impacts the ability of correctional facilities to implement necessary precautions.[10] Based on declarations that I have been provided from prisoners Joseph Denbow and Sean Ragsdale, I understand that many of these challenges—particularly the inability to perform social distancing, the absence of alcohol-based hand sanitizer, and lack of necessary hygiene at shared spaces—are also present in the Maine Department of Corrections.

26. The risk of exposure to and transmission of infectious diseases, as well as the risk of harm from developing severe complications or death if infected, is significantly higher in jails, prisons, and detention centers than in the community.

27. Close, poorly ventilated living quarters and often overcrowded conditions in these facilities foster the rapid transmission of infectious diseases, particularly those transmitted by airborne droplets through sneezing, speaking, or coughing. In these congregate settings, large numbers of people are closely confined and forced to share living spaces, bathrooms,

[10] *Study of COVID-19 in Correctional Facilities*, Harvard University and National Commission on Correctional Health Care, April 9, 2020.

eating areas, and other enclosed spaces. Groups of persons are often moved from space to space, for example, from a dormitory to a cafeteria. Persons congregate and come in close contact while standing in lines for medication, commissary, fresh laundry, telephones, showers, or restroom use. These group movements, which may cluster large numbers of people together in small spaces, increase the risk of transmission. It is common for prisoners in a given housing unit to routinely be subjected to such group movements multiple times each day. They are physically unable to practice social distancing, which the CDC has identified as the "cornerstone of reducing transmission of respiratory diseases such as COVID-19."[11]

28. This forced congregation spreads infection from one area of a prison to other areas, too. In addition, prisons often rely on prisoners to perform work that supports the operation of the facility, such as food service, laundry, and cleaning. To perform these work assignments, they typically travel from their housing units to other parts of the facility. Officers and other facility staff routinely have direct physical contact with prisoners, especially when handcuffing or removing handcuffs from prisoners who are entering or exiting the facility. Staff members also move around within the facility, which creates opportunities for transmission both among staff in different parts of the facility and transmission to and from prisoners in different parts of the facility. This regular circulation makes the spread of infection throughout a prison all but inevitable.

29. While jails, prisons, and detention centers are often thought of as closed environments, this is not the case. Custody, medical, and other support staff and contractors enter and leave

[11] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last accessed May 14, 2020).

the facility throughout the day. Prisoners and inmates are often transferred between housing units, or into and out of isolation. This further increases the likelihood of transmission of COVID-19.

30. It has long been known that jails, prisons, and detention centers can be hotbeds of disease transmission. Due to the frequent ingress and egress of employees at these facilities, an outbreak within a jail, prison, or detention center can quickly spread to surrounding communities. For example, the tuberculosis epidemic that broke out in New York City in the early 1990s began in jails and was spread to the community by jail employees who became infected and then returned home to their families and communities.

31. As stated above, according to the CDC, up to 25 percent of people infected with COVID-19 will remain asymptomatic.[12] Similarly, infected individuals may experience only mild symptoms. These newly infected, asymptomatic, and mildly symptomatic individuals can, and do, transmit the virus, contributing to its rapid spread. As a result, such inadequate screening presents a critical problem. The possibility of asymptomatic transmission means that monitoring staff and incarcerated people for symptoms and fever is inadequate to identify all who may be infected and to prevent transmission.

32. It is my understanding that the Department of Corrections is testing only symptomatic prisoners as a method of prevention and identification of possible COVID-19 exposure and infections. The problem with testing only symptomatic prisoners is that there are likely many asymptomatic individuals, coupled with constant staff movement in and out of the facility. Without constant and widespread testing, potential sources of infection would be

[12] Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html (last accessed May 14, 2020).

very difficult to establish. Without constantly testing everyone to detect asymptomatic individuals, testing symptomatic prisoners alone is not a meaningful method of prevention.

33. Social distancing is the most effective method of preventing the spread of COVID-19. Current CDC recommendations for reducing the transmission of COVID-19 in prisons emphasize that "[a]lthough social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19."[13] Social distancing must be utilized conjointly with other practices, like testing, isolation, and quarantine, to achieve maximal efficacy in reducing transmission. If a facility is not practicing social distancing, CDC testing protocols are not sufficient to prevent the spread of the illness.

34. Ultimately, once confirmed cases of COVID-19 exist in a prison, like the Department of Corrections' facilities, the population density and inability to properly sanitize areas of dense congregation will result in widespread transmission of the disease inside of the facility and in the broader community through daily staff ingress and egress.

35. While every effort should be made to reduce exposure in correctional facilities through internal mitigation efforts, this may be extremely difficult to achieve and sustain quickly enough. Further, no mitigation effort can change the inherent nature of detention facilities, which force people to live in close proximity to one another. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons

[13] U.S. Centers for Disease Control and Prevention, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("Interim Guidance"), at 9-10, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last accessed May 14, 2020).

in prison as quickly as possible. Indeed, that is the only public health solution available at this time to reduce the spread of COVID-19 and potentially save lives.

36. Given the experience in China as well as the literature on infectious diseases in jail, additional outbreaks of COVID-19 among the U.S. jail and prison populations are highly likely. Releasing as many inmates as possible is important to protect the health of inmates, correctional facility staff, health care workers at jails and other detention facilities, and the community as a whole. Indeed, according to the WHO, "enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages."[14]

37. It is difficult to overstate the devastation that a COVID-19 outbreak could inflict on a correctional facility such as the Department of Corrections' facilities. For example, at Rikers Island jail in New York, between April 1 and April 15, 2020, the number of COVID-19 positive incarcerated individuals and staff members grew by 104 and 114 people, respectively, upping the jail's total numbers of confirmed cases to 288 among the incarcerated population, 488 among correction staff, and 78 among health care workers.[15,16] The first known case of COVID-19 at Rikers was confirmed on March 18,[17]

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[14] World Health Organization, Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention: Interim guidance (Mar. 15, 2020), http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf (last accessed May 14, 2020).

[15] Julia Craven, *Coronavirus Cases Are Spreading Rapidly on Rikers Island*, Slate (Apr. 2, 2020), https://slate.com/news-and-politics/2020/04/rikers-coronavirus-cases-increase.html (last accessed May 14, 2020).

[16] Jan Ranson, Jailed on a Minor Parole Violation, He Caught the Virus and Died, N.Y. Times (Apr. 10, 2020).

[17] New York Times, *As Testing Expands, Confirmed Cases of Coronavirus in N.Y.C. Near 2,000* (Mar. 18, 2020), https://www.nytimes.com/2020/03/18/nyregion/coronavirus-new-york-update.html (last accessed May 14, 2020).

illustrating just how quickly this disease can and will overwhelm detention facilities. Two Ohio prisons, Marion Correctional Institution and Pickaway Correctional Institution, have emerged as the largest-known sources of U.S. coronavirus infections, according to data compiled by The New York Times. To date 3,808 cases have been connected to the two prisons.[18] Over 80% of the approximately 2,500 prisoners in Marion tested positive.[19] In addition, 169 staff have tested positive for COVID-19.[20] Eight of the ten largest-known infections sources in the U.S. are jails or prisons.

38. At Ohio's Marion Correctional, close to 95% of those who tested positive were asymptomatic and would otherwise not have been tested.[21] This underscores the risk of the spread of COVID-19 by asymptomatic individuals.

39. If infected, prisoners are at greater risk for harm from COVID-19 than those in the general community. This is due to a number of factors including the fact that people in prisons have high rates of chronic illnesses, such as diabetes, heart disease, chronic lung disease, and immunosuppressive illnesses such as HIV that increase the risk from COVID-19; often have had poor or absent prior health care; and often have made unhealthy life-style choices, including alcohol and drug use. For these reasons, it is well accepted within the medical

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[18] New York Times, *Coronavirus in the U.S.: Latest Map and Case Count*, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?action=click&module=Top%20Stories&pgtype=Homepage&action=click&module=Spotlight&pgtype=Homepage#states (last accessed May 14, 2020).

[19] Ohio Department of Rehabilitation & Correction, COVID-19 Inmate Testing Updated May 7, 2020, https://coronavirus.ohio.gov/static/DRCCOVID-19Information.pdf (last accessed May 14, 2020).

[20] *Id*.

[21] Linda So & Grant Smith, In Four U.S. State Prisons, Nearly 3,300 Inmates Test Positive for Coronavirus -- 96% Without Symptoms, New York Times (April 25, 2020), https://www.nytimes.com/reuters/2020/04/25/us/25reuters-health-coronavirus-prisons-testing-insight.html?searchResultPosition=8 (last accessed May 14, 2020).

community that jail inmates are physiologically 10 years older than their chronological age. The CDC has identified the people with the following illnesses as being particularly vulnerable to severe illness for COVID-19:

- Diabetes mellitus
- Lung disease including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
- Heart disease
- Blood disorders (e.g., sickle cell disease or on blood thinners)
- Chronic kidney disease
- Chronic liver disease
- Compromised immune system (immunosuppression)
- Current or recent pregnancy in the last two weeks
- Endocrine disorders
- Metabolic disorders
- Neurological and neurologic and neurodevelopment conditions [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury][22]
- Severe obesity[23]

The CDC also deems people 65 or older to be particularly vulnerable to COVID-19. However, in my professional opinion the proper figure for jail inmates is no older than 55 years old.

40. Based on these understandings, it is my opinion that the exponential infection of rate for COVID-19 we already see in the community would be magnified within the Department of Corrections' facilities. Adequate social distancing would be impossible to achieve. What's more, infection in the Department of Corrections' facilities would not stay limited

[22] U.S. Centers for Disease Control and Prevention, *Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission*, https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf (last accessed May 14, 2020).
[23] U.S. Centers for Disease Control and Prevention, *Groups at Higher Risk for Severe Illness*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html#severe-obesity (last accessed May 14, 2020).

to those facilities, but would worsen infection rates in the broader community. The infection rate will increase substantially before it starts to diminish without major interventions.

Conclusions

41. For the reasons above, it is my professional opinion that persons currently detained at the Department of Corrections' facilities are at significantly greater risk of contracting COVID-19 than if they were permitted to shelter in place in their home communities. If infected, many are at increased risk of suffering severe complications and outcomes particularly given the underlying health conditions of many people in correctional settings as well as the constrained provision of health care within facilities during the pandemic.
42. It is my professional opinion that conditions in the Department of Corrections' facilities threaten the health and safety of every individual within those facilities—prisoners and staff alike—and in their surrounding communities.
43. It is my professional opinion that a necessary component of bringing the Department of Corrections' facilities into compliance with the recommendations of the CDC to minimize the risk of COVID-19 transmission within the facility and to the larger community is to substantially reduce the population. Doing so will allow the facility to significantly reduce the risk of infection for both incarcerated people and correctional officers, which in turn protects the communities where corrections staff live.
44. It is my professional opinion that those who are medically vulnerable[24] need to be moved out of the Department of Corrections' facilities to the absolute maximum extent possible.

[24] E.g., persons held at the Department of Corrections' facilities over the age of 55, as well as all current and future persons held at the facilities of any age who experience (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as

In addition, the overall population needs to be significantly lowered to reduce the density in the prisons to allow for adequate social distancing, minimize the strain on the jail's medical care system, ensure adequate space is available for necessary quarantining.

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

Executed this 14th of May, 2020

/s/ Joseph Goldenson
Joseph Goldenson, M.D.

congenital heart disease, congestive heart failure and coronary artery disease, or other chronic conditions associated with impaired heart function; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; and/or (l) a current or recent (last two weeks) pregnancy.