

## Declaration of Dr. Jaimie Meyer

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

### **I. Background and Qualifications**

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.
2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.
3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.
4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.
5. I am being paid \$50 an hour for my time reviewing materials and preparing this report.
6. I have not testified as an expert at trial or by deposition in the past four years.
7. In addition to my knowledge, training, education, and experience in the field of prison healthcare and infectious diseases, and the resources relied upon by experts in infectious diseases and prison health, I also reviewed specifically the Centers for Disease Control

and Prevention (CDC) guidance on management of COVID-19 in correctional facilities (available at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>), the Bureau of Prisons (BOP) modified operations plan (available at [https://www.bop.gov/coronavirus/covid19\\_status.jsp](https://www.bop.gov/coronavirus/covid19_status.jsp)), the National Commission on Correctional Health Care (NCCHC) materials on COVID-19 (available at <https://www.ncchc.org/COVID-Resources>), and the World Health Organization interim guidance on Preparedness, prevention and control of COVID-19 in prisons and other places of detention (available at [http://www.euro.who.int/\\_data/assets/pdf\\_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1)). I have also reviewed the guidance and information that ICE has posted on their website, <https://www.ice.gov/coronavirus>.

## **II. Heightened Risk of Epidemics in Jails and Prisons**

8. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.
9. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.
10. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.
11. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in

medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

12. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.
13. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.
14. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.<sup>1</sup> This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.
15. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.
16. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

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

17. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.
18. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.
19. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.
20. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.<sup>2</sup> Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.<sup>3</sup> Even facilities on “quarantine” continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

### III. Profile of COVID-19 as an Infectious Disease<sup>4</sup>

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<sup>2</sup> *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012),

<https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm>.

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

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

21. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be available for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.
22. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.<sup>5</sup> Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.<sup>6</sup> Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.
23. The care of people who are infected with COVID-19 depends on how seriously they are ill.<sup>7</sup> People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.
24. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with

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

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

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

people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

25. The time to act is now. Data from other settings demonstrate what happens when detention centers, jails and prisons are unprepared for COVID-19. Recent outbreaks of COVID-19 in ICE detention facilities in New York and New Jersey demonstrate how easily the virus enters facilities and rapidly spreads to detainees and staff when community epidemics are widespread, even when the best possible infection preparedness plans are in place.

#### **IV. Risk of COVID-19 at the Buffalo Federal Detention Facility**

26. I have reviewed the following materials in making my assessment of the danger of COVID-19 at the Buffalo Federal Detention Facility (“BFDF”): (1) a declaration by Jeffrey Searls, the Officer in Charge at BFDF, dated March 30, 2020, and filed as ECF 120 in *Hassoun v. Searls*, No. 19-CV-370 (W.D.N.Y.); (2) a declaration by Adham Hassoun, a detainee at BFDF, dated April 1, 2020, and filed as ECF 124 in *Hassoun v. Searls*, No. 19-CV-370 (W.D.N.Y.); (3) the BFDF Detainee Handbook; (4) a declaration by Captain Abelardo Montalvo, M.D., dated April 3, 2020, and filed as ECF 45 in *Jones v. Wolf*, No. 20-CV-361 (W.D.N.Y.); and (5) a supplemental declaration by Jeffrey Searls, the Officer in Charge at BFDF, dated April 4, 2020, and filed as ECF 47 in *Jones v. Wolf*, No. 20-CV-361 (W.D.N.Y.).
27. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that BFDF is dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.
28. Detainees in this facility are at imminent risk of harm from COVID-19 because they are unable to protect themselves through cleaning and disinfection. There is no mention in the March 30, 2020 Searls declaration of whether detainees are provided adequate supplies for cleaning and disinfecting living areas. Although the CDC recommends that high-touch surfaces be cleaned frequently with products containing bleach or 70% alcohol, there is no mention in Mr. Searls’s March 30, 2020 declaration or the declaration of Captain Montalvo dated April 3, 2020 about whether detainees are provided with these products. Per Mr. Hassoun’s declaration, inmates have no way to clean and disinfect common use surfaces, such as computers and tablets, microwaves, phone booth, and a telephone. This means that COVID-19, a virus that can survive for days on these surfaces, can easily be spread from person to person.
29. Handwashing is central to COVID-19 infection prevention strategies and the CDC recommends that individuals in detention be provided with no-cost access to soap. Although Mr. Searls’s March 30, 2020 declaration notes soap is provided as per best

practices, it is unclear how this is being implemented. The BFDF Detainee Handbook describes that soap is available from communal dispensers and replenished weekly on request, but it is not clear whether these practices have changed since COVID-19 procedures began.

30. Mr. Hassoun's declaration reflects inconsistent use of personal protective equipment (PPE) by staff, including medical staff. While his declaration states that some healthcare workers "do not wear masks or gloves" others are "covered head-to-toe...completely wrapped up in protective gear." Inconsistent use of PPE suggests that a) healthcare workers have not been trained in when and how to use PPE, b) PPE is not consistently available, or c) that infection prevention policies are unclear. This is particularly concerning because healthcare workers have extremely high risk of being exposed to COVID-19 and can transmit to other detainees/patients, even in the absence of symptoms.
31. Declarations from Mr. Searls and Captain Montalvo state that new detainees and staff are undergoing screening but there is no mention of whether and how contractors are also undergoing screening prior to entering the facility. This is especially important for BFDF because all medical care is provided by contractors. If healthcare workers are not adequately screened for signs and symptoms of COVID-19 infection, there is high risk that they will unwittingly bring the infection into the facility.
32. BFDF does not have adequate bed capacity to isolate people infected with COVID-19 if and when COVID-19 infection in the facility occurs. Mr. Searls's March 30, 2020 declaration describes 32 single cells in SHU that can be dedicated for medical isolation. At least some of these cells are already occupied, leaving an unclear number left for people with COVID-19 infection. Captain Montalvo describes that the medical unit has 3 beds, only 2 of which are specially equipped for negative pressure isolation, meaning that air flows from outside to inside the space to prevent spread of infected droplets to the remainder of the facility. It is unclear how many of these 3 medical unit beds are already occupied. Mr. Searls's April 4, 2020 declaration states that "due to logistical constraints and restrictions" individuals designated for medical isolation were unable to be moved to the expected units. If the facility is unable to adequately isolate individuals with COVID-19 infection, there is high likelihood the infection will rapidly spread unabated throughout the facility.
33. While it is reassuring that there are no confirmed cases of COVID-19 in BFDF to date, the number of cases in the surrounding community is rapidly rising. As of April 3, 2020 when data were last reported out, there were 21 cases in Genesee county and an additional 49 individuals were under quarantine ([https://www.co.genesee.ny.us/departments/health/coronavirus\\_2019/index.php](https://www.co.genesee.ny.us/departments/health/coronavirus_2019/index.php)), representing a 700% increase from the 3 cases described just one week prior in Mr. Searls's March 30, 2020 declaration. Once a case of COVID-19 is identified in a facility, it will be too late to prevent a widespread outbreak. Recent outbreaks of COVID-19 in ICE detention facilities in New York and New Jersey demonstrate how easily the virus enters facilities and rapidly spreads to detainees and staff when community epidemics are widespread, even when the best available infection preparedness plans are in place. We

absolutely cannot afford to wait until the first case appears in facilities to act. By the time someone (a detainee or staff member) develops COVID-19 symptoms to warrant isolation or testing, they will likely have already infected many others. It is estimated that the average person with COVID-19 infects 2.5-3.3 other people (including before they develop symptoms)- and this is a relatively low estimate from community settings where social distancing is possible. At that point, the spread of COVID-19 in the facility will be unstoppable. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. The time to act is now.

## V. Conclusion and Recommendations

34. For the reasons above, it is my professional judgment that individuals held at BFDF are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.
35. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.
36. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in BFDF at this time. I am also strongly of the opinion that individuals who are already in this facility should be evaluated for release.
37. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 65. They are in even greater danger in this facility, including a meaningfully higher risk of death.
38. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in this facility is a matter of days, not weeks. Once a case of COVID-19 identified in the facility, it will likely be too late to prevent a widespread outbreak.
39. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

April 7, 2020  
New Haven, Connecticut

  
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Dr. Jaimie Meyer