EXHIBIT C

Declaration of Dr. Josiah Rich, M.D., MPH

1. I am a doctor duly licensed to practice medicine in the state of Rhode Island.

2. I am currently Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital.

3. I have been a practicing Infectious Disease Specialist since 1994. I provide clinical care at The Miriam Hospital Immunology Center, as well as at the Rhode Island Department of Corrections, where I care for prisoners with HIV infection and work in the correctional setting doing research.

4. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I am an elected member of the National Academy of Medicine and I have served as an expert for the National Academy of Sciences, the Institute of Medicine, and many others. I have also been appointed by Rhode Island Governor Gina Raimondo to the Overdose Prevention and Intervention Task Force Expert Team. I have published close to 190 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions, and incarceration.

5. The matters that I discuss below are proceeding at a rapid pace across the country. I have published about these urgent concerns in the New England Journal of Medicine, the Washington Post, and elsewhere. I attach copies of those articles to this affidavit.

The extreme challenges Covid-19 poses for Connecticut's prison system.

6. As we are quickly seeing throughout the United States and the world, highly transmissible novel respiratory pathogens such as SARS-CoV-2—the virus that causes Covid-19—create a perfect storm for correctional settings.

7. First, correctional settings are ideal for rapid spread of viruses that are transmitted person-to-person, especially those passed by droplets through coughing and sneezing. When people must share dayrooms, bathrooms, showers, and other common areas, the opportunities for transmission are great. And while there continues to be disagreement about whether SARS-CoV-2 is an airborne virus, in the context of limited information, we must assume that it is. In that case, the poor ventilation systems within correctional facilities will ensure maximal opportunities for transmission.

8. When viruses are transmitted from person to person, the best initial strategy is to practice social distancing. Yet social distancing is extremely challenging in correctional settings. Even when facilities are locked down and use of common space are limited, there is inevitably frequent contact among prisoners, and especially between prisoners and staff. Even a quick cell change or shower involves multiple opportunities for contact with others. Accordingly, no matter what measures we take, correctional facilities are congregate settings that are poorly designed to prevent the inevitable rapid and widespread dissemination of this virus.

9. I understand that Connecticut, like other systems, has suspended visitation and facility transfers, and has taken certain other measures to try to limit infection. Irrespective of these interventions, however, infected persons—especially staff members—will inevitably continue to enter correctional settings. It is essential to understand that, despite being physically secure, jails and prisons are not isolated from the community. Rather, the boundaries between

correctional institutions and the communities in which they sit are extremely porous. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, population turnover means that people cycle between facilities and communities. And people often need to be transported to and from facilities, including for disciplinary and/or quarantining purposes. All of this is problematic in the context of this pandemic: While entry temperature checks may be effective screening mechanisms for symptomatic infections, they are ineffective with SARS-CoV-2 due to high rates of asymptomatic or pre-symptomatic infection.

10. Moreover, there are reduced prevention opportunities in prisons. During an infectious disease outbreak, free people can protect themselves by washing hands. Correctional facilities do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. These facilities are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for both 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 bleach is often unavailable, and cleaning agents used by correctional settings may not have been shown to effectively neutralize this virus, particularly in the diluted form commonly employed. There may also be a lack of people available to perform necessary cleaning procedures, which is exacerbated as people fall ill and movement is restricted.

11. A containment strategy for this virus requires both widespread screening and that people who are symptomatic be immediately isolated. It also requires that correctional officers and caregivers have access to personal protective equipment, including gloves, masks, gowns, and face shields. Yet correctional settings 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 where an outbreak is occurring. Correctional settings are also unlikely to be able to perform the widespread screening and contact-tracing necessary to prevent further infection.

12. All of the above is compounded by the fact that half of all incarcerated people in the United States have at least one chronic disease. With limited ability to protect themselves and others by self-isolating, thousands of susceptible people are at heightened risk for severe illness.

Lessening the spread of Covid-19 requires urgent, scaled-up decarceration.

13. The more preemptive measures taken by legal, public health, and correctional health partnerships, the lighter the burden the correctional facilities and their surrounding communities will bear. The global context offers some precedent here. Iran, for example, responded to its escalating pandemic by releasing 70,000 prisoners, something that may have helped "bend the curve" of that country's epidemic. Conversely, failure to calm incarcerated populations in Italy led to widespread rioting in Italian prisons.

14. At minimum, Connecticut must be prepared to isolate and separate incarcerated persons who are infected and those who are under investigation for possible infection from the general prison population; to hospitalize those who are seriously ill; and to cope with the high burden of disease and severe staff shortages that are likely to come.

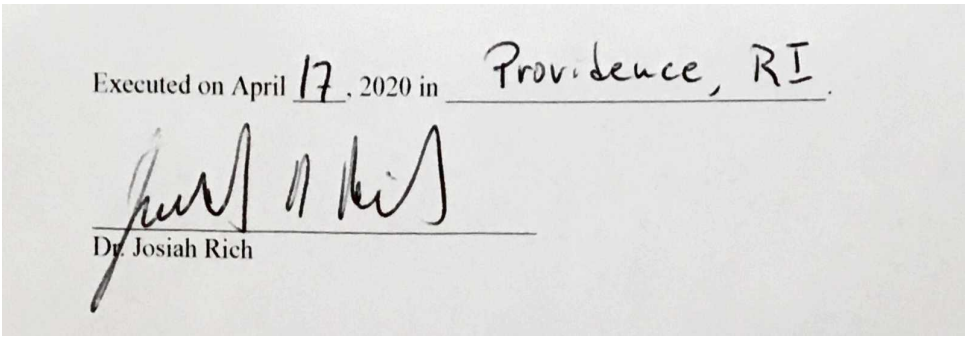
15. But this won't be enough. I understand that as of April 15, 2020, there were 199 confirmed positive COVID-19 cases among incarcerated people in Connecticut, and 139 confirmed positive cases among DOC staff. I also understand that Connecticut is transitioning people who test positive to the state's maximum security prison. This raises the concern that

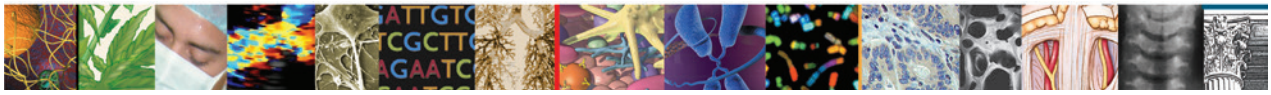
incarcerated people will be deterred from reporting symptoms of COVID-19 or seeking medical attention. It is also not clear to me how a maximum security prison is positioned to provide the level of medical care and observation that COVID-19 patients may require, including a low provider-to-patient ratio and specialized medical equipment. While the initial presentation of COVID-19 may seem mild, I have seen from firsthand experience that patients can decompensate rapidly, requiring intubation and ICU-level care in a matter of hours. Finally, while current guidelines by the CDC recommend that patients be quarantined for 14 days or 72 hours without symptoms, whichever is longer, we know that some patients continue to shed the virus for as long as 30 days.

16. As shown by the drastic surge in COVID-19 positive cases within DOC in a very short period of time, it is imperative to scale up efforts to "decarcerate," or release, as many people as possible, including those detained on bail. Each person needlessly infected in a correctional setting who develops severe illness will be one too many. And public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in correctional facilities during a pandemic.

17. It is my strong opinion that urgent decarceration is imperative to flatten the curve of Covid-19 cases among incarcerated populations and to limit the impact of transmission both inside correctional facilities and in the community. The abrupt onset of severe Covid-19 infections among incarcerated individuals will require mass transfers to local hospitals for intensive medical and ventilator care—highly expensive interventions are already in very short supply. Each severely ill patient coming from the Department of Correction who occupies an ICU bed may mean others may die for inability to obtain care. These are preventable infections, and we should act to prevent them.

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





The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Flattening the Curve for Incarcerated Populations — Covid-19 in Jails and Prisons

Matthew J. Akiyama, M.D., Anne C. Spaulding, M.D., and Josiah D. Rich, M.D.

Because of policies of mass incarceration over the past four decades, the United States has incarcerated more people than any other country on Earth. As of the end of 2016, there were nearly 2.2 million people in U.S. prisons and jails.[1] People entering jails are among the most vulnerable in our society, and during incarceration, that vulnerability is exacerbated by restricted movement, confined spaces, and limited medical care. People caught up in the U.S. justice system have already been affected by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and improved preparation is essential to minimizing the impact of this pandemic on incarcerated persons, correctional staff, and surrounding communities.

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. 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. Yet implementation of interventions to address these conditions is often challenging in correctional settings owing to resource limitations and policy constraints. Therefore, comprehensive responses that straddle correctional facilities and the community often need to be devised.

For example, HCV, which is the most prevalent infectious disease in incarcerated populations, is most commonly spread through injection drug use. Transmission can be reduced using measures known to reduce high-risk behaviors, such as opioid agonist therapy and syringe exchange. Although much of the country has yet to implement these strategies in correctional settings, managing transitions in care to and from the community and providing such services to people after incarceration has a large impact. Similarly, we have learned that controlling infections such as HIV and HCV in correctional settings can have positive effects both in these settings and on surrounding communities, as a form of treatment as prevention.

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. By the spring of 2010, vaccine was plentiful, yet most small jails never received vaccine, despite the presence of high-risk persons, such as pregnant women, and the increased risk of transmission among unvaccinated persons who spent time detained in close proximity to one another.[2]

"Social distancing" is a strategy for reducing transmission and "flattening the curve" of cases entering the health care system. Although correctional facilities face risks similar to those of community health care systems, social distancing is extremely challenging in these settings. Furthermore, half of all incarcerated persons have at least one chronic disease,[3] 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. With limited ability to protect themselves and others by self-isolating, hundreds of thousands of susceptible people are at heightened risk for severe illness.

To date, the Federal Bureau of Prisons and certain states and municipalities have opted to suspend visitation by community members, limit visits by legal representatives, and reduce facility transfers for incarcerated persons. To reduce social isolation and maintain a degree of connectedness for incarcerated people, some correctional systems are providing teleconferencing services for personal and legal visits. Irrespective of these interventions, infected persons — including staff members — will continue to enter correctional settings. By March 14, some U.S. correctional staff members had tested positive for SARS-CoV-2, and the first Covid-19 diagnosis in a detained person was announced on March 16. A recent SARS-CoV-2 outbreak among cruise-ship passengers and crew in Yokohama, Japan, provides a warning about what could soon happen in correctional settings.[4]

To operationalize a response for incarcerated populations, 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. The better the mitigation job done by legal, public health, and correctional health partnerships, the lighter the burden correctional facilities and their surrounding communities will bear. We have learned from other epidemics, such as the 1918 influenza pandemic, that nonpharmaceutical interventions are effective, but they have the greatest impact when implemented early.[5]

Therefore, we believe that we need to prepare now, by "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; urging police and courts to immediately suspend arresting and sentencing people, as much as possible, for low-level crimes and misdemeanors; isolating and separating incarcerated persons who are infected and those who are under investigation for possible infection from the general prison population; hospitalizing those who are seriously ill; and identifying correctional staff and health care providers who became infected early and have recovered, who can help with custodial and care efforts once they have been cleared, since they may have some degree of immunity and severe staff shortages are likely.

All these interventions will help to flatten the curve of Covid-19 cases among incarcerated populations and limit the impact of transmission both inside correctional facilities and in the community after incarcerated people are released. Such measures will also reduce the burden on the correctional system in terms of stabilizing and transferring critically ill patients, as well as the burden on the community health care system to which such patients will be sent. Each person needlessly infected in a correctional setting who develops severe illness will be one too many.

Beyond federal, state, and local action, we need to consider the impact of correctional facilities in the global context. The boundaries between communities and correctional institutions are porous, as are the borders between countries in the age of mass human travel. Despite security at nearly every nation's border, Covid-19 has appeared in practically all countries. We can't expect to find sturdier barriers between correctional institutions and their surrounding communities in any affected country. Thus far, we have witnessed a spectrum of epidemic responses from various countries when it comes to correctional institutions. Iran, for example, orchestrated the controlled release of more than 70,000 prisoners, which may help "bend the curve" of the Iranian epidemic. Conversely, failure to calm incarcerated populations in Italy led to widespread rioting in Italian prisons. Reports have also emerged of in-

carceration of exposed persons for violating quarantine, a practice that will exacerbate the very problem we are trying to mitigate. To respond to this global crisis, we need to consider prisons and jails as reservoirs that could lead to epidemic resurgence if the epidemic is not adequately addressed in these facilities everywhere.

As with general epidemic preparedness, the Covid-19 pandemic will teach us valuable lessons for preparedness in correctional settings. It will also invariably highlight the injustice and inequality in the United States that are magnified in the criminal justice system. As U.S. criminal justice reform continues to unfold, emerging communicable diseases and our ability to combat them need to be taken into account. To promote public health, we believe that efforts to decarcerate, which are already under way in some jurisdictions, need to be scaled up; and associated reductions of incarcerated populations should be sustained. The interrelation of correctional-system health and public health is a reality not only in the United States but around the world.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Medicine, Divisions of General Internal Medicine and Infectious Diseases, Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY (M.J.A.); the Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta (A.C.S.); and the Departments of Medicine and Epidemiology, Division of Infectious Diseases, Brown University and the Miriam Hospital, Providence, RI (J.D.R.).

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The Washington Post
Democracy Dies in Darkness

We must release prisoners to lessen the spread of coronavirus

By **Josiah Rich**, **Scott Allen** and **Mavis Nimoh**

March 17, 2020 at 4:01 p.m. EDT

Josiah Rich is professor of medicine and epidemiology at Brown University. Scott Allen is professor of medicine emeritus at the University of California at Riverside. Mavis Nimoh is executive director of the Center for Prisoner Health and Human Rights at the Miriam Hospital, of which Rich and Allen are co-founders.

Unless government officials act now, the novel coronavirus will spread rapidly in our jails and prisons, endangering not only prisoners and corrections workers but the general public as well. As the country prepares for further spread of the pandemic, authorities should take immediate steps to limit the risk posed by mass confinement, including releasing those detained on bail, along with elderly prisoners who pose little danger to the public.

Early on in this pandemic, we learned that, as with other closed spaces such as cruise ships and nursing homes, the covid-19 coronavirus spread rapidly in Chinese correctional facilities. Now the United States, which leads the world when it comes to incarceration, faces that same challenge.

It is essential to understand that, despite being physically secure, jails and prisons are not isolated from the community. People continuously enter and leave, including multiple shifts of corrections staff; newly arrested, charged and sentenced individuals; attorneys; and visitors. Even if this flow is limited to the extent possible, correctional facilities remain densely populated and poorly designed to prevent the inevitable rapid and widespread dissemination of this virus.

At the same time, jails and prisons house individuals at higher risk than in other settings, such as schools and restaurants, that have been closed to mitigate contamination. Although corrections facilities cannot be closed, they must be included in any plan aimed at slowing the surge in infections and protecting public safety.

Reassessing security and public health risks and acting immediately will save the lives of not only those incarcerated but also correctional staff and their families and the community at large. There are several steps that authorities should implement as quickly as possible.

They must screen incoming individuals to prevent and delay infected individuals from entering facilities. They must rapidly identify cases and isolate exposed groups to limit the spread, as well as quickly transfer seriously ill patients to appropriate facilities.

But that won't be enough. Authorities should release those who do not pose an immediate danger to public safety, while also reducing arrests and delaying sentencings. These moves carry inherent political risks, but they are for the greater good of the public at large. The abrupt onset of severe covid-19 infections among incarcerated individuals will require mass transfers to local hospitals for intensive medical and ventilator care — highly expensive interventions that may soon be in very short supply. Each severely ill patient coming from corrections who occupies an ICU bed will mean others may die for inability to obtain care.

Our ability to release people rapidly will vary by type of facility and jurisdiction. Those being held in jails simply due to their inability to afford bail, or for minor infractions or violations, can generally be released promptly by the judiciary or even the local sheriff. Some jurisdictions are already discussing such mitigation efforts.

Already sentenced individuals pose a greater challenge — one compounded by the punitive policies of the past few decades (mandatory minimum sentences, three strikes and life without parole) that have led to a large, aging incarcerated population especially vulnerable to severe disease. Additionally, half of all incarcerated people suffer from at least one chronic illness, which means even more will be at risk of a poor prognosis if they become infected.

Those eligible for parole can and should be released. Provisions for "compassionate release/parole" exist in every state; however, that process is typically slow, underutilized and very limited. Fortunately, the people at highest risk for severe complications of covid-19 who are incarcerated (the aging and chronically ill), are, on average, the least likely to commit a new crime or need to be re-incarcerated. In some states, governors have the ability to commute sentences or pardon individuals, as does the president in the federal system.

On the federal level as well, there is a parallel public health danger lurking in the immigration detention system, where thousands of people are being held in jail-like conditions that pose similar risks. The Trump administration could, if it wished, institute a simple and even temporary policy change to release those individuals into the community rather than contain them in an environment where rapid spread is likely. As unlikely as this may be given the administration's approach to immigration detention, this may be the easiest fix, given the broad discretion of the Department of Homeland Security to change policy.

The spread of the coronavirus may only be the tipping point for what can happen when we fail to consider all the costs and consequences of our system of mass incarceration. We justify locking people up to protect public safety. Yet public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in jails, prisons and detention facilities during a pandemic.

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