

# **EXHIBIT B**

### **Declaration of Dr. Jonathan Giftos**

I, Jonathan Giftos, declare as follows:

1. I am a doctor duly licensed to practice medicine in the State of New York. I am board-certified in internal medicine and addiction medicine. I received my Bachelor of Science degree from Boston College, and my Medical Degree from Mount Sinai School of Medicine.
2. I am currently the Medical Director, Addiction Medicine & Drug User Health at Project Renewal and a Clinical Assistant Professor in the Department of Medicine at Albert Einstein College of Medicine.
3. Between August 2016 and January 2020, I was an Attending Physician and the Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island. During this time, I provided primary medical care to detainees and sentenced patients, and supervised the nation's oldest and largest jail-based opioid treatment program. I successfully led an effort to remove non-clinical barriers to opioid treatment program enrollment in 2017, which dramatically expanded treatment access from 25% to over 80%, while also reducing post-release mortality for people with opioid use disorder.
4. I have extensive experience working with vulnerable populations such as the incarcerated and those experiencing homelessness.
5. In the course of my duties as Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island, I entered every facility in the New York City Department of Correction. I have firsthand knowledge of the various housing types—from dormitory housing to single-cell units—in correctional facilities.

#### **The Coronavirus Pandemic**

6. On March 11, 2020, the World Health Organization declared that the rapidly spreading outbreak of COVID-19, a respiratory illness caused by a novel coronavirus, is a pandemic, announcing that the virus is both highly contagious and deadly. To date, the virus is known to spread from person-to-person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects. The CDC also warns of “community spread” where the virus spreads easily and sustainably within a community where the source of the infection is unknown.
7. There is currently no vaccine or cure. The primary focus is on preventing the spread of the virus at this juncture. To prevent new infections, the Centers for Disease Control and Prevention strongly recommend the following actions: thorough and frequent handwashing, cleaning surfaces with EPA-approved disinfectants, keeping at least six

feet of space between people, and avoiding group settings. Social distancing has also been encouraged to slow the rate of COVID-19 infections so that hospitals have the resources to address infected individuals with urgent medical needs. In correctional settings, such sanitation, social distancing, and self-quarantining measures are nearly impossible.

8. Experts continue to learn more about the transmission of novel coronavirus. Recent evidence has aided scientists and healthcare professionals in understanding why COVID-19 spreads so rapidly and dangerously. While it is well-known that symptomatic people transmit the virus, two additional transmission categories are essential to understanding the alarming rate of infection linked with the novel coronavirus: (1) asymptomatic transmission, or people who are infected and contagious but never display the symptoms associated with COVID-19, and (2) presymptomatic transmission, or people who are contagious *before* they begin to show symptoms.
9. On April 1, 2020, the CDC published a critically important study finding evidence of presymptomatic transmission.<sup>1</sup> In it, the CDC warned that “[t]he potential for presymptomatic transmission underscores **the importance of social distancing, including the avoidance of congregate settings**, to reduce COVID-19 spread” (emphasis added).<sup>2</sup>
10. Given what we now know about how the novel coronavirus spreads and how often transmission occurs when an infected person is not displaying any symptoms whatsoever, even robust efforts to screen symptoms and isolate presumed positives are *not enough to prevent transmission*. Any system that relies on such a screening model will not stop the spread of the virus. From what we have learned, a combination of genuine and strict social distancing, handwashing, sanitation, and widespread testing and contact tracing are the measures effective to protect populations from rapid infection.
11. The Centers for Disease Control have identified two groups of people at higher risk of contracting and succumbing to COVID-19: adults over 60 years old and people with chronic medical conditions. COVID-19 is more dangerous to persons in these high-risk groups than to the general population. Older people who contract COVID-19 are more likely to die than people under the age of 60. It has been found that older people diagnosed with COVID-19 are more likely to be very sick and require hospitalization to survive because the acute symptoms include respiratory distress, cardiac injury, arrhythmia, septic shock, liver dysfunction, kidney injury and multi-organ failure. Access to a mechanical ventilator is often required. People with chronic medical conditions (no matter their age) are also at significantly greater risk from COVID-19 because their already-weakened systems are less able to fight the virus. These chronic medical conditions include lung disease, cancer, heart failure, cerebrovascular disease, renal

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<sup>1</sup> Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020. *MMWR. Morbidity and Mortality Weekly Reports*, at <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6914-H.pdf>.

<sup>2</sup> *Id.*, p.412.

disease, liver disease, diabetes, immunocompromising conditions, and pregnancy. Those with pre-existing medical conditions have a higher probability of death if infected.

### **COVID-19 Within Correctional Settings**

12. Based on my years of providing medical care at Rikers Island, I know that correctional settings increase the risk of contracting an infectious disease like COVID-19. This is because there are high numbers of people with chronic, often untreated, illnesses housed in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and no possibility of staying at a distance from others.
13. Correctional facilities house large groups of inmates together, and move inmates in groups to eat, bathe, and recreate. They frequently have insufficient medical care for the population, and, in times of crisis, even those medical staff cease coming to the facility. Hot water, soap, disinfectants, and paper towels are frequently in limited supply, and inmates, rather than professional cleaners, are responsible for cleaning the facilities. As a result, there are more people susceptible to getting infected congregated together in a context in which fighting the spread of an infection is nearly impossible.
14. Indeed, outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases. In the current outbreak, Rikers Island went from just one confirmed case of COVID-19 on March 18 to 231 confirmed cases in just two weeks.<sup>3</sup>

### **COVID-19 and the Physical Infrastructure of Prison**

15. I understand that Connecticut correctional settings are a mix of dormitory settings and single-cell settings. Both settings pose significant challenges to the ability of staff and incarcerated people alike to abide by CDC guidelines.
16. Dorm housing areas are particular breeding grounds for COVID-19. Beds in these units are typically in one room, and far less than six feet apart. People housed in dorms must share common sinks, toilets, showers, phones, tables and chairs.
17. Adequately sanitizing a space with those characteristics would require constant diligence and a continuous abundance of cleaning supplies. Cleaning once a day, or even a few times a day, would not prevent transmission of the virus. Social distancing, even at significantly reduced capacity, is virtually impossible due to the physical realities of the shared spaces in the dorms and the difficulty of adequately sanitizing a space inhabited by a constantly rotating population of incarcerated people and staff.

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<sup>3</sup> *Compare As Testing Expands, Confirmed Cases of Coronavirus in N.Y.C. Near 2,000*, N.Y. Times (Mar. 18, 2020), <https://www.nytimes.com/2020/03/18/nyregion/coronavirus-new-york-update.html> (first positive case at Rikers) *with* The Legal Aid Society, *Covid-19 Tracking in NYC Jails*, Apr. 2, 2020, <https://www.legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails> (231 cases today).

18. Single-cell housing areas also pose elevated risk of transmitting the virus. Though single cell units are typically equipped with a toilet and sink, incarcerated people must leave the cell for many reasons: to use a shared shower, or to go to the clinic, or potentially to use a shared phone or perform a job. Meals are still prepared and delivered from other parts of the jail. Incarcerated people housed in single cells are also subject to exposure from the myriad operational characteristics endemic in the jail setting, described below. All of these factors demonstrate the difficulty of effective social distancing and sanitation even in more isolated single-cell units.

### **COVID-19 and the Operational Characteristics of Prison**

19. My experience in correctional health also exposed me to the limitations of correctional health care. Similar to an outpatient primary care clinic, correctional health care is designed to provide urgent care for ailments that are non-life threatening. It is not capable of providing the type of care one receives in a hospital, let alone in an intensive care unit. As a result, when an incarcerated person requires hospitalization or intensive care, they are transferred to a hospital in the community. During my time at Rikers Island, we routinely transferred incarcerated people to community hospitals to receive care that we could not provide at the facility.
20. For prison systems that are already understaffed, staffing shortages will only increase as employees need to stay home to care for children whose schools are closed, elderly family members, and—if infected or exposed to infection—themselves. With fewer staff, correctional officers are even less able to monitor prisoners' health.
21. During the COVID-19 pandemic, these limitations in correctional health care have important public health implications not just for incarcerated populations, but for the general population as well. According to the most recent estimates, at least 15% of people who contract COVID19 will require hospitalization, and 5% will require intensive care. Based on the vulnerability of the incarcerated population, it is likely that these numbers would be at least as high, if not higher, within a correctional setting.
22. A person who contracts COVID-19 in jail or prison and requires hospitalization will need to be transferred to a community hospital. As a result, the problem of a prison outbreak of COVID-19 infections cannot and will not be contained within the institution itself. Instead, it will explode into the community, increasing the pressure on our already taxed community hospitals.
23. Even at baseline, ICU beds and ventilators in our community hospitals are a scarce commodity. A recent analysis by the Harvard Global Health Institute indicates that under most scenarios, "vast communities in America are not prepared to take care of the COVID-19 patients" that require hospital care. An outbreak of COVID-19 at a jail or prison, which would likely require numerous transfers to a community hospital, could push a hospital even further past its breaking point. Specifically, a surge in COVID-19

infections in a correctional setting could mean that ICU beds in the community hospital would no longer be available to everyone who needed them.

24. A final characteristic of prison that must be considered in the instant health crisis is the inevitable operational gaps in a system of Connecticut's size and the risks that those gaps pose to staff and people in custody. DOC's filings contain descriptions of policies that would certainly play a critical role in reducing the harm from the COVID-19 pandemic: frequent and thorough cleaning and sanitizing regimens, ongoing health education, and adequate provision of soap, sinks, and cleaning supplies. In order to be effective, of course, policies must be implemented with fidelity and require adequate staffing levels to do so. In my time in correctional health, I witnessed many instances in which execution of policies relating to sanitation, provision of basic items, and other requirements fell short. When staffing levels are short and the numbers of those infected continue to rise, I remain gravely concerned that people in custody do not have the supplies and environmental controls necessary to protect them and staff from the pandemic, notwithstanding effort to create policies to address this problem.

#### **Correctional Settings Cannot Be Equipped to Keep People Safe from COVID-19**

25. Every effort should be made to reduce chances of exposure to COVID-19. However, based on my experience in correctional health, I do not believe that screening, social distancing, and quarantining measures can be sufficiently employed within correctional settings to combat the spread of COVID-19.
26. Correctional settings simply cannot be equipped to keep people safe during this pandemic. There are too many structural limitations, and correctional health care can only do so much. Decreasing the incarcerated population so that there is more ability to physically distance within the facility, fewer people who can contract the virus inside the facility, and more medical care for those who need it is the only way to prevent the complications from surging. Otherwise, the unchecked transmission of COVID-19 in jail or prison will have serious, and fatal, implications for the broader community.
27. Decreasing the incarcerated population will also decrease the necessary staffing for the facility and protect staff from exposure. Reducing the number of needed correctional officers and healthcare workers will, in turn, reduce the number of people entering and exiting the facility on a daily basis. This too will reduce the spread of COVID-19 to the broader community.
28. It is my professional opinion that these steps are both necessary and urgent, and that reducing population via standard, one-by-one mechanisms will fall far short of what is required to prevent a public health crisis. The infection rate inside Rikers is now eight times higher than the infection rate in New York City. I understand that Connecticut has gone from one incarcerated person testing positive to 182 positive tests in two weeks, along with 118 staff. These surging numbers mean that, without immediate action, Connecticut will likely follow the same trajectory.

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

Executed on April 17, 2020 in **New York, New York**.

A handwritten signature in black ink, appearing to read "J. Giftos". The signature is written in a cursive style with a large initial "J" and a stylized "Giftos".

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Jonathan Giftos, M.D.