EXHIBIT D
I, Brie Williams, hereby affirm as follows:

1. I am a doctor licensed to practice medicine in the State of California.

2. I am currently a Professor of Medicine at the University of California, San Francisco (“UCSF”) in the Geriatrics Division, Director of UCSF’s Amend: Changing Correctional Culture Program, as well as Director of UCSF’s Criminal Justice & Health Program. In that capacity, my clinical research has focused on improved responses to disability, cognitive impairment, and symptom distress in older or seriously ill prisoners; a more scientific development of compassionate release policies; and a broader inclusion of prisoners in national health datasets and in clinical research. I have developed new methods for responding to the unique health needs of criminal justice-involved older adults—including an evidence-based approach to reforming compassionate release policies and the design of a new tool to assess physical functioning in older prisoners. I was previously a consultant for the California Department of Corrections and Rehabilitation, as well as for other state prison systems.

3. I have extensive experience working with vulnerable populations, in particular the incarcerated and the elderly.


4. Prisons and jails are not actually isolated from our communities: hundreds of thousands of correctional officers and correctional healthcare workers enter these facilities every day, returning to their families and to our communities at the end of their shifts, bringing back and forth to their families and neighbors and to incarcerated patients any exposures they have had during the day. Access to testing for correctional staff has been “extremely limited,”
guards—including, as I understand, those in Connecticut—have reported a very “short supply” of protective equipment, and prisons are not routinely or consistently screening correctional officers for symptoms.¹

5. The risk of exposure is particularly acute in pre-trial facilities where the inmate populations shift frequently.² For example, despite the federal government’s guidance to stay inside and many states’ stay-in-place orders, many prosecutors are still arresting individuals and seeking detention.³ Pre-trial detention facilities are still accepting new inmates who are coming from communities where COVID-19 infection is rampant.

6. Because inmates live in close quarters, there is an extraordinarily high risk of accelerated transmission of COVID-19 within jails and prisons. Inmates share small cells, eat together and use the same bathrooms and sinks. In dorm settings, they eat together at small tables that are cleaned only irregularly. Some are not given tissues or sufficient hygiene supplies.⁴


Effective social distancing in most facilities is virtually impossible, and is often compounded by inadequate sanitation, such as a lack of hand sanitizer or sufficient opportunities to wash hands.\(^5\)

**Inmate Populations Also Have the Highest Risk of Acute Illness and Poor Health Outcomes if Infected with COVID-19.**

1. There are more than 2.3 million people incarcerated in the United States\(^6\) approximately 16% of whom are age 50 or older.\(^7\) The risk of coronavirus to incarcerated seniors is high. “Their advanced age, coupled with the challenges of practicing even the most basic disease prevention measures in prison, is a potentially lethal combination.”\(^8\) To make matters worse, correctional facilities are often ill-equipped to care for aging prisoners, who are more likely to suffer from chronic health conditions than the general public.

2. An estimated 39-43% of all prisoners, and over 70% of older prisoners, have at least one chronic condition, some of the most common of which are diabetes, hypertension, and heart problems.\(^9\) According to the CDC, each of these conditions—as well as chronic bronchitis,
emphysema, heart failure, blood disorders, chronic kidney disease, chronic liver disease, any condition or treatment that weakens the immune response, current or recent pregnancy in the last two weeks, inherited metabolic disorders and mitochondrial disorders, heart disease, lung disease, and certain neurological and neurologic and neurodevelopment conditions\textsuperscript{10}—puts them at a “high-risk for severe illness from COVID-19.”\textsuperscript{11}

9. However, even many young federal prisoners suffer from asthma, rendering them also very vulnerable to coronavirus.\textsuperscript{12}

10. But it is not only the elderly, or those with preexisting medical conditions that are at risk of coronavirus in a correctional setting. As of March 23, 2020, New York City reported that “[p]eople ranging in ages from 18 to 44 have accounted for 46 percent of positive tests.”\textsuperscript{13} Across the United States, 38\% of those hospitalized are between the ages of 20 and 54 and 12\% of the intensive care patients are between 20 and 44.\textsuperscript{14}

11. This data is of particular concern for inmate populations, since prisoners’ physiological age averages 10 to 15 years older than their chronological age.\textsuperscript{15} Therefore, the

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  \item \textsuperscript{14} Id.
consensus of those who study correctional health is that inmates are considered “geriatric, by the age of 50 or 55 years.” It is not clear that prison health care administrations are taking accelerated ageing into account when determining the eligibility criteria for age-related screening tools and medical care protocols for coronavirus, potentially leaving large swathes of the prison population at risk.

12. In one study, we found that inmates who died in hospitals were, on average, nearly two decades younger than non-incarcerated decedents, had significantly shorter hospitalizations, and had higher rates of several chronic conditions including cancer, liver disease and/or hepatitis, mental health conditions, and HIV/AIDS.

The Entire Community is at Risk If Prison Populations Are Not Reduced

13. As the World Health Organization has warned, prisons around the world can expect “huge mortality rates” from Covid-19 unless they take immediate action including screening for the disease.

16 Brie A. Williams et al., The Older Prisoner and Complex Chronic Medical Care 165-70 in World Health Organization, Prisons and Health (2014). https://pdfs.semanticscholar.org/64aa/10d3cff6800ed42dd152fcf4e13440b6f139.pdf.


18 Id. at 20.

14. Jails and prisons are fundamentally ill-equipped to handle a pandemic. Medical treatment capacity is not at the same level in a correctional setting as it is in a hospital. Some correctional facilities have no formal medical ward and no place to quarantine sick inmates, other than the facilities’ Special Housing Unit (SHU).\(^{20}\) While the cells in the SHU often have solid doors to minimize the threat of viral spread in otherwise overcrowded facilities, they rarely have intercoms or other ways for sick inmates to contact officers in an emergency.\(^{21}\) This is particularly dangerous for those with COVID-19 infection since many patients with COVID-19 descend suddenly and rapidly into respiratory distress.\(^{22}\)

15. Even those facilities that do have healthcare centers can only treat relatively mild types of respiratory problems for a very limited number of people.\(^{23}\) This means that people who become seriously ill while in prisons and jails will be transferred to community hospitals for care. At present, access to palliative care in prison is also limited.

16. Corrections officers may also be particularly vulnerable to coronavirus due to documented high rates of diabetes and heart disease.\(^{24}\) Multiple prison staff in Connecticut, like those in Pennsylvania, Michigan, New York and Washington state, among others, have tested


\(^{23}\) Ellis, Covid-19 Poses a Heightened Threat in Jails and Prisons; Li and Lewis, This Chart Shows Why the Prison Population is So Vulnerable to COVID-19.

positive for the virus, resulting in inmate quarantines. Fifty-nine federal prison staffers have also tested positive.\(^{25}\)

17. For this reason, correctional health is public health. Decreasing risk in prisons and jails decreases risk to our communities.

18. Reducing the overall population within correctional facilities will also help medical professionals spread their clinical care services throughout the remaining population more efficiently. With a smaller population to manage and care for, healthcare and correctional leadership will be better able to institute shelter in place and quarantine protocols for those who remain. This will serve to protect the health of both inmates as well as correctional and healthcare staff.

\[\text{[Signature]}\]

Dr. Brie Williams

San Francisco, California
April 6, 2020

-Notarized copy to follow-