

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

No. SJ 2020-757

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Plaintiffs,

v.

BARNSTABLE COUNTY SHERIFF'S OFFICE, BERKSHIRE COUNTY SHERIFF'S
OFFICE, BRISTOL COUNTY SHERIFF'S OFFICE, DUKES COUNTY SHERIFF'S
OFFICE, ESSEX COUNTY SHERIFF'S OFFICE, FRANKLIN COUNTY SHERIFF'S
OFFICE, HAMPDEN COUNTY SHERIFF'S OFFICE, HAMPSHIRE COUNTY
SHERIFF'S OFFICE, MIDDLESEX COUNTY SHERIFF'S OFFICE, NORFOLK
COUNTY SHERIFF'S OFFICE, PLYMOUTH COUNTY SHERIFF'S OFFICE,
SUFFOLK COUNTY SHERIFF'S OFFICE and
WORCESTER COUNTY SHERIFF'S OFFICE
Defendants.

PLAINTIFFS' REPLY BRIEF IN SUPPORT OF
COMPLAINT FOR DECLARATORY AND EQUITABLE RELIEF
AND RELIEF UNDER G. L. C. 211, § 3

Table of Contents

TABLE OF AUTHORITIES	3
INTRODUCTION	5
ARGUMENT	6
I. THE HOCs’ TESTING AND DEPOPULATION PRACTICES VIOLATE THE EIGHTH AMENDMENT AND ART. 26 RIGHTS OF SENTENCED PRISONERS.....	6
A. <i>There can be no meaningful dispute that COVID-19 presents a substantial risk of serious harm to incarcerated individuals.</i>	6
B. <i>The HOCs’ failure to take reasonable steps to mitigate the substantial risk posed by COVID-19 demonstrates deliberate indifference.</i>	10
i. The HOCs’ failure to conduct routine, comprehensive testing demonstrates deliberate indifference.....	10
ii. The HOCs’ failure to exercise their statutory authorities to meaningfully depopulate demonstrates deliberate indifference.	15
II. THE HOCs’ TESTING AND DEPOPULATION PRACTICES VIOLATE THE DUE PROCESS RIGHTS OF PRETRIAL DETAINEES.	17
III. BY FAILING TO PROVIDE CONFIDENTIAL REMOTE LEGAL COMMUNICATION OPTIONS DURING THE PANDEMIC, INCLUDING VIDEOCONFERENCING WITH SCREEN SHARING CAPABILITY, THE FIVE HOCs ARE VIOLATING INCARCERATED INDIVIDUALS’ RIGHT TO COUNSEL.	18
CONCLUSION.....	20

Table of Authorities

Cases

<i>Baez v. Moniz</i> , 460 F. Supp. 3d 78 (D. Mass. 2020)	7
<i>Castro v. Cty. of Los Angeles</i> , 833 F.3d 1060 (9th Cir. 2016)	17
<i>Committee for Public Counsel Services v. Chief Justice of the Trial Court</i> , 484 Mass. 431 (2020)	6, 10, 15, 16
<i>Commonwealth v. Nash</i> , 486 Mass. 394 (2020)	7, 8
<i>da Silva Medeiros v. Martin</i> , 458 F. Supp. 3d 122 (D.R.I. 2020)	18
<i>Darnell v. Pineiro</i> , 849 F.3d 17 (2d Cir. 2017)	17
<i>Edmo v. Corizon, Inc.</i> , 935 F.3d 757 (9th Cir. 2019)	11
<i>Farmer v. Brennan</i> , 511 U.S. 825 (1970)	9
<i>Feeney v. Corr. Med. Servs., Inc.</i> , 464 F.3d 158 (1st Cir. 2006)	11
<i>Foster v. Comm’r of Correction</i> , 484 Mass. 698 (2020)	7, 11
<i>Gaudreault v. Municipality of Salem, Mass.</i> , 923 F.2d 203 (1st Cir. 1990)	18
<i>Gomes v. US Dep’t of Homeland Sec., Acting Sec’y</i> , 460 F. Supp. 3d 132 (D.N.H. 2020)	18
<i>Kinglsey v. Hendrickson</i> , 576 U.S. 389 (2015)	17
<i>Kosilek v. Spencer</i> , 774 F.3d 63 (1st Cir. 2012)	12
<i>Leite v. Bergeron</i> , 911 F.3d 47 (1st Cir. 2018)	10
<i>Madrid v. Gomez</i> , 889 F. Supp. 1146 (N.D. Cal. 1995)	12
<i>Miranda v. Munoz</i> , 770 F.2d 255 (1st Cir. 1985)	10
<i>Miranda-Rivera v. Toledo-Dávila</i> , 813 F.3d 64 (1st Cir. 2016)	18

<i>Petties v. Carter</i> , 836 F.3d 722 (7th Cir. 2016)	11
<i>Richardson v. Sheriff of Middlesex Cty.</i> , 407 Mass. 455 (1990)	17
<i>S. Poverty Law Ctr. v. United States Dep’t of Homeland Sec.</i> , U.S. Dist. Ct., No. 18-760 (D.D.C. June 17, 2020)	19
<i>Savino v. Souza</i> , 459 F. Supp. 3d 317 (D. Mass. 2020)	7, 11
<i>Torres v. Comm’r of Correction</i> , 427 Mass. 611 (1989)	12
<i>United States v. Davis</i> , 449 F. Supp. 3d 532 (D. Md. 2020)	19
<i>United States v. Shaheed</i> , 455 F. Supp. 3d 225 (D. Md. 2020)	19
<i>Yanes v. Martin</i> , 464 F. Supp. 3d 467 (D.R.I. 2020).....	18
Statutes	
G. L. c. 126, § 26.....	16
G. L. c. 127, § 20B.....	16
G. L. c. 127, § 49A.....	16
G. L. c. 127, §49.....	16
Other Authorities	
Michael P. Norton, <i>Sheriffs Gearing up for Vaccine Administration</i> , WWLP-22News (Jan. 14, 2021)	7
Moises Velasquez-Manoff, <i>What If You Never Get Better From Covid-19?</i> , N.Y. Times Magazine (Updated Jan. 26, 2021).....	10
Travis Andersen, <i>Baker Says Vaccine Will Be Administered Beginning Monday at Shelters and Prisons</i> , Boston Globe (Jan. 13, 2021).....	7

Introduction

The Houses of Correction (HOCs) admit that they are not conducting routine, comprehensive testing of non-symptomatic prisoners or staff. They do not claim that they are using their statutory authority to release incarcerated people. And in the main, their description of the limitations on attorney-client communication at Bristol, Essex, Hampden, Plymouth, and Worcester (the Five HOCs) matches that of the plaintiffs. Nevertheless, the HOCs argue that this factual record conclusively establishes that they are complying with the constitutional guarantees concerning cruel and unusual punishment, due process, and the right to counsel. It does not.

The HOCs' first response to plaintiffs' Eighth Amendment, art. 26, and due process claims is the argument that COVID-19 does not pose a substantial risk of serious harm in their facilities because, after declining to meaningfully test for it, they have not found what they are not looking for. This is like an ostrich burying its head in the sand and then proclaiming that the sun has disappeared. Courts that have addressed this question have repeatedly found that people held in Massachusetts correctional facilities face a substantial risk of serious harm due to COVID-19, and even the DOC does not dispute that this will be true for the foreseeable future. See *Foster v. Mici*, No. 2084CV00855D, Dkt. #96, Def. Opp. 19 (Mass. Super. Ct. Jan. 22, 2021). This Court should do the same.

The HOCs' arguments that their testing or release practices are neither deliberately indifferent nor objectively unreasonable are similarly unsuccessful. With respect to testing, the HOCs do not suggest that they lack the resources to implement surveillance testing; they assert that they decline to do so on the advice of Dr. Alysse Wurcel. During the months of Special Master calls before the filing of this case, plaintiffs repeatedly asked to speak with Dr. Wurcel to learn the basis of her advice. But the HOCs never provided that opportunity, and Dr. Wurcel's affidavit in this case does not provide any clarity. Her statements should either be rejected outright or tested at

an evidentiary hearing. As for releases, the HOCs argue against the strawman of “wholesale release,” Def. Br. 4, but plaintiffs do not contend that wholesale releases are required by the constitution. Plaintiffs’ claim is that the HOCs’ refusal to even consider releasing people, despite having the power to do so, is unconstitutional. The HOCs evidently believe that they have no constitutional obligation to consider releasing more people under their statutory authority than the trial courts already ordered pursuant to *Committee for Public Counsel Services v. Chief Justice of the Trial Court*, 484 Mass. 431 (2020) (hereinafter, *CPCS*). That is not so, and the HOCs’ decision not to consider prisoner releases reflects deliberate indifference.

Finally, the Five HOCs argue that their proffered opportunities for attorney-client communications meet the constitutional requirements both because it is a defense attorney’s “choice” not to meet in person, Def. Br. 20, and because the additional modes of communications they offer are sufficient alternatives to such meetings. Yet it is not unreasonable to avoid entering a congregate setting that does not meaningfully test its population or staff for COVID-19; and the Five HOCs do not offer sufficient access to videoconferencing—the closest approximation of in-person communication—to satisfy the requisite constitutional standard during the pandemic.

This Court should therefore hold that the HOCs have violated the U.S. Constitution and the Massachusetts Declaration of Rights and grant the relief requested in the Complaint.

Argument

- I. The HOCs’ testing and depopulation practices violate the Eighth Amendment and art. 26 rights of sentenced prisoners.**
 - A. There can be no meaningful dispute that COVID-19 presents a substantial risk of serious harm to incarcerated individuals.**

Less than two months ago, the Supreme Judicial Court reiterated, “there can be no real dispute that the increased risk of contracting COVID-19 in prisons, where physical distancing may be infeasible to maintain, has been recognized by the [Centers for Disease Control] and by courts

across the country.” *Commonwealth v. Nash*, 486 Mass. 394, 408 n.18 (2020), quoting *Foster v. Comm’r of Correction*, 484 Mass. 698, 718 (2020).¹ And last month, Governor Baker explained the decision to prioritize vaccinating incarcerated people by stating, “[w]e made the decision early on that we were going to focus on what we consider to be populations that were most at-risk, and all the data and all the evidence makes it pretty clear that congregate care settings are at-risk communities, no matter how you define them.”² Around the same time, Dr. Wurcel acknowledged that “people who are in jail and prison represent one of the highest-risk populations.”³ Nevertheless, relying on a one-week comparison between facility and community case rates, the HOCs argue that incarcerated people are safer than community members.⁴ See Def. Br. 5, 9. For four reasons, this argument lacks merit.

First, without increased testing, the facilities’ rates of detected cases are not informative.⁵ The HOCs emphasize that seven counties reported zero new infections among incarcerated people between December 31, 2020, and January 6, 2021. See Def. Br. 9. But two of those seven facilities tested zero incarcerated people during that period, a third tested a single incarcerated person, and the rest tested fifteen or fewer. See Ex. 1 to Def. Br. 5, 9, 18, 30, 42, 45, 48.⁶ The

¹ See also *Savino v. Souza*, 459 F. Supp. 3d 317, 328 (D. Mass. 2020); *Baez v. Moniz*, 460 F. Supp. 3d 78, 89 (D. Mass. 2020).

² Travis Andersen, *Baker Says Vaccine Will Be Administered Beginning Monday at Shelters and Prisons*, Boston Globe (Jan. 13, 2021), <https://www.bostonglobe.com/2021/01/13/metro/baker-says-vaccine-will-be-administered-people-shelters-prisons-seniors-housing-developments>.

³ Michael P. Norton, *Sheriffs Gearing up for Vaccine Administration*, WWLP-22News (Jan. 14, 2021), <https://www.wwlp.com/news/state-politics/sheriffs-gearing-up-for-vaccine-administration>.

⁴ The HOCs use the terms “positivity rate” and “facility rate” to refer to the rate of COVID-19 infections in a facility. Def. Br. 5, 9. Because the term “positivity rate” generally refers to the percent of tests that return positive results, plaintiffs use the term “case rate” to refer to the rate of infection in a facility. See Supplemental Affidavit of Dr. Monik Jiménez and Tori L. Cowger, attached as Exhibit A (hereinafter, Jiménez Suppl.) ¶ 12.

⁵ See Supplemental Affidavit of Dr. Yonatan Grad and Emma Accorsi, attached as Exhibit B (hereinafter, Grad Suppl.) ¶ 5; Jiménez Suppl. ¶¶ 20, 24-30, 43.

⁶ Because the HOCs did not insert page numbers to Exhibit 1, plaintiffs’ citations refer to the pagination on the bottom of the cited Special Master’s report.

three facilities the HOCs highlight for “report[ing] no positives since the onset of the pandemic,” Def. Br. 5, collectively tested a total of 124 incarcerated people as of January 6, 2021. See Ex 1 to Def. Br. 5, 9, 18. The counties cannot refuse to monitor their populations for infection and then assert the threat of COVID is not present in their facilities.

Second, the HOCs’ calculations are misleading; in fact, the facilities’ case rates are far worse than the rates in their surrounding communities. The HOCs’ reported COVID-19 case rate is nearly *three times* the rate in Massachusetts overall. See Jiménez Suppl. Aff. ¶¶ 21-22. And because of their low testing rates, this likely *underreports* the true extent of COVID-19 infection in their facilities. See *id.* at ¶¶ 40-41, 45. In Plymouth, Hampden and Essex, whose higher testing rates allow them to detect more cases, the reported COVID-19 case rates were 3.1, 5.0 and 7.3 times the reported rate in Massachusetts, respectively. See *id.* at ¶ 43-44.

Third, the HOCs fail to explain how a snapshot of a facility’s case rates could ever demonstrate that its residents are free from a substantial risk of being infected with COVID. A week’s worth of data is rarely used as a relevant epidemiological measure. See *id.* at ¶¶ 5, 13. For good reason. As *Nash* explained, “a few cases, or even no reported cases, on any given day or in any given place can quickly change to many cases,” especially in congregate living facilities like prisons. 486 Mass. at 408. Consequently, “[a] judge should not . . . use the absence of or a reduction in the number of outbreaks of the virus when determining the general risk to a defendant.” *Id.* The HOCs similarly cannot rely on low reported cases in the past to argue that the people in their custody do not still face a serious risk of contracting COVID-19.

Fourth, although the COVID-19 vaccine is being made available to prisoners and staff, the serious risk of harm facing incarcerated people will not be eliminated via “community immunity”⁷ until at least 70-90% of the population is vaccinated. See Jiménez Suppl. ¶ 59. Because the facilities

⁷ Community immunity is colloquially referred to as “herd immunity.” See Jiménez Suppl. ¶ 52.

report only the total and weekly number of vaccinations, and because their populations turn over, their reports do not disclose the proportion of currently incarcerated individuals who have been vaccinated. As of February 3, 2021, however, the vaccinations administered to incarcerated people exceeded 50% of the incarcerated population at just three facilities, while it was between 26 and 29% at five, and under 15% at two, indicating that HOCs are far from reaching the necessary level of inoculation.⁸ Nor do the reports disclose the proportion of staff who have been vaccinated; none of the HOCs have reported the total number of staff at each facility, and only two of the eleven HOCs have reported information on staff “refusals.” Making matters worse, it is unclear how the HOCs understand the term “refusal.” The DOC, for example, has reported 3,074 staff “refusals,”⁹ but that number appears to encompass unvaccinated staff *and* some unknown number of staff who have been vaccinated elsewhere. Plaintiffs do not know if that inscrutable practice is shared by the HOCs. But until the HOCs demonstrate that they have vaccinated at least 70-90% of all people currently living and working in their facilities, incarcerated people will continue to face “a substantial risk of serious harm.” *Farmer v. Brennan*, 511 U.S. 825, 828 (1970).

The HOCs’ reported rates of hospitalizations and deaths do not change this calculus. COVID-19 infections can cause serious harm even when they do not result in hospitalization or death. The CDC recognizes that “[e]ven people who are not hospitalized and who have mild illness can experience persistent or late symptoms.”¹⁰ These patients, often called “COVID long-haulers,” experience symptoms including fatigue, pain, shortness of breath, light sensitivity, insomnia, memory problems, and “a debilitating brain fog” that can “make it hard to put a cogent

⁸ See SJC-12926, Dkt. # 150 App’x 1, 10, 13, 16, 19, 31, 34, 37 40, 43, 46, 49, 55, 58, and 61 (Feb. 5, 2021).

⁹ See *id.* at App’x 1.

¹⁰ Centers for Disease Control and Prevention, *Long-Term Effects* (updated Nov. 13, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html> (last visited Feb. 10, 2021).

sentence together.”¹¹ According to the head of Mt. Sinai Hospital’s Center for Post-COVID Care, about ten percent of COVID-19 patients end up developing long-term symptoms.¹² In the medical community, “[t]he palpable fear is that years from now, after the dead have been buried and victory over the coronavirus declared, some long-haulers will continue to suffer; and that their ongoing ordeal will be reckoned among the pandemic’s more awful, lasting legacies.”¹³

B. The HOCs’ failure to take reasonable steps to mitigate the substantial risk posed by COVID-19 demonstrates deliberate indifference.

The HOCs concede that, far from conducting routine comprehensive testing, they “do not test asymptomatic inmates or staff unless they have been in close contact with a COVID infected individual.” Answer ¶ 31. At the same time, despite the Supreme Judicial Court’s recognition that “a reduction in the number of people who are held in custody is necessary,” *CPCS*, 484 Mass at 445, the HOCs are not meaningfully using their own authority to release people. These decisions reflect deliberate indifference to the health and safety of the people in their custody.

i. The HOCs’ failure to conduct routine, comprehensive testing demonstrates deliberate indifference.

As the HOCs recognize, deliberate indifference encompasses instances where a jail does not implement measures that could have “easily prevented” the harm. Def. Br. 12 (quoting *Leite v. Bergeron*, 911 F.3d 47, 52-53 (1st Cir. 2018)). Implementing some safety measures will not insulate a facility from liability if it fails to include a necessary step that renders its other safety measures inadequate. Cf. *Miranda v. Munoz*, 770 F.2d 255, 259 (1st Cir. 1985) (holding that ignoring clear warnings that the care provided is inadequate can evidence deliberate indifference).

¹¹ Moises Velasquez-Manoff, *What If You Never Get Better From Covid-19?*, N.Y. Times Magazine (Updated Jan. 26, 2021), <https://www.nytimes.com/2021/01/21/magazine/covid-aftereffects.html>.

¹² See *id.*

¹³ *Id.*

The HOCs therefore cannot, as they suggest, rely on “enhanced cleaning protocols, screening of staff and inmates, quarantining and education,” Def. Br. 13, to justify their failure to conduct routine, comprehensive testing of non-symptomatic prisoners and staff because, as the Supreme Judicial Court has recognized, testing is indispensable to protecting individuals from COVID-19. See *Foster*, 484 Mass. at 722-723. Widespread testing is the baseline upon which many measures to prevent the spread of COVID-19 rely, and without which other measures to protect against infection will be insufficient.¹⁴ Reflecting this understanding, Judge Young concluded in *Savino v. Souza*, that “[k]eeping individuals confined closely together in the presence of a potentially lethal virus, while neither knowing who is carrying it nor taking effective measures to find out, likely displays deliberate indifference to a substantial risk of serious harm.” *Id.* at 331. This Court should reach the same conclusion.

The HOCs do not contend that they lack the resources to conduct surveillance testing. Instead, they say that they have decided against it, on the advice of Dr. Wurcel. Def. Br. 13. Although the HOCs correctly note that “a dispute, between medical professionals, over the proper course of treatment” typically does not establish deliberate indifference, Def. Br. 12 (quoting *Feeney v. Corr. Med. Servs., Inc.*, 464 F.3d 158, 162 (1st Cir. 2006)), “that is true only if the dueling opinions are medically acceptable under the circumstances.” *Edmo v. Corizon, Inc.*, 935 F.3d 757, 786 (9th Cir. 2019). “To hold otherwise would mean that *any* treatment decision a doctor made, regardless of whether it had any scientific basis, would be immune from scrutiny.” *Petties v. Carter*, 836 F.3d 722, 729 n.2 (7th Cir. 2016). That is not, and cannot be, the

¹⁴ See Affidavit of Dr. Yonatan Grad and Emma Accorsi, attached as Exhibit A to Pltfs. Memo of Law (hereinafter Grad) ¶ 40 (“The positive impact of quarantining, masking, distancing and hygiene is severely limited if the facilities do not first identify infectious individuals through routine testing.”); Affidavit of Dr. Monik C. Jiménez, attached as Exhibit B to Pltfs. Memo of Law (hereinafter Jiménez) ¶ 33 (“[I]n prisons and jails, the efficacy of isolation and contact tracing depend upon the routine testing of staff and residents who are not yet experiencing symptoms.”).

constitutional test. As the First Circuit made clear, facilities cannot avoid a finding of deliberate indifference by “find[ing] a single practitioner willing to attest that some well-accepted treatment is not necessary.” *Kosilek v. Spencer*, 774 F.3d 63, 90 n.12 (1st Cir. 2012). It is only where a facility chooses between two alternatives, *both* of which are “reasonably commensurate with the medical standards of prudent professionals” and *both* of which provide “a significant measure of relief,” that its decision “does not violate the Eighth Amendment.” *Id.* at 90.

That is not the case here. Surveillance testing “is the medical standard of care to protect the public health of prisoners, staff, and the surrounding community.”¹⁵ Plaintiffs have submitted expert declarations¹⁶ detailing the prevalence of non-symptomatic transmission of COVID-19; describing numerous studies demonstrating that symptoms-based testing does not stop the spread of COVID-19 in congregate settings; and listing “[t]esting protocols at congregate facilities in Massachusetts and throughout the country [that] reflect the reality that regular testing of pre-symptomatic and asymptomatic people is central to public health.”¹⁷ These experts concluded that, “in congregate living environments like prisons and jails, any reasonable response to the COVID-19 pandemic” must “include[] routine, comprehensive testing of residents and staff without

¹⁵ Grad ¶ 37; see also Grad ¶ 22 (“[P]ublic health and infectious diseases researchers and officials recognize that, particularly in vulnerable communal living environments, the frequent testing of individuals without symptoms is necessary to contain the pandemic”).

¹⁶ The HOCs’ assertion that experts cannot opine on whether an action constitutes cruel and unusual punishment as a matter of law, while true, is irrelevant. Def. Br. 13 n.9. Plaintiffs’ experts do not assert legal conclusions, but rather speak to factual matters that are squarely within their purview. See, e.g., *Torres v. Comm’r of Correction*, 427 Mass. 611, 614 n.5 (1989) (noting “while ‘the opinions of experts are entitled to little weight in determining whether a condition is ‘cruel and unusual punishment’ under the Eighth Amendment . . . expert opinion may be considered in assessing the effects of challenged conditions or practices’”), quoting *Madrid v. Gomez*, 889 F. Supp. 1146, 1159 (N.D. Cal. 1995).

¹⁷ Grad ¶ 29; see also Grad ¶¶ 30-33.

symptoms,” and that, without such a policy, “the HOCs are not taking the necessary steps to protect the people who live and work in their facilities.”¹⁸

Plaintiffs repeatedly asked the HOCs for the opportunity to speak with Dr. Wurcel to understand the basis of the HOCs’ contrary practices, but her affidavit in this case—the first time plaintiffs received any response to these queries—raises more questions than it answers. Her affidavit does not mention, let alone address, the science, research, or testing policies described in plaintiffs’ experts’ affidavits. Nor does she acknowledge the large-scale outbreaks at Massachusetts facilities like Essex and Plymouth, where low testing rates preceded an explosion of positive cases among both incarcerated people and staff. She states only that her decision not to recommend routine, comprehensive testing of non-symptomatic prisoners and staff “fall[s] in line with the CDC and DPH recommendations.”¹⁹ The available evidence does not support this conclusion.

As to the CDC, Dr. Wurcel cites conversations with unnamed CDC epidemiologists before concluding, “[t]he CDC does not discuss or recommend for facility-wide repetitive surveillance testing in the most recent guidelines.”²⁰ In fact, recent CDC guidance *does* discuss broader use of asymptomatic testing of incarcerated people and staff in jails and prisons in communities with moderate to substantial levels of community transmission where there are available resources “to reduce the risk of introducing SARS-CoV-2 into the correctional or detention facility” and “to reduce the risk of widespread transmission through early identification of infection” in the population.²¹ Moreover, the CDC’s “Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2” emphasizes that jurisdictions should consider expanding

¹⁸ Jimenez ¶¶ 30, 36; see also Grad ¶ 39.

¹⁹ Ex. 3 to Def. Br. (hereinafter, Wurcel) ¶ 9.

²⁰ Wurcel ¶¶ 8, 9.

²¹ CDC, Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities (updated Dec. 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html> (last visited Feb. 10, 2021).

testing of non-symptomatic individuals, and includes incarcerated people among those to prioritize for expanded testing.²² As of February 7, 2021, the state profile report generated by the White House COVID-19 Team and the Data Strategy and Execution Workgroup reported that every county in Massachusetts had a cumulative number of new cases per 100,000 over the past 7 days that placed them in a tier for which the CDC recommends consideration of weekly or twice-weekly testing.²³ Dr. Wurcel does not even acknowledge these CDC statements, let alone explain why she has nevertheless not considered such routine testing of non-symptomatic people in the HOCs.

As to DPH, Dr. Wurcel states, “[i]n the absence of outbreak investigations, DPH has not recommended repetitive facility-wide COVID-19 surveillance testing in the jails.”²⁴ Dr. Wurcel’s declaration does not cite any formal DPH guidance regarding testing in jails or prisons, and to the best of plaintiffs’ knowledge, no such guidelines exist.²⁵ Instead, once again citing a conversation with unnamed sources, Dr. Wurcel states, “I asked DPH if jails should consider universal screening,” and “during the spring of 2020, DPH did not recommend universal screening.”²⁶ This referenced recommendation came at a time when the understanding of COVID-19 and testing capacity were both severely limited. “Over the course of the last ten months, there has been a rapid evolution of testing recommendations based on our increased understanding about the nonsymptomatic spread of COVID-19, the growth of our testing capacity, and the explosion of

²² Grad Suppl. ¶ 11; CDC, CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2 (updated Jan. 21, 2021) (hereinafter, CDC Silent Spread), <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html> (last visited Feb. 10, 2021).

²³ Compare CDC Silent Spread with COVID-19 State Profile Report – Massachusetts, p.7 (updated Feb. 9, 2021), <https://beta.healthdata.gov/Community/COVID-19-State-Profile-Report-Massachusetts/j75q-tgps> (last visited Feb. 10, 2021).

²⁴ Wurcel ¶ 11.

²⁵ Grad. Suppl. ¶ 14.

²⁶ Wurcel ¶ 11.

community spread throughout the Commonwealth.”²⁷ Any testing advice DPH provided in the spring is “outdated and should no longer be relied upon for any medical decision.”²⁸

“Medical and scientific consensus no longer supports the recommendation to avoid routine, comprehensive testing where there have been no allegations that there are practical impediments to such testing.”²⁹ Because Dr. Wurcel does not provide any evidence to contradict this conclusion—aside from an inaccurate description of CDC guidance and outdated DPH advice—this Court should hold that the HOCs’ continued refusal to conduct routine, comprehensive testing of non-symptomatic prisoners and staff evidences deliberate indifference to the substantial risk posed by COVID-19. In the alternative, this Court should hold a limited evidentiary hearing so that plaintiffs may elicit testimony from Dr. Wurcel about her medical reasoning and from DPH about its past and current testing recommendations.

ii. The HOCs’ failure to exercise their statutory authorities to meaningfully depopulate demonstrates deliberate indifference.

The HOCs do not dispute that they could release more prisoners under their own statutory authority if they wanted to. But they have made a “decision” — a deliberate choice — not to release any “sentenced inmates beyond what was mandated by the Court in *C.P.C.S.*” Def. Br. 15. The HOCs appear to reason that the limited relief ordered in *CPCS* justifies this decision. See *id.* at 4, 15-17. That is not so.

First, unlike the *CPCS* litigation, this case involves constitutional claims, including the claim that under the circumstances of this pandemic it is unconstitutional for the HOCs to undertake a blanket refusal to exercise their authority to release incarcerated people. See Complaint ¶¶ 79-99, 151-53, 160-62. Just as it would be unconstitutional for the HOCs to withhold soap from prisoners

²⁷ Grad Suppl. ¶ 16.

²⁸ Grad Suppl. ¶ 15.

²⁹ Grad Suppl. ¶ 16.

during the pandemic when they had an ample supply of soap, here it is unconstitutional for the HOCs to withhold releases from incarcerated people, because the HOCs have an ample supply of release authorities but have made a “decision” not to use them. Def. Br. 15. Contrary to the HOCs’ suggestion, this does not mean that plaintiffs seek “wholesale” release or ask this Court to sit as “Super Sheriff[]” as a remedy for this constitutional violation. *Id.* at 4, 15. Instead, plaintiffs ask this Court to declare that the HOCs’ failure to exercise their statutory authority to depopulate violates the rights of the people in their custody, and to order the HOCs to conduct an individualized consideration of each person eligible for release under various authorizing statutes. See G. L. c. 126, § 26; G. L. c. 127, § 20B; G. L. c. 127, § 49; G. L. c. 127, § 49A.

Second, the HOCs have all but conceded deliberate indifference by acknowledging that they have taken *CPCS*’s pronouncements concerning *the judiciary’s* lack of authority to order the release of sentenced prisoners under G. L. c. 211, § 3, as a license to refuse to even consider exercising *their own* authority to depopulate. Although *CPCS* held that the Supreme Judicial Court could not exercise its superintendence authority to “order that relief be granted to sentenced inmates who have been serving a legal sentence,” 484 Mass. at 452, the HOCs now say that they are not releasing sentenced prisoners under their statutory authority because they insist, incorrectly, that “all previously sentenced inmates still incarcerated have already been evaluated and deemed not appropriate for release under the conditions set forth by the Court in *C.P.C.S.*”, Def. Br. 16. In other words, the HOCs have knowingly abandoned the exercise of their own release and transfer discretion. This intentional choice to refuse to even consider individualized assessments under the powers granted to them by the Legislature is deliberate indifference.

Critically, there is a serious need for further releases. Although the HOCs claim that they “have released a total of 3,070 inmates” since April 3, 2020, Def. Br. 16, in at least eight counties

the reported release numbers include only *court-ordered* releases.³⁰ Far from a “red herring,” Def. Br. 16, the fact that the HOCs’ combined population is back up to 87% of pre-pandemic levels³¹ reflects the HOCs’ failure to exercise their statutory authority to depopulate.

II. The HOCs’ testing and depopulation practices violate the due process rights of pretrial detainees.

The HOCs acknowledge that, “[u]nlike convicted prisoners, who may be punished as long as the punishment is not ‘cruel and unusual’ under the Eighth Amendment to the United States Constitution, pretrial detainees may not be punished at all.” Def. Br. 17 (quoting *Richardson v. Sheriff of Middlesex Cty.*, 407 Mass. 455, 461 (1990)). Nevertheless, they still argue that an identical analysis should apply to both Eighth Amendment and due process claims. Because the HOCs’ refusal to implement a reasonable testing protocol and to evaluate people who are statutorily eligible for release demonstrates deliberate indifference, see *supra*, this Court could simply hold that the HOCs violate the due process rights of pretrial individuals under any applicable standard. But if this Court chooses to squarely address this question, it should join the Second, Seventh, and Ninth Circuits in reading *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), to require an objective standard for pretrial detainees.³²

³⁰ During their weekly calls with the Sheriffs’ designated representative and the Special Master’s team, plaintiffs asked whether each HOC’s pre-trial and sentenced release numbers included individuals released under the HOC’s own authority. Based on the Sheriffs’ designated representative’s response, it is plaintiffs’ understanding that at least eight counties report only court-ordered releases, one reports all released individuals, and four did not respond to the question.

³¹ See SJC-12926, Dkt. # 150 App’x 2, 4 (Feb. 5, 2021); see also Jiménez Suppl. ¶¶ 47-50.

³² See *Darnell v. Pineiro*, 849 F.3d 17, 35, 36 (2d Cir. 2017) (observing “*Kingsley*’s broad reasoning extends beyond the excessive force context in which it arose,” and holding that “[t]he same objective analysis should apply to an officer’s appreciation of the risks associated with an unlawful condition of confinement in a claim for deliberate indifference under the Fourteenth Amendment”); *Castro v. Cty. of Los Angeles*, 833 F.3d 1060, 1070 (9th Cir. 2016) (holding that *Kingsley* applies to all Fourteenth Amendment claims brought by pretrial detainees against individual defendants based on its conclusion that “[t]he Court did not limit its holding to ‘force’ but spoke to ‘the challenged governmental action’ generally”), quoting *Kingsley*, 576 U.S. at 398;

The HOCs’ only argument to the contrary is their suggestion that this Court should not “break with the First Circuit.” Def. Br. 18. But the First Circuit has not answered this question. The sole First Circuit case cited by the HOCs simply noted that the boundaries of the duty to provide medical care to pretrial detainees “have not been plotted exactly.” *Miranda-Rivera v. Toledo-Dávila*, 813 F.3d 64, 74 (1st Cir. 2016), quoting *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990). See also *Gomes v. US Dep’t of Homeland Sec., Acting Sec’y*, 460 F. Supp. 3d 132, 147 (D.N.H. 2020) (noting “the First Circuit’s approach to the deliberate indifference claims in [post-*Kingsley*] cases does not appear to foreclose a ruling that *Kingsley* has changed the standard”).³³ Based on the reasoning above, this Court can reach a similar conclusion and leave the question of due process standards for another day. But if this Court decides that the HOCs have not been deliberately indifferent, it should hold that their actions still violate the due process rights of pretrial detainees because they are objectively unreasonable.

III. By failing to provide confidential remote legal communication options during the pandemic, including videoconferencing with screen sharing capability, the Five HOCs are violating incarcerated individuals’ right to counsel.

The Five HOCs’ failure to provide meaningful, timely, and confidential modes of communication between incarcerated people and their attorneys violates the right to counsel under the state and federal constitutions. In response, the Five HOCs assert that it is simply a matter of personal “choice” that defense attorneys have not utilized in-person visits, Def. Br. 20, and that, in all events, they have provided sufficient alternative methods of communication to meet the constitutional standards, Def. Br. 21-22. Neither argument is accurate.

Miranda v. Cty. of Lake, 900 F.3d 335, 352 (7th Cir. 2018) (applying objective standard to pretrial detainee’s claim for denial of medical care).

³³ After *Miranda-Rivera*, several district courts in the First Circuit have applied an objective standard to pretrial detainees’ claims regarding the failure to provide adequate medical care. See, e.g., *da Silva Medeiros v. Martin*, 458 F. Supp. 3d 122, 128 (D.R.I. 2020); *Yanes v. Martin*, 464 F. Supp. 3d 467, 469 n.3 (D.R.I. 2020).

As to the first, while plaintiffs acknowledge that in-person visits are generally permitted, defense attorneys cannot reasonably be expected to undertake the risk of visiting a congregate living facility in the midst of a pandemic. Courts have agreed, finding that in-person legal visits may be “a theoretical option for counsel,” but are “not a practical option” given the “significant health risks.” *United States v. Shaheed*, 455 F. Supp. 3d 225, 237 (D. Md. 2020). See also *United States v. Davis*, 449 F. Supp. 3d 532, 541 (D. Md. 2020) (finding that “attorneys who . . . venture into [carceral] facilities during this public health crisis . . . do so at their own risk”). As a result, courts have recognized that “in-person legal visitation is no longer viable as a primary vehicle of communication” and, “out of necessity,” remote legal communications have taken their place. *S. Poverty Law Ctr. v. United States Dep’t of Homeland Sec.*, U.S. Dist. Ct., No. 18-760, slip op. at 2 (D.D.C. June 17, 2020). Such remote legal communications must approximate, to the extent possible, in-person visits.

The sheriffs’ affidavits do not support their argument that they provide constitutionally adequate alternative means of attorney-client communication during the pandemic. The closest approximation to an in-person meeting is videoconferencing, which, unlike a phone call, provides the opportunity to review documents, observe non-verbal cues, and visually-confirm confidentiality. It is a constitutional necessity for incarcerated people whose attorneys do not visit. Yet the available evidence demonstrates that the Five HOCs do not provide sufficient videoconferencing to facilitate meaningful attorney-client communication during the pandemic. Neither Bristol nor Hampden regularly offers attorney-client videoconferencing. See Answer ¶¶ 124-25. At the other three facilities, videoconferencing is too limited to adequately supplement in-person visitation during the pandemic. Essex County has only two attorney-client videoconferencing modules for a population of over 900 people. See Coppinger Aff. ¶¶ 17(f), 21. At Worcester HOC, video visits are only available three days per week. See Tuttle Aff. ¶ 27. And at Plymouth, while there are now

sufficient videoconferencing capabilities with the installation of Jurislink kiosks, see *McDonald Aff.* ¶ 11(e), plaintiffs are unaware of any videoconferencing for those in quarantine.

Videoconferencing is even more essential given the lack of confidential telephone calls at the Five HOCs. In their answer, the Five HOCs deny that they “do not always assure confidential legal telephone communications.” Complaint ¶ 113; Answer ¶ 113. But the information provided by the Five HOCs does not refute this claim. Bristol, Essex, Plymouth, and Worcester admit that attorney-client calls are made from housing unit phones and do not claim that calls made from these phones cannot be overheard. See Answer ¶ 114; *Coppinger Aff.* ¶ 17(a); *McDonald Aff.* ¶ 11(b); *Tuttle Aff.* ¶ 27. Hampden County states that phone calls are confidential due to phone spacing and designated call table spacing, see *Cocchi Aff.* ¶ 15(c)(viii), but calls are sometimes still made from counselors’ offices or shared cells, where confidentiality is not assured, see *Magdalene Aff.* ¶¶ 22-23. And while Essex and Worcester maintain that incarcerated people have access to tablets for attorney-client communications, they do not assert that incarcerated people have access to locations where they can use the tablets without being overheard by staff or other prisoners. See *Coppinger Aff.* ¶ 17(b); *Tuttle Aff.* ¶ 27.

In sum, because in-person legal visitation is not a viable option for many attorneys, the failure of the Five HOCs to provide adequate remote legal communication options—which must include sufficient access to videoconferencing—violates the right to counsel.

Conclusion

For the foregoing reasons, plaintiffs ask this Court to provide the relief requested in the Complaint for Declaratory and Equitable Relief and Relief under G. L. c. 211, § 3.

[signature block on next page]

Respectfully submitted,

/s/ Rebecca A. Jacobstein

Rebecca Jacobstein, BBO 651048
Benjamin H. Keehn, BBO 542006
Committee for Public Counsel Services
100 Cambridge Street, 14th Floor
Boston, MA 02114
(617) 910-5726
rjacobstein@publiccounsel.net

*Counsel for the Committee for
Public Counsel Services*

/s/ Matthew R. Segal

Matthew R. Segal, BBO 654489
Jessie J. Rossman, BBO 670685
Laura K. McCready, BBO 703692
ACLU Foundation of
Massachusetts, Inc.
211 Congress Street
Boston, MA 02110
(617) 482-3170
msegal@aclum.org

Chauncey B. Wood, BBO 600354
Massachusetts Association of Criminal
Defense Lawyers
50 Congress Street, Suite 600
Boston, MA 02109
(617) 248-1806
cwood@woodnathanson.com

Victoria Kelleher, BBO 637908
Massachusetts Association of Criminal
Defense Lawyers
One Marina Park Drive, Ste. 1410
Boston, MA 02210
(978) 744-4126
victoriouscause@gmail.com

*Counsel for Massachusetts Association of
Criminal Defense Lawyers*

February 10, 2021

EXHIBIT A

**COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT**

Suffolk, ss.

No. SJ-2020-757

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Plaintiffs,

v.

BARNSTABLE COUNTY SHERIFF'S OFFICE, BERKSHIRE COUNTY
SHERIFF'S OFFICE, BRISTOL COUNTY SHERIFF'S OFFICE, DUKES COUNTY
SHERIFF'S OFFICE, ESSEX COUNTY SHERIFF'S OFFICE, FRANKLIN
COUNTY SHERIFF'S OFFICE, HAMPDEN COUNTY SHERIFF'S OFFICE,
HAMPSHIRE COUNTY SHERIFF'S OFFICE, MIDDLESEX COUNTY SHERIFF'S
OFFICE, NORFOLK COUNTY SHERIFF'S OFFICE, PLYMOUTH COUNTY
SHERIFF'S OFFICE, SUFFOLK COUNTY SHERIFF'S OFFICE and
WORCESTER COUNTY SHERIFF'S OFFICE
Defendants.

SUPPLEMENTAL AFFIDAVIT OF
MONIK C. JIMÉNEZ (ScD, SM) AND TORI L. COWGER (B.S., MPH)

1. I, Monik Jiménez, previously submitted a declaration in this case based on my professional expertise. In that declaration, I explained that routinely testing individuals without symptoms is necessary to stop the spread of COVID-19 in jails and prisons.
2. I, Tori L. Cowger, am a PhD candidate in Population Health Sciences in the Department of Epidemiology at the Harvard T.H. Chan School of Public Health and a doctoral affiliate with the François-Xavier Bagnoud Center for Health and Human Rights at Harvard. Before my doctoral studies, I earned a B.S. in biochemistry from the University of Minnesota and an MPH in epidemiology at Emory University. I worked as an infectious disease epidemiologist at the U.S. Centers for Disease Control and Prevention (CDC). My research interests include social and structural determinants of infectious diseases and substance use related harms, health impacts of the criminal legal system and incarceration, geospatial methods, and social networks. A copy of my curriculum vitae is attached as Exhibit A.

3. We now submit this declaration in response to several assertions in the Houses of Corrections' (HOCs) January 15th memorandum of law and supporting exhibits. SJC-2020-757, Dkt. #5 (Jan. 15, 2021) [hereinafter Def. Br.].

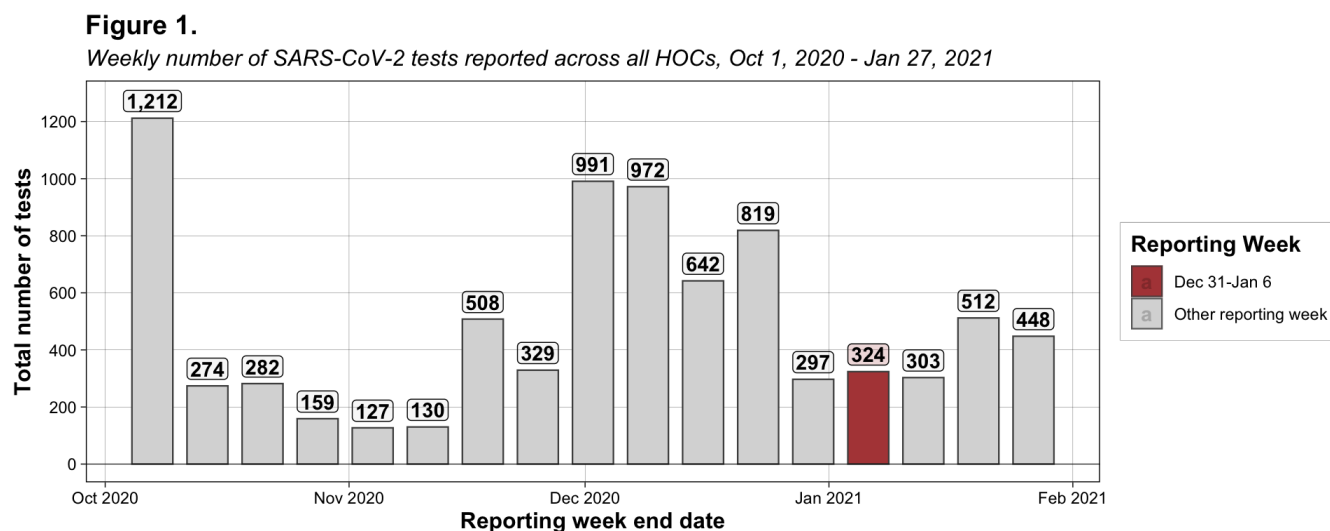
Overview

4. We have reviewed the HOCs' January 15th memorandum of law and supporting exhibits. That filing reported incomplete and misleading calculations characterizing the COVID-19 burden in the Houses of Correction (HOCs).
5. The HOCs highlighted the number of new COVID-19 cases per 100 population from a single reporting week between December 31, 2020 and January 6, 2021, when testing was low and true COVID-19 burden was likely underestimated. Def. Br. at 5. As reported, this is not a typical epidemiologic metric to measure the burden of an infectious disease.
6. Three key public health indicators that are often used to gain a better understanding of COVID-19 risks and burden within a given community are (1) average daily testing rate per 100,000 population, (2) average daily case rates per 100,000 population, and (3) percent test positivity, all measured over a period of time rather than a single time point.
7. We analyzed these three indicators in the seventeen weeks between October 1, 2020 and January 27, 2021 to give a more accurate picture of the COVID-19 burden in the HOCs. As detailed below, our analysis reveals several epidemiologic facts that in our professional opinion demonstrate a risk of substantial harm to persons incarcerated in the HOCs.
8. Our analysis of the HOCs' data also reveals that declines in the HOCs' incarcerated population have slowed or reversed since the first few months of the pandemic.
9. Finally, given the transmission rate of COVID-19 in congregate settings, it is our expert opinion that the vast majority of incarcerated people and staff will need to be vaccinated before the HOCs achieve community immunity (often referred to as herd immunity). To increase vaccination rates, the HOCs must undertake effective education efforts.

The HOCs' reliance on a single week of data misrepresents facility case rates.

10. In their affidavit, the HOCs report what they label COVID-19 "facility rates" or "positivity rates" for each HOC during a single week from December 31, 2020 to January 6, 2021, and use these rates to assert that "it can be determined that as of January 6, 2021, the county correctional facilities have low positivity rates." Def. Br. at 5.
11. This statement is misleading for several reasons.

12. First, the HOCs calculate their “facility rate” or “positivity rate” as cases per population. Def. Br. at 5 n.6. Their indicator, however, conflates two standard indicators used to measure COVID-19 burden – percent test positivity and COVID-19 case rates. The indicator calculated by the HOCs more closely resembles COVID-19 case rates than percent test positivity. However, this indicator is usually reported as the average daily number of COVID-19 cases per 100,000 population. As reported, the HOCs present their own calculation as a percent (*i.e.*, per 100) rather than the standard per 100,000. When compared to standard case rates which are measured per 100,000, this falsely gives the impression that COVID-19 case rates are lower in the HOCs.
13. Second, it is methodologically unsound to base epidemiological conclusions on a single measure from a single week of reported data, especially where – as here – there are months of data available.
14. Third, case rates are usually reported alongside the testing rates as well as percent test positivity. That is because, in the absence of adequate testing, low reported case rates cannot be interpreted as evidence of low COVID-19 burden. Because only individuals tested and with a positive SARS-CoV-2 test result can be counted and reported as cases, lower testing rates and testing of only symptomatic individuals will underestimate the true burden of COVID-19.
15. In the week the HOCs selected to highlight, the HOCs performed only 324 tests among 6,209 incarcerated persons. This equates to an average daily testing rate of 746 tests per 100,000 persons.
16. Figure 1 presents the weekly number of SARS-CoV-2 tests reported across all HOCs from October 1, 2020, to January 27, 2021. The red bar represents the week the HOCs chose to report their facility rates. This week had one of the lowest number of tests since the beginning of December.



17. The HOCs report a “0% positivity rate” for 7 HOCs the week reported. Def. Br. at 9. However, all 7 of these HOCs conducted 15 tests or fewer and two of these HOCs conducted no tests at all (Middlesex: 15 tests, Franklin: 14 tests, Berkshire: 6 tests, Hampshire: 5 tests, Dukes: 1 test, Norfolk: 0 tests, Barnstable: 0 tests).
18. Given the low testing rate during the selected week, it is unsurprising that few cases were reported, and it is likely that the true COVID-19 case rates are much higher.

The reported COVID-19 case rate in the HOCs is nearly three times the rate in Massachusetts overall.

19. In their January 25th brief, the HOCs assert that “[t]he objective, statistical evidence demonstrates that inmates confined to county correctional facilities in Massachusetts are as least as safe as they are in the community.” Def. Br. at 9. This is not true. In fact, the objective, statistical evidence demonstrates that people confined to county correctional facilities in Massachusetts are at far greater risk than people in the community.
20. As elaborated below, because the HOCs’ testing rates are low, their reported case rates underestimate their true case rates. Nevertheless, even the HOCs’ reported case rates are dramatically higher than the case rates in Massachusetts at large.
21. From October 1, 2020 to January 27, 2021, the HOCs reported 954 COVID-19 cases across an average daily population of 6,281 incarcerated individuals – a reported average daily rate of 127.6 cases per 100,000 persons. This rate is *2.9 times* the rate reported in Massachusetts (daily average of 44.2 cases per 100,000 persons).¹
22. In other words, even using the HOCs’ reported data, which are almost certainly undercounts, the COVID-19 incidence rate among people living in Massachusetts county correctional facilities is *almost three times* that observed among people in the non-incarcerated community in Massachusetts.
23. The Massachusetts DPH considers any community with an average daily case rate of greater than 10 cases per 100,000 population to be in the highest (*i.e.*, red) tier for

¹ The average daily COVID-19 case rate is calculated by dividing the total number of new COVID-19 cases over the total incarcerated “person-days,” which is the reported incarcerated population multiplied by the number of days in the reporting period. It is standard epidemiologic practice to use “person-days” in such calculations, because this allows for accurate comparisons between jurisdictions with different reporting frequencies and comparisons across periods of different length.

COVID-19 rates.² The reported average daily COVID-19 case rate of 127.6 cases per 100,000 persons in the HOCs is more than *twelve times* this threshold.

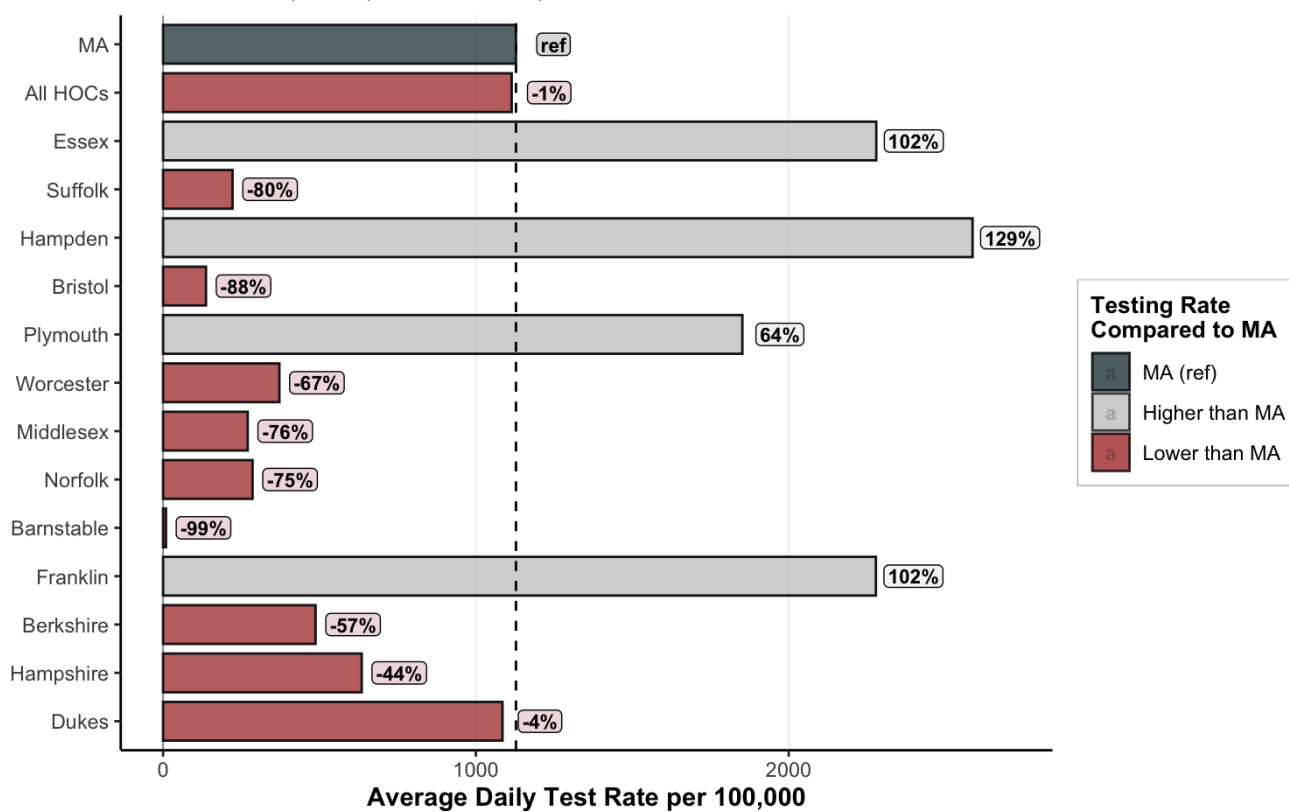
Months of available data indicate that low testing rates are obscuring the true COVID-19 burden in the HOCs.

24. Without adequate testing, it is impossible to get an accurate picture of the COVID-19 burden within a given community.
25. Notably, low testing rates were not limited to the single week the HOCs highlighted. Indeed, months of available data reveal that the testing rate is lower in the HOCs combined than in Massachusetts overall. Strikingly, in most HOCs, the testing rate is *less than half* of that in Massachusetts.
26. Figure 2 represents the average daily testing rate per 100,000 population in the HOCs compared to Massachusetts between October 1, 2020 and Jan 27, 2021. Massachusetts' average daily testing rate is represented by top bar and the dotted line. The percentage next to the bars indicates the percentage difference of the HOCs' average daily testing compared to the Commonwealth as a whole.

² See Mass. Dep't of Public Health, Weekly COVID-19 Public Health Report, 25 (Feb. 4, 2021), <https://www.mass.gov/doc/weekly-covid-19-public-health-report-february-4-2021/download>.

Figure 2.

Average daily SARS-CoV-2 testing rate per 100,000 population in HOCs compared to Massachusetts, Oct 1, 2020 - Jan 27, 2021



Bars are ordered by descending size of incarcerated population. The label over each bar represents the percent higher or lower the testing rate is for each HOC compared to Massachusetts, the reference group, depicted as the top bar & dotted line.

27. From October 1, 2020 through Jan 27, 2021, the HOCs conducted 8,329 SARS-CoV-2 tests across an average daily incarcerated population of 6,281 – an average daily testing rate of 1,114 tests per 100,000 persons. This was slightly lower than the average daily testing across Massachusetts during this period – 1,128 tests per 100,000 persons (9.25 million tests conducted across an estimated population of 6.89 million). See Figure 2; Appendix Table 1.

28. Importantly, the overall testing rate in the HOCs was driven largely by testing in just four facilities – Hampden, Essex, Franklin, and Plymouth – where the testing rate actually exceeded that of Massachusetts. Despite representing 42% of the incarcerated population (n=2,653 of 6,281), these four facilities accounted for 87% of all SARS-CoV-2 tests in the HOCs (n=7,217 of 8,329).

29. The remaining HOCs all had testing rates that were substantially lower than Massachusetts' rate. Indeed, eight HOCs had testing rates more than 40% lower than Massachusetts' general rate – Hampshire, Berkshire, Worcester, Norfolk, Middlesex, Suffolk, Bristol, and Barnstable. These HOCs represented 57% of the

incarcerated population yet accounted for just 13% of total tests in the HOCs (n=1,106 of 8,329).

30. As discussed in Dr. Jiménez's initial affidavit, testing in correctional facilities must be comprehensive and routine to identify COVID-19 cases and prevent spread. See Jiménez Aff. ¶¶ 36-47. Alongside high test percent positivity, discussed below, the HOCs' low testing rates therefore indicate that the HOCs' reported cases underrepresent the true COVID-19 burden in those facilities.

Test percent positivity is higher in the HOCs than in Massachusetts overall. Given their low testing rates and high test percent positivity, the true COVID-19 case rates in the HOCs are likely even higher than reported.

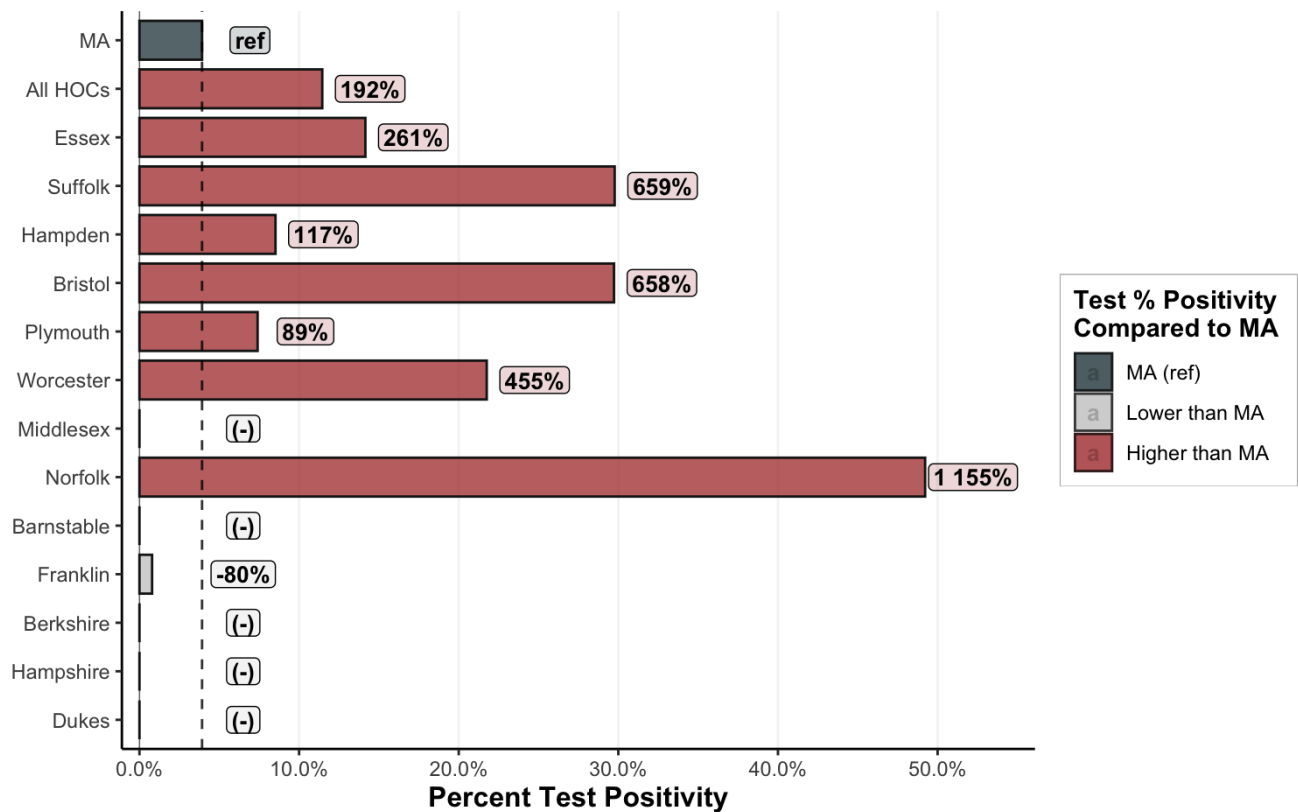
31. In addition to testing rate, another important indicator that provides insight into burden of COVID-19 in a given setting is test percent positivity. Test percent positivity is calculated as the total number of new positive tests (*i.e.*, cases) over the total number of tests conducted.³ Test percent positivity is widely used and reported by state and local governments.
32. A high test percent positivity occurs when a high proportion of the tests administered in a given setting return positive results. Test percent positivity increases with higher case rates and generally decreases with higher testing rates. Thus, a high test percent positivity in a congregate setting can indicate two problems: (1) that a jurisdiction is not doing enough tests, and/or (2) widespread infections in the community tested.⁴
33. While the threshold varies between settings, many authorities agree that a test percent positivity of more than 5% indicates one or both of the two problems identified in the immediately preceding paragraph.
34. Figure 3 presents the test percent positivity in the HOCs compared with the test percent positivity in Massachusetts overall. Massachusetts' test percent positivity, 3.9%, is represented by the top dark bar and the dotted line. The number next to the bars is the percent difference between the HOCs' test percent positivity and Massachusetts' test percent positivity.

³ There are several ways to calculate percent positivity. Here, we report the number of new positive tests (*i.e.*, cases) over the total number of tests so that numbers are comparable between HOCs and Massachusetts. See CDC, Calculating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Laboratory Test Percent Positivity: CDC Methods and Considerations for Comparisons and Interpretation (Sept. 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/calculating-percent-positivity.html#:~:text=The%20formula%20for%20calculating%20percent,results%20and%20excludes%20in%20determinate%20results>.

⁴ See *id.*

Figure 3.

Test percent positivity in HOCs compared to Massachusetts, Oct 1, 2020 - Jan 27, 2021



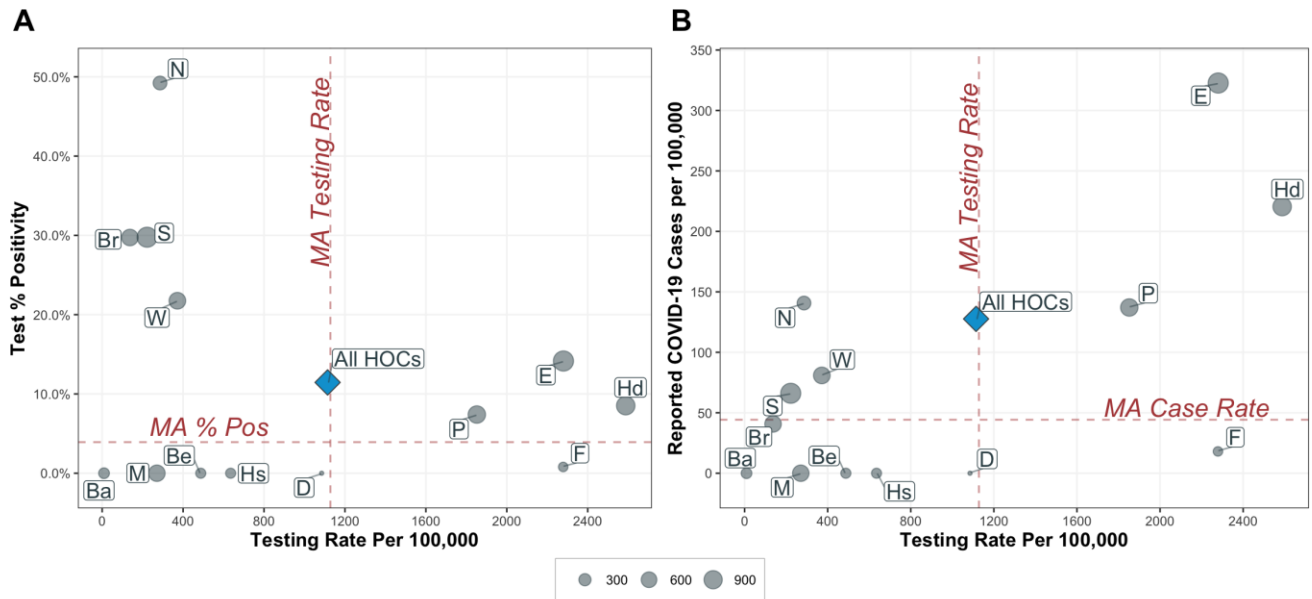
Bars are ordered by descending size of incarcerated population. The label over each bar represents the percent higher or lower the test percent the reference group, depicted as the top bar & dotted line. HOCs with no positive tests for that interval are labelled (-)

35. From October 1, 2020 to January 27, 2021, the HOCs had a combined test percent positivity of 11.5% (954 cases, 8,329 tests). This is nearly 200% higher than in Massachusetts during the same period, where test percent positivity was 3.9% (362,836 cases, 9,252,689 tests), even though Massachusetts had only slightly higher testing rates than the HOCs combined.
36. Seven HOCs reported test percent positivity of greater than the 5% recommended threshold.
37. Four HOCs (Worcester, Bristol, Suffolk, and Norfolk) reported test percent positivity of 29% or higher. The highest test percent positivity was observed in Norfolk, where nearly half of all tests were positive (49.2% test percent positivity).
38. While test percent positivity is an informative factor on its own, it can yield even more information regarding the true COVID-19 burden in a facility when reported alongside testing rates and case rates.

39. Figure 4A shows the average daily testing rate and the test percent positivity in the HOCs and Massachusetts between October 1, 2020 and January 27, 2021, and Figure 4B shows the average daily testing rate and the average daily reported cases per 100,000 people in the HOCs and Massachusetts during the same period.

Figure 4.

Average daily testing rate per 100,000 persons vs. (A) percent test positivity and (B) average daily reported COVID-19 case rates per 100,000 persons in HOCs compared to Massachusetts, Oct 1, 2020 - Jan 27, 2021



Ba: Barnstable; Be: Berkshire; Br: Bristol; D: Dukes; DOC: Department of Corrections; E: Essex; F: Franklin; Hd: Hampden; Hs: Hampshire; M: Middlesex; N: Norfolk; P: Plymouth; S: Suffolk; W: Worcester

40. As discussed above, the lower the testing rates and the higher the test percent positivity, the more extreme the underestimation of the true COVID-19 burden in a jurisdiction. Conversely, the degree of underestimation is generally less severe the higher the testing rate and/or the lower the test positivity rate in a jurisdiction.

41. Bristol, Norfolk, Suffolk and Worcester all have significantly *lower* testing rates than Massachusetts and significantly *higher* test percent positivity. See Figure 4A. This suggests that the reported case rates substantially undercount the true COVID-19 burden in these four facilities.

42. At Barnstable, Berkshire, Hampshire, and Middlesex, the testing rates are too low to reliably interpret these counties' case rates and percent test positivity.⁵

43. Hampden, Franklin, Essex, and Plymouth have testing rates that exceed that of Massachusetts and that are far higher than the testing rate at the

⁵ Similarly, Dukes' population is too low to reliably interpret its case rate and percent test positivity.

other HOCs. See Figure 4A. These higher testing rates likely indicate that the degree of underestimation of the true case rates may be less severe at these four HOCs than at the others.⁶

44. Only one of these four facilities—Franklin—reported a lower case rate than Massachusetts. See Figure 4B. The three other facilities reported case rates that far exceeded those observed in Massachusetts. See Figure 4B. Specifically, Plymouth, Hampden, and Essex, reported COVID-19 case rates that were 3.1, 5.0, and 7.3 times the reported rate in Massachusetts, respectively. See Appendix Table 1.
45. Given these case rates at the facilities that likely have the lowest degree of underestimation, it is our expert opinion that the remaining HOCs' reported COVID-19 case rates may substantially undercount the true COVID-19 burden in the HOCs.

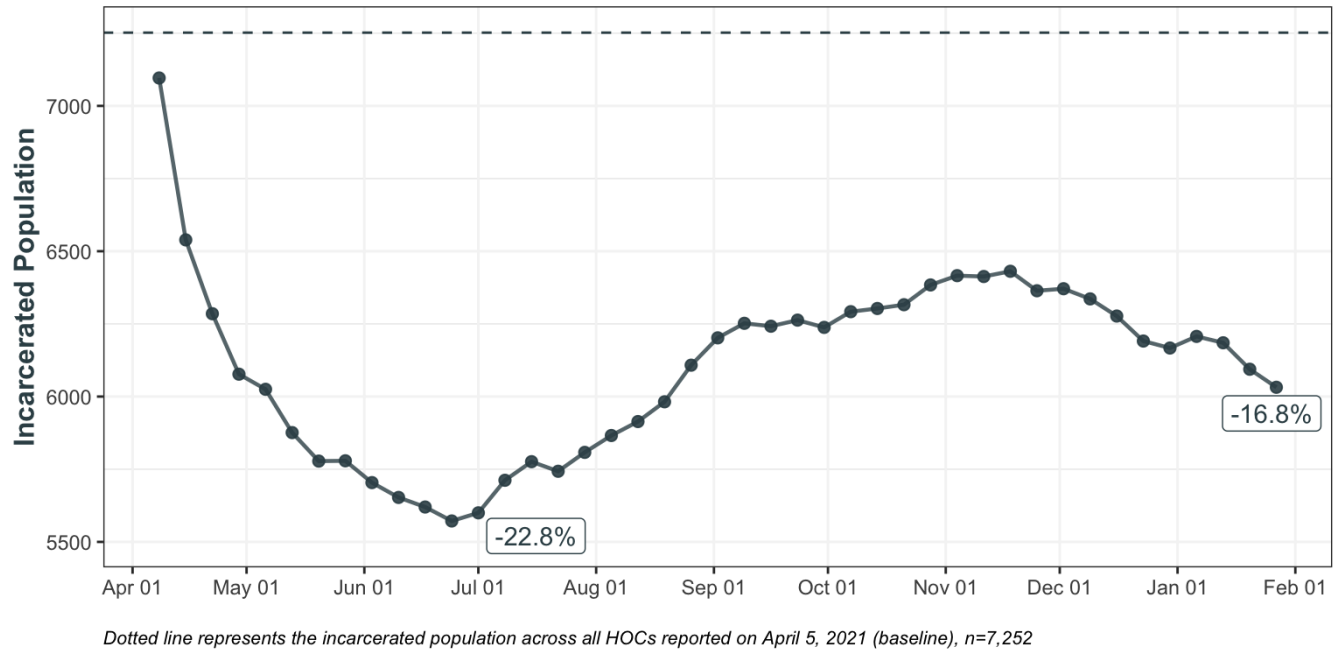
Declines in the HOCs' incarcerated population have slowed or reversed since July 2020.

47. The HOCs' reported data also reveal that their incarcerated populations have grown since July 2020.
48. Figure 5 shows the combined incarcerated population at all of the HOCs since the beginning of April 2020. Across all of the HOCs, a total of 7,252 individuals were incarcerated at the beginning of April 2020. In the first months of the pandemic, the incarcerated population declined by 23% to 5,600 individuals on July 1, 2020. See Figure 5; Appendix Table 2. But after these initial population declines in the first months of the pandemic, the overall HOC incarcerated population has increased.

⁶ In the HOCs with the highest testing rates—Hampden, Essex, and Plymouth—test percent positivity was still higher than in Massachusetts overall. These data suggest that even though testing rates in these facilities exceeded the testing rate in Massachusetts, their current testing levels may still be insufficient to capture the full extent of COVID-19 burden in these facilities.

Figure 5.

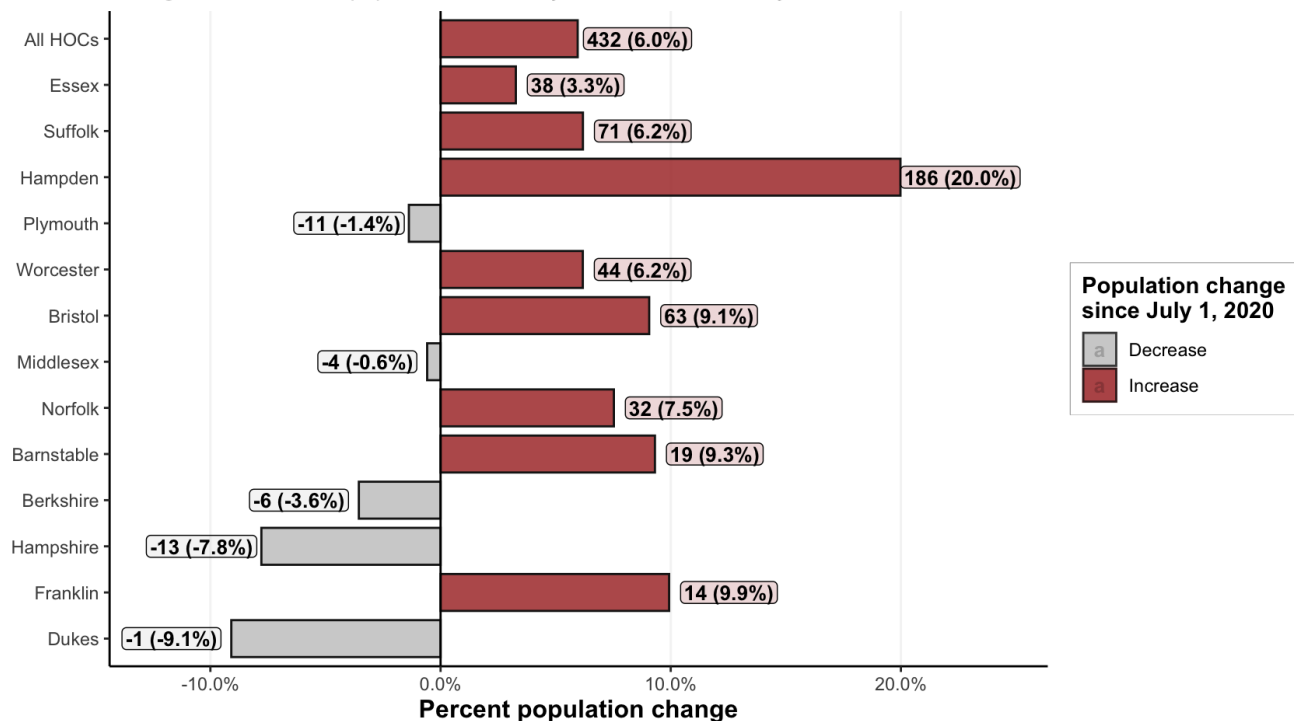
Weekly incarcerated population across all HOCs and percent change from baseline as of July 1, 2020 and January 27, 2021



49. Figure 6 shows the change in incarcerated population between July 1, 2020, and January 27, 2021 for each HOC. As of January 27, 2021, only 5 of 13 facilities (Plymouth, Middlesex, Berkshire, Hampshire, Dukes) reported populations lower than those reported on July 1, 2020.
50. In contrast, most HOCs had substantially higher populations on January 27, 2021 than on July 1, 2020. Overall, the HOCs' population increased 6%; Bristol's, Barnstable's and Franklin's populations each increased by more than 9%; and Hampden's population was up 20%.

Figure 6.

Change in incarcerated population since July 1, 2020 as of January 27, 2021.



Bars are ordered by descending size of incarcerated population. Labels show the absolute number and percent change in incarcerated population as a percent of the baseline population for each HOC since July 1, 2020.

The vast majority of staff and incarcerated people in the HOCs must be vaccinated in order to achieve community immunity.

51. As discussed in Dr. Jiménez’s initial affidavit, people in jails and prisons are especially vulnerable to contracting COVID-19. See Jiménez Aff. ¶¶ 8-17. It therefore makes sense from a public health perspective to prioritize vaccinating incarcerated people and staff, as the Commonwealth has done.

52. Community immunity (colloquially referred to as “herd immunity”) is “a situation in which a sufficient proportion of a population is immune to an infectious disease (through vaccination and/or prior illness) to make its spread from person to person unlikely.”⁷ When a community has reached community immunity, “[e]ven individuals not vaccinated (such as newborns and those with chronic illnesses) are offered some protection because the disease has little opportunity to spread within the community.”⁸ Community immunity is therefore the end result of a successful vaccination campaign.

⁷ CDC, Vaccines & Immunizations, “Community immunity,” <https://www.cdc.gov/vaccines/terms/glossary.html> (last visited Feb. 9, 2021).

⁸ *Id.*

53. The number of individuals who need to be vaccinated to induce such indirect protection varies based on several factors, all of which are dependent upon the vaccine's ability to inhibit viral transmission, which has not yet been scientifically established. These factors include the real-world effectiveness of the vaccines to inhibit transmission of SARS-CoV-2; the extent of variability of effectiveness within sub-groups; the length of immunity provided by the vaccine and natural immunity, which impacts the number of susceptible people available for transmission; and the underlying transmission dynamics in the population.⁹
54. In the general non-incarcerated population, epidemiologists estimate that the vaccine coverage required to achieve community immunity is between 70% and 90%.¹⁰
55. Several of the factors influencing the community immunity threshold suggest that community immunity will require *higher* vaccine uptake in prisons and jails than in the general population.
56. First, the effectiveness of the vaccine in a carceral setting is likely to be lower than that observed in non-incarcerated populations due to high rates of infection, overcrowding, inconsistent access to best practices for masking, high levels of movement of incarcerated individuals and staff (movement within facilities, between facilities and between facilities and the local community), and a lack of proper sanitation.
57. Second, and relatedly, available evidence indicates that COVID-19 transmission in the carceral setting is higher than in other settings, including other congregate settings. See Jiménez Aff. ¶¶ 13-15.¹¹
58. Due to the dynamics described above, estimates of vaccine coverage based on data from the general non-incarcerated population will underestimate the level of vaccine coverage needed within a carceral system. Moreover, infection dynamics which do not estimate the complex interactions within carceral settings—including

⁹ See Paltiel AD, Schwartz JL, Zheng A, Walensky RP. Clinical Outcomes Of A COVID-19 Vaccine: Implementation Over Efficacy. *Health Aff (Millwood)*. 2021;40(1):42-52. 10.1377/hlthaff.2020.02054; Bartsch SM, O'Shea KJ, Ferguson MC, et al. Vaccine Efficacy Needed for a COVID-19 Coronavirus Vaccine to Prevent or Stop an Epidemic as the Sole Intervention. *Am J Prev Med*. 2020;59(4):493-503. PMC7361120. 10.1016/j.amepre.2020.06.011; Fine P, Eames K, Heymann DL. "Herd immunity": a rough guide. *Clin Infect Dis*. 2011;52(7):911-916. 10.1093/cid/cir007.

¹⁰ See Randolph HE, Barreiro LB. Herd Immunity: Understanding COVID-19. *Immunity*. 2020;52(5):737-741. PMC7236739. 10.1016/j.immuni.2020.04.012; Bartsch, *supra* n.10; Iboi EA, Ngonghala CN, Gumel AB. Will an imperfect vaccine curtail the COVID-19 pandemic in the U.S.? *Infect Dis Model*. 2020;5:510-524. PMC7409819. 10.1016/j.idm.2020.07.006.

¹¹ See Puglisi LB, Malloy GSP, Harvey TD, Brandeau ML, Wang EA. Estimation of COVID-19 basic reproduction ratio in a large urban jail in the United States. *Ann Epidemiol*. 2021;53:103-105. PMC7480336. 10.1016/j.annepidem.2020.09.002.

the interactions between incarcerated people and staff who are entering the community and the facility on a daily basis—will further underestimate the transmission rates and the necessary vaccine coverage.

59. Given these factors, in our professional opinion, we anticipate that the required vaccine coverage in jails and prisons to achieve community immunity would at least be on the high end of the 70-90% range and may be even higher. In other words, the vast majority of the people living and working at the HOCs will have to be vaccinated before the HOCs achieve community immunity.

To increase vaccination rates among HOC staff members and people in HOC custody, the HOCs must undertake effective education efforts.

60. Education is a critical component to increase vaccination uptake among incarcerated people and staff. Effective vaccine education requires trust building, which can be built through shared decision making.
61. The World Health Organization (the WHO) provides clear evidence-based recommendations on best practices to communicate health risk and health related treatment as part of a comprehensive emergency response. The WHO's recommendations are centered on trust-building through transparent, simple, education administered across various modalities with community engagement.¹²
62. According to the WHO, effective education efforts must affirm the lived experience of incarcerated populations, and address linguistic needs, literacy levels, and cultural and religious values.¹³ Trusted community members should be engaged to ensure tailored messaging which address community needs and the accurate dissemination of information. Hence, in the context of carceral settings, formerly incarcerated individuals, family members and staff should be directly involved in the design, implementation, adaptation and dissemination of the education as needed.¹⁴

¹² See World Health Organization (WHO). Communicating Risk in Public Health Emergencies A WHO Guideline for Emergency Risk Communication (ERC) policy and practice. Geneva: World Health Organization;2018.

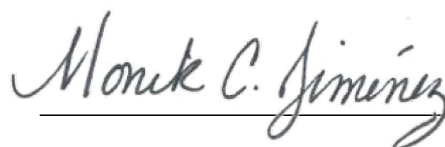
¹³ See *id.*; Salmon D, Opel DJ, Dudley MZ, Brewer J, Breiman R. Reflections On Governance, Communication, And Equity: Challenges And Opportunities In COVID-19 Vaccination. Health Aff (Millwood). 2021;101377hlthaff202002254. 10.1377/hlthaff.2020.02254; Lewandowsky, S., Cook, J., Schmid, P., Holford, D. L., Finn, A., Leask, J., Thomson, A., Lombardi, D., Al-Rawi, A. K., Amazeen, M. A., Anderson, E. C., Armaos, K. D., Betsch, C., Bruns, H. H. B., Ecker, U. K. H., Gavaruzzi, T., Hahn, U., Herzog, S., Juanchich, M., Kendeou, P., Newman, E. J., Pennycook, G., Rapp, D. N., Sah, S., Sinatra, G. M., Tapper, K., Vraga, E. K (2021). The COVID-19 Vaccine Communication Handbook. A practical guide for improving vaccine communication and fighting misinformation. Available at: <https://sks.to/c19vax>.

¹⁴ See Salmon, *supra* n.15.

63. In addition, concerns regarding delayed onset of adverse events should be addressed by increased access to medical care as needed.
64. The WHO also recommends fully integrating education into the health system with clear roles for health communicators.¹⁵ A plan for personnel training and a funding commitment should be implemented to ensure continuity and sustainability. Moreover, educators should receive appropriate training to build trust and provide clear messaging, without coercion.
65. Finally, the WHO also recommends that communication should be adaptive.¹⁶ Communication strategies should evolve and pivot as necessary depending on shifting misconceptions and points of distrust.¹⁷ Sources of misconception include but are not limited to COVID-19 severity and modes of transmission, materials used in the vaccine, safety profile and potential adverse reactions, and right to care.¹⁸ Multiple modalities of information should be provided with opportunities for bi-directional communication between the patient and a trusted source of health information.¹⁹ Moreover, assessment of the effectiveness of employed strategies should be evaluated and adapted as needed.

Appendix follows on next page.

Signed under the pains and penalties of perjury on February 10, 2021.



Monik C. Jiménez, ScD, SM

Signed under the pains and penalties of perjury on February 10, 2021.



Tori L. Cowger, B.S., MPH

¹⁵ WHO, *supra* n.14.

¹⁶ *Id.*

¹⁷ Salmon, *supra* n.15; Lewandowsky, *supra* n.15.

¹⁸ Lewandowsky, *supra* n.15.

¹⁹ Opel, *supra* n.15.

APPENDIX

Table 1. COVID-19 testing and case indicators and comparisons to Massachusetts, October 1, 2020 to January 27, 2021

County	Average Daily Population	Number of Tests	Total Cases	Test Percent Positivity	Average Daily Testing Rate Per 100,000	Average Daily Case Rate per 100,000	Case Rate Ratio vs. MA	% Difference in Testing Rate v. MA	% Difference in Test positivity v. MA
Massachusetts	6,892,503	9,252,689	362,836	3.9%	1128.09	44.24	-	-	-
All HOCs	6,281	8329	954	11.5%	1114.32	127.63	2.89	-1.0%	192.0%
Essex	997	2706	383	14.2%	2279.98	322.70	7.29	102.0%	261.0%
Suffolk	991	262	78	29.8%	222.06	66.11	1.49	-80.0%	659.0%
Hampden	903	2781	237	8.5%	2587.84	220.54	4.99	129.0%	117.0%
Bristol	680	111	33	29.7%	137.11	40.76	0.92	-88.0%	658.0%
Plymouth	613	1351	100	7.4%	1851.85	137.07	3.10	64.0%	89.0%
Worcester	592	262	57	21.8%	371.79	80.89	1.83	-67.0%	455.0%
Middlesex	553	178	0	0.0%	270.46	0.00	0.00	-76.0%	-100.0%
Norfolk	376	128	63	49.2%	285.94	140.73	3.18	-75.0%	1155.0%
Barnstable	182	2	0	0.0%	9.22	0.00	0.00	-99.0%	-100.0%
Franklin	140	379	3	0.8%	2278.74	18.04	0.41	102.0%	-80.0%
Berkshire	138	80	0	0.0%	487.36	0.00	0.00	-57.0%	-100.0%
Hampshire	110	83	0	0.0%	635.09	0.00	0.00	-44.0%	-100.0%
Dukes	5	6	0	0.0%	1084.99	0.00	0.00	-4.0%	-100.0%

Table 2. Population incarcerated in the HOCs and change over time

	Total Incarcerated Population			Change in Population from Baseline		Change in Population since July 1	
	Baseline	July 1, 2020	January 27, 2021	n	%	n	%
All HOCs	7,252	5,600	6,032	-1,220	-16.8%	432	6.0%
Essex	1,162	958	996	-166	-14.3%	38	3.3%
Suffolk	1,148	866	937	-211	-18.4%	71	6.2%
Hampden	931	648	834	-97	-10.4%	186	20.0%
Plymouth	799	576	565	-234	-29.3%	-11	-1.4%
Worcester	712	511	555	-157	-22.1%	44	6.2%
Bristol	695	613	676	-19	-2.7%	63	9.1%
Middlesex	688	553	549	-139	-20.2%	-4	-0.6%
Norfolk	425	320	352	-73	-17.2%	32	7.5%
Barnstable	204	158	177	-27	-13.2%	19	9.3%
Berkshire	169	145	139	-30	-17.8%	-6	-3.6%
Hampshire	167	117	104	-63	-37.7%	-13	-7.8%
Franklin	141	127	141	0	0.0%	14	9.9%
Dukes	11	8	7	-4	-36.4%	-1	-9.1%

EXHIBIT A

TORI COWGER

• Email: vcowger@g.harvard.edu • Phone: 810-853-9924 •
• Address: 120 Day Street, Unit 3, Boston, MA 02130 •

EDUCATION

Harvard T.H. Chan School of Public Health, Harvard University, Boston, MA

Ph.D in Social Epidemiology – Expected August 2021

Dissertation Title: Social and Political Geographies of Health Equity and Criminal Justice in the U.S. Overdose Crisis

Adviser: Dr. Lisa Berkman

Dissertation Committee: Dr. Rachel Nethery, Professor Leo Beletsky, and Dr. Mary T. Bassett

Rollins School of Public Health, Emory University, Atlanta, GA

Masters of Public Health in Epidemiology

University of Minnesota, Minneapolis, MN

Bachelors of Science in Biochemistry

PROFESSIONAL & RESEARCH EXPERIENCE

Harvard FXB Center for Health and Human Rights

Boston, MA, USA

Doctoral Scholar

Oct 2019 – Present

- Conducted research to systematically describe inequities in drug overdose deaths, to assess exposure to the criminal justice system as a structural driver of these inequities, and to explore mechanisms by which systemic racism in the criminal justice system may impact substance use-related harms
- Worked with an interdisciplinary team of doctoral students and faculty to conduct research to evaluate the availability, quality, and reporting methods for COVID-19 outcomes across U.S. state and federal public health agencies and to develop theoretical framework for understanding and eliminating racial and ethnic and socioeconomic inequities COVID-19 exposure, infection, and mortality.

Centers for Disease Control and Prevention (CDC), Global Tuberculosis Branch

Atlanta, GA, USA

Epidemiologist

Oct 2013 – Aug 2017

- Worked with collaborators to plan and conduct research to understand and address TB and HIV in high-risk populations through a variety of study designs and diverse data sources including clinical trials, prospective and retrospective cohort studies, implementation science research, molecular and laboratory data, population surveys and censuses, geospatial data, disease registries, and surveillance data
- Cleaned, analyzed and summarized research data into accurate and concise tables, figures, scientific presentations, and publications and disseminated scientific findings to domestic and international partners including leadership from international Ministries of Health and scientific audiences
- Provided technical assistance to international governments and non-governmental organizations on TB care and treatment in vulnerable and hard-to-reach populations, outbreak investigation, TB epidemiology and surveillance, and implementation of international and national guidelines
- Served as co-principal investigator on a study in Mozambique to introduce novel diagnostics for childhood TB and electronic tools through a community health worker model to improve TB and HIV case-finding activities and linkage to appropriate care

CDC, Emergency Operations Center, Ebola Response

Port Loko District, Sierra Leone

Field Epidemiologist

Dec 2015 – Feb 2016

- Deployed to Sierra Leone as a field epidemiologist for the Ebola response
- Analyzed and interpreted used epidemiologic data to drive decision making for public health activities for Ebola prevention in Port Loko District

TORI COWGER

• Email: vcowger@g.harvard.edu • Phone: 810-853-9924 •
• Address: 120 Day Street, Unit 3, Boston, MA 02130 •

PROFESSIONAL & RESEARCH EXPERIENCE (2)

CDC, Emergency Operations Center, Ebola Response (2)

Port Loko District, Sierra Leone

Field Epidemiologist

Dec 2015 – Feb 2016

- Conducted and supported the implementation of contact tracing, case investigation and infection prevention and control efforts to support and coordination between governmental and NGO partners
- Provided technical assistance and training to the staff at Lungi International Airport in Sierra Leone on border health activities and screening programs for travelers and airport employees
- Conducted training and oversight of Sierra Leone Ministry of Health staff in epidemiology of Ebola, contact listing, contact tracing and case investigations.

CDC, Division of Preparedness and Emerging Infections

Pago Pago, American Samoa

Graduate Research Assistant

May 2013 – Aug 2013

- Led team of multidisciplinary team to investigate a typhoid outbreak by interviewing cases and their household contacts, sending samples to the CDC headquarters for testing, corresponding with the local media, and implementing strategies for prevention of further cases
- Enhanced epidemiological capacity for timely detection of outbreaks through enhancement of syndromic surveillance systems and strategic infectious disease mapping and monitoring
- Coordinated collaboration between department of health and local health organizations to establish standardized protocol, reporting instruments and databases for nationally notifiable diseases

Georgia Department of Public Health - Emerging Infections Program

Atlanta, GA, USA

Graduate Research Assistant

Oct 2012- May 2013

- Collected and analyzed large amounts of foodborne disease surveillance data through routine surveillance interviews, case-control study interviews and laboratory reports to inform foodborne disease preparedness and prevention campaigns
- Entered, cleaned, and analyzed exposure data in SAS and Excel from hundreds foodborne illness surveys for descriptive analysis of disease burden of E. coli non-O157 in Georgia

CDC, Bioterrorism Rapid Response and Advanced Technology Lab

Atlanta, GA, USA

Graduate Research Assistant

Oct 2012- May 2013

- Bolstered preparedness capacity through optimization of portable pathogen detection assays for minimal energy usage to mimic field response situations
- Compared sensitivity and specificity of portable Bacillus anthracis detection assays to standard Laboratory Response Network (LRN) methods for use in outbreak situations

Emory University Student Outbreak and Response Team (SORT)

Atlanta, GA, USA

Response Team Member

Sep 2012- May 2014

- Assisted with outbreak response and preparedness activities such as CDC's fungal meningitis outbreak response, Middle East Respiratory Syndrome (MERS-CoV) response, and Emory University's drive-through immunization clinic
- Completed FEMA's Incident Command System and CDC's Emergency Operation Center's trainings in preparation for emergency response activities

United States Agency for International Development (USAID) Kenya

Nairobi, Kenya

HIV Program Intern

Jan 2011 – May 2011

- Worked with Kenyan public health officials to build local public health capacity in the field under the AIDS, Population, and Health Integrated Assistance (APHIA) initiative
- Assisted with organization mapping and program design during the transition through funding periods to ensure cost-effectiveness, equitable access and sustainable initiatives

TORI COWGER

• Email: vcowger@g.harvard.edu • Phone: 810-853-9924 •
• Address: 120 Day Street, Unit 3, Boston, MA 02130 •

PROFESSIONAL & RESEARCH EXPERIENCE(3)

Kenyan Medical Research Institute

Nairobi, Kenya

Undergraduate Research Assistant

Jan 2011 - May 2011

- Collaborated with an epidemiologist on a study to examine utilization of voluntary HIV testing centers in both rural and urban settings in Kenya to help improve centers' effectiveness
- Created data collection instrument and subsequently conducted interviews of more than 300 Kenyans and compiled, entered and analyzed survey data

University of Minnesota Center for Infectious Disease and Translational Research

Minneapolis, MN USA

Undergraduate Laboratory Assistant

Apr 2012- Sep 2012

- Collaborated on a clinical trial with investigators at the University of Cape Town, South Africa to improve sensitivity and specificity of the Lateral Flow Assay (LFA), a Rapid Detection Test (RDT) for Tuberculosis using thermal contrast
- Researched antibody chemistry and lateral flow sensitivity and specificity for multiple infectious diseases including tuberculosis, malaria and cryptococcal meningitis.

Minnesota AIDS Project

Minneapolis, MN, USA

Red Cross Certified HIV Educator

May 2011 - Aug 2012

- Provided in-person, group-level trainings that educate employers, persons recovering from substance use disorders, service organizations, and civic groups who work with those affected by HIV

TEACHING EXPERIENCE

Harvard T.H. Chan School of Public Health

Fall 2019

Head Graduate Teaching Fellow, Core Principles of Biostatistics and Epidemiology for Public Health Practice (ID 201), Professors: Dr. Kim Gauvreau and Dr. Elizabeth Mostofsky

Fall 2020
& 2018

Graduate Teaching Fellow, Core Principles of Biostatistics and Epidemiology for Public Health Practice (ID 201), Professors: Dr. Kim Gauvreau and Dr. Elizabeth Mostofsky

Emory University Rollins School of Public Health

Spring 2014

Graduate Teaching Assistant, Epidemiologic Methods II (EPI 534), Professor: Dr. Harland Austin

Fall 2013

Graduate Teaching Assistant, Epidemiologic Methods I (EPI 530), Professor: Dr. Michael Goodman

PEER-REVIEWED PUBLICATIONS

Published

Jiménez MC, **Cowger TL**, Simon LE, Behn M, Cassarino N, & Bassett MT (2020). Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons. *JAMA Network Open*, 3(8), e2018851–e2018851. <https://doi.org/10.1001/jamanetworkopen.2020.18851>

Cowger TL, Davis BA, Etkins OS, Makofane K, Lawrence JA, Bassett MT, & Krieger N (2020). Comparison of Weighted and Unweighted Population Data to Assess Inequities in Coronavirus Disease 2019 Deaths by Race/Ethnicity Reported by the US Centers for Disease Control and Prevention. *JAMA Network Open*, 3(7), e2016933–e2016933. <https://doi.org/10.1001/jamanetworkopen.2020.16933>

Cowger TL, Wortham JM, & Burton DC (2019). Epidemiology of tuberculosis among children and adolescents in the USA, 2007–17: an analysis of national surveillance data. *The Lancet Public Health*, 0(0). [https://doi.org/10.1016/S2468-2667\(19\)30134-3](https://doi.org/10.1016/S2468-2667(19)30134-3)

TORI COWGER

• Email: vcowger@g.harvard.edu • Phone: 810-853-9924 •
• Address: 120 Day Street, Unit 3, Boston, MA 02130 •

PEER-REVIEWED PUBLICATIONS (2)

Published

- Cowger TL**, Thai LH, Duong BD, Danyuttapolchai J, Kittimunkong S, Nhung NV, Nhan DT, Monkongdee P, Thoa CK, Khanh VT, Nateniyom S, Yen NTB, Ngoc DV, Thinh T, Whitehead S, & Pevzner ES (2017). Programmatic Evaluation of an Algorithm for Intensified Tuberculosis Case Finding and Isoniazid Preventive Therapy for People Living With HIV in Thailand and Vietnam. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 76(5), 512. <https://doi.org/10.1097/QAI.0000000000001551>
- Cowger TL**, Burns CC, Sharif S, Gary HE, Iber J, Henderson E, Malik F, Zahoor Zaidi SS, Shaukat S, Rehman L, Pallansch MA, & Orenstein WA (2017). The role of supplementary environmental surveillance to complement acute flaccid paralysis surveillance for wild poliovirus in Pakistan – 2011–2013. *PLOS ONE*, 12(7), e0180608. <https://doi.org/10.1371/journal.pone.0180608>
- Zetola NM, Modongo C, Moonan PK, Click E, Oeltmann JE, Shepherd J, & Finlay A, *Collaborators*: Basotli J, Bile E, Boyd R, Dima M, Fane O, Shin SS, Surie D, **Cowger TL**, Katlholo T, Radisowa K, Kwaadira K, Matsire O, Posey J, Serumola C and Tobias J. (2016) "Protocol for a Population-Based Molecular Epidemiology Study of Tuberculosis Transmission in a High HIV-Burden Setting: The Botswana Kopanyo Study." *BMJ Open*.

In Preparation

- Pevzner ES, **Cowger TL**, Thai LH, Duong BD, Nhung NV, Nhan DT, Thoa CK, Khanh VT, Thinh T, Dung NH, Yen NTB, Ngoc DV, McConnell M, Whitehead S "Yield and impact of repeated TB screening and isoniazid preventive therapy for tuberculosis among people living with HIV in Vietnam"

PRESENTATIONS

- Cowger TL**, Wortham J, Burton D "Contribution of global tuberculosis to the burden of childhood TB in the United States, 2007-2015" 47th World Conference on Lung Health. International Union Against Tuberculosis and Lung Disease. 29 Oct 2016. Oral Presentation.
- Cowger TL**, Finlay A "CDC's Ebola Response and Global Health Security." 21st Annual Regional Security Conference. International Security Management Association and the Overseas Security Advisory Council, Gaborone, Botswana. 16 Sept 2015.
- Cowger, TL** et al. "Yield and impact of intensified case finding and isoniazid preventive therapy for tuberculosis among people living with HIV in Vietnam" 46th World Conference on Lung Health. International Union Against Tuberculosis and Lung Disease. 2 Dec 2015. Oral Presentation.
- Cowger TL**, Pevzner E "From Research to Practice: Finding, Treating, and Preventing Tuberculosis among People Living with HIV in Vietnam." Division of Global HIV and Tuberculosis Annual Meeting. Atlanta, GA. 3 June 2015.
- Burns CC and **Cowger TL** "Environmental Surveillance for Poliovirus in Pakistan." World Health Organization Polio Research Committee Meeting. Geneva, Switzerland. 26 Sept 2014. Oral Presentation.
- Cowger TL**, Burns CC, and Orenstein WA. "The Role of Supplementary Environmental Surveillance to Complement Acute Flaccid Paralysis Surveillance for Wild Poliovirus in Pakistan." CDC's Global Immunization Division Polio Technical Seminar. U.S. Centers for Disease Control and Prevention, Atlanta, Georgia. 12 June 2014. Oral Presentation.

TORI COWGER

• **Email:** vcowger@g.harvard.edu • **Phone:** 810-853-9924 •
• **Address:** 120 Day Street, Unit 3, Boston, MA 02130 •

AWARDS & RECOGNITION

2013 Delta Omega Honor Society

Nominated and selected by Emory University faculty based on scholastic performance, dedication to public health, and commitment to health in all populations

2013 Emory Global Health Field Scholar

Grant proposal for innovative global health program chosen from a pool of more than 200 applicants to receive additional funding

2014 University of Minnesota's College of Biological Sciences "20-under-30" Award

Selected as one of 20 alumni under 30 years old making a difference in their respective disciplines

PROGRAMMING LANGUAGES

R • SAS • Python • Stata • LaTeX

EXHIBIT B

**COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT**

Suffolk, ss.

No. SJ-2020-757

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Plaintiffs,

v.

BARNSTABLE COUNTY SHERIFF'S OFFICE, BERKSHIRE COUNTY SHERIFF'S
OFFICE, BRISTOL COUNTY SHERIFF'S OFFICE, DUKES COUNTY SHERIFF'S
OFFICE, ESSEX COUNTY SHERIFF'S OFFICE, FRANKLIN COUNTY SHERIFF'S
OFFICE, HAMPDEN COUNTY SHERIFF'S OFFICE, HAMPSHIRE COUNTY
SHERIFF'S OFFICE, MIDDLESEX COUNTY SHERIFF'S OFFICE, NORFOLK
COUNTY SHERIFF'S OFFICE, PLYMOUTH COUNTY SHERIFF'S OFFICE,
SUFFOLK COUNTY SHERIFF'S OFFICE and
WORCESTER COUNTY SHERIFF'S OFFICE
Defendants.

SUPPLEMENTAL AFFIDAVIT OF
DR. YONATAN GRAD (MD, PhD) AND EMMA ACCORSI (BS)

I, Dr. Yonatan Grad, and I, Ms. Emma Accorsi, state that the following is a true and accurate statement to the best of our knowledge and belief:

1. We previously submitted a declaration in this case based on our professional expertise and opinions. In that declaration, we explained that routinely testing individuals without symptoms in jails and prisons is necessary to stop the spread of COVID-19 infections within the facilities and emphasized that the failure to do so prevented facilities from taking effective action to protect their incarcerated population from COVID-19.
2. We are submitting this declaration to respond to several assertions in the Houses of Correction's January 15th memorandum of law and supporting exhibits. SJ-2020-757, Dkt. #5 (Jan. 15, 2021).

**THE CLAIM THAT INDIVIDUALS ARE MORE PROTECTED FROM COVID-19
INFECTION WITHIN JAILS AND PRISONS THAN IN THE COMMUNITY IS
UNSUPPORTED AND MISLEADING**

3. Our understanding is that several Sheriffs have submitted affidavits suggesting that incarcerated individuals are safer within their facilities than in the general population. For

example, Sheriff Cummings asserted, “it has been established that the inmates are far safer from the COVID-19 virus inside the Barnstable County Correctional Facility than in the community.” Ex. 2a (Cummings Aff., ¶ 14). Similarly, Sheriff Quinn stated, “the inmates proved to be far safer inside the Berkshire County Jail and House of Correction than in the community.” Ex 2a (Quinn Aff., ¶ 15).

4. To make these assertions, the Sheriffs largely rely on a comparison between the purportedly lower case rates within their facilities to the higher case rates in the general population. *See, e.g.*, Ex. 2a (Cummings Aff., ¶ 14); Ex 2a (Quinn Aff., ¶ 15). But for several reasons, this comparison does not demonstrate that individuals are more protected from COVID-19 within a carceral facility.
5. First, numerous facilities have such a low number of tests to render their case rates practically meaningless. For example, Barnstable has tested just three incarcerated individuals since October 14, 2020, and in the more than a month since this case was filed, Bristol, Hampshire, and Berkshire have tested only 27, 28, and 43 incarcerated individuals, respectively. Facilities cannot assert that incarcerated individuals and staff members are safe from a danger that they are not actually measuring.
6. Second, comparing the danger posed by COVID-19 within the general population to the danger posed by COVID-19 in prison is not an apples-to-apples comparison. That is because the risk and rate of spread in congregate settings are much higher than in the community, as has repeatedly been observed in nursing homes, long-term care facilities, and jails. As the Governor explained, the very reason that incarcerated individuals are included in phase one of the vaccination plan is “because of the possibility of outbreak and the heightened risk of close quarters.”¹
7. Third, because jails and prisons are not closed environments, spread in the surrounding community can meaningfully impact the introduction and spread of COVID-19 within the facility itself. Staff members from the surrounding communities enter the facilities every day, presenting daily opportunities for the virus to enter the facility. It is therefore not surprising that the CDC recommends that jurisdictions should consider expanding testing to individuals without symptoms in a variety of settings, including jails and prisons, when the case rates in the surrounding communities are high.²
8. Given these issues, the suggestion that individuals are more protected from COVID-19 while incarcerated than in the community is unsupported and misleading.

¹ *Gov. Baker Defends Decision to Vaccinate Inmates Before General Public*, NBC Boston (Jan. 14, 2021), <https://www.nbcboston.com/news/local/gov-baker-defends-decision-to-vaccinate-inmates-before-general-public/2280523>.

² CDC, *CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2* (Jan. 21, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html>.

**DR. WURCEL DOES NOT PROVIDE ANY SCIENTIFIC OR MEDICAL
JUSTIFICATION TO SUPPORT HER DECISION NOT TO RECOMMEND ROUTINE,
COMPREHENSIVE TESTING OF NON-SYMPTOMATIC INCARCERATED
INDIVIDUALS**

9. We have reviewed Dr. Alysse Wurcel’s affidavit submitted in this case. (Ex. 3). In that affidavit, Dr. Wurcel states “[a]t this point, I have not recommended facility-wide repetitive surveillance testing in the jails.” (Ex. 3 ¶9). In our professional opinion, there is no scientific or medical justification for this decision.
10. Dr. Wurcel states that “[t]he CDC does not discuss or recommend for facility-wide repetitive surveillance testing in the most recent guidelines,” (Ex. 3 ¶9), but that is not correct.
11. To the contrary, the CDC’s most recent guidance for “Testing in Correctional and Detention Facilities” instructs that “correctional and detention facilities may consider testing asymptomatic individuals without known or suspected SARS-CoV-2 exposure in communities with moderate to substantial levels of community transmission.”³ Moreover, the CDC’s “Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2” similarly emphasized that jurisdictions should consider expanding testing of non-symptomatic individuals and explicitly included residents and staff in correctional facilities to prioritize for such expanded testing.⁴
12. Our understanding of this CDC guidance is that it encourages jails and prisons to conduct routine, comprehensive testing of non-symptomatic incarcerated individuals and staff where there is a moderate to high degree of community spread and no asserted resource constraints on testing.
13. Dr. Wurcel’s failure to mention these guidelines is especially puzzling given that six Massachusetts counties currently have a positivity rate that places them in the moderate or high tier, for which the CDC recommends weekly or twice weekly surveillance testing.⁵
14. Dr. Wurcel suggests that her recommendations are in line with DPH recommendations. (Ex 3 ¶9). To our knowledge, DPH has not created or issued any guidelines regarding testing in Massachusetts jails and prisons, and Dr. Wurcel does not cite to any such guidance. Instead, Dr. Wurcel states, “I asked DPH if jails should consider universal screening, meaning testing each individual in the jail regardless of the conditions in the jail. At the time, during the spring of 2020, DPH did not recommend universal screening.” (Ex. 3 ¶11).

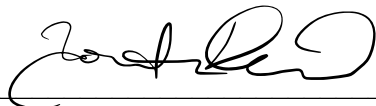
³ CDC, *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities*, (Dec. 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html>.

⁴ CDC, *CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2*, (Jan. 21, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html>.

⁵ Mass. Dep’t of Public Health, *Count and Rate of Confirmed COVID-19 Cases and Tests Performed in MA by County* (Feb. 3, 2021), <https://www.mass.gov/doc/county-level-positivity-rates-february-3-2021/download>; CDC, *CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2*, (Jan. 21, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html>.

15. Based on this statement, it is our understanding that Dr. Wurcel has not spoken to DPH about routine, comprehensive testing since this spring. If that is the case, the advice is outdated and should no longer be relied upon for any medical decision.
16. Over the course of the last ten months, there has been a rapid evolution of testing recommendations based on our increased understanding about the non-symptomatic spread of COVID-19, the growth of our testing capacity, and the explosion of community spread throughout the Commonwealth. Medical and scientific consensus no longer supports the recommendation to avoid routine, comprehensive testing where there have been no allegations that there are practical impediments to such testing.

Signed under the pains and penalties of perjury on February 8, 2021.



Yonatan Grad, MD, PhD

Signed under the pains and penalties of perjury on February 8, 2021.



Emma Accorsi, BS