I, Homer Venters, hereby declare the following:

Background

1. I am a physician, internist and epidemiologist with over a decade of experience in providing, improving and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with ICE on numerous individual cases of medical release, formulation of health-related policies as well as testimony before U.S. Congress regarding mortality inside ICE detention facilities.
2. After my fellowship training, I became the Deputy Medical Director of the NYC Jail Correctional Health Service. This position included both direct care to persons held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry and morbidity and mortality reviews as well as all training and oversight of physicians, nursing and pharmacy staff. In these roles I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacts almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection and several other smaller outbreaks.
3. In March 2017, I left Correctional Health Services of NYC to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers.
4. In December 2018 I became the Senior Health and Justice Fellow for Community Oriented Correctional Health Services (COCHS), a nonprofit organization that promotes evidence-based improvements to correctional practices across the U.S. In January 2020, I became the president of COCHS. I also work as a medical expert in cases involving correctional health and I have a book on the health risks of jail (*Life and Death in Rikers Island*) which was published in early 2019 by Johns Hopkins University Press. A copy of my curriculum vitae is attached to this report which includes my publications, a listing of cases in which I have been involved and a statement of my compensation.

COVID-19 in WV Prison Settings

5. Coronavirus disease of 2019 (COVID-19) is a viral pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.
6. COVID-19 infection rates are growing exponentially in the U.S. The outbreak curve is in the early stages, meaning that communities are beginning to see their first cases, and that the number of cases overall is rising rapidly, with doubling times between one and three days. The Governor of California predicted that over half of all residents will become infected with COVID-19 and the Commissioner of

Health for New Jersey predicted "I'm definitely going to get it, we all will."[1] The Centers for Disease Control (CDC) now reports COVID-19 cases in all 50 states.

7. West Virginia DCR will not be able to stop the entry of COVID-19 into DCR facilities, and the reality is that the infection is likely inside multiple facilities already. When COVID-19 impacts a community, it will also impact the detention and correctional facilities. For instance, in New Jersey, one employee at an ICE detention facility has already tested positive,[2] and this is likely just the tip of the iceberg in terms of the number of ICE staff that are already infected but are unaware due to the lack of testing nationwide, and the fact that people who are infected can be asymptomatic for several days. In New York, one of the areas of early spread in the U.S., multiple correctional officers and jail and prison inmates have become infected with COVID-19. The medical leadership in the NYC jail system have announced that they will be unable to stop COVID from entering their facility and have called for release as the primary response to this crisis. Staff are more likely to bring COVID-19 into a facility, based solely on their movement in and out every day.
8. I have been inside multiple prison settings in the U.S. My experience is that the densely packed housing areas, the manner in which health services, food services, recreation, bathroom and shower facilities for detained people, as well as the entry points, locker rooms, meal areas, control rooms for staff, all contribute to many people being in small spaces. One of the most ubiquitous aspects of detention, the sally-port, or control port, a series of two locked gates that bring every staff member and detained person past a windowed control room as they stop between locked gates, provides but one example of this concern. The normal functioning of prisons demands that during shift change for staff, or as the security count approaches for detained people, large numbers of people press into sally-ports as they move into or out of other areas of the facility. This process created close contact and the windows in these sally ports that are used to hand out radios, keys and other equipment to staff ensure efficient passage of communicable disease from the control rooms into the sally port areas on a regular basis. Prisons are designed to force close contact between people and rely on massive amounts of movement every day from one part of the facility to another, e.g., for programming, access to cafeterias, commissary, medical, just to name a few. This movement is required of detained people as well as staff. My experience managing smaller outbreaks is that it is impossible to apply hospital-level infection control measures on security staff. In a hospital or nursing home, staff may move up and down a single hallway over their shift, and they may interact with one patient at a time. In detention settings, officers move great distances, are asked to shout or yell commands to large numbers of people, routinely apply handcuffs and operate heavy doors/gates, operate large correctional keys and are trained in the use of force. These basic duties cause the personal protective equipment they are given to quickly break and become useless, and even when in good working order, may impede their ability talk and be understood, in the case of masks. For officers working in or around patients at risk or with symptoms, there may be an effort to have them wear protective gowns, as one would in any other setting with similar clinical risks. These gowns cover their radios, cut down tools and other equipment located on their belts and in my experience working with correctional staff, are basically impossible to use as a correctional officer. Efforts to lock detained people into cells will worsen, not improve this facility-level contribution to infection control. When people are locked into cells alone, for most of the day, they quickly experience psychological distress that manifests in self-harm and suicidality, which requires rapid response and intensive care outside the facility for mental and physical health emergencies. In addition, units that are comprised of locked cells require additional staff to escort people to and from their cells for showers and other encounters, and medical, pharmacy and nursing staff move on and off these units daily to

[1] https://www.10news.com/news/coronavirus/newsom-56-percent-of-california-expect-to-get-coronavirus
[2] https://www.buzzfeednews.com/article/hamedaleaziz/ice-medical-worker-coronavirus

assess the welfare and health needs of these people, creating the same movement of virus form the community into the facilities as if people were housed in normal units.

9. Another critical way in which detention settings promote transmission of communicable disease involves lack of access to hand washing. Many common areas lack operable sinks with access to soap and paper hand towels. In addition, many of the sinks utilized in correctional settings do not operate with a faucet that can be turned and left on, but rely on pushing a button which provide a limited amount of water over a limited amount of time. These metered faucets are designed to save water by limiting the amount of time water flows. This approach makes adequate hand washing with soap for at least 20 seconds very difficult if not impossible. As these examples illustrate, my experience is that the design and operation of detention settings promotes the spread of communicable diseases such as COVID-19.
10. WV DCR currently detains thousands of people with risk factors that increase their risk of serious complications from COVID-19, including death and long-lasting complications after recovery. The risk factors included by the CDC include people with heart disease, lung disease, diabetes, immune compromising conditions and patients who are older. In correctional settings, the age of 50 is used to identify older patients, because of the extremely high level of physical and behavioral health problems among this cohort of people.
11. I have reviewed recent reports of bedding capacity and institutional population, as made available through the news media. While inmate population has declined, the overcrowded populations of certain jails will increase the risk of rapid and unabated transmission of COVID-19, and lead to the potential of overwhelming community hospitals and jail and prison health care operations.

Review of WV DCR COVID-19 Response Plan & Inmate Reports

12. I have reviewed the interim guidance provided by the CDC as well as the policy and exhibits provided by WV DCR. I am concerned that WV DCR will be unable to implement these standards and recommend that the WV DCR immediately complete the worksheet found in the attached COVID-19 response policy, and report out the answers.
13. My concern that WV DCR is unable to meet the most basic elements of the CDC guidance is based on reports from people currently incarcerated within this system. I have reviewed notes from five discussions with inmates that raise concerns including the following:
    a. Failure to provide hand washing supplies including soap, paper towels;
    b. Failure to check symptoms among newly arrived detained people;
    c. Failure to ask about risk factors of serious illness or death from COVID-19 infection.;
    d. Failure to provide adequate supplies for cleaning of housing areas;
    e. Failure to establish standards of use of gloves and masks by security personnel;
    f. Failure to ensure access to hand washing, including operable sinks, soap and hand towels;
    g. Failure to enact social distancing among staff and detained people;
    h. Lack of communication regarding COVID-19 status inside quarantined housing areas;
    i. Lack of symptom screening of staff arriving to work;
    j. Lack of communication to inmates of waiver of sick call fees, leading to potential underreporting and failure to seek timely care.
14. I am especially concerned about the lack of adequate staffing plan to conduct what will certainly amount to more work requirements for both security and health staff in responding to COVID-19. Some of the most basic elements of the CDC guidance on COVID-19 response in correctional settings, including opening new housing areas for symptomatic patients, others who are not symptomatic, but being quarantined due to known contact with a positive case, use of heavily staggered time out of cell, meal times, and other elements of basic operations to reduce the close contact between and among detained

people and staff will require significantly more security and health staffing just at the time when these staff are likely to be depleted by illness among their own ranks. My experience in managing outbreaks behind bars is that this element requires new arrangements with staffing services for health staff, and collaborations with security partners across jurisdictions. The lack of staffing will impact basic operations, as well as the ability to cohort high risk and symptomatic patients (in different areas) as well as provide care inside the facility and even conduct escort for emergency room evaluation and inpatient hospitalization. The protocol also fails to detail how patient education will occur, both for newly arrived people and those already in detention.

15. The census of the DCR facilities presents a related challenges to responding to COVID-19 in a manner consistent with CDC guidelines. In order to respond to new cases of COVID-19 infection by placing symptomatic patients into one setting while the and others are tested, and asymptomatic contacts into a separate setting, more housing areas will be required than are currently in use. My experience in managing h1n1 infection in particular is that any facility that is over 75% capacity today will face extreme challenges in appropriately cohorting detained people based on the clinical guidelines of the CDC for COVID-19. Facilities with a greater than 75% capacity will struggle to find adequate housing areas as the infection spreads, and may end up cutting short quarantine periods, mixing people from multiple quarantine time periods, or may fail altogether to separate symptomatic from asymptomatic patients until and unless tests are conducted, all of which will seriously damage efforts to control the spread of COVID-19.
16. I am concerned that the current protocol provided by the DCR does not include any plan to create special protections for people with known risk factors for serious illness or death form COVID-19 infection. DCR staff have knowledge of who among their patients have these risk factors, and also can reasonably identify and conduct active surveillance of these patients. These patients should be cohorted in housing areas where DCR health staff can conduct active surveillance that includes symptom and temperature checks on a daily basis. These patients should not be left in the mix of the larger population since we now know that should they develop COVID-19, they are at heightened risk of rapid decompensation and death.

Conclusion

17. I conclude, based on the information obtained from inmates in DCR custody combined with the materials provided by WV DCR and represented to be exhaustive of its measures, that sufficient measures are not being taken to protect inmates from serious injury or death, including measures to ensure adequate supplies, adequate testing and screening, adequate standards for personal protective equipment, adequate social distancing, and other necessary measures. Further, it does not appear that WVDCR has ensured adequate communication and chain of command and/or auditing or medical quality control measures to ensure that staff and inmates are protected from widespread infection and death in WVDCR facilities.
18. To correct these deficiencies, I recommend the following as immediate first steps to be taken to protect against the substantial risk to life and health:
    a. Each WV DCR facility should complete the worksheet set forth in its policy, and provide those to the Court and the parties, to ensure that all necessary measures are being uniformly adopted and followed in all facilities.
    b. An individual in each facility be tasked with reporting daily on implementation of the WV DCR COVID-19 response.
    c. WV DCR should undertake all available measures, including coordinating with other agencies, to release as many inmates as possible prior to an outbreak starting, especially from

those jails that are currently overcrowded, making social distancing impossible. WV DCR should take adequate measures to ensure that facilities are reduced to 75% capacity.

d. WV DCR should provide a detailed staffing plan setting forth how it plans to surge nursing/health coverage and security staff coverage to address the inevitable outbreak.
e. WV DCR should create and provide a housing area plan for how it intends to cohort inmates.
f. WV DCR should create a testing plan, including setting forth who will get tested for COVID-19 and when such testing will occur.
g. WV DCR should create and provide a PPE plan for both staff and patients.
h. WV DCR should create a protocol to create special protections for inmates with known risk factors and engage in active surveillance of these inmates.
i. WV DCR should take immediate steps to ensure that all portions of its plan are being implemented, including the provision of free adequate supplies to inmates and staff.

Signed

Homer Venters MD, MS