UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

JOSEPH A. DENBOW and SEAN R. RAGSDALE, *on their own and on behalf of a class of similarly situated persons,* *Petitioners*, v. RANDALL A. LIBERTY, Commissioner of Maine Department of Corrections *in his official capacity*, MAINE DEPARTMENT OF CORRECTIONS, *Respondents*	Case No. _____

DECLARATION OF JOSEPH GOLDENSON, MD

I, Joseph Goldenson, MD, declare as follows:

Background

1. I am a medical physician with 33 years of experience in correctional health care. For 28 years, I worked for Jail Health Services of the San Francisco Department of Public Health. For 22 of those years, I served as the Director and Medical Director. In that role, I provided direct clinical services, managed public health activities in the San Francisco County jail, including the management of HIV, tuberculosis, Hepatitis C, and other infectious diseases in the facility and the planning and coordination of the jail's response to H1N1, and administered the correctional health enterprise, including its budget, human resources services, and medical, mental health, dental, and pharmacy services.
2. I served as a member of the Board of Directors of the National Commission on Correctional Health Care for eight years and am past President of the California chapter of the American Correctional Health Services Association. In 2014, I received the Armond Start Award of

Excellence from the Society of Correctional Physicians, which recognizes its recipient as a representative of the highest ideals in correctional medicine.

3. For 35 years, I held an academic appointment as an Assistant Clinical Professor at the University of California, San Francisco.

4. I have worked extensively as a correctional health medical expert and court monitor. I have served as a medical expert for the United States District Court for the Northern District of California for 25 years. I am currently retained by that Court as a medical expert in *Plata v. Newsom*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to inmate patients in the California Department of Correctional Rehabilitation. I have also served as a medical expert and monitor at Cook County Jail in Chicago; Los Angeles County Jail; at other jails in Washington state, Texas, and Florida; and at prisons in Illinois, Ohio, and Wisconsin.

5. My curriculum vitae is attached as exhibit A.

6. Within the preceding four (4) years, I have testified as an expert by deposition or trial in the following cases:

- *Charlotte Diana Winkler v. Madison County, Kentucky, et al.*, United States District Court, Eastern District of Kentucky, Central Division at Lexington, Case No. 5:15-CV-45-KKC, Deposition (June 2016)
- *Jane Doe #1, et al. v. Johnson, et al.*, United States District Court for the District of Arizona, No. CV-15-00250-TUC-DCB, Hearing for Preliminary Injunction (November 2016)
- *Eugene McCain v. St. Clair County, et al.*, United States District Court, Eastern District of Michigan, Southern Division, Case No. 2:16-cv-10112 (March 2017)
- *Jane Doe #1, et al. v. Johnson, et al.*, United States District Court for the District of Arizona, No. CV-15-00250-TUC-DCB, Deposition (December 2017)
- *The Estate of Rachel M. Hammers, Deceased, et al. v. Douglas County, Kansas Board of Commissioners, et al*, District Court of Douglas County, Kansas at Lawrence, Case No. 2:14-CV-02188-JTM-KMH, Trial (June 2018)
- *Jane Doe #1, et al. v. Johnson, et al.*, United States District Court for the District of Arizona, No. CV-15-00250-TUC-DCB, Trial (January 2020)

The Nature of COVID-19

7. The SARS-CoV-2 virus ("COVID-19"), and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the World Health Organization ("WHO"). Cases first began appearing between December 1 and December 31, 2019, in Hubei Province, China.

8. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus that caused the 2002–2003 SARS epidemic.

9. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.1 to 3.5%, which is up to 35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.

10. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardiovascular diseases, hypertension, respiratory diseases, like asthma and COPD, diabetes, and immune compromise.

11. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS), which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and in parts of China.

12. COVID-19 is widespread. Since it first appeared in China in late 2019, outbreaks have subsequently occurred in more than 160 countries and all populated continents; heavily affected countries include Italy, Spain, Iran, South Korea, and the U.S. The U.S. is now the world's most affected country. As of May 7, 2020, there have been 4,413,597 confirmed human cases globally and 300,798 known deaths.[1] It is not contained, and cases are growing exponentially.

13. In the United States alone, the Centers for Disease Control and Prevention ("CDC") reports 1,384,930 cases and 83,947 deaths as of May 14, 2020.[2] As of May 14, 2020, Maine has had 1,405 coronavirus cases and seen 207 hospitalizations and 69 deaths as a result of the virus.[3] All these numbers are likely underestimates because of limited availability of testing.

14. COVID-19 is now known to be fully adapted to human-to-human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

15. COVID-19 is a highly contagious respiratory illness. It is transmitted between persons in close proximity (within about six feet) by airborne droplets released by infected individuals when they cough or sneeze. The droplets can survive in the air for up to three hours. It may also be possible for an individual to become infected by touching a surface or object that has the virus on it and then touching his or her own mouth, nose, or possibly eyes. Infected

[1] https://coronavirus.jhu.edu/map.html (last accessed May 14, 2020).
[2] https://www.cdc.gov/covid-data-tracker/index.html (last accessed May 14, 2020)
[3] https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml (last accessed May 14, 2020)

droplets can survive on surfaces for variable lengths of time, ranging from up to four hours on copper, to 24 hours on cardboard, to two to three days on plastic or stainless steel.

16. The U.S. CDC estimates that the reproduction rate of the virus, the R0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20–30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2–14 days, which is why isolation is generally limited to 14 days.

17. CDC has recently added to the list of possible signs and symptoms of COVID-19 to include fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.[4] In severe cases, infection can result in respiratory failure or death. The care of people infected with COVID-19 depends on the seriousness of their illness. People with moderate symptoms may require hospitalization for supportive treatment, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics.

18. A significant number of infected individuals do not exhibit symptoms, however, and asymptomatic individuals—either before the onset of symptoms or because no symptoms will ever manifest—can nevertheless transmit the disease to others. According to the CDC,

[4] Centers for Disease Control and Prevention, Symptoms of Coronavirus, https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (last accessed May 14, 2020).

up to 25 percent of people infected with COVID-19 will remain asymptomatic.[5] Similarly, infected individuals may experience only mild symptoms. These asymptomatic and mildly symptomatic individuals can, and do, transmit the virus, contributing to its rapid spread. Because of the high risk of transmission by asymptomatic individuals, CDC recently recommended everyone wear a mask when they leave their homes.[6]

19. There is currently no vaccine for COVID-19, and no cure. The only known ways to prevent the spread of COVID-19 involve measures such as thorough handwashing, frequent decontamination of surfaces, and maintaining six feet of physical distance between individuals ("social distancing").

The Risks of COVID-19 in Correctional Facilities

20. COVID-19 poses a serious risk to prisoners, workers, and anyone else in correctional facilities. Correctional facilities, including facilities like Maine's prisons, have long been associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis. For example, in 2011, the Maine Department of Corrections experienced a seasonal flu epidemic that sickened a large number of inmates and staff in 2011, even killing one prisoner.[7] The Hepatitis C virus is also common among prisoners

[5] Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html (last accessed May 14, 2020).
[6] U.S. Centers for Disease Control and Prevention, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("Interim Guidance"), at 8-12, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last accessed May 14, 2020).
[7] *Influenza Outbreaks at Two Correctional Facilities – Maine, March 2011*, Centers for Disease Control and Prevention (Apr. 6, 2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm (last accessed May 14, 2020).

in Department of Corrections custody. Department of Corrections records indicate that, as of October 2017, there were 580 inmates in Department of Corrections custody infected with Hepatitis C.[8]

21. The severe epidemic of tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities surrounding a prison.

22. Infections that are transmitted through droplets, like influenza and COVID-19, are particularly difficult to control in detention and correctional facilities, as social distancing and proper decontamination of surfaces are virtually impossible.

23. For example, several deaths were reported in the U.S. in immigration detention facilities associated with ARDS following influenza A, including a 16-year old immigrant child who died of untreated ARDS in custody in May 2019.

24. It is estimated that during the Spanish influenza of 1918 half of the 1900 inmates at San Quentin Prison in California contracted the disease during the first wave of the epidemic. Sick calls increased from 150 to 700 daily. Most of the ill were kept in the general prison population because the hospital ward was full.[9]

25. Current recommendations for social distancing and frequent cleansing of surfaces to prevent infection and the spread of the virus are extremely difficult, if not impossible, to

[8] Amended Compl., Ex. 1, *Loisel v. Clinton*, Docket No. 19-cv-81-NT, ECF No. 26-1 (June 26, 2019) (stating that as of October 31, 2017, there are 580 [Hepatitis C Virus positive] prisoners housed in the Maine Department of Corrections").

[9] L.L. Stanely, MD., 43 Public Health Reports (1896-1970), *Influenza at San Quentin Prison, California* (May 9, 1919), https://www.jstor.org/stable/4575142?seq=1#metadata_info_tab_contents.

implement in the correctional setting. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as population density in close confinement; insufficient ventilation; and shared toilet, shower, and eating environments. Shared spaces and equipment (such as telephones) are commonly not adequately disinfected, especially during the current pandemic when more frequent cleaning and disinfecting are required. Limits on alcohol-based hand sanitizer are also risks for spread. The nationwide shortage of personal protective equipment (PPE), as well as ancillary products (such as cleaning supplies and thermometer probes) further impacts the ability of correctional facilities to implement necessary precautions.[10] Based on declarations that I have been provided from prisoners Joseph Denbow and Sean Ragsdale, I understand that many of these challenges—particularly the inability to perform social distancing, the absence of alcohol-based hand sanitizer, and lack of necessary hygiene at shared spaces—are also present in the Maine Department of Corrections.

26. The risk of exposure to and transmission of infectious diseases, as well as the risk of harm from developing severe complications or death if infected, is significantly higher in jails, prisons, and detention centers than in the community.

27. Close, poorly ventilated living quarters and often overcrowded conditions in these facilities foster the rapid transmission of infectious diseases, particularly those transmitted by airborne droplets through sneezing, speaking, or coughing. In these congregate settings, large numbers of people are closely confined and forced to share living spaces, bathrooms,

[10] *Study of COVID-19 in Correctional Facilities*, Harvard University and National Commission on Correctional Health Care, April 9, 2020.

eating areas, and other enclosed spaces. Groups of persons are often moved from space to space, for example, from a dormitory to a cafeteria. Persons congregate and come in close contact while standing in lines for medication, commissary, fresh laundry, telephones, showers, or restroom use. These group movements, which may cluster large numbers of people together in small spaces, increase the risk of transmission. It is common for prisoners in a given housing unit to routinely be subjected to such group movements multiple times each day. They are physically unable to practice social distancing, which the CDC has identified as the "cornerstone of reducing transmission of respiratory diseases such as COVID-19."[11]

28. This forced congregation spreads infection from one area of a prison to other areas, too. In addition, prisons often rely on prisoners to perform work that supports the operation of the facility, such as food service, laundry, and cleaning. To perform these work assignments, they typically travel from their housing units to other parts of the facility. Officers and other facility staff routinely have direct physical contact with prisoners, especially when handcuffing or removing handcuffs from prisoners who are entering or exiting the facility. Staff members also move around within the facility, which creates opportunities for transmission both among staff in different parts of the facility and transmission to and from prisoners in different parts of the facility. This regular circulation makes the spread of infection throughout a prison all but inevitable.

29. While jails, prisons, and detention centers are often thought of as closed environments, this is not the case. Custody, medical, and other support staff and contractors enter and leave

[11] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last accessed May 14, 2020).

the facility throughout the day. Prisoners and inmates are often transferred between housing units, or into and out of isolation. This further increases the likelihood of transmission of COVID-19.

30. It has long been known that jails, prisons, and detention centers can be hotbeds of disease transmission. Due to the frequent ingress and egress of employees at these facilities, an outbreak within a jail, prison, or detention center can quickly spread to surrounding communities. For example, the tuberculosis epidemic that broke out in New York City in the early 1990s began in jails and was spread to the community by jail employees who became infected and then returned home to their families and communities.

31. As stated above, according to the CDC, up to 25 percent of people infected with COVID-19 will remain asymptomatic.[12] Similarly, infected individuals may experience only mild symptoms. These newly infected, asymptomatic, and mildly symptomatic individuals can, and do, transmit the virus, contributing to its rapid spread. As a result, such inadequate screening presents a critical problem. The possibility of asymptomatic transmission means that monitoring staff and incarcerated people for symptoms and fever is inadequate to identify all who may be infected and to prevent transmission.

32. It is my understanding that the Department of Corrections is testing only symptomatic prisoners as a method of prevention and identification of possible COVID-19 exposure and infections. The problem with testing only symptomatic prisoners is that there are likely many asymptomatic individuals, coupled with constant staff movement in and out of the facility. Without constant and widespread testing, potential sources of infection would be

[12] Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html (last accessed May 14, 2020).

very difficult to establish. Without constantly testing everyone to detect asymptomatic individuals, testing symptomatic prisoners alone is not a meaningful method of prevention.

33. Social distancing is the most effective method of preventing the spread of COVID-19. Current CDC recommendations for reducing the transmission of COVID-19 in prisons emphasize that "[a]lthough social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19."[13] Social distancing must be utilized conjointly with other practices, like testing, isolation, and quarantine, to achieve maximal efficacy in reducing transmission. If a facility is not practicing social distancing, CDC testing protocols are not sufficient to prevent the spread of the illness.

34. Ultimately, once confirmed cases of COVID-19 exist in a prison, like the Department of Corrections' facilities, the population density and inability to properly sanitize areas of dense congregation will result in widespread transmission of the disease inside of the facility and in the broader community through daily staff ingress and egress.

35. While every effort should be made to reduce exposure in correctional facilities through internal mitigation efforts, this may be extremely difficult to achieve and sustain quickly enough. Further, no mitigation effort can change the inherent nature of detention facilities, which force people to live in close proximity to one another. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons

[13] U.S. Centers for Disease Control and Prevention, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("Interim Guidance"), at 9-10, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last accessed May 14, 2020).

in prison as quickly as possible. Indeed, that is the only public health solution available at this time to reduce the spread of COVID-19 and potentially save lives.

36. Given the experience in China as well as the literature on infectious diseases in jail, additional outbreaks of COVID-19 among the U.S. jail and prison populations are highly likely. Releasing as many inmates as possible is important to protect the health of inmates, correctional facility staff, health care workers at jails and other detention facilities, and the community as a whole. Indeed, according to the WHO, "enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages."[14]

37. It is difficult to overstate the devastation that a COVID-19 outbreak could inflict on a correctional facility such as the Department of Corrections' facilities. For example, at Rikers Island jail in New York, between April 1 and April 15, 2020, the number of COVID-19 positive incarcerated individuals and staff members grew by 104 and 114 people, respectively, upping the jail's total numbers of confirmed cases to 288 among the incarcerated population, 488 among correction staff, and 78 among health care workers.[15,16] The first known case of COVID-19 at Rikers was confirmed on March 18,[17]

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[14] World Health Organization, Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention: Interim guidance (Mar. 15, 2020), http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf (last accessed May 14, 2020).

[15] Julia Craven, *Coronavirus Cases Are Spreading Rapidly on Rikers Island*, Slate (Apr. 2, 2020), https://slate.com/news-and-politics/2020/04/rikers-coronavirus-cases-increase.html (last accessed May 14, 2020).

[16] Jan Ranson, Jailed on a Minor Parole Violation, He Caught the Virus and Died, N.Y. Times (Apr. 10, 2020).

[17] New York Times, *As Testing Expands, Confirmed Cases of Coronavirus in N.Y.C. Near 2,000* (Mar. 18, 2020), https://www.nytimes.com/2020/03/18/nyregion/coronavirus-new-york-update.html (last accessed May 14, 2020).

illustrating just how quickly this disease can and will overwhelm detention facilities. Two Ohio prisons, Marion Correctional Institution and Pickaway Correctional Institution, have emerged as the largest-known sources of U.S. coronavirus infections, according to data compiled by The New York Times. To date 3,808 cases have been connected to the two prisons.[18] Over 80% of the approximately 2,500 prisoners in Marion tested positive.[19] In addition, 169 staff have tested positive for COVID-19.[20] Eight of the ten largest-known infections sources in the U.S. are jails or prisons.

38. At Ohio's Marion Correctional, close to 95% of those who tested positive were asymptomatic and would otherwise not have been tested.[21] This underscores the risk of the spread of COVID-19 by asymptomatic individuals.

39. If infected, prisoners are at greater risk for harm from COVID-19 than those in the general community. This is due to a number of factors including the fact that people in prisons have high rates of chronic illnesses, such as diabetes, heart disease, chronic lung disease, and immunosuppressive illnesses such as HIV that increase the risk from COVID-19; often have had poor or absent prior health care; and often have made unhealthy life-style choices, including alcohol and drug use. For these reasons, it is well accepted within the medical

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[18] New York Times, *Coronavirus in the U.S.: Latest Map and Case Count*, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?action=click&module=Top%20Stories&pgtype=Homepage&action=click&module=Spotlight&pgtype=Homepage#states (last accessed May 14, 2020).

[19] Ohio Department of Rehabilitation & Correction, COVID-19 Inmate Testing Updated May 7, 2020, https://coronavirus.ohio.gov/static/DRCCOVID-19Information.pdf (last accessed May 14, 2020).

[20] *Id*.

[21] Linda So & Grant Smith, In Four U.S. State Prisons, Nearly 3,300 Inmates Test Positive for Coronavirus -- 96% Without Symptoms, New York Times (April 25, 2020), https://www.nytimes.com/reuters/2020/04/25/us/25reuters-health-coronavirus-prisons-testing-insight.html?searchResultPosition=8 (last accessed May 14, 2020).

community that jail inmates are physiologically 10 years older than their chronological age. The CDC has identified the people with the following illnesses as being particularly vulnerable to severe illness for COVID-19:

- Diabetes mellitus
- Lung disease including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
- Heart disease
- Blood disorders (e.g., sickle cell disease or on blood thinners)
- Chronic kidney disease
- Chronic liver disease
- Compromised immune system (immunosuppression)
- Current or recent pregnancy in the last two weeks
- Endocrine disorders
- Metabolic disorders
- Neurological and neurologic and neurodevelopment conditions [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury][22]
- Severe obesity[23]

The CDC also deems people 65 or older to be particularly vulnerable to COVID-19. However, in my professional opinion the proper figure for jail inmates is no older than 55 years old.

40. Based on these understandings, it is my opinion that the exponential infection of rate for COVID-19 we already see in the community would be magnified within the Department of Corrections' facilities. Adequate social distancing would be impossible to achieve. What's more, infection in the Department of Corrections' facilities would not stay limited

[22] U.S. Centers for Disease Control and Prevention, *Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission*, https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf (last accessed May 14, 2020).
[23] U.S. Centers for Disease Control and Prevention, *Groups at Higher Risk for Severe Illness*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html#severe-obesity (last accessed May 14, 2020).

to those facilities, but would worsen infection rates in the broader community. The infection rate will increase substantially before it starts to diminish without major interventions.

Conclusions

41. For the reasons above, it is my professional opinion that persons currently detained at the Department of Corrections' facilities are at significantly greater risk of contracting COVID-19 than if they were permitted to shelter in place in their home communities. If infected, many are at increased risk of suffering severe complications and outcomes particularly given the underlying health conditions of many people in correctional settings as well as the constrained provision of health care within facilities during the pandemic.

42. It is my professional opinion that conditions in the Department of Corrections' facilities threaten the health and safety of every individual within those facilities—prisoners and staff alike—and in their surrounding communities.

43. It is my professional opinion that a necessary component of bringing the Department of Corrections' facilities into compliance with the recommendations of the CDC to minimize the risk of COVID-19 transmission within the facility and to the larger community is to substantially reduce the population. Doing so will allow the facility to significantly reduce the risk of infection for both incarcerated people and correctional officers, which in turn protects the communities where corrections staff live.

44. It is my professional opinion that those who are medically vulnerable[24] need to be moved out of the Department of Corrections' facilities to the absolute maximum extent possible.

[24] E.g., persons held at the Department of Corrections' facilities over the age of 55, as well as all current and future persons held at the facilities of any age who experience (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as

In addition, the overall population needs to be significantly lowered to reduce the density in the prisons to allow for adequate social distancing, minimize the strain on the jail's medical care system, ensure adequate space is available for necessary quarantining.

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

Executed this 14th of May, 2020

/s/ Joseph Goldenson
Joseph Goldenson, M.D.

congenital heart disease, congestive heart failure and coronary artery disease, or other chronic conditions associated with impaired heart function; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; and/or (l) a current or recent (last two weeks) pregnancy.