Exhibit 2

Declaration of Dr. Jaimie Meyer

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Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I am being paid $200 per hour for my time reviewing materials and preparing this report.

6. I have not testified as an expert at trial or by deposition in the past four years.

7. In addition to my knowledge, training, education, and experience in the field of prison healthcare and infectious diseases, and the resources relied upon by experts in infectious

diseases and prison health, I also reviewed specifically the Centers for Disease Control and Prevention (CDC) guidance on management of COVID-19 in correctional facilities (available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html), the Bureau of Prisons (BOP) modified operations plan (available at https://www.bop.gov/coronavirus/covid19_status.jsp), the National Commission on Correctional Health Care (NCCHC) materials on COVID-19 (available at https://www.ncchc.org/COVID-Resources), and the World Health Organization interim guidance on Preparedness, prevention and control of COVID-19 in prisons and other places of detention (available at http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1).

II. Heightened Risk of Epidemics in Prisons

8. The risk posed by infectious diseases in prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

9. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover in prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

10. Reduced prevention opportunities: Congregate settings in prisons allows for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

11. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff. If

solitary confinement is the facility's response to COVID-19 cases, people who are ill will be deterred from reporting their symptoms, resulting in their increased risk of severe disease and death and ongoing spread to others.

12. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

13. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

14. Increased susceptibility: People incarcerated in prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

15. Prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

16. Prisons lack access to vital community resources to diagnose and manage infectious diseases. Prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

[1] *Active case finding for communicable diseases in prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

17. Prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

18. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

19. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

20. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[4]

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[2] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

[3] David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/.

[4] This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections.

21. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be available for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

22. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

23. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

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[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.

[6] *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States,* February 12–March 16, 2020. MMWR Morb Mortal Wkly Rep 2020;69:343-346. DOI: http://dx.doi.org/10.15585/mmwr.mm6912e2external icon; *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

24. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

25. The time to act is now. Data from other settings demonstrate what happens when detention centers, jails and prisons are unprepared for COVID-19. Recent outbreaks of COVID-19 in jails and detention facilities in New York and New Jersey demonstrate how easily the virus enters facilities and rapidly spreads to detainees and staff when community epidemics are widespread, even when the best possible infection preparedness plans are in place.

IV. Risk of COVID-19 in the South Carolina Department of Corrections ("SCDC")

26. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the institutions run by the SCDC: (1) the report by Tom Roth entitled *Security Staffing Assessment: South Carolina Department of Corrections* (March 2018); (2) *A Limited Review of the S.C. Department of Corrections* by the South Carolina General Assembly Audit Council (August 2019) (https://lac.sc.gov/reports/reports-agency-a-k/scdc-2019) ("Audit Report"); (3) the South Carolina Department of Corrections (SCDC) COVID-19 Action Plan (http://www.doc.sc.gov/) ("SCDC Action Plan"); (4) *Interim Guidance for COVID-19 for Correctional Facilities*, South Carolina Department of Health and Environmental Control (March 24, 2020); (5) the declaration of Shirene Hansotia Re: Allen Slaughter, Brandon Moore and Herbert Palmer; and (6) the declaration of Patrick Nelson Brooks Re: Jeanne Voltz-Loomis, Denise Edgar, Brison Akeem Allison, Gary Zachariah Thomas, and Gary Opel Stanley.

27. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

28. To prevent a widespread COVID-19 outbreak within a facility, it is critical to identify inmates and staff who are ill and medically isolate them or exclude them from work, respectively. Although some symptoms are "typical" for COVID-19, testing is needed to definitively diagnose infection. As of April 17, 2020, the SCDC has reported that 32 staff have tested positive for COVID-19. This is the tip of the iceberg and there are likely many more prison employees and inmates who are already infected because the average infected individual transmits the virus to at least 2-3 other individuals and even before symptoms develop. In addition, community spread in the state is rapidly rising, with

4,246 confirmed cases and 119 deaths as of April 18, 2020, according to the South Carolina Department of Health and Environmental Control. The SCDC website currently reports zero positive cases of COVID-19 in inmates and the SCDC chief medical officer stated on April 10, 2020 that a total of 15 inmates had been tested.[8] Rather than being reassuring, this zero case rate likely reflects that the SCDC is not testing inmates in any meaningful way. Given the fact that the SCDC houses approximately 19,000 inmates across 21 facilities, such a small number of executed tests is functionally meaningless.

29. Once staff are diagnosed with COVID-19, they need to be excluded from work. SCDC's interim guidance for staff to stay home if ill for 24 hours after symptoms resolve is entirely inconsistent with CDC guidance that home isolation should only be discontinued once 1) at least 7 days have passed from symptoms onset *and* 2) at least 3 days have passed without fever and without the need for fever-reducing medications *and* 3) respiratory symptoms are resolving. In some correctional settings, repeat testing dictates return to work and employees are only allowed to return once repeat COVID-19 testing is negative. It can take as long as 4-6 weeks after symptoms resolve to obtain negative repeat testing. If staff with COVID-19 infection return to work too early, they will likely transmit the virus to others. Inadequate screening, testing, and isolation procedures will contribute to widespread COVID-19 transmission in SCDC facilities as in other prisons, in what some have called "a tinderbox scenario."

30. Per CDC guidance, infection prevention and control in correctional settings requires detailed plans for personnel, including screening on entry, detailed sick leave policies, plans for absenteeism, and revised duties. Adequate personnel plans are needed because, during a community-wide and facility-wide outbreak in which staff experience personal or family illness, staffing will be strained. Staffing will be impossible in systems that are overtaxed at baseline. Such is the case in SCDC where severe understaffing has been well documented. The Roth Report found that half of the 13 institutions reviewed were operating with fewer than 50% of needed security personnel and not one of the institutions was operating at higher than 62%. The Audit Report found a 27.5% vacancy rate of frontline staff (with direct inmate contact) across all 21 SCDC institutions for 2017-18. The Audit Report also found that 72.4% of all SCDC corrections officers had less than 3 years' experience including over half with less than one year of experience. This chronic and severe problem resulted in SCDC issuing an emergency notice on March 26, 2020 that it was 900 officers short of anticipated staffing needs during the COVID-19 pandemic.[9] This is a strong signal that SCDC is ill-prepared to handle this public health crisis. Inadequate staffing threatens the safety, security, and health of all individuals who reside and work in SCDC facilities.

31. Prisons are meant to contain people, not infections. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak,

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[8] *See* Gregory Yee Gyee, *How SC authorities are working to protect inmates from coronavirus,* The Post and Courier (April 10, 2020).

[9] *See* Stephen Hobbs, *SC prisons seek emergency help to hire officers amid coronavirus, high unemployment,* The Post and Courier (Apr. 2, 2020).

making it especially difficult for the facilities to contain any infections and to treat those who are infected. The lack of staff within SCDC results in regular program and treatment services being delayed and curtailed. The Roth Report details that outside medical appointments are routinely rescheduled or cancelled due to limited transport security personnel. It is also unclear whether SCDC facilities have adequate capacity of infirmary beds to care for COVID-19 patients. The Roth report details multiple facilities with infirmaries that were not operational or, if open, were already full of patients with other health conditions. This suggests that health systems within SCDC facilities will quickly become overwhelmed during a widespread facility outbreak with multiple COVID-19 patients, resulting in complications and preventable deaths.

32. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

33. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

34. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

35. Because SARS-CoV-2, the virus that causes COVID-19, is carried on droplets, social distancing is needed to prevent person-to-person spread. Social distancing is challenging if not impossible in many prisons, which are inherently congregate settings. SCDC houses the general population of inmates in dormitories or cells. The cells typically house two or three inmates and contain a toilet and wash basin. Showers are generally in a shared space. In one facility (Tyger River), over 100 inmates are housed in "dry" cells which do not contain a toilet or wash basin. Inmates in that facility must use a shared common area to access toilets, wash basins and showers. Several SCDC facilities also utilize dormitory-style housing where inmates sleep in an open-air environment in close proximity to all others in the unit. These housing arrangements will make distancing impossible and contribute to widespread infection once a single inmate becomes ill.

36. Beyond housing, social distancing is needed in all common spaces as per CDC guidance. The SCDC Action Plan states that the Agency will implement modified operations to maximize social distancing and limit group gatherings "depending on the facility's population and physical layout." However, given the physical layout and housing in the SCDC institutions and the severe staffing shortage, it is virtually impossible for proper social distancing to be maintained. Similarly, implementation of proper hygiene and

cleaning/disinfecting procedures is extremely difficult given the layout and understaffing. Ms. Hansotia's declaration on Mr. Slaughter describes that housing unit leaders "often run out of cleaning supplies, leaving the men vulnerable in the meantime." Ms. Hansotia's declaration on Mr. Palmer describes "there is no hand sanitizer available anywhere on the yard and no bleach or cleaning supplies had been provided." These issues coalesce to exacerbate COVID-19 transmission and will likely result in a widespread outbreak. The provision of a cloth mask to all inmates is contrary to CDC guidance and insufficient to overcome the social distancing problem in SCDC facilities.

V. Conclusion and Recommendations

37. For the reasons above, it is my professional judgment that individuals placed in SCDC's institutions are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and death.

38. Reducing the size of the population in jails and prisons is crucial to reducing the level of risk both for those within those facilities and for the community at large.

39. As such, from a public health perspective, it is my strong opinion that individuals in SCDC institutions should be evaluated for release.

40. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes, mental health conditions) or older age. They are in even greater danger in these facilities, including a meaningfully higher risk of death. While the CDC suggests age >65 portends highest risk for COVID-19 severity and death, emerging data suggests even age >50 is a risk factor for COVID-19 severity and death.

41. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Given that 32 SCDC staff have already tested positive for COVID-19, a widespread outbreak is likely imminent.

42. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

April 18, 2020
New Haven, Connecticut

Dr. Jaimie Meyer