Exhibit 12

Declaration of Dr. Marc Stern

DECLARATION OF MARC STERN, M.D.

I, Marc Stern, declare as follows:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. On a regular basis, I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts. My prior experience includes working with the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails. Through 2013, I taught the National Commission on Correctional Health Care's (NCCHC) correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course. I currently also serve as the COVID-19 expert resource to the National Sheriffs Association and the Washington Association of Sheriffs and Police Chiefs. In the past four years alone, I have been qualified as an expert in several jurisdictions on correctional health care systems and conditions of confinement. Attached as Exhibit A is a copy of my curriculum vitae.

2. I am not receiving payment in exchange for providing this declaration. In light of the emergency conditions occurring in prisons across the country, I am providing my services *pro bono*.

3. COVID-19 is a serious disease and has reached pandemic status. As of April 16, 2020, 1,991,562 people worldwide have confirmed diagnoses, including 604,070 people in the

United States, which is now the epicenter of the crisis. Worldwide, 130,885 people have died after contracting COVID-19, including 25,871 in the United States.[1] In South Carolina, 3,656 people have confirmed diagnoses. 107 South Carolinians have died of COVID-19.[2] These numbers will continue to increase. Moreover, the numbers for the United States currently must be considered in light of nationwide shortages of COVID-19 tests, thus the actual numbers are likely significantly higher than those reported.

4. The South Carolina Department of Corrections ("SCDC") reports that so far 29 employees have COVID-19.[3] The SCDC reports that zero residents have COVID-19, however, given the prevalence of the infection among staff, it is likely that this number reflects incomplete testing rather than the absence of infection.

5. COVID-19 is a novel respiratory virus. It is spread primarily through droplets generated when an infected person coughs or sneezes, or through droplets of saliva or discharge from the nose. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has prior immunity. The only way to control the virus is to use preventive strategies, including social distancing.

6. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that. It is believed that people can transmit the virus without being symptomatic and, indeed, that a significant amount of transmission may be from people who are infected but asymptomatic or pre-symptomatic.

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[1] Coronavirus (COVID-19) (last visited Apr. 15, 2020), https://who.sprinklr.com/.
[2] South Carolina Announces Latest COVID-19 Update (April 15, 2020), South Carolina Department of Health and Environmental Control (last visited Apr. 15, 2020), https://www.scdhec.gov/index.php/news-releases/south-carolina-announces-latest-covid-19-update-april-15-2020.
[3] COVID-19 Information, South Carolina Department of Corrections (last visited Apr. 15, 2020), http://www.doc.sc.gov/covid.html.

7. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

8. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure. In the absence of a vaccine and a cure, a significant number of people who are infected with the virus will die. To the extent that the health care infrastructure is overloaded, people will die unnecessarily because necessary respirators and hospital facilities are unavailable.

9. Controlling the spread of the virus by limiting person-to-person contact is critical to saving lives. This is very challenging in prisons, because they are congregate environments, i.e. places where people live and sleep in close proximity. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in this environment. To the extent that incarcerated people are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, infectious diseases that are transmitted via the air or touch (like COVID-19) are more likely to spread, placing people at risk. This is especially true when large numbers of people are housed in open dormitories rather than one or two-person cells. This is a condition which Plaintiffs' counsel represents to me exists in several prison facilities in South Carolina. For these reasons, when COVID-19 is introduced into a prison, the risks of spread is greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in three other congregate environments: nursing homes, cruise ships, and aircraft carriers, where a high percentage of sailors aboard the USS Theodore Roosevelt have tested positive for the virus, including one who recently died.

10. In addition to the increased risk from COVID-19 to *any* individual in the prisons, there is an especially increased risk of harm to the elderly and people with certain underlying health conditions. They are not only more likely to become seriously ill, but also, therefore, more likely to require transport to a community hospital.

11. SCDC already has reported 29 confirmed cases of COVID-19 amongst staff in the prisons, indicating that the infection is almost certainly in some facilities and is likely to spread and underscoring the need to take swift and robust action to reduce risks. In addition, prisons house a higher percentage than the community of people with underlying health conditions that put them at increased risk of serious complications (including death) from COVID-19. Therefore, based on the increased concentration of people with high risk of complications, including death, from COVID-19, **incarcerated people in South Carolina prisons are at an extraordinary risk of dying from the COVID-19 virus.**

12. I have reviewed the SCDC's COVID-19 Action Plan[4] and the Interim Guidance for COVID-19 for Correctional Facilities issued by the South Carolina Department of Health and Environmental Control ("SCDHEC")[5] listing the precautions they report to have implemented in the prisons. Even if fully implemented as described, these steps reduce, but do not eliminate significant risk compared to risk in the community.

13. For these reasons, I recommend giving immediate consideration to downsizing the population of these prisons, taking into account the totality of the risk to public safety, a risk which includes criminal justice-related risks as well as public health-related risks. Priority should be given to those at high risk of harm due to their age and health status. **To be effective in reducing the spread of the virus, these downsizing measures must occur as soon as possible.**

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[4] South Carolina Department of Corrections COVID-19 Action Plan (last visited Apr. 15, 2020), http://www.doc.sc.gov/scdc_covid-19_action_plan_031620.pdf.

[5] Interim Guidance for COVID-19 for Correctional Facilities, South Carolina Department of Health and Environmental Control (last visited Apr. 15, 2020), https://www.scdhec.gov/sites/default/files/media/document/Correctional-Facilities-Guidance-03-24-20.pdf.

14. There are two values to immediate downsizing. First, downsizing will reduce the density of congregation. This will allow people in prison to maintain better social distancing. The reduction in population will also make it easier for prison authorities to implement infection prevention measures such as: provision of cleaning supplies to residents; frequent laundering of towels and clothes; provision of soap for handwashing; frequent cleaning of transactional surfaces; frequent showers; etc. The reduction in population while implementing these enhanced measures helps prevent overloading the work of prison staff such that they can continue to ensure the safety of incarcerated people. For those people housed in dormitories, reducing the density will enable people to live in group settings with sufficient space to maintain six feet of distance from others. All these steps can help slow the spread of infection, to the benefit of residents and staff and, ultimately, the community at large.

15. Second, immediate downsizing that prioritizes residents who are elderly and those with underlying health conditions reduces the likelihood they will contract the disease. Individuals in these groups are at the highest risk of severe complications from COVID-19 and when they develop severe complications they will be transported to community hospitals. Prisons are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a state prison slows the rate at which people, if not reduces, the number of people, who will become ill enough to require hospitalization where they will be using scarce community resources (ER beds, general hospital beds, ICU beds) which also in turn reduces the health and economic burden to the local community at large.

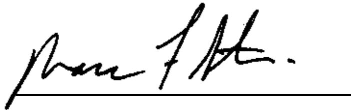
16. In addition to recommending immediate consideration of downsizing, I also recommend that the prisons begin planning now to downsize further as conditions change. The change in conditions we need to anticipate is reduction in workforce (custody and health care staff) as workers respond to their personal needs (self-quarantine or isolation, caring for ill relatives, staying home with school-age children). Insufficient custody staffing poses an obvious risk to the safety of the institution. Insufficient health care staffing poses an obvious risk to the health of residents.

17. The risks to which incarcerated people at the 21 SCDC prisons are exposed stem from the congregate nature of their living environment and, for the elderly and chronically ill, from their medical histories. Thus, incarcerated people living in these prisons are at substantial risk of illness and death.

18. Thus, in summary, immediately considering reducing the number of individuals imprisoned in the 21 SCDC Prisons, with plans made for further reductions as staffing levels change, is necessary for the health and safety of the prisons and our communities.

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

Executed this 16th day in April, 2020 in Tumwater, Washington.



Marc F. Stern, MD, MPH