

FILED  
SUPREME COURT  
STATE OF WASHINGTON  
3/25/2020 8:00 AM  
BY SUSAN L. CARLSON  
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No. \_\_\_\_\_

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**SUPREME COURT OF THE STATE OF WASHINGTON**

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SHYANNE COLVIN, SHANELL DUNCAN, TERRY KILL, LEONDIS  
BERRY, and THEODORE ROOSEVELT RHONE,

*Petitioners,*

v.

JAY INSLEE, Governor of the State of Washington, and STEPHEN  
SINCLAIR, Secretary of the Washington State Department of Corrections,

*Respondents.*

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**DECLARATION OF FREDERICK L. ALTICE, M.D.**

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I, Frederick L. Altice, declare under penalty of perjury under the laws of the State of Washington that the contents of this declaration are true and correct.

1. I am a professor of Medicine (Infectious Diseases), Epidemiology (Microbial Diseases), and Public Health, and a clinician, clinical epidemiologist, intervention and implementation researcher at Yale University School of Medicine and School of Public Health.

2. I received a B.A. degree from Texas A&M in 1982, an M.A. from Universidad de Santiago de Compostela, Spain in 1982, and an M.D. from Emory University in 1986. I completed my residency in internal medicine (1989) and fellowship in infectious diseases (1992) at Yale University.

3. I am a Board-certified internist, specializing in infectious diseases. My primary research focuses on interventions and implementation science at the interface between infectious diseases and addiction, and I have conducted research in several global health settings.

4. I have extensive experience working with vulnerable populations and their exposure to infectious diseases, including people in jails and prisons, and those otherwise involved with the criminal justice system. I also have developed programs that link HIV-infected inmates to community health care when they leave prison.

5. For the past 29 years, I have been the Director of the HIV in Prisons Program at Yale University School of Medicine, which consults with the Connecticut Department of Correction and treats inmates with HIV, viral hepatitis, tuberculosis and other infectious diseases. This program conducts research and provides expert consultation for criminal justice systems in over 30 countries world-wide.

6. I am a board member of the Health in Prisons Program for the World Health Organization and a member of the Health in Prisons Program for the United Nations. We develop and write guidance for healthcare delivery systems in prisons globally. Additionally, I have the highest number of publications in the world related to infectious diseases in prisons, including in high impact journals such as Lancet.

7. As a clinical epidemiologist, health services and intervention researcher, I have created novel programs for the treatment of HIV, HCV, and tuberculosis, including for people who inject drugs in HIV clinical, addiction treatment and community and correctional settings.

8. I have several current research projects involving infectious diseases and their impacts on people currently or formerly in prison, including (a) two randomized, placebo-controlled trials for people with HIV in prison and transitioning to the community; (b) a randomized controlled trial of methadone maintenance and Holistic Health Recovery

Project among people in prison who are HIV-positive; (c) a randomized controlled trial of directly administered antiretroviral therapy among people who are HIV-positive and transitioning to the community; (d) a project targeting expansion of medications to treat opioid use disorder as HIV prevention for people released from prison who are at risk for HIV/AIDS; (e) implementation science projects to expand HIV prevention and treatment in 6 countries; and (f) scaling up addiction treatment programs in jails and prisons in five states to coordinate a more effective strategy to address the related the HIV and opioid epidemics.

9. I have provided expert opinion in a number of legal cases, including serving as the plaintiffs' lead expert in *Henderson v. Thomas*, 913 F. Supp.2d 1267 (M.D. Ala. 2012) (addressing discrimination against Alabama prisoners based on their HIV status) and *Tribble v. Greene*, No. 2013 CA 003237 B (D.C. Super. Ct, 2016) (awarding damages for wrongfully convicted man who suffered serious medical conditions while incarcerated). I have also been a court-appointed monitor in several cases including *Doe v Meachum*, Civ. No. H-88-562 (PCD) (class action suit addressing the delivery of HIV prevention and treatment in Connecticut).

10. COVID-19 is a novel coronavirus. It is a highly infectious disease that spreads from person-to-person and is a serious national and global public health risk. It is 10-times more deadly than the common flu

(Influenza A). Unlike Influenza A and other flu-like viral infections, COVID-19 can be infectious 24-48 hours before symptoms develop, making transmission possible before we are able to self-quarantine. All 50 states have reported cases of COVID-19 to the CDC. I am aware that, as of March 22, 2020, there have been almost 1,800 reported cases in Washington State alone, with 94 confirmed deaths. Within the United States, 15,219 total cases of COVID-19 have been reported, with 201 fatalities attributed to the virus as of March 20, 2020.

11. Older adults – those over 50 years of age – and people with serious underlying medical conditions such as heart disease, HIV, diabetes, lung disease, and other respiratory maladies are at a substantially higher risk of developing severe illness, including hospitalization, intensive care needs and death, from contraction of the COVID-19 virus. Approximately 66% of individuals who have contracted COVID-19 in the United States were over 45 years old; nearly half (48%) were 55 years of age and older.

12. The illness can quickly progress from basic symptoms like cough, congestion and fever to more life-threatening symptoms as the virus spreads into the lungs and other organs. COVID-19 can cause serious and permanent damage to the lungs and can affect other organs as well. In the most severe cases, COVID-19 can be deadly. While it can be

difficult to report death rates with total accuracy, initial global estimates of death rates were 3.5% in China; 0.8% in China, excluding Hubei Province; 4.2% overall among a group of 82 countries, territories, and areas; and 1.7% thus far in the U.S.

13. Transmission of COVID-19 is thought to occur mainly from person-to-person; specifically, between those who are in close contact with each other and become exposed when an infected person coughs or sneezes, passing the virus through respiratory droplets. These droplets may travel as far as 6 feet and land on surfaces where the virus can live for several days if not sanitized. Moreover, transmission of the virus can occur when a person comes into contact with surfaces or objects that contain the virus. COVID-19 can remain in the air and on surfaces for several hours to several days, respectively. Consequently, the virus is more likely to spread rapidly in congregate settings, like nursing homes, cruise ships, homeless shelters, schools, and workplaces.

14. Prisons and jails are congregate settings that are particularly susceptible to the spread of infectious diseases like COVID-19. For example, other infectious diseases, such as HIV, Hepatitis B and C virus, and tuberculosis are substantially concentrated in prisons and jails relative to the community-at-large and have resulted in impressive outbreaks. Of the 10.5 million people incarcerated annually in the U.S.,

approximately 4% have HIV, 15% have hepatitis C, and 3% have active tuberculosis. These prevalences are far higher than found in the general population.

15. Spread of infectious diseases is a serious problem within prisons worldwide. In addition to HIV, viral hepatitis and tuberculosis, we have previously experienced endemic outbreaks of strains of staphylococcus aureus bacteria that are resistant to methicillin (MRSA), which occurs in crowded, congregate settings. Prisons are dense facilities with generally poor and unsanitary conditions. Due to overcrowding, people in prison are in close proximity to one another on a constant basis. High density of people exists within common areas and dining areas. Cells are generally small areas that people in prison must share with one or multiple other individuals. Due to overcrowding, people in prison are often housed in dormitory settings. Furthermore, people in prison often must share showers, toilets and urinals, and sinks with hundreds of other people in prison on a regular basis.

16. It is almost inevitable that COVID-19 will enter prisons. Prisons are porous, congregate settings where a number of people enter and exit regularly. The dynamics of 10.5 million people entering and leaving jails and prisons annually alongside the 2.2 million people who are housed there on a daily basis make these settings especially vulnerable.

Entry and exit of massive numbers of correctional and medical staff who enter and leave prisons three shifts per day increases the likelihood of a COVID-19 outbreak. Settings like these are a formula for disaster for spread of COVID-19. Social distancing is absolutely necessary to reducing the spread of the virus to prevent a public health crisis; however, this can be nearly impossible in prison without swift action now. At almost any given time, people in prison are always within a couple feet of other people in prison, increasing the likelihood that infected persons will quickly spread the virus to other people in prison and correctional staff.

17. Prisons are poorly equipped to handle COVID-19 when it makes its way into prisons. Outbreaks of tuberculosis in prisons, a bacterial infection that is much less infectious relative to COVID-19, has proven hazardous and in some cases deadly in prisons due to lack of ability to efficiently diagnosis, isolate and treat people in prison. COVID-19 differs substantially from tuberculosis due to its higher prevalence in the community, its more efficient mode of transmission, the ability to rapidly isolate people with or at risk for COVID-19, and the increased likelihood that correctional officers and staff will be at substantially higher risk for COVID-19 than for TB.

18. Many of the people in prison who contract the virus – particularly those who are most vulnerable to exposure to COVID-19 –



will need to be transported to community hospitals and likely to intensive care units (ICU) beds at high rates as prisons do not have the adequate facilities or equipment to treat seriously ill patients. Most prison health care systems are more akin to outpatient health care clinics. They do not have the necessary level of emergency medical equipment, personal protective equipment and other necessary supplies to treat those in respiratory distress. Community health systems are likewise not prepared to handle this influx of patients from prisons and this influx could be substantial, as we have seen from skilled nursing facilities, should an outbreak start.

19. Social distancing, the practice of increasing the physical space between people to avoid spreading illness, is among the most important measures that can be taken to curb the spread of a highly infectious and contagious disease like COVID-19. Staying at least six feet away from other people lessens your chances of catching or transmitting COVID-19 to others. This strategy, however, cannot be effectively accomplished in a prison setting.

20. COVID-19 has created an extraordinary public health emergency, which will require an extraordinary response now to prevent widespread fatalities in prisons and the community. As such, urgent and drastic action is required to immediately reduce the prison population.

Reducing the prison population immediately is the primary way to achieve recommended social distancing within those facilities. This, in turn, will reduce exposure to COVID-19 prisoners and the staff who work there and the need for providing life-saving medical care.

21. As an immediate first step, prisons should prioritize immediately releasing patients most at-risk of harm from COVID-19, specifically older individuals and those with health risks that would increase their likelihood of an adverse medical consequence. Not only would this strategy immediately reduce the risk of spread of the disease to other people in prison and staff alike, but would have the greatest impact on reducing transmission to those at the highest risk for hospitalization, intensive care use utilization and death, and consequently reduce further burden to the already substantial amount of community resources should they fall ill.

22. Releasing people in prison now will reduce prison density and thus the likelihood that infected people in prison will expose other people in prison to the virus. As an added social distancing precaution, prisons should also consider further reducing total population density by releasing other younger individuals in prison who may not experience substantially elevated risk for morbidity or mortality from complications from COVID-19, especially considering more recent reports showing that

many COVID-19 carriers are asymptomatic, especially those who are younger with intact immune systems. This will provide added social distancing and further reduce the public health risk that prisons pose to fellow people in prison, custodial staff, and the community in light of the COVID-19 crisis. Decisions about who to release among this population at elevated, but lower risk, should balance the benefits between public health (i.e., blunting the volatile COVID-19 epidemic) and public safety risk (i.e., risk for criminal harms) these individuals pose when returned to the community.

23. The U.S. healthcare system is poorly equipped to handle a widespread outbreak of COVID-19. For reasons stated, utilizing Influenza A preparedness strategies is likely to fail. A burden on hospital beds already exists. Prisons could significantly contribute to the stresses on currently inadequate health care resources. Furthermore, prisons are often located in rural or outlying areas, where access to healthcare facilities and hospitals with appropriate levels of equipment and staff are already scarce. These hospitals are also least likely to be prepared for managing patients with COVID-19, especially those who must have custodial supervision at their bedside.

24. Additionally, prisons, absent reduction of the population, are not equipped to address a COVID-19 outbreak. Internally, they lack

essential health care equipment needed to treat infected patients, such as sufficient numbers of isolation rooms and ventilators, which seldom, if ever, exist in prisons. Even on a more basic level, prisons lack the capacity to treat an outbreak. For example, they do not possess personal protective equipment for staff and other people in prison that is necessary to protect themselves from transmission of the virus. This staff rotates through the prison typically on 8-hour shifts and return to families, many of whom are susceptible to adverse health outcomes if infected with COVID-19.

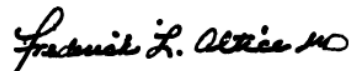
25. Other methods for addressing a highly infectious disease like COVID-19 in prisons, aside from a vaccine that we do not expect to be available for another 12 to 18 months, will not be successful for containing the virus in any meaningful way. For instance, isolating people once they are screened has already proven futile in other settings; notably, the quarantining of individuals on cruise ships. In my opinion, efforts to isolate people in prison will likely fare far worse than cruise ship isolation efforts. Cruise ship efforts included taking measures like restricting people to their cabins and having helicopters available to drop off test kits. Restricting people in prison to their living units will not contain the virus because many prisoners live in dormitory-style housing and they share many common public spaces showers, meals and restrooms. Providing massive testing in prison, as was done on cruise ships, has many logistical

challenges in prisons and is a luxury that will not be afforded to most people in prison.

26. Release from prison is a necessary strategy for increasing social distancing and reducing the risk of a fatal outbreak of COVID-19. It needs to be done thoughtfully, however, by balancing public health and public safety. People released from prison must have a safe place to go for an extended period of time upon release. Social distancing will need to continue while they are in the community as well and steps will have to be taken to ensure that can occur. Prisons will need to educate those being released as to these best practices and plan for how resources can be provided to assist this population to remain in safe settings where social distancing can happen.

27. With Washington State being one of the national epicenters of the COVID-19 pandemic, its response is going to serve as a test case for how the country addresses widespread outbreak of this infectious disease. If the DOC takes bold action and thoughtfully incorporates into their response plan the exceptional but necessary public health recommendation to reduce the prison population, many lives can be saved.

DATED this 22<sup>nd</sup> day of March 2020 in New Haven, Connecticut.



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Frederick L. Altice, M.D.

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March 24, 2020 - 7:13 PM

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Declaration in Support of Petition for Mandamus

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