# 22-244

## 22-652

IN THE

## UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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MICHAEL MILCHIN AND KENNETH PELLETIER,
*Petitioners-Appellants*,

KEVIN DIMARTINO, STEVEN PAGARTAINIS, JOHN NATERA AND EUGENE CASTELLE,
*Petitioners*,

v.

ACTING WARDEN JESSICA SAGE,
*Respondent-Appellee,*

D. EASTER, WARDEN FCI DANBURY, ACTING WARDEN OF FCI DANBURY, AND CURRENT CURRENT UNKNOWN,
*Respondents*

On Appeal from the U.S. District Court
for the District of Connecticut, No. 21-cv0498

**JAMES WHITTED'S MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PETITIONERS-APPELLANTS MICHAEL MILCHIN, ET AL AND IN SUPPORT OF REVERSAL OF THE DISTRICT COURT'S ORDER OF DISMISSAL**

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*Attorneys for Amicus Curiae James Whitted*

Pursuant to Federal Rule of Appellate Procedure 29(a)(3) and Local Rule 29.1, James Whitted respectfully moves this Court for leave to file the attached Brief of Amicus Curiae in support of petitioners in this appeal. In support of this Motion, Mr. Whitted states as follows:

1. Petitioners have consented to the filing of the attached brief. Respondent's counsel has advised that respondent takes no position with regards to the relief sought in this motion.

2. *Amicus Curiae* James Whitted was the named Petitioner in *Whitted v. Easter*, 3:20-cv-00569 (MPS) (D. Conn.). For more than a year, *Amicus* litigated that class action habeas case and worked to enforce the resulting Settlement Agreement, which provided expedited consideration for home confinement for people incarcerated at FCI Danbury who were at increased risk of severe illness from COVID-19. In the District Court in the present case, respondent cited the Settlement Agreement in *Whitted v. Easter* as a basis for dismissing the petition. AA 35-37. *Amicus* is interested in ensuring that the Settlement Agreement is properly interpreted and not inappropriately broadened to preclude actions that the parties and the court did not intend it to cover.

3. The petition, pursued by petitioners pro se in the District Court, alleges that prison officials at FCI Danbury were deliberately indifferent to petitioners' serious medical needs in violation of the Eighth Amendment. *Amicus*,

who struggled himself to access urgently-needed medical care at FCI Danbury and is familiar with the difficulties of securing legal assistance, has an interest in ensuring that pro se pleadings are liberally construed and that individuals in prison can access courts to enforce their constitutional right to adequate medical care. As the named petitioner for the class in *Whitted v. Easter*, *Amicus* also has an interest in sharing information he and his counsel learned in the course of litigating that case about the problems of access to medical care at FCI Danbury.

4. *Amicus* therefore seeks leave to submit the attached brief to provide important information relevant to the issues before the Court. Because of his role as named petitioner in the *Whitted* case, *Amicus* has a unique perspective to provide on the scope of the Settlement Agreement should respondent assert to this Court that the Agreement provides a basis for affirming the District Court's dismissal of the petition. In addition, in this case, the District Court dismissed the petition based on a narrow reading of pro se pleadings. *Amicus* and his counsel have information to share with this Court—relevant to the need to liberally construe pro se pleadings—about the difficulties that people incarcerated at FCI Danbury have in conducting legal research and in securing the assistance of counsel to challenge conditions of confinement. Finally, information learned by *Amicus* and his counsel about the systemic failures of the medical department at

FCI Danbury are relevant to the importance of allowing petitioners' claims of inadequate medical care at the facility to proceed.

5. For these reasons, and those more fully expressed in his brief, James Whitted respectfully requests leave to file its amicus curiae brief in support of petitioners.

July 18, 2022

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

1. The foregoing motion complies with the type-volume limitation of FED. R. APP. P. 27(d)(2) because the motion contains 520 words, excluding the parts of the document exempted from counting.

2. The foregoing motion complies with the typeface and type-style requirements of FED. R. APP. P. 27(d)(1)(E), 32(a)(5), and 32(a)(6) because the brief has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

Dated: July 18, 2022

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

I hereby certify that on July 18, 2022, I electronically filed the foregooing with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system and delivered three copies to the Clerk by overnight mail pursuant to Local Rule 27.1.

Dated: July 18, 2022

/s/ *Jonathan M. Levine*
JONATHAN M. LEVINE

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ACTING WARDEN JESSICA SAGE,
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D. EASTER, WARDEN FCI DANBURY, ACTING WARDEN OF FCI DANBURY, AND CURRENT CURRENT UNKNOWN,
*Respondents*

On Appeal from the U.S. District Court
for the District of Connecticut, No. 21-cv0498

**PROPOSED BRIEF OF AMICUS CURIAE JAMES WHITTED IN SUPPORT OF PETITIONERS-APPELLANTS MICHAEL MILCHIN, ET AL AND IN SUPPORT OF REVERSAL OF THE DISTRICT COURT'S ORDER OF DISMISSAL**

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# TABLE OF CONTENTS

# TABLE OF AUTHORITIES

STATUTES:

OTHER AUTHORITIES:

## INTEREST OF AMICUS CURIAE[1]

*Amicus Curiae* James Whitted was the named Petitioner in *Whitted v. Easter*, 3:20-cv-00569 (MPS) (D. Conn.). For more than a year, *Amicus* litigated that class action habeas case and worked to enforce the resulting Settlement Agreement, which provided expedited consideration for home confinement for people incarcerated at FCI Danbury who were at increased risk of severe illness from COVID-19.

In the District Court in the present case, respondent cited the Settlement Agreement in *Whitted v. Easter* as a basis for dismissing the petition. *Amicus* is interested in ensuring that the Settlement Agreement is properly interpreted and not inappropriately broadened to preclude actions that the parties and the court did not intend it to cover. *Amicus* is familiar with the challenges that incarcerated people face in obtaining the assistance of counsel and in accessing courts to enforce their constitutional right to adequate medical care under the Eighth Amendment. *Amicus* understands the importance of a district court's equitable powers under 28 U.S.C. § 2241 and the need for courts to liberally construe pro se pleadings filed by people in prison. In addition, *Amicus* has an interest in sharing information, relevant to

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[1] This brief has not been authored, in whole or in part, by counsel to any party in this appeal. No party or counsel to any party contributed money intended to fund preparation or submission of this brief. No person, other than the amicus or his counsel, contributed money that was intended to fund preparation or submission of this brief.

this case, about the problems of access to medical care at FCI Danbury—problems that were made starkly evident in the course of litigating *Whitted v. Easter*.

## SUMMARY OF ARGUMENT

Incarcerated individuals denied adequate medical care in violation of the Eighth Amendment may seek through a § 2241 habeas petition an order requiring prison officials to provide the necessary care or to release the person if they cannot provide the care. Here, pro se petitioners denied urgently-needed care at FCI Danbury sought relief from the court. Adopting a narrow interpretation of petitioners' claims for relief as seeking only release to home confinement, the District Court concluded such relief was barred by the Prison Litigation Reform Act (PLRA) and dismissed the petition. The Court should have instead liberally construed the pro se pleadings as seeking appropriate care in prison, and, if appropriate care was not possible, release—rather than construing the pleadings as seeking only home confinement. A liberal reading of pro se pleadings is particularly important when civil rights cases are brought by people incarcerated in prison who have difficulty accessing legal assistance.

Over the course of the litigation in *Whitted v. Easter*, *Amicus* and his counsel learned of systemic problems plaguing the medical care system at FCI Danbury and the failure of the facility to provide adequate medical care to the people incarcerated there. Individuals incarcerated at FCI Danbury must be able to enforce

their right to constitutionally adequate medical care when they are denied urgently-needed care. The District Court's dismissal should be reversed and the matter remanded.

## ARGUMENT

### I. Conditions of Confinement Claims are Fully Cognizable under 28 U.S.C. § 2241 and District Courts have Broad Equitable Powers to Remedy Unconstitutional Conditions

Individuals denied adequate medical care in prison in violation of the Eighth Amendment may seek through habeas corpus petitions appropriate medical care or transfer or release if such medical care cannot be provided.

It is well-established in the Second Circuit that individuals may assert in petitions filed pursuant to 28 U.S.C. § 2241 claims that their conditions of confinement violate the Constitution. *See, e.g.*, *Thompson v. Choinski*, 525 F.3d 205, 209 (2d Cir. 2008); *Jiminian v. Nash*, 245 F.3d 144, 146 (2d Cir. 2001); *McPherson v. Lamont*, 457 F. Supp. 3d 67, 75 (D. Conn. 2020); *Ilina v. Zickefoose*, 591 F. Supp. 2d 145 (D. Conn. 2008). With respect to petitions alleging deliberate indifference to serious medical needs in violation of the Eighth Amendment, an incarcerated person may seek an order requiring that adequate medical care be provided at the facility, or, if the custodian is unable to provide care in accordance with constitutional standards, transfer to another facility or release. *See, e.g.*, *Duverge v. Zickefoose*, No. 3:09CV45 (SRU), 2010 WL 466709, at *1 (D. Conn.

Feb. 8, 2010) ("Inmates may challenge their conditions of confinement in an action filed pursuant to 28 U.S.C. § 2241. A cognizable challenge to conditions of confinement encompasses a request for certain medical care in the facility in which the inmate is confined as well as requests for transfer to another facility or a change in the level of confinement."). Indeed, as the D.C. Circuit has explained:

> In a place of confinement claim, the petitioner's rights may be vindicated by an order of transfer, while in a conditions of confinement claim, they may be vindicated by an order enjoining the government from continuing to treat the petitioner in the challenged manner. But even this distinction is largely illusory, as either of these two forms of relief may be reframed to comport with the writ's more traditional remedy of outright release. That is, in both types of cases, a court may simply order the prisoner released unless the unlawful conditions are rectified, leaving it up to the government whether to respond by transferring the petitioner to a place where the unlawful conditions are absent or by eliminating the unlawful conditions in the petitioner's current place of confinement.

*Aamer v. Obama*, 742 F.3d 1023, 1035 (D.C. Cir. 2014); *cf. Martinez-Brooks v. Easter*, 459 F. Supp. 3d 411, 431 (D. Conn. 2020) ("Respondents cite no Supreme Court or Second Circuit decision suggesting that release is categorically unavailable to a Section 2241 petitioner asserting an Eighth Amendment claim."); *Preiser v. Rodriguez*, 411 U.S. 475 (1973) ("It is clear . . . that the essence of habeas corpus is an attack by a person in custody upon the legality of that custody, and that the traditional function of the writ is to secure release from illegal custody").

District courts have broad equitable powers under 28 U.S.C. § 2243 to dispose of habeas petitions "as law and justice require." This power includes the authority to order prison officials to remedy unconstitutional conditions of confinement and order release where they fail to do so. *Cf. Martinez v. McAleenan*, 385 F. Supp. 3d 349, 355 (S.D.N.Y. 2019) (noting that "the writ derives from broad equitable principles which, while aimed at securing release, provide courts with flexibility to use other forms of relief as justice requires"); *Carafas v. LaVallee*, 391 U.S. 234, 239 (1968) (stating that "the statute does not limit the relief that may be granted to discharge of the applicant from physical custody" but rather "[i]ts mandate is broad with respect to the relief that may be granted" as the statute instructs courts to "'dispose of the matter as law and justice require'").

## II. District Courts Must Liberally Construe Pro Se Petitions Brought by Incarcerated People

The District Court erroneously denied the petition in this case based on an exceedingly narrow view of the pleadings brought by the pro se incarcerated petitioners. The amended petition in this case alleged that staff at FCI Danbury had been deliberately indifferent to petitioners' serious medical needs in violation of the Eighth Amendment. AA 16. Petitioners sought relief in the form of class certification, appointment of counsel, transfer to home confinement so that petitioners could "obtain timely, competent medical care," and "[a]ny further relief

that the court deems necessary." AA 17. Respondent moved to dismiss, asserting that petitioners were seeking only release to home confinement—relief respondent claimed was barred by the Settlement Agreement as well as the PLRA. In response, petitioners sought to explain to the District Court that the petition, "brought by pro se petitioners with no legal education, should be construed as seeking an order for the BOP to remedy the unconstitutional conditions of confinement and, if it cannot remedy the conditions, an order of release." AA 80. Nevertheless, despite its broad equitable powers to dispose of habeas petitions "as law and justice require," 28 U.S.C. § 2243, the District Court narrowly interpreted petitioners' pleadings, concluding that petitioners' request for "any further relief" could not include a request to address their medical needs because the phrase was preceded by their request for home confinement. AA 152.

District courts are required to liberally construe pro se submissions. *See Triestman v. Fed. Bureau of Prisons*, 470 F.3d 471, 474 (2d Cir. 2006) (stating that pro se submissions are to be reviewed with "special solicitude" and "must be construed liberally and interpreted to raise the strongest arguments that they suggest") (internal quotation marks omitted); *McEachin v. McGuinnis*, 357 F.3d 197, 200 (2d Cir. 2004) ("[W]hen the plaintiff proceeds pro se, as in this case, a court is obliged to construe his pleadings liberally, particularly when they allege civil rights violations."). Liberally construing petitions brought by people in prison

is particularly important given the barriers incarcerated people face in accessing legal resources. At FCI Danbury, residents cannot access the internet to conduct legal research and find sample pleadings. During the pandemic, residents often have been prevented from accessing the law library because of lockdowns and staffing shortages. There can be long delays in receiving and sending mail. Access to photocopies is limited. Some incarcerated people have limited education or do not have the ability to read, write, or speak English.

Moreover, for individuals at FCI Danbury, it is extremely difficult to obtain counsel to assist in pursuing conditions of confinement claims. *Cf. McDonald v. Head Criminal Court Supervisor Officer*, 850 F.2d 121, 124 (2d Cir. 1988) (noting incarcerated individuals have limited access to "resources, knowledge and experience needed to find counsel willing to represent them without charge"). For many months of the pandemic, the BOP prohibited in-person legal visits and it can take multiple weeks, if not longer, to receive a legal call. People at FCI Danbury can send email correspondence (for a charge) but only with the consent of the recipient. Connecticut has no organization that is devoted to representing people in conditions of confinement cases. The legal services organizations in Connecticut generally do not pursue such cases, and few law firms litigate conditions of confinement lawsuits. Organizations that do occasionally take on these cases, such as the ACLU of Connecticut and the legal clinics at Quinnipiac School of Law and

Yale Law School, have capacity to take on very few cases. Counsel is particularly hard to find in cases where plaintiffs are seeking injunctive relief, since no contingency fee arrangement is possible, and attorney's fees are more difficult to obtain in cases brought against federal officials as compared to state or local officials.[2] Accordingly, unless the district court appoints counsel, most incarcerated people subject to unconstitutional conditions of confinement in Connecticut must pursue relief pro se.[3] In this case, petitioners diligently attempted to secure counsel to assist with their case in the District Court—first by contacting lawyers and organizations[4] and then by seeking appointment of counsel from the District Court. AA 63-68. The Court declined to appoint counsel.

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[2] Unlike in Section 1983 cases, plaintiffs suing federal officials must not only be prevailing parties but must also demonstrate that the government position was not "substantially justified." 28 U.S.C. § 2412(d)(1)(A); *Vincent v. Comm'r of Soc. Sec.*, 651 F.3d 299, 302–03 (2d Cir. 2011). In addition, fees awarded in civil rights cases against the government are traditionally capped at $125 per hour absent specific circumstances. 28 U.S.C. § 2412(d)(2)(A)(ii); *Kerin v. U.S. Postal Serv.*, 218 F.3d 185, 189 (2d Cir. 2000).

[3] For the 12-month period ending September 30, 2021, of the "prisoner petitions" filed in the District of Connecticut, 93% were pro se cases. *See* U.S. Courts, Table C-13, U.S. District Courts–Civil Pro Se and Non-Pro Se Filings, by District, During the 12-Month Period Ending September 30, 2021, https://www.uscourts.gov/sites/default/files/data_tables/jb_c13_0930.2021.pdf

[4] Petitioners asserted to the District Court that they unsuccessfully reached out to various firms and legal clinics to try to obtain representation. AA 67. Since their incarceration, petitioners have no outside income, so obtaining *pro bono* counsel was their only feasible option. AA 66.

Under these circumstances, the District Court should have liberally construed petitioners' request for relief as seeking an order for BOP to remedy the unconstitutional conditions of confinement and, if it could not remedy the conditions, an order of release so that petitioners could obtain adequate medical care in the outside community.

## III. The Settlement Agreement in *Whitted v. Easter* Does Not Preclude This Action

In the District Court, respondent asserted that the petition ought to be dismissed as precluded by the Settlement Agreement in *Whitted v. Easter* because the petitioners in this case were also medically vulnerable class members bound by the Agreement in *Whitted v. Easter* and sought transfer to home confinement. AA 35-37. Although the District Court did not rely on this argument as a basis for dismissing the petition, *Amicus* wishes to address this issue in the event that respondent raises this argument before this Court as a ground for affirming the District Court's decision.

The Agreement in *Whitted v. Easter* does not preclude a claim for relief based on conditions of confinement and does not preclude the petition in this case. The Settlement Agreement in *Whitted v. Easter*, which expired on October 31, 2021, ensured expedited consideration for home confinement for medically vulnerable class members under the standards set forth in the Agreement. The

Agreement does not contain any provisions governing conditions of confinement at FCI Danbury.[5] The release in the Agreement provides:

> The named Petitioner and all members of the Medically Vulnerable Class, as defined in Section 1, individually and behalf of all their respective heirs, beneficiaries, successors and assigns, in consideration of the benefits of this Agreement, release and forever discharge the Respondent and BOP, and all their respective present and former officers, employees, agents, heirs, successors and assigns, from all actions, causes of action, suits, claims, or controversies, for any and all forms of non-monetary relief arising from or based on either: (i) any denial of home confinement or exercise of the BOP's statutory authority to transfer prisoners to home confinement which may be brought during the time this Agreement is in effect, except as otherwise provided under this Agreement, or (ii) any acts or omissions alleged or that could have been alleged in the Action relating to the COVID-19 pandemic occurring prior to the Effective Date. For the avoidance of doubt, this release applies to any and all Medically Vulnerable Class members' habeas corpus cases pursuant to 28 U.S.C. § 2241 seeking any relief due to the COVID-19 pandemic for acts or omissions occurring prior to the Effective Date. The aforementioned releases do not apply to sentence reduction/compassionate release motions filed pursuant to 18 U.S.C. § 3582.

*Whitted v. Easter*, 3:20-cv-569 (D. Conn.), ECF 134-1 ¶ 16.

The parties' agreed-upon Notice to the Class of Settlement Agreement explained that the Settlement Agreement "does not prevent any claims (other than those challenging the BOP's home confinement decisions) based on conditions at FCI Danbury after July 27, 2020." *Whitted v. Easter*, 3:20-cv-569 (D. Conn.), ECF 141-1 at 4. This point was underscored again at the fairness hearing on the

[5] On July 24, 2020, the BOP made various, non-binding commitments relating to conditions at the facility. *See* Attachment 1, Letter from the U.S. Attorney's Office.

Agreement, when the Court explained that class members "are not precluded from suing for damages or from seeking nonmonetary relief for the period after July 27, 2020." *Whitted v. Easter*, 3:20-cv-569 (D. Conn.), ECF 222, Tr. 9/18/20, at 56.

Nothing in the Settlement Agreement prohibits a petition based on conditions of confinement arising after the Agreement's effective date. *See id.*, ECF 134-1 ¶ 16 (precluding claims based on acts or omissions "occurring *prior to* the Effective Date") (emphasis added). Indeed, in the District Court, respondent did not assert that the petition was precluded because of the conditions of confinement claim. Rather, the respondent contended the claim was precluded because petitioners "are only seeking relief in the form of a release to home confinement." AA 37. But, as has been noted, the petitioners did not seek only release to home confinement. Rather, for petitioners whose "serious medical concerns . . . are not being addressed at FCI Danbury," they sought "timely, competent medical care," as well as "[a]ny further relief that the court deems necessary." AA 17.

Moreover, the Settlement Agreement's preclusion of home confinement claims was intended to bar challenges to individual denials of home confinement or the BOP's exercise of home confinement authority in individual cases. Here, petitioners were not challenging individual denials or the exercise of BOP's authority; they were seeking home confinement as a form of release if the BOP

was unable to provide adequate medical care. A petition seeking an order of *release* from the Court if the conditions cannot be remedied (rather than an order requiring BOP to effectuate a transfer to home confinement) was not precluded by the Agreement. The District Court should have construed the petition as seeking an order requiring BOP to remedy the unconstitutional conditions of confinement or to release petitioners if the conditions could not be remedied.

Finally, the Settlement Agreement barred home confinement claims only while the Agreement was in effect, and the Agreement expired on October 31, 2021—before the District Court dismissed the petition. The expired Agreement would not govern should the case be remanded.

## IV. The *Whitted v. Easter* Litigation Raised Significant Concerns Regarding Inadequate Medical Care at FCI Danbury

In light of some overlapping issues raised in the *Whitted* litigation and the instant suit, *Amicus* offers information to the Court, learned through representing the class in the *Whitted* litigation, relating to inadequate medical care at FCI Danbury. Over the course of the litigation in *Whitted v. Easter*, *Amicus* and his counsel learned of systemic problems plaguing the medical care system at FCI Danbury and the failure of the facility to provide adequate medical care to the people incarcerated there. These problems include extreme delays for people in receiving urgently needed consultations and procedures in the community, lengthy waits to be seen by medical staff at the facility, and significant understaffing in the

medical department. The inadequate medical care at FCI Danbury predates the COVID-19 pandemic, which only further exacerbated the problems, and continues to cause needless, serious harm to persons incarcerated there.

### A. Lengthy Waits for Consultations and Procedures in the Community

Individuals incarcerated at FCI Danbury who require outside medical care—usually specialist care and/or diagnostic or surgical procedures that cannot be performed at the facility—often have to wait many months to receive needed, often urgent, care. Dr. Homer Venters, M.D., the expert for Petitioners in *Whitted v. Easter*, catalogued this problem in his June 6, 2020 report, which noted that there were, at that time, 340 pending requests for outside care, consultations, or procedures for individuals at FCI Danbury, many of which had been pending for months. Of those 340 requests, 115 had been categorized by the doctor or APRN as "urgent" requests and 12 "emergent." Attachment 2, Report of Dr. Homer Venters at 33.[6] Dr. Venters noted that this situation is "extremely dangerous"

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[6] Dr. Venters found that of these pending requests:

- 144 were pending "consult", with 56 of those categorized by the doctor or APRN as "urgent" requests and one "emergent"
- 127 were pending "scheduling" with 32 of them categorized as "urgent" and 8 "emergent"
- 69 requests were "pending institution clinic director action"; 27 of these were "urgent" requests and 3 were in the category of "emergent."
- One request was pending 'UR Committee Action"

Lists of pending consultations and procedures are maintained electronically at FCI Danbury.

because health problems may go undiagnosed or untreated, which increases the risk of preventable morbidity and death. *Id.*[7]

The delays at FCI Danbury in people receiving necessary procedures and urgently-needed care from specialists have persisted. For example, medical records confirm that a specialist indicated in September 2019 that a 68-year-old man diagnosed with bladder cancer and numerous other serious health conditions needed a CT scan and IVP, followed by cystoscopy. Orders for these procedures were entered by the prison doctor in October 2019 and marked "urgent." On at least three occasions, the procedures could not be completed at scheduled appointments because FCI Danbury staff failed to make the necessary pre-test arrangements. Counsel for *Amicus* wrote to the U.S. Attorney's Office on December 30, 2020, February 28, 2021, and June 4, 2021 expressing concern about the delay in the procedure. *See* Attachment 3, at 36, 40, 47 (Letters of 12/30/20, 2/28/21, 6/4/21). Medical records show that it was not until July of 2021 that he finally received a cystoscopy, which revealed a return of advanced bladder cancer.

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[7] The problem of delays in consultations and procedures at FCI Danbury is longstanding and predates the pandemic. *See, e.g., United States v. Almontes*, No. 3:05-CR-58 (SRU), 2020 WL 1812713, at *7 (D. Conn. Apr. 9, 2020) (granting compassionate release to a man based in part on FCI Danbury's failure to provide him with urgently needed spinal decompression surgery for more than a year, noting that the "BOP has been indifferent to Almonte's condition under normal circumstances, and there is no reason to think that that will change").

Moreover, after an abnormal October 2021 screening for prostate cancer and a subsequent biopsy, the man was diagnosed with advanced prostate cancer in November 2021. A PET scan, which was not conducted until end of January 2022, revealed evidence that the cancer has spread beyond his prostate to other lymph nodes. The cancer is scored a nine out of ten in aggressiveness. A physician who reviewed this man's medical records confirmed that he needs radiation or surgery following by chemotherapy, as well as consistent follow-up care to monitor his conditions. As of May 2022, this man had received hormone treatment but neither radiation nor surgery to treat his aggressive and spreading cancer.

Medical records confirm that Kevin DiMartino, a petitioner in the present litigation in the District Court, began complaining about blood in his stool in June 2020. On October 2, 2020, he saw a gastroenterologist who recommended colonoscopy and esophagogastroduodenoscopy to rule out or diagnose possible cancer. On November 4, 2020, medical staff at FCI Danbury requested the procedures and marked the request as urgent. Counsel for *Amicus* wrote to the U.S. Attorney's Office on November 23, 2020 and again on February 28, 2021 expressing concern that the procedures had not been performed. *See* Attachment 3, at 17, 41 (Letters of 11/23/20, 2/28/21). In May 2021, a colonoscopy revealed that Mr. DiMartino has colon cancer. This diagnosis came seven months after Mr. DiMartino was first referred for a colonoscopy because of concerns he might have

cancer. In early June 2021, counsel for *Amicus* wrote again to the U.S. Attorney's Office expressing concern that no action had been taken following Mr. DiMartino's diagnosis. *See id.* at 47 (Letter of 6/4/21). Counsel for *Amicus* understands that in late June 2021, Mr. DiMartino had surgery to resect a portion of his colon. He was informed that he had stage 3 colon cancer that had spread to his lymph nodes. Since then, Mr. DiMartino has had to undergo extensive chemotherapy and he continues to battle the cancer.

Review of medical records confirms numerous other delays in urgently needed consultations and procedures in the community including, for example:

- A woman who was hospitalized following a heart attack waited more than three months to see a cardiologist following the heart attack despite her discharge papers stating she should be seen by the cardiologist within one week.
- Multiple men with serious heart conditions waited many months to see cardiologists despite FCI medical staff marking the consultation requests as "urgent."
- A man waited more than a year for vitreoretinal surgery—losing his eyesight while he waited—despite FCI Danbury doctors marking a consultation with the surgeon "urgent."
- In early 2019, a GI doctor recommended a colonoscopy to rule out a tumor for a man suffering from irregular bowel movements. Despite a FCI Danbury doctor ordering a GI consult and colonoscopy in December 2019 and marking the requests "urgent," the consultation and procedures were not conducted before the man's eventual release in late 2021.
- Delays of many months in individuals seeing other specialists including urologists, neurologists, gastroenterologists, nephrologists, and dermatologists for urgently needed consultations.[8]

[8] The examples set forth here are just some of many instances of delays in consultations and procedures that have been confirmed by review of medical records.

*See* Attachment 3.

### B. Delays in Responses to Sick Call Requests

Evidence obtained in the *Whitted* litigation also revealed that individuals incarcerated at FCI Danbury often have waited days or weeks for medical care in response to the "sick call" requests through which they seek medical attention for medical issues, including urgent ones. In his report, Dr. Venters reported that people at FCI Danbury often waited days or weeks to be seen by medical staff after submitting sick call slips, and described instances where individuals were so desperate for care while waiting for sick call requests to be answered that they showed up at medical and begged to be seen by a doctor. Attachment 2, at 14-17. For example, one woman submitted three separate sick calls, which included reports of COVID-19 symptoms. She was ultimately hospitalized for a heart condition. *Id.* at 15. Although Dr. Venters' report described the issue at an earlier stage of the pandemic, the problem preceded the pandemic and persists even as the COVID-19 situation ebbs and flows. Counsel for *Amicus* continue to learn of lengthy delays in response times to sick call requests and requests relating to medication.

### C. Understaffing

The medical care department at FCI Danbury has had serious problems with understaffing. Dr. Venters noted that, as of the writing of his report, there were

only two physicians and one part-time nurse responding to sick call requests for the entire prison complex (including requests from individuals housed at the women's minimum security Camp, the women's low security satellite facility, and the men's facility—over 1000 people). Attachment 2, at 19. On July 24, 2020, the U.S. Attorney's Office reported that 7 of the 25 positions in the medical department were unfilled. *See* Attachment 1. In March 2021, one of the two physicians employed at the facility left. It does not appear she has been replaced with another physician. Moreover, as of the time of Dr. Venters' report, physicians and nurses were at the facility only until 4pm on weekdays; no medical staff were at the facility overnight and there were only two EMT-paramedics at the facility on the weekends. *See* Attachment 2, at 19. Dr. Venters stressed that the staffing levels "pose crucial risk for the health and welfare of prisoners" because it requires security staff, who are not trained medical professionals, to make triaging decisions for emergencies that occur overnight. *Id.* at 20. Further, the delay in sick call responses and understaffing forces the medical providers to respond only to the most urgent requests while leaving others with serious medical issues to continue to deteriorate without care. *Id.*

The staffing problems in the medical care department have persisted. *See, e.g.*, Carrie Engel, *FCI Danbury sees 'really large numbers' of COVID cases amid accusations of 'inadequate practices'*, News-Times, Jan. 9. 2022 (stating that,

according to FCI Danbury employee and union official, "staffing shortages extended to 'bureau-wide' issues with retaining essential medical staff like nurses, doctors and emergency medical technicians");[9] Julia Perkins, *Staff shortage and double shifts: Danbury prison union workers decry conditions*, News-Times, Dec. 14, 2021 (same official reported that prison "is so short staffed that it's common for non-officer employees, including cooks, teachers, nurses and maintenance staff to be forced to fill in as corrections officers").[10]

For more than two years, counsel for *Amicus* have brought to the attention of government lawyers and BOP officials specific concerns about delays in access to urgently-needed medical care for individuals incarcerated at FCI Danbury. Unfortunately, lengthy delays often persisted even after counsel raised specific concerns. No doubt many more concerns have not come to counsel's attention. Petitioners in this case raise concerns about medical care at FCI Danbury. District courts have broad equitable powers to grant relief, and they should broadly construe requests from pro se petitioners who assert they have been denied

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[9] The article is attached as Attachment 4, https://www.newstimes.com/news/article/FCI-Danbury-sees-really-large-numbers-of-16758396.php

[10] The article is attached as Attachment 4, https://www.newstimes.com/news/article/Staff-shortage-and-double-shifts-Danbury-prison-16701723.php

urgently-needed medical attention, particularly where there is a documented history of failure to provide adequate care at the facility.

## V. CONCLUSION

For the foregoing reasons, Amicus Curiae urges this Court to reverse the District Court's order of dismissal.

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# CERTIFICATE OF COMPLIANCE

1. The foregoing amicus brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(a)(5), because, excluding the parts of the document exempted from counting by Fed.R.App.P. 32(f), the brief contains 4,785 words.

2. The foregoing motion complies with the typeface and type-style requirements of Fed. R. App. P. 32(a)(5), and 32(a)(6) because the brief has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

Dated: July 18, 2022

Respectfully submitted,

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# ATTACHMENT 1

**United States Department of Justice**

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July 24, 2020

*Via E-Mail*
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Re: *Martinez-Brooks et al. v. Easter et al.*, Case No. 3:20-cv-00569-MPS

Dear Attorney Golub:

On July 24, 2020, the Petitioners, who are class representatives of inmates at FCI Danbury, and the Respondent, Diane Easter, the Warden of FCI Danbury, entered into a Civil Settlement Agreement ("Settlement Agreement") to resolve allegations made in *Martinez-Brooks et al. v. Easter et al.*, Case No. 3:20-cv-00569 (MPS).

Beyond the terms of the Settlement Agreement, Petitioners requested that the Bureau of Prisons ("BOP") make certain assurances regarding actions being taken at FCI Danbury to meet the medical needs of inmates during the COVID-19 pandemic and to mitigate and control the spread of the virus. The BOP declares that the following actions are currently being performed at FCI Danbury and will continue to be performed at FCI Danbury for the time period that the Settlement Agreement remains in effect.

1. Inmates exhibiting symptoms indicative of a COVID-19 infection will be seen by a nurse or doctor the same day that the COVID-19 symptoms are reported by either the inmate or BOP personnel (or, for those reporting symptoms in the evening, the next morning).

2. Daily temperature checks of inmates will be conducted by a member of the medical staff or a lieutenant (or higher ranking staff member). During temperature checks, inmates will be asked a series of scripted questions designed to screen for COVID-19

symptoms.[1] These questions will be addressed to each housing unit at large. Logs of symptom and temperature screenings will be preserved.

3. Sick call slips will be collected on a daily basis. Sick call slips collected Monday through Friday will be triaged by a medical provider (nurse or doctor) that same day. Sick call slips submitted on a Saturday or Sunday will be triaged by a medical provider (paramedic or nurse) that same day. Sick call slips will be retained and scanned into the inmate's BEMR medical record. Sick call appointments and procedures will be conducted in accordance with BOP's Program Statement 6031.04, Patient Care. The U.S. Attorney's Office will contact FCI Danbury when counsel for Petitioners bring to their attention instances where counsel have a good faith basis to believe an individual's access to medical care has been delayed and that the individual is demonstrating COVID symptoms or is otherwise urgently in need of medical care.

4. Inmates exhibiting COVID-19 symptoms will be tested. The BOP will follow its current guidance on testing, including its now current guidance issued on June 19, 2020. If any inmate tests positive for COVID-19, all inmates housed within the COVID-19-positive inmate's housing unit will be tested.

5. Staffing at FCI Danbury will be commensurate with its classification as a Care Level 2 institution pursuant to BOP's Clinical Guidance. Currently, there are 18 of 25 medical staff positions filled. There are current certificates for one Advanced Practice Nurse position and one Medical Officer position. There are current postings for one Medication Technician position, one Staff Pharmacist position, and Clinical Nurse position. One Chief Pharmacist position is pending posting. One Nurse Practitioner will enter on duty effective July 16, 2020.

6. Medical rounds for wellness checks will be made daily in all isolation and quarantine spaces. On weekdays, the wellness checks will be performed by a doctor or nurse. On weekends, a paramedic may do the wellness checks if a nurse or doctor is not at the facility. FCI Danbury will continue to use its available space for quarantine and isolation purposes. This includes the Special Housing Unit ("SHU"). Inmates quarantined and/or isolated in the SHU will not be subject to punitive housing measures. Inmates quarantined and/or isolated in SHU for COVID-19 purposes will be eligible to receive the following benefits: commissary, use of computer and phone, and personal property will be available at times that do not disrupt the administrative needs necessary to accommodate the quarantine/isolation function. Additionally, reasonable restrictions on the amount of personal property allowed in the SHU isolation/quarantine unit may be imposed to prevent fire/safety hazards. Inmates quarantined and/or isolated in SHU for COVID-19 purposes will have access to appropriate bedding, showers suitable meals, and drinking water, as well as to mail and legal calls. While there is a BOP requirement that all inmates in the SHU be handcuffed while going to the showers, a waiver of

[1] Subject to a change in CDC guidance, inmates will be asked the following verbal screening questions: "*Today or in the past 24 hours, have you had any of the following symptoms: Fever, felt feverish, or had chills? Cough? Difficulty breathing?*" *See* Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

this requirement has been submitted to the Central Office for inmates isolated and/or quarantined in the SHU for COVID-19 purposes.

7. For the safety of inmates and the community, it is BOP policy that all inmates who are approved for home confinement or residential reentry center placement be quarantined for 14 days prior to release from FCI Danbury. Inmates may seek a waiver of the 14-day quarantine requirement before being released to home confinement. Decisions regarding this waiver request will be based on circumstances in existence at the time the wavier is sought.

8. The BOP recognizes there is a backlog of non-COVID-19-related, non-emergent outside medical care consultation requests due to the shutdown of medical care facilities in the community during the COVID-19 pandemic. In addition to the Program Statement on Patient Care (Number 6031.04), and the Institution Supplement (Number DAN 6031.01D), the BOP will employ the following practices to deal with the backlog:

a. The Utilization Review Committee will continue to prioritize outside medical care consultation requests based on need.

b. FCI Danbury will begin the use of telemedicine in order to assist with the backlog. In the future, FCI Danbury plans on employing telemedicine by video as well.

c. Consistent with current practice, where practicable, FCI Danbury will bring specialists into the institution to deal with volume appointments within the same specialty.

FCI Danbury intends to keep the foregoing protocols in place for so long as the Settlement Agreement is in effect. The foregoing protocols may be suspended or modified in part or in their entirety if the Warden or her designees determine that a "genuine emergency" exists at FCI Danbury.[2] Moreover, FCI Danbury reserves the right to change the foregoing protocols based on significant operational needs or presently unforeseen events or conditions, including but not limited to substantial changes in established infection control practices or the standard of care for treatment of COVID-19 infection.

This letter is being provided to you for informational purposes only, and is not intended as any sort of consideration for, nor should it be construed as forming any part of, the Settlement Agreement.

[2] "Genuine emergency" means any special circumstances under which it is reasonable to conclude that there is any actual or potential threat to the security of FCI Danbury, or to the safety of the staff, prisoners or other persons within any one of the institution's facilities.

Very truly yours,

JOHN H. DURHAM
UNITED STATES ATTORNEY

John B. Hughes, Chief Civil Division
Assistant United States Attorney

# ATTACHMENT 2

**Dianthe Martinez-Brooks et al v. D. Easter, Warden**

**No. 3:20-cv-569 (MPS)**

**Homer Venters**

**FCI Danbury Inspection Report**

## I. 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 as part of my public health fellowship where I conducted analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security and evaluated individual asylum applications for torture survivors. This work included and resulted in collaboration with U.S. Immigration and Customs Enforcement ("ICE") on numerous individual cases of medical release, the formulation of health-related policies, as well as testimony before the U.S. Congress regarding mortality inside ICE detention facilities.

2. After my fellowship training, I became the Deputy Medical Director of the Correctional Health Services of New York City. 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, nurses, 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 provided numerous datasets and other forms of cooperation for the U.S. Department of Justice investigation into brutality in the NYC jail system, and worked with my team to support their critical efforts. Many of the data systems that I implemented in the NYC jails were identified and reported in the U.S. Attorney's Office for the Southern District of New York's substantiation of the health consequences of a pattern and practices of brutality regarding adolescent detainees.[1]

3. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacted almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection, and several other smaller outbreaks.

4. In March 2017, I left the Correctional Health Services of New York City 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. I subsequently worked with the nonprofit Community Oriented Correctional Health Services (COCHS) in promoting evidence-based health services for people with justice involvement. I have also worked as an independent correctional health expert since 2017. In my roles as a correctional health physician I have conducted over 50 facility inspections, three of which have been specific for assessing the adequacy of COVID-19 response. My CV with a list of cases I have testified in, and my compensation rate is attached hereto as **Appendix A**.

[1] *See* Report on CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island, U.S. Dep't of Justice (Aug. 4, 2014), https://www.justice.gov/sites/default/files/usao-sdny/legacy/2015/03/25/SDNY%20Rikers%20Report.pdf.

## II. Methodology

5. The purpose of this report is to focus on the adequacy of the FCI Danbury's response to COVID-19 with focus on infection control and other public health measures currently being implemented to prevent serious illness and death among staff and detained people.

6. In order to prepare this report, I visited the various facilities of FCI Danbury on May 27, 2020 and physically inspected the facility including the main FCI campus, the female Federal Prison Camp (FPC) and the female Federal Satellite Low (FSL).

7. In FCI, I toured and examined the entry and screening area, health services unit, the intake area, the SHU, D unit, I unit, M unit, and A unit.

8. In FSL I toured and examined the entry area, the dorm, common room, food service area, visitation room, classrooms, and isolation room.

9. In FPC I toured and examined the entry area, B dorm and the medical clinic.

10. My interactions with detained people included in most cases asking the following questions, with follow-up as appropriate:

a. Have you been around anyone you thought had COVID-19?

b. What has this facility done to prepare for COVID-19?

c. Have you been asked any questions about COVID-19 by health staff?

d. How have you reported concerns about your health (including COVID-19) in this facility?

e. Who wears masks and gloves in this facility and how do they get this equipment?

f. Who cleans inside cells in this facility and how and how often do they get cleaning supplies?

g. Who cleans outside cells in this facility and how and how often do they get cleaning supplies?

11. I have conducted this assessment and review of information with the following questions in mind:

a. Do current practices in the FCI Danbury adequately detect the number and severity of COVID-19 cases among staff and prisoners and respond in a manner consistent with CDC guidelines and other established clinical standards of care?

b. Do current practices in the FCI Danbury adequately slow the spread of COVID-19 through the facility and between people, both staff and prisoners, in a manner consistent with CDC guidelines and other clinical standards of care?

c. Do current practices in the FCI Danbury adequately identify and protect high-risk prisoners from serious illness and death from COVID-19?

12. In addition to my inspection of the facility, I was able to review the following records and information:

a. Declarations from 28 incarcerated or recently released people;[2]

b. FCI Danbury/BOP policies and procedures relating to COVID-19;

c. Photographs taken during the facility inspection;

d. The deposition transcripts of the following FCI Danbury staff: HSA [redacted], Health Services Administrator for FCI Danbury; Diane Easter, Warden, FCI Danbury

e. The Complaint and Exhibits filed in this case, the Motion for Temporary Restraining Order and Exhibits, the Second Supplemental Memorandum of Law in Support of the Temporary Restraining Order and Exhibits.

f. The government's interrogatory responses

g. Documents USA 003129-5637 (prisoner medical records); 007547-8439 (temperature check logs); 005898-005974 (Danbury memos and policies re

[2] I have reviewed the declarations of the following people who are detained at, or were recently released from, the FCI Danbury; [redacted]

COVID-19); 005975-006115 (Danbury memos and policies re COVID-19); 008400-8447 (health services activity logs); 008457-8806 (health services activity logs); 008807-8811 (administrative remedy request re COVID-19); 00812-59 (Health Services Activities Reports); 008867-68 (Coronavirus Phase Seven Action Plan); 008893-94 ([redacted]); 008920-30 (CST memos); 008955 (Emails re COVID screening, testing, staffing); 008956 (COVID 19 local plan); 009231-9444 (sick call slips); 9445 (testing by units spreadsheet); 009446-47 (testing information).

13. The information I have gathered from the above referenced documents, in conjunction with the results of my physical site visit, are sufficient for me to come to the conclusions drawn below with a high degree of confidence.

## III. Assessment of the COVID-19 Response in FCI Danbury

### A. Visual Observations from the Inspection

14. The inspection of the various parts of the three facilities in FCI Danbury lasted approximately 4.5 hours and consisted of observations and photography of various housing units, as well as interviews of inmates both cell-side and in open areas. All interviews were conducted in the presence of at least one representative of the Respondent, including in many cases MCC staff. I spoke with 11 detained people.[3]

15. Visual observations from FCI started with the entry and health services area. Observations included the tape markings on the floor outside the health services unit, which were presented as guides for how far apart people should stand while in medication or pill line. The markings appeared 2 or 3 feet apart. Four clinical examination rooms were also

[3] I spoke with the following FCI Danbury detainees; [redacted]

observed in the health services unit and the only no touch waste receptacle appeared to be a biohazard container. The testing area was also inspected and FCI staff explained that all inmates would be tested by 5/29/20 and that the primary testing modality being utilized was a Quest test. Staff explained that the Abbott ID Now test has been utilized initially and that all of those samples were being confirmed/rerun with the Quest test and that they had a roster of which tests were still pending confirmation. Staff also explained that no staff testing is done, only inmate/patient testing. Contact tracing was explained to be under the purview of the infectious disease coordinator, but the specifics of how people who conduct contact tracing are trained or how the adequacy of their work is reviewed was not assessed or presented in the context of CDC guidelines.[4]

16. The intake area at FCI, also referred to as 'R and D' comprised of two cell areas, a body scanner and an office identified as the location for medical encounters (including screenings, COVID-19 temperature and symptoms checks and testing) for people arriving and leaving the facility. Women are brought into this unit from the Camp to quarantine before being released. The fridge in the office designated for clinical encounters was being used for staff food storage (photo). The office designated for medical encounters housed several file cabinets, some other office storage, and two chairs. No medical equipment, examination table or other evidence of health encounters was present in this room.

17. The SHU area at FCI was being used as a punitive segregation or solitary confinement as well as a COVID-19 quarantine area for women from FSL. Staff reported that this unit had been recently approved as use for housing of women. This unit comprised of open bar stock, no doors (photo), with one bunk per cell. The upper tier was being used for solitary confinement/punitive segregation and the lower for medical isolation. No PPE cart was present at the entry to the unit and no hand sanitizer was present at the entry or on the unit.

[4] https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf

No clinical examination space existed on this unit. The practice of having people under quarantine for COVID-19 in the same housing area as people who are being punished via solitary confinement, with open passage of air from one cell to another is completely inconsistent with basic infection control and CDC guidelines. In CDC guidelines for COVID-19 response in detention settings quarantine specifically mention "solid wall and doors" for separation of quarantined individuals from others who are not in quarantine.[5] Basic infection control also identified any quarantine as requiring physical separation of one group of individual from another. Put simply by the CDC "Quarantine is used to **keep someone who might have been *exposed* to COVID-19 away from others**."[6] At the time of my inspection, the women on the top tier were in open cells, as were the women on the bottom tier, and I was able to hear conversations with all of them due to the open bars in all cells. There is clearly free flow of air throughout the unit. Having women placed into open bar cells for punishment in the same unit where women are held for COVID-19 quarantine essentially exposes the first group to COVID-19 as part of their punishment, a practice that is unethical and breaches both basic correctional and infection control standards.[7] At the time, staff indicated that there were no women placed into this unit who were suspected of having COVID-19 but since my inspection I have reviewed a declaration from a prisoner who reports placement of someone suspected of having COVID-19 onto this same unit. Another prisoner reports that, in the last few days and after close contact with a woman from Camp who tested positive, she was moved to R&D and then to SHU. She observed other women on the lower tier of SHU, which is supposed to be for women in quarantine, who she knows to be in SHU for disciplinary reasons not quarantine.[8] If true,

[5] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

[6] https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine-isolation html

[redacted]

[8] [redacted].

this would sabotage the very idea of quarantine, expose all people in the unit to COVID-19 and create significant risk not only for them but the communities they are leaving this unit to return to.

18. D unit was the next housing area observed, comprised of bunk beds approximately 3-4 ft. apart. Most people wore masks, but not all and social distancing was not observed or possible in the close confines of the bunks or bathrooms. Several people yelled out comments communicating that the unit had only recently been cleaned or that sick call appointments take months to occur. Several large fans were blowing on the unit. Staff reported that the entire unit had been tested for COVID-19 the day before, and that no person had been identified as being a potential COVID-19 case for several weeks. Staff also reported that daily temperature checks were conducted by non-medical staff in this and other units. Officers on this unit were unsure who would clean and collect the belongings of a person who is suspected of having COVID-19. Review of declarations by detained people indicates that no cleaning was conducted when a person was identified as having COVID-19.[9] No PPE cart was present at the entry to the unit and no hand sanitizer was present at the entry or on the unit. The bathrooms had filled soap dispensers. No clinical examination space existed on this unit.

19. The next unit observed and inspected was I unit. This two-tier unit was comprised of cells with solid doors and was described by staff as a unit for people with intellectual or developmental disabilities. Most, but not all, people wore masks, and social distancing was not observed or possible in the close confines of the unit. There were tables in the center of the unit with computers towards the back of the room, phones at the front, and bathrooms off the front of the room. A bottle of cleaning solution was present near the computers. No cleaning solution was visible near the phones. No paper towels or means

[9] [redacted]

to wipe down the surfaces was present at either area. No PPE cart was present at the entry to the unit and no hand sanitizer was present at the entry or on the unit. The bathrooms had filled soap dispensers. No clinical examination space existed on this unit.[10]

20. The next unit observed and inspected was M unit. This two-tier unit was comprised of cells with solid doors and was described by staff as now being utilized for quarantine. A PPE cart was located outside the unit with 10-12individual clear plastic bags, each with one gown, n95 mask, gloves, and reusable face shields were also available. There was some confusion among staff as to whether this level of PPE was needed for this unit but is was ultimately decided to put on full PPE. I observed the temperature checks taking place on this unit while we were there, which appeared to take approximately 20 seconds, and involved confirming a person's name and taking their temperature. A sink and trash can were present at the entry to the tiers for hand washing and disposal of PPE. No hand sanitizer was present at the entry or on the unit. No clinical examination space existed on this unit.

21. The next unit observed and inspected was A unit. This two-tier unit was comprised of cells with solid doors and was described by staff as identical to M unit, but was being utilized for medical isolation. At the time of our visit, no people were being held on the bottom tier. A PPE cart was located outside the unit with 10-12 individual clear plastic bags, each with one gown, n95 mask, gloves, and reusable face shields were also available. The medical isolation patients were in the top tier, which I observed. Staff reported that at some point, quarantine patients were housed below on the bottom tier, and isolation patients on the top.[11] If true, the housing of quarantine patients in the same housing area as medical isolation would represent a failure of basic infection control practices. Because the same

[10] [redacted] (lack of ventilation in I Unit).

[11] This is confirmed by the record. [redacted]

staff would work on both parts of the unit, this practice would potentially expose the quarantine patients to COVID-19 form the already diagnosed or symptomatic patients in the isolation cells. In addition, when new cases or symptoms emerged among people in the quarantine cells, it would be impossible to know whether these cases of COVID-19 originated from the original quarantine exposure or a transmission inside the housing area, thus foiling the original intent of quarantine.

22. The next area observed and inspected was the FSL. We started with the dormitory which was a very large, open building (11,924 sq ft) that had 100-200 office cubicles with bunk beds in each of them. The size and open floor and ceiling of this building are consistent with standard 10,000 square foot buildings used commonly for construction and warehouses, with some additional dedicated space for bathrooms and the common room. Most but not all detainees were observed wearing masks, few were engaging in social distancing, which was not possible given the layout of the office cubicles. A computer room and phone area were observed, neither of which would allow for social distancing. No cleaning solution or paper towels were observed near the phones or computers. No clinical examination space existed on this unit. Tables with attached seats were present near the entry to this unit (photo), with many people seated directly next to each other. There was no hand sanitizer present at the entry or on the unit.

23. The next area observed and inspected was the dining hall. Staff expressed differing opinions about whether this dining hall had had been utilized for medical isolation, quarantine or both. After discussion, it was related to us that the area had been utilized for both purposes at different times.[12] The room was a standard cafeteria style dining hall with a food service counters and kitchen on one side and a large open area on the other. No PPE

[12] This is confirmed in the government's interrogatory responses at p 2-3.

or hand sanitizer or hand washing stations were present in this room. No clinical examination space existed on this unit.

24. The next area we observed was a visitation room, which we observed from the outside. This appeared to be a medium sized room with chairs and several office cubicles and a portable commode inside. Staff relayed that this area had been used for isolation.

25. The next area observed was a series of rooms referred to as classrooms that were reported to have been used for quarantine. One classroom had steel bed frames on their sides, and staff reported that some women used those beds during quarantine and others simply brought their mattresses from their original housing areas and placed them on the floor. We were shown a bathroom in the hallway of these rooms.

26. The next area observed was an isolation cell in the same hallway as the classrooms, being utilized for medical isolation. This cell was not negative pressure, per staff.

27. The next area observed and inspected was the Camp. I was able to walk through Dorm B, which consisted of a very tight series of office-type cubicles with bunks, spaced with barely room to pass in between, in a layout that seemed designed for classrooms or office space. There was no evidence of or ability to engage in any social distancing in this unit. Most of the women had masks on. No common areas were seen on this housing area and bathrooms were not observed.

28. The next area observed was the medical clinic in the camp. Clinic staff indicated that patients would wait outside the door to the clinic to receive medications, lined up on the stairs leading up to the door. The clinic itself comprised of two examination areas and one office area. No PPE carts were observed anywhere in the Camp area, and no hand sanitizer dispensers were observed.

## IV. Detection of and Response to COVID-19 Cases

### 29. Screening

FCI Danbury relies on a screening system that fails to identify new cases of COVID-19. Most notably, it is clear from speaking with FCI Danbury staff and detained people alike, that the approach utilized involved having non-medical staff measuring temperature, and not asking about and recording symptoms of COVID-19.[13] This is a material failing because many people experience days of COVID-19 symptoms before their temperature becomes elevated, and some may even become gravely ill without an increased temperature being appreciated. This appears to have happened in the case of Mr. [redacted] who experienced liver pains, trouble breathing, loss of sense of taste, but who did not have a fever and was told that he could not go to medical unless his temperature was more than 100 degrees. He ultimately was isolated and tested positive for COVID-19 after being sick for almost two weeks.[14] This lack of attention to symptoms of COVID-19 appears to involve all aspects of FCI Danbury operations. For example, Ms. [redacted], who was in a quarantine unit, awaiting release to the community, reported that nobody ever asked her about symptoms of COVID-19 in her unit. This is especially worrisome since this unit exists to ensure that people leaving FCI Danbury do not have COVID-19. In addition, even the taking of temperatures appears sporadic. Ms. [redacted] reported that temperatures were taken several days in a row then not taken for 2 or 3 days. Ms. [redacted] also reported very inconsistent temperature taking in the camp, with no symptom screening.

The lack of screening for symptoms of COVID-19 is especially concerning given clear CDC guidance on the need to initiate testing based on the presence of symptoms in

[13] [redacted]

[14] [redacted]

congregate settings, including prisons. CDC guidance lists people who are at high priority for testing, including "Residents in long-term care facilities or other congregate living settings, including prisons and shelters, **with** symptoms."[15] FCI Danbury has taken an important first step in testing all detained people, although confirmatory testing is still pending for some.[16] However, the Health Services Administrator reports no plan to test the entire institution again.[17] And there will be a need to conduct more testing for many months and the CDC and even the BOP's own policies regarding COVID-19 identify the need to incorporate patient symptoms as triggers of testing. Given the systematic lack of asking detainees about COVID-19 symptoms at FCI Danbury, this will pose a real threat to adequate identification of new cases. In addition, more than one person reports that some aspects of testing are conducted by correctional staff, who do not appear to correctly utilize the testing swabs.[18] This practice represents a core challenge to the ability of testing to identify COVID-19 cases and slow the spread of the virus throughout the facilities.

Another concern regarding the current screening practices involves the use of the infrared thermometers. I have reviewed temperature data representing 17,517 temperature readings. Normal human body temperature range between 97-99 degrees Fahrenheit, with a less common distribution of temperatures above and below this range. Data from FCI Danbury revealed that temperatures recorded by staff fall far lower than the ranges reported in medical and scientific literature. For example, while most (83%) of the temperatures did fall in the 97-99 range, roughly 60 temperatures were recorded as being less than 95 degrees. This represents clinical hypothermia and is not only rare, but very worrisome if

[15] https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

[16] FCI Danbury initially utilized the Abbott ID Now test, which the FDA has reported as having high false-negative rates. The facility is re-testing all of the samples originally run on the Abbott test via another method and reported during the tour that they have a roster of pending and completed confirmatory tests.

[17] See HSA Deposition p 83-84.

[18] [redacted].

true. By comparison, only one temperature reading appeared to be more than 100.4, the clinical cutoff for fever. Because the range of normal human body temperatures extends both above and below the 97-99 range, one would expect to observe a much higher number of elevated temperature readings than was found.[19] Taken together these data raise concerns that there may be a systematic reduction in temperature readings with these devices, which is very concerning given that the temperature of 100.4 appears to be virtually the only metric that FCI Danbury is utilizing to find new potential COVID-19 cases. Prisoner reports bear out this concern. Ms. [redacted] states that her temperature was taken using one of these thermometers shortly before she was taken to the hospital. Her temperature at the facility registered 97. At the hospital less than an hour later it registered 102.[20]

**a. Sick Call**

It is clear that people detained at FCI Danbury face widespread barriers in receiving care through the sick call system. Among the people I spoke with, the lack of any timely response to sick call requests, for both COVID-19 related and other medical concerns was reported. The lack of timely responses to COVID-19 related symptoms is particularly concerning. Even when patients directly reported symptoms of COVID-19 to FCI Danbury staff, it appears that their reports often go ignored. This was true at all three facilities.

In the men's facility, Mr. [redacted] stated that he reported his COVID-19 symptoms multiple times to staff soon after he started to feel ill on March 20th. His complaints went unaddressed until his counselor personally escorted him to medical on the 29th or 30th of March, where he was tested and placed into medical isolation. Mr.

[19] https://www.scientificamerican.com/article/normal-body-temperature-is-surprisingly-less-than-98-6/ and

[20] [redacted].

[redacted] reports that he experienced a fever, trouble breathing, and loss of taste in mid-March. When he reported his symptoms to an officer on duty he was told to see medical staff in the morning. Medical staff told him he had a cold and to drink water and rest. Mr. [redacted] reports that over the course of a few days he sought medical care but was not seen. He was told he could not see medical unless his temperature was above 100 degrees, which it was not. Finally, after almost two weeks of being ill, and after coughing up blood he was taken to medical and then placed in isolation and tested for COVID-19. He ended up going to the hospital. He tested positive for COVID-19.[21] Mr. [redacted] reports that he told staff he was coughing, felt weak, his body hurt and he was tired, but he was turned away from medical before there was no staff there on that day of the week. He was able to see medical a couple of days later because he went there without waiting for sick call and begged a prisoner who worked there to help him have a doctor see him.[22]

The women from FSL reported similar concerns. Ms. [redacted] stated that she reported COVID-19 symptoms in sick call slips multiple times in March without any response from health staff. Ms. [redacted] reported that she submitted three separate sick call requests to the health staff who gave out medications in her housing area but was never called to be seen, despite the fact that all three forms reported COVID-19 symptoms. She was ultimately hospitalized for a heart condition after she went to the clinic herself. On March 22nd or 23rd, she and others in the FSL began to directly tell health staff of their COVID-19 symptoms, with no response. She reported her symptoms of body aches, fever, chills and headache to health staff when they came through the housing area, but to no avail. She reports laying in her bed for approximately one week with COVID-19 symptoms, but because her

[21] [redacted]

[22] [redacted].

temperature wasn't elevated staff did not take her seriously. She was only seen because she went to the clinic and asked to be seen by the physician, approximately one week after her initial request, and she was sent to the hospital. Ms. [redacted] also reported that her COVID-19 symptoms were ignored by the health staff who came to their medical unit. Ms. [redacted] reported similarly being ignored when she reported COVID-19 symptoms to health staff, and was even told after her temperature was found to be 101.7 that she probably has a nonspecific respiratory infection, without any physical examination or medical assessment. Ultimately, she was only seen when she went to pill line days later and refused to leave until she was seen. She was placed into the suicide watch cell and tested for COVID-19, which was positive.[23]

This lack of response to symptoms is extremely concerning, because it represents willful disregard not only to the potential clinical worsening of individual patients but the ongoing transmission to other detainees and staff. This lack of responsiveness to symptoms reported by patients not only increases the risk that COVID-19 will spread unabated, but also that people facing life-threatening emergencies unrelated to COVID-19 will die because their concerns go unaddressed.

Interviewees and declarants consistently describe problems and delays in accessing medical care more generally at the facility. Ms. [redacted] reported that she had submitted a paper sick call request in February for a medical problem that included pain and still had not received a response. Ms. [redacted] reported that is takes weeks to be seen by medical staff. On the day of our visit, she reported that she had put in a sick call request for bleeding from her ear eight days earlier, for what she worried

[23] See also [redacted] Declaration par 20 (sick in February with fever, chills, cough, chest pain; submitted sick call; not seen for six weeks).

was a perforated eardrum, and still had not been seen. Ms. [redacted] reports that she put in two sick call requests for vomiting, diarrhea, stomach ache and body pain, and was not seen for two weeks.[24] Sick call was also reported to be slow or unresponsive at the Camp, where Ms. [redacted] reported that there is a 4-6 week wait for sick call and that the provider, a nurse practitioner, had just returned from being away for 10 days during which sick call was not conducted. Ms. [redacted] from the camp also reported that sick call (whether paper or electronic) takes weeks for any response, if one comes. Medical staff are unavailable on the weekend.[25] Prisoners report days or weeks-long delays in seeing a doctor.[26]

i. The testimony of the Health Services Administrator revealed that prior to June 1, 2020, FCI Danbury has been purposefully destroying the paper sick call requests submitted by patients.[27] This represents a gross deficiency in the standard of care. The National Commission on Correctional Health Care, which accredits some BOP facilities, addresses the retention and documentation of sick call requests in the following manner: "Without documentation of these steps, it is not possible to evaluate the responsiveness of your sick-call system, and if you are seeking accreditation, to determine if you are in compliance. Request slips are usually filed in the health records and begin the documentation trail. If you do not file the slips in the record, a log may be kept to monitor the stages of the response. The log needs to include the request date, date and result of triage, date of the sick-call visit if required, etc."

[24] [redacted]

[25] [redacted]

[26] See, e.g., [redacted].

[27] See HSA [redacted] Deposition p 21-29.

The NCCH further identifies that "you should have documentation of compliance, either through the health records or through logs spanning three years."[28] This correctional standard of retaining sick call records is not limited to facilities that receive NCCHC accreditation. For example, in the New York City jail system (in which most facilities are not NCCHC accredited), retention of sick call information is mandated for three years as a matter of local law via the NYC Board of Correction Standards.[29]

The failure of FCI Danbury to retain these records creates multiple predictable problems in prisoner health care and COVID-19 response. Because it is not clear from the records that have been retained when sick call requests were submitted or what was written as the concern of patients, is it then impossible to monitor whether the facility responses were either timely or adequate. In general, any symptom or medical complaint by a patient should be responded to with a face to face encounter within 24 hours and my experience in correctional health is that the timeliness and adequacy of responding to sick call requests is a basic metric that is measured on a monthly basis and reviewed along with other correctional quality assurance metrics. During an outbreak, sick call requests become even more vital documents as they serve to allow for daily review of symptoms of the outbreak that can a) lead to expedited assessment of individual patients and b) provide aggregable data that is used to track the spread of the outbreak throughout the facility.

[28] https://mail.google.com/mail/u/0/?tab=wm&ogbl#inbox/FMfcgxwHNDCtkrkKqHjGPZnvXGkNfjGd

[29] http://library.amlegal.com/nxt/gateway.dll/New%20York/rules/title40boardofcorrection/chapter3healthcareminimumstandards?f=templates$fn=default.htm$3.0$vid=amlegal newyork_ny$anc=JD_T40C003

I have reviewed sick call slips that have not been destroyed, and there are indications from these slips of significant delays in care, even for those reporting symptoms consistent with COVID-19. For example, on May 15, 2020, Mr. [redacted] wrote on his slip: "I have been suffer lack of breath between three to four weeks" and checked off "I am felling short of breath" on his form. Yet the form indicates he was not seen until June 1, 2020. [redacted]

30. **Extreme medical staffing shortages.**

FCI Danbury has a severe shortage of medical staff available to see patients for sick call. Currently, there are only two physicians (Dr. [redacted] and Dr. [redacted]) and one part-time nurse (Ms. [redacted]) who are available for sick call appointments. Dr. [redacted] as medical director, has administrative responsibilities on top of seeing patients (his specialty is ob-gyn). None of these clinicians are at the facility on the weekend or after 4pm on weekdays. On the weekends, there are two EMT-paramedics present at the facility. (FCI Danbury employs a total of three EMT-Paramedics). There are no medical staff at the facility overnight on any day of the week.[30]

[redacted] It is unclear from the materials I have

[30] Interrogatory Response 6; HSA [redacted] Dep. 84.

[31] USA005897 (April 9 email).

[32] USA005897 (April 21 email).

reviewed what their responsibilities were during that time and they have all now concluded their temporary service at the facility in any event.[33]

Health Services Administrator HSA has acknowledged that FCI Danbury has had a "staff shortage for quite some time," which pre-dated the COVID-19 outbreak at the facility. She elaborated: "We have been short midlevel practitioners prior to this occurring. We've also had our nurse out on military leave, as you've seen. We also have some vacancies for a nurse or paramedic positions."[34] These shortages pre-dated COVID-19 and have continued.

These levels of staffing pose crucial risk for the health and welfare of prisoners, and force security staff to make crucial decisions about triaging emergencies overnight. In addition, this short staffing creates a situation in which the small amount of clinical time dedicated to sick call and chronic care only respond to the most emergent cases, leaving people with serious health problems to decompensate further. I have overseen medical care in 13 different correctional facilities, ranging in size from 800 to 2,400 and including women, men, pre-trial and sentenced people. I believe that the staffing levels described above represent less than half of what is needed during normal operations, and that the current levels are even more insufficient. In particular, the type of COVID-19 screening that is required at FCI Danbury relies on nursing staff to conduct. Additional staff are also required to ensure daily review of sick call and other medical requests and integrate all symptoms of COVID-19 (whether received from sick call, screening or other sources) into a facility database that tracks the outbreak. In addition, there is a need for more primary care physician staffing to supplement the lack of access to specialty care. My experience

[33] HSA Dep. 94-95.

[34] (HSA 105-108).

during widespread outbreaks and after large natural disasters is that incarcerated patients may be cut off from specialty care they absolutely need to diagnose or treat life-threatening illness. Primary care physicians are required to triage and manage these complex patients and neither nursing staff, nor mid-level providers are adequate to manage these crucial decisions. If telehealth can be implemented to supplement some of the specialty care, then mid-level providers can provide an important role. It is also important to recognize that the effects on health of these staffing shortages will become apparent in the coming weeks. The time course for chronic diseases to worsen, and undiagnosed disease to manifest in emergencies usually occurs over 2-3 months, and I fear that many patients who needed treatment in March, April and May will experience serious consequences in June and July.

31. **Patient education.**

The CDC identified education of patients in congregate settings as a critical element of identification of new cases. Multiple people I spoke with, including those who has been in medical isolation, quarantine and other specialized units, reported never receiving any basic education on the symptoms of COVID-19 to be aware of. In addition, in the one setting where a "town Hall" was reported, the message to prisoners from the facility staff was to "stop rabble rousing" regarding access to testing and care for COVID-19.[35]

32. **Inadequate medical isolation.**

a. **Use of punitive segregation or inappropriate settings for isolation.** One feature of the inadequacy of medical isolation at FCI Danbury is the reliance on punitive segregation as the primary response to COVID-19. The practice of locking people into cells with little no outside contact, meaningful medical care, and loss of privileges represents a stark disincentive to reporting COVID-19 symptoms.

[35] [redacted]

Medical isolation is not solitary confinement but the practices of MCI Danbury have essentially placed almost all the punitive experiences reserved for people who receive disciplinary infractions onto people who report COVID-19 symptoms or are found to have COVID-19.

Several prisoners reported fear of being placed in medical isolation or quarantine. Ms. [redacted] relayed that she was terrified to go into medical isolation because she didn't want to be left alone in one of the facility's suicide rooms.[36] While she was in that room she had no access to running water.[37] Ms. [redacted] reports being locked in a cell 24 hours a day and being cuffed to go to the shower while she was in SHU for quarantine.[38] Mr. [redacted] reports that the isolation room floors were dirty and that the soiled clothes of the person in the room before him were still in his cell.[39] Similarly, Mr. [redacted] reports a filthy isolation unit with broken tiles and dirt on the shower floor.[40] Ms. [redacted] stated this explicitly to me, that people are afraid to report their symptoms lest they be isolated without care or outside contact. Ms. [redacted] reported the same: "they [women at FSL] don't want to go to quarantine and be stuck in a cell or stuck in a classroom or be cuffed to go to shower."[41] Mr. [redacted] describes being sick for a week in April with fever, headaches, and lost sense of taste and smell, but not reporting symptoms because "I saw people who are sick being dragged to a quarantine unit where they're only allowed to shower once a week and they can't use the phone and aren't allowed outside at all to get

36 [redacted]

37 [redacted]

38 [redacted]

39 [redacted].

40 [redacted].

41 [redacted]

fresh air."[42] Similarly, Mr. [redacted] reports, "I did not put in a request to see medical because, like others, I fear the treatment in quarantine."[43]

Some of the women in FSL were placed into completely inappropriate settings for medical isolation, including classrooms and dining halls. Ms. [redacted] reported spending multiple days in the unheated library, sleeping on top of desks, when she returned from the hospital. She had no access to a bathroom without ringing a bell for correctional staff to come unlock her room. Medical staff did not check on her when she was in the library.[44] A number of women were isolated in the facility's visiting room.

The first woman to test positive to the Camp, a woman with documented heart conditions, has reported being placed in an isolation room that is 59 degrees, with a frosted window that does not open, with the lights on overnight, without regular access to phone or email, and without medical consultation for at least 48 hours.[45]

b. **Deficiencies in medical care in isolation.** Another inadequacy with medical isolation is the deficiencies of medical attention or care for COVID positive prisoners in isolation. Prisoners I spoke with who had experienced medical isolation reported little to no medical assessment or care while confined to their cell for 24 hours per day. Mr. [redacted] reported spending the first four days in his cell, with no access to shower or phone, and with no clinical assessments aside from daily temperature checks.[46] Ms. [redacted] reports that medical staff didn't interact with

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42 [redacted]

43 [redacted].

44 [redacted]

45 [redacted].

46 [redacted] (no record of medical consultation between 4/1 and 4/6.

the women in isolation when she was housed in the visiting room other than to distribute pills and take her temperature when she asked for it.[47] Ms. [redacted] reported that during her time in medical isolation, no health staff ever listened to her lungs with a stethoscope. She also reports that despite her positive COVID-19 test, she was returned to her original housing unit after less than a week in medical isolation. Ms. [redacted] also reports that no health staffer ever listened to her lungs during her 20 days in the library and time afterwards in the SHU, despite reporting shortness of breath.[48] Mr. [redacted] reports being left in an isolation unit for over a day without medical attention and without staff even realizing that he was in there or checking on him. He reports: "I was scared to go to sleep. I started crying in the cell. I'm a fairly tough guy but I started feeling like I was going to die in that cell alone."[49] He also describes being treated while he was in isolation, "like I did something wrong."[50]

Review of medical records reveals that when Mr. [redacted], a patient with a history of asthma, went to his chronic care visit, health staff identified symptoms of upper respiratory tract infection as well as the fact that many people in his housing area were coughing. His medical records note "Suspect for COVID-19 Coronavirus illness" and that "unable to do test for Covid-out of testing supplies". He was placed into medical isolation but there is only one record of any clinical assessment in the following week.

Those prisoners in isolation with COVID-19 are not seen by a doctor or nurse on the weekend, as the only medical staff at the facility on the weekends are EMT-

[47] [redacted]

[48] Ms. [redacted] reports the same during her stay in isolation. [redacted]

[49] [redacted] (no record of medical assessment 4/1-4/6.

[50] [redacted]

paramedics. Even during weekdays, COVID-19 patients are not consistently examined each day. Of the medical records I reviewed, it appeared that of the 90 prisoners whose records clearly reflected a positive COVID-19 test and placement in isolation, 62% of them were not seen by medical staff for at least one weekday while in isolation. More than half were not seen on at least two consecutive weekdays in isolation. The medical records of Mr. [redacted] indicate that despite being placed into medical isolation, and despite having documented seizure disorder, he was not assessed by clinical staff for a several day period during his isolation from 4/1/20-4/6/20. Other patients whose medical records reveal periods of no documented medical assessment include Mr. [redacted] (three days between assessments), Ms. [redacted] (five days between assessments), [redacted] (five days between assessments).

c. **Lack of follow-up care.** In addition some prisoners who tested positive report lack of follow-up care for continuing symptoms. For example, Mr. [redacted] reports that he had to wait several weeks for follow up care after reporting liver and kidney pains and trouble urinating, as well as a swollen foot. He reports submitting numerous sick call requests as well as a grievance before seeing a doctor. He only saw the doctor because she was on the unit to see someone else.[51] Mr. [redacted] reports complaining of chest pain after he was returned to his unit from isolation. Several sick call slips he submitted were not responded to.[52]

d. **Inadequate segregation of positive prisoners**. Multiple other prisoners report instances where there was inadequate efforts to segregate suspected positive and negative prisoners during testing. For example, men in the L-unit at FCI were left

[51] [redacted]

[52] [redacted].

in the unit after testing was done. One man who thought he was being put into quarantine before going home shook everyone's hands. He turned out to test positive.[53] In another instance men were left on the unit even after they were determined to be positive.[54] In the I Unit, Mr. [redacted] reports moving into a cell only to be informed that the person who occupied the cell immediately before him had tested positive for COVID-19 and that the cell had not been cleaned or disinfected. He and his cellmate cleaned the cell themselves without protective equipment to do so.[55]

33. **Testing.**

FCI Danbury staff, records and prisoner declarations reveal that despite an important step of testing all prisoners, important gaps remain in the approach to testing. One critical weakness is the adequacy of contact tracing and the testing of known contacts when new cases occur. This approach to testing is critical for responding to new cases of COVID-19 and has been identified as a core strategy by the CDC. CDC guidelines for congregate care settings, including nursing homes and prisons, identify that contact tracing is critical to slowing the spread of COVID-19 and the testing people with even mild symptoms is important. CDC guidelines further identify that to slow the spread of COVID-19 in nursing homes, new cases should result in testing of either the entire facility, or in cases where testing supplies are limited, all close contacts of the new case.[56] This latter approach was presented to me by facility staff as the approach being taken at FCI Danbury, however it appears that either the contact tracing or linkage to testing is incomplete. Multiple declarations from prisoners indicate that after at least one new COVID-19 case was

[53] [redacted]

[54] [redacted]

[55] [redacted]

[56] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

identified in the FSL dorm on May 7th, other residents of the same housing area were not tested. I understand that all the units at FCI Danbury were tested at the end of May by Quest tests. In the men's unit, positive cases were found in the E, F, G, H, I, J, Z, and SHU units. Everyone in a unit was tested on the same day. Because the tests results took multiple days to receive, everyone in the unit was exposed to the positive cases while awaiting the test results. At the time of the inspection, there had been no positive case in the Camp. On May 28, the Camp women were tested. On June 3, a woman was removed from the Camp based on a positive test. Two dorm-mates were also removed and put into the SHU, along with women being quarantined for home confinement.

34. **Slowing the Spread of COVID-19**

a. **Lack of social distancing.** Mr. [redacted] reported that social distancing was not possible in his unit, especially in the double cell bunks. The lack of social distancing is especially concerning in pill or medication lines. Ms. [redacted] and [redacted] also reported that there is no social distancing in the pill line of FSL.[57] Similarly, Ms. [redacted] and Ms. [redacted] at the camp both reported no social distancing in the pill line outside the clinic. Ms. [redacted] also reported that people from multiple housing areas report to pill line at the same time and they stand close enough that they are touching each day in pill line.

b. **Lack of adequate cleaning and disinfection.** The CDC makes clear that when a suspected COVID-19 case is identified, careful attention to cleaning and disinfecting areas where they spend time must occur. The CDC detention guidelines have a dedicated section for this critical work, which starts with the introduction "**Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as**

[57] [redacted]

Case 3:20-cv-00559-MPS Document 111-2 Filed 07/28/22 Page 35 of 79

**well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19."**[58] Mr. [redacted] reports that when he returned to his housing area after medical isolation, his personal effects and bed were as he had left them, that no effort had been made to clean or disinfect the area he had spent 9 or 10 days in while he developed symptoms of COVID-19 and was unable to receive care. Mr. [redacted] reports that the cell of a man who tested positive was not cleaned before the man's cellmate was placed back into the cell after testing.[59] Ms. [redacted] reports a lack of cleaning of bedding and other property of people with COVID-19. Even when some cleaning does occur it is because a Bunkie is asked to or volunteers to do so, often without any PPE.[60]

Other concerns regarding cleaning and infection control are apparent at FCI Danbury. While the soap dispensers were observed to be full during our inspection of FCI Danbury, multiple prisoners report that was not a normal occurrence and that soap dispensers are often empty and soap unavailable. [61] Hand sanitizer is reported to be similarly unavailable.[62] In addition, prisoners report lack of paper towels to dry their hands in the bathrooms.[63] Prisoners also report that the facility was cleaned thoroughly before our visit, and that such a cleaning was not otherwise regular.[64] Commonly used areas and objects are not cleaned regularly. There was no cleaning solution visible by the computers and phones in FSL, and the cleaning

[58] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

[59] [redacted]

[60] [redacted].

[61] [redacted]

[62] [redacted].

[63] [redacted]

[64] [redacted]

bottle observed in the cell block in the men's unit had no paper towels or towels nearby for application. Prisoners report that phones and computers are not cleaned between every use.[65]

c. **Lack of wearing masks.** Multiple detained people reported that facility staff had made a special effort to get everyone to wear a mask for the inspection, but that this is not the normal state of affairs. Ms. [redacted] stated that most people wear the masks "as a chin strap" most of the time. Ms. [redacted] reported that the attention to wearing of gloves, masks, cleaning of floors and posting of signs in her unit had occurred in the run-up to the facility inspection. She also expressed fear of retaliation for speaking about her observations. Records document complaints from staff that masks aren't available[66] and that staff and prisoners have been disciplined for not wearing masks.[67]

35. **Protecting High-Risk Detainees**

There does not appear to be any effort to identify and protect high-risk inmates from COVID-19 in the FCI-Danbury facilities. These efforts would generally involve maintaining a roster of all people who meet CDC criteria for being at high-risk of serious illness or death from COVID-19, and then cohorting these people in specialized housing areas that have higher levels of infection control, staff training and also allow for more reliable delivery of health care and medications. Such a plan is envisioned in the BOP 2012 pandemic flu plan.

a. **Identification of medically vulnerable.** [redacted]

[65] [redacted].

[66] [redacted].

[67] [redacted].

Case 3:20-cv-00559-MPS Document 111-2 Filed 07/28/22 Page 37 of 79

[redacted]

HSA indicated at her deposition that she asked FCI Danbury physicians to review the list and identify the "true risk factors."[70] It appears that she made this request on May 7, 2020, as an email from HSA to Drs [redacted] Nurse [redacted] says: "please look at this list and let me know if you think any inmate meets criteria for Medical Exemption Release. Focus on the 3s and 2s."[71]

HSA says that the doctors sent back names of around 20 people that they thought were higher risk and would do better outside the institution, and she forwarded these names to the Warden.[72] HSA says she did not do anything else with the April 1 list.[73] The April 1 list included Mr. Gentile, who died of COVID-19 related complications on April 9. The April 1 list indicated that Mr. Gentile was a 59-year-old enrolled in the facilities cardiac chronic care clinic.[74]

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[68] USA006103.

[69] USA008860-8865; HSA Dep. 41.

[70] HSA Dep. 47-49.

[71] USA 008953.

[72] HSA Dep. 58, 69.

[73] HSA Dep. 50.

[74] USA008860-8865, HSA Dep. 64:8-19.

FCI Danbury did not develop a plan to provide special protection to the medically vulnerable at the institution. The plan for the medically vulnerable was the same plan they applied to everyone else, which HSA describes as screening and sick call.[75]

b. **Attempt at cohorting.** I am aware of only one attempt—an inadequate one that has already been discontinued—to cohort medically vulnerable inmates at FCI Danbury during the COVID-19 crisis. Inmates in the E Unit were moved to 10-man rooms within the unit called "bus stops."[76] The men in the bus stops had to share the bathrooms and showers with the other men in E Unit.[77] FCI Danbury abandoned this approach, apparently because there was mingling with other men in the unit.[78] My understanding is that there has been an explicit decision *not* to create designated areas for medically vulnerable inmates at FCI Danbury.[79]

Among the inmates that we spoke with who meet CDC criteria for being high-risk, none of them had been placed into specialized units for increased surveillance or protection from COVID-19 and none of them was receiving any additional screening for COVID-19 symptoms. In fact, none of them was receiving any symptom screening. In addition, the reports by numerous detainees of lack of social distancing in the pill lines of the various FCI Danbury facilities creates a special risk for the very people who are high-risk because they are the ones most likely to be going to pill lines.

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[75] HSA 66-67.

[76] HSA Dep. 55.

[77] HSA Dep. 56.

[78] HSA Dep. 56.

[79] HSA Dep. 57-58.

c. **Response to COVID symptoms for high-risk patients.** Review of medical records indicates that FCI Danbury health staff have been slow to respond to COVID-19 symptoms among high risk patients. Mr. [redacted], who has asthma, reported his COVID-19 symptoms via sick call and during his encounter with a paramedic, he reported increased use of his asthma inhaler. He is the type of patient that should be screened at least once per day for COVID-19 symptoms and also housed in a high-risk settings with increased infection control precautions and staff training. Instead, his COVID-19 symptoms of shortness of breath and 'mild cold symptoms' were treated as a viral cold. He returned four days later, was seen by a physicians who documented that "Pt reports hx of asthma and has been feeling sick for 5 days. Pt states that he isolated himself and stayed in his room because he was feeling sick." Mr. [redacted] was sent to the hospital with respiratory and cardiac symptoms of COVID-19 and tested positive for COVID-19.

d. **Lack of adequate care for chronic health problems.** It is also my assessment that a lack of access to adequate care for chronic health problems at FCI Danbury will create additional risk of serious illness or death from COVID-19. The CDC has made clear in addition to the chronic disease risk factors for COVID-19 severity, there is additional risk created when those conditions are poorly controlled. This is exactly the circumstance that is created by lack of access to chronic and specialty care at FCI Danbury. For example, Ms. [redacted] reports that she has been unable to receive specialty care for her Crohn's disease for several months despite reporting abdominal pain, rectal bleeding and inability to eat. She reports being told by the facility physician that she doesn't currently have access to specialty care.

e. I have reviewed the pending consultation requests for FCI Danbury and find that many of the specialty encounters are still pending after months of waiting.[80] Notably, there are a total of 340 pending requests from physicians or APRNs for specialty consultations or outside procedures for prisoners at FCI Danbury. In particular:

   i. 69 requests are "pending institution clinical director action"; 27 of these have been categorized by the doctor or APRN as "urgent" requests and 3 are in the category "emergent"

   ii. 1 request is pending "UR Committee Action"

   iii. 144 are pending "consult" occurring; 56 are urgent and 1 emergent

   iv. 127 are pending "scheduling"; 32 are urgent and 8 are "emergent"

   This circumstance is extremely dangerous as chronic health problems that are treatable go undiagnosed or untreated, increasing the risk of preventable morbidity and mortality.

f. Ms. [redacted] and Ms. [redacted] also report two instances which raise concerns that lack of access to care for non-COVID-19 problems may have led to emergency hospitalizations. They both report one instance in late May when a women developed a rash that spread covered her entire body and caused her eyes to swell shut and that over three days health staff ignored her worsening condition, giving Benadryl and steroid shots without removing her to an infirmary or the hospital. She was ultimately sent to the hospital and had not returned several weeks later when Ms. [redacted] and Ms. [redacted] gave their declarations.[81] A second case reported by Ms. [redacted] involved a woman developing a "mini-stroke" which

[80] USA 005227

[81] [redacted]

involved acute arm numbness, that was treated by health staff with a sling for her arm for a day until she was finally transferred to the hospital.

g. **Lack of air-conditioning a concern for high-risk individuals.** I am also concerned about the lack of any air-conditioned units in FCI Danbury[82], especially for high risk patients who have health issues that make them heat sensitive. Patients with chronic heart or lung problems, with serious mental illness, and people prescribed medications that impair heat regulation or promote dehydration, including certain antipsychotics, medications for hypertension, diabetes, cancer, antibiotics and others are "heat sensitive" and require air conditioning in warm settings. These patients will be doubly vulnerable in high-heat conditions should they become infected with COVID-19. As subsequent waves of COVID-19 arrive in the summer months, it is especially important to have this group, which largely approximates the high-risk COVID-19 cohort, identified, subject to active surveillance of signs and symptoms of COVID-19 and protected from excessive heat.

36. **Case of** [redacted]

The deficiencies identified above represent multiple systemic carriers to prevention, identification and response to COVID-19 in FCI Danbury. But the case of one patient, [redacted], and the people around, her reveal how interconnected these failures are in amplifying the spread and severity of COVID-19 in FCI Danbury. Ms. [redacted] timeline of events starts on April 24, when she became ill in the evening. No medical staff are present in the facility to respond to requests for assistance. She spent several hours in the bathroom toilet stall vomiting and retching, with several of the women in her housing area

[82] See, e.g., [redacted] (no air conditioning and temperatures can run over 100 degrees).

intermittently helping her. Some of them were also vomited on, they were not wearing masks or gloves. Late that evening or early in the morning of the 25th, a Lieutenant calls EMS and she is transported to the hospital, where she is quickly intubated for respiratory protection, and tests positive for COVID-19. The next morning, other women are told to clean the bathroom floor where she was vomiting for several hours, without gloves. That day, some of the people in the housing area are tested, but not all of the women who were in close contact with Ms. [redacted]. Of 40 women who were tested, approximately 10 were positive and moved to be housed in a visiting room while the 30 who were negative were moved to the dining hall. At least one of the women in the dining hall would be subsequently hospitalized with COVID-19. I also spoke with several women who identified and reported their own COVID-19 symptoms in Ms. [redacted] housing area in the weeks before she became ill. Their reports appear to have gone largely ignored, initiating the spread of the virus throughout the large, densely packed FSL, and ultimately, to Ms. [redacted] and others. [83]

## V. Recommendations

FCI Danbury should implement the following recommendations:

Institute daily symptom screening of all detained people, along with temperature checks. This screening would utilize a standardized tool that records the presence or absence of the CDC verified symptoms of COVID-19. Screenings would be scanned or otherwise entered into each person's medical record and any positive symptoms or signs would not only trigger clinical assessment, but would also be entered into a facility tracking database of COVID-19 symptoms;

[83] See [redacted]

Implement same-day review of every sick-call slip and electronic submission by a nurse, midlevel provider or physician that will (i) trigger immediate (same day or next morning) assessment for COVID-19 and (ii) provide data that creates a facility wide symptom tracking dashboard that health care staff will use. FCI Danbury and BOP generally should stop the practice of destroying sick call requests and retain them as part of medical records;

All patients who are suspected or confirmed to have COVID-19 should receive a standardized clinical evaluation at least daily by nursing or physician staff in a clinical setting and not cell-side;

Identify, cohort and regularly test all prisoners who possess risk factors for serious illness or death from COVID-19;

All quarantine units should follow CDC guidelines for management of COVID-19 including the use of appropriate PPE, cleaning of common surfaces, and exclude individuals not suspected to or confirmed to have COVID-19; including twice daily sign and symptom surveillance in addition to temperature check;

Test patients who possess more than one sign and/or symptom of COVID-19;

Test staff who possess (i) risk factors for serious illness or death from COVID-19; or (ii) more than one sign and/or symptom of COVID-19[84];

Use of medical professionals, not security staff for symptom screenings as well as COVID-19 testing;

[84] The CDC recommends re-testing an entire facility when a new case occurs in a nursing home. This approach may prove most expedient for FCI Danbury but the approach outlined in these recommendations represent a minimum of what is needed.

Increase medical staffing levels to allow for timely access to nursing sick call and physician evaluation seven days per week.

Lower census in housing areas to allow for social distancing.

Implement social distancing in medication lines and other congregate movement and activities.

Complete confirmatory testing of COVID-19 samples originally run with Abbott ID Now tests.

Facilitate release of medically vulnerable individuals who do not represent a danger to the community.

My assessment of the COVID-19 response at FCI Danbury is based on the information available to me and I reserve the right to supplement this assessment based on additional information.

Dated: June 6th, 2020
Port Washington, New York

# ATTACHMENT 3

Quinnipiac School of Law

Legal Clinics

October 30, 2020

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter,* Concerns about Conditions

Dear Ms. McConaghy and Mr. Putnam:

As you know, on July 24, 2020, the U.S. Attorney's Office issued a letter stating the Bureau of Prisons' intention to take certain actions at FCI Danbury to meet the medical needs of prisoners during the COVID-19 pandemic and to mitigate and control the spread of the virus. ("Letter," attached as Exhibit A.). We are concerned that FCI Danbury is not taking many of the actions referenced in the Letter. We write to request that you work with the facility to correct these failures. We note that the BOP website reports four active COVID-19 cases among prisoners at the facility now, with one staff member also infected. As you may know, the City of Danbury itself is currently experiencing increased rates of infection, raising further concern. *See* Connecticut COVID-19 Data Tracker, https://portal.ct.gov/Coronavirus/COVID-19-Data-Tracker. Given these circumstances, we hope that FCI Danbury will move expeditiously to address the concerns we raise in this letter.

## I. Sick Call Slips/Access to Health Care at the Facility

The Letter provided assurances that "sick call slips will be collected on a daily basis" and triaged by a medical provider that same day. BOP also stated that these slips "will be retained and scanned into the inmate's BEMR medical records." (Ex. A ¶ 3) However, we have not seen any sick call slips in the hundreds of medical records we have received from August 13, 2020 to present. We ask that you ensure that these slips are indeed being preserved and incorporated into the BEMR medical records. The slips, as part of the BEMR record, should be provided when we request the inmate's records. Indeed, they may contain information relevant to a client's vulnerability to COVID-19. Note that outside of the commitments in the Letter, BOP policy requires that these slips be made part of the inmate's medical records. *See* BOP Program Statement 6090.04, Health Management, at 20; BOP Program Statement 6031.04, Patient Care, at 21.

In addition, although the Letter commits to collecting and triaging sick call slips on weekends, there are reports in the men's facility that sick call slips are not being collected at all on the weekends. Across all three facilities, we continue to hear about concerning delays in treatment for serious medical issues, including delays in individuals being seen by staff and delays of multiple weeks

in obtaining prescribed medication. We have heard reports from individuals in both the FSL and the men's facility about delays in access to medical care even where prisoners are exhibiting symptoms consistent with COVID-19.

Finally, the painful and irritating rash continues to afflict many in multiple units at the men's facility. We request an update on this concerning situation.

## II. Medical Staffing Levels

In the Letter, BOP assured that "[s]taffing at FCI Danbury will be commensurate with its classification as a Care Level 2 institution pursuant to BOP's Clinical Guidance." (Ex. A ¶ 5) As of July 24, 2020, only 18 of the 25 medical staff positions were filled. We ask that you provide us an update on the current medical staffing levels at FCI Danbury.

## III. Delays in Consultations and Procedures in the Community

BOP also committed in the Letter to take steps to reduce the backlog in medical consultations and procedures in the community. (Ex. A ¶ 8) We have heard numerous reports of individuals still waiting to see specialists for critical consultations and procedures. Here are some examples:

- An urgent surgery consultation has been pending for more than three months for a woman with a history of cancer who has masses growing on her genital region.
- A man suffering from congestive heart failure has required urgent evaluation and treatment by a cardiologist for many months (in January 2020, an X-ray showed cardiac enlargement and an EKG had critically abnormal findings).
- A man in urgent need of a colonoscopy has been waiting for the procedure since 2019.
- A man is awaiting urgently needed orthopedic, podiatry, and pulmonology consultations that were ordered many months ago. His condition has deteriorated in the interim and he is now confined to a wheelchair.
- A man with cerebrovascular disease and uncontrolled diabetes is suffering from severe retinopathy in both eyes. In January 2020 an ophthalmologist said he needed a "consult with a vitreoretinal specialist/surgeon ASAP." In June 2020, Dr. Schindler, noting that the man had still not been seen for the condition by a specialist, said: "It is felt this pt. will be better served in the community where he can receive the treatment he desperately needs to prevent blindness." Yet this man remains at FCI Danbury, going blind, and still awaiting consultation and treatment from a specialist.

We, or other attorneys, have previously brought each of these situations to your attention. Their names are included on the attached list. (*See* Ex. B). These are just a few of the many examples of people awaiting urgently needed consultation and procedures in the community. We are concerned that FCI Danbury has not taken sufficient action in the past three months to reduce the backlog of pending consultations and procedures that are urgently needed.

## IV. Daily Temperature and Symptom Checks

The Letter states that "[d]aily temperature checks of inmates will be conducted by a member of the medical staff or a lieutenant (or higher ranking staff member)" and during temperature checks "inmates will be asked a series of scripted questions designed to screen for COVID-19 symptoms." In addition, "[l]ogs of symptom and temperature screenings will be preserved." (Ex. A ¶ 2) We have heard reports from all three facilities (the Camp, FSL, and men's facility) that correctional officers—rather than medical staff or higher ranking staff members—are conducting the temperature checks. The checks are not occurring consistently each day (i.e., there have been many missed days). The equipment used is at times producing implausible temperature readings (e.g., 91 degrees). In addition, staff are not asking about COVID-19 symptoms during these checks. We ask that a comprehensive audit of this screening process be conducted by your office or the Warden. Compliance with proper screening procedures is particularly critical as there are now again active cases of COVID-19 at the facility.

## V. Isolation and Quarantine

We also have concerns about isolation and quarantine practices including the length of quarantine being required before release, the use of inappropriate spaces for medical isolation and quarantine, and the conditions within isolation and quarantine areas.

We understand that BOP has a policy requiring all individuals approved for home confinement or residential reentry center placement to be quarantine for 14 days prior to release. However, there are reports that individuals are being required to quarantine for 21 days rather than 14 days prior to release from FCI Danbury.

In addition, we understand that women from the Camp are now being quarantined in the Special Housing Unit ("SHU") at the men's facility before release—despite the existence of empty dorm rooms in the Camp. This practice places minimum-security women in unnecessarily punitive conditions and exposes them to interactions with staff and prisoners at the men's facility, where there are now active COVID-19 cases. In addition, we understand that because of space constraints in SHU, fewer women are able to quarantine at the same time and release dates are being postponed. Women from the Camp were previously permitted to quarantine at the Camp. With the population of the Camp down, we request that this previous practice be allowed.

We have also heard reports about the use of inappropriate spaces for medical isolation and quarantine in the FSL. As an example, a woman who tested positive for COVID-19 in the FSL was housed in the suicide observation room and other women were required to sit immediately outside the room, with an open food slot allowing air to move from one area to another, without access to PPE. This positive woman was then moved to the library as a quarantine/isolation measure.

Finally, according to the Letter, the BOP assured that while FCI Danbury will use the SHU as an available space for quarantine and isolation purposes, prisoners "will not be subject to punitive housing measures." The Letter referenced a requirement to handcuff individuals in SHU while going to

the showers, but stated that "a waiver of this requirement has been submitted to the Central Office for inmates isolated and/or quarantined in the SHU for COVID-19 purposes." (Ex. A ¶ 6) We understand that handcuffs are still being used for showers, and we ask that you provide an update on the status of that waiver request.

## VI. Testing

The Letter commits that "if any inmate tests positive for COVID-19, all inmates housed within the COVID-19 positive inmate's housing unit will be tested." (Ex. A ¶ 4) BOP's website now reports 4 active inmate cases at the facility and 1 staff member infected. Please confirm that all individuals have been tested who were housed in the same unit as these positive individuals. We understand that facility-wide testing has not been done since late May. Given the high rate of community spread in Danbury and surrounding areas—and the number of positive cases now within FCI Danbury—we recommend that the entire facility be tested.

In sum, we are concerned that many of the commitments made in the Letter are not being implemented. As a result, individuals at FCI Danbury continue to be at increased risk from both COVID-19 and other health issues during the pandemic. We hope that you will address these issues promptly with the facility.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Alexis Farkash, *Law Student Intern*
Abigail Mason, *Law Student Intern*
George Morgan, *Law Student Intern*
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David S. Golub
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Silver Golub & Teitell LLP
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# Exhibit A

**United States Department of Justice**

*United States Attorney*
*District of Connecticut*

*Connecticut Financial Center*
*157 Church Street, 25th Floor*
*New Haven, Connecticut 06510*

*(203) 821-3700*
*Fax (203) 773-5376*
*www.justice.gov/usao-ct*

July 24, 2020

*Via E-Mail*
David S. Golub, Esq.
Silver Golub & Teitell LLP
184 Atlantic Street
Stamford, CT 06901
dgolub@sgtlaw.com

Re: *Martinez-Brooks et al. v. Easter et al.*, Case No. 3:20-cv-00569-MPS

Dear Attorney Golub:

On July 24, 2020, the Petitioners, who are class representatives of inmates at FCI Danbury, and the Respondent, Diane Easter, the Warden of FCI Danbury, entered into a Civil Settlement Agreement ("Settlement Agreement") to resolve allegations made in *Martinez-Brooks et al. v. Easter et al.*, Case No. 3:20-cv-00569 (MPS).

Beyond the terms of the Settlement Agreement, Petitioners requested that the Bureau of Prisons ("BOP") make certain assurances regarding actions being taken at FCI Danbury to meet the medical needs of inmates during the COVID-19 pandemic and to mitigate and control the spread of the virus. The BOP declares that the following actions are currently being performed at FCI Danbury and will continue to be performed at FCI Danbury for the time period that the Settlement Agreement remains in effect.

1. Inmates exhibiting symptoms indicative of a COVID-19 infection will be seen by a nurse or doctor the same day that the COVID-19 symptoms are reported by either the inmate or BOP personnel (or, for those reporting symptoms in the evening, the next morning).

2. Daily temperature checks of inmates will be conducted by a member of the medical staff or a lieutenant (or higher ranking staff member). During temperature checks, inmates will be asked a series of scripted questions designed to screen for COVID-19

symptoms.[1] These questions will be addressed to each housing unit at large. Logs of symptom and temperature screenings will be preserved.

3. Sick call slips will be collected on a daily basis. Sick call slips collected Monday through Friday will be triaged by a medical provider (nurse or doctor) that same day. Sick call slips submitted on a Saturday or Sunday will be triaged by a medical provider (paramedic or nurse) that same day. Sick call slips will be retained and scanned into the inmate's BEMR medical record. Sick call appointments and procedures will be conducted in accordance with BOP's Program Statement 6031.04, Patient Care. The U.S. Attorney's Office will contact FCI Danbury when counsel for Petitioners bring to their attention instances where counsel have a good faith basis to believe an individual's access to medical care has been delayed and that the individual is demonstrating COVID symptoms or is otherwise urgently in need of medical care.

4. Inmates exhibiting COVID-19 symptoms will be tested. The BOP will follow its current guidance on testing, including its now current guidance issued on June 19, 2020. If any inmate tests positive for COVID-19, all inmates housed within the COVID-19-positive inmate's housing unit will be tested.

5. Staffing at FCI Danbury will be commensurate with its classification as a Care Level 2 institution pursuant to BOP's Clinical Guidance. Currently, there are 18 of 25 medical staff positions filled. There are current certificates for one Advanced Practice Nurse position and one Medical Officer position. There are current postings for one Medication Technician position, one Staff Pharmacist position, and Clinical Nurse position. One Chief Pharmacist position is pending posting. One Nurse Practitioner will enter on duty effective July 16, 2020.

6. Medical rounds for wellness checks will be made daily in all isolation and quarantine spaces. On weekdays, the wellness checks will be performed by a doctor or nurse. On weekends, a paramedic may do the wellness checks if a nurse or doctor is not at the facility. FCI Danbury will continue to use its available space for quarantine and isolation purposes. This includes the Special Housing Unit ("SHU"). Inmates quarantined and/or isolated in the SHU will not be subject to punitive housing measures. Inmates quarantined and/or isolated in SHU for COVID-19 purposes will be eligible to receive the following benefits: commissary, use of computer and phone, and personal property will be available at times that do not disrupt the administrative needs necessary to accommodate the quarantine/isolation function. Additionally, reasonable restrictions on the amount of personal property allowed in the SHU isolation/quarantine unit may be imposed to prevent fire/safety hazards. Inmates quarantined and/or isolated in SHU for COVID-19 purposes will have access to appropriate bedding, showers suitable meals, and drinking water, as well as to mail and legal calls. While there is a BOP requirement that all inmates in the SHU be handcuffed while going to the showers, a waiver of

[1] Subject to a change in CDC guidance, inmates will be asked the following verbal screening questions: "*Today or in the past 24 hours, have you had any of the following symptoms: Fever, felt feverish, or had chills? Cough? Difficulty breathing?*" *See* Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

this requirement has been submitted to the Central Office for inmates isolated and/or quarantined in the SHU for COVID-19 purposes.

7. For the safety of inmates and the community, it is BOP policy that all inmates who are approved for home confinement or residential reentry center placement be quarantined for 14 days prior to release from FCI Danbury. Inmates may seek a waiver of the 14-day quarantine requirement before being released to home confinement. Decisions regarding this waiver request will be based on circumstances in existence at the time the wavier is sought.

8. The BOP recognizes there is a backlog of non-COVID-19-related, non-emergent outside medical care consultation requests due to the shutdown of medical care facilities in the community during the COVID-19 pandemic. In addition to the Program Statement on Patient Care (Number 6031.04), and the Institution Supplement (Number DAN 6031.01D), the BOP will employ the following practices to deal with the backlog:

a. The Utilization Review Committee will continue to prioritize outside medical care consultation requests based on need.

b. FCI Danbury will begin the use of telemedicine in order to assist with the backlog. In the future, FCI Danbury plans on employing telemedicine by video as well.

c. Consistent with current practice, where practicable, FCI Danbury will bring specialists into the institution to deal with volume appointments within the same specialty.

FCI Danbury intends to keep the foregoing protocols in place for so long as the Settlement Agreement is in effect. The foregoing protocols may be suspended or modified in part or in their entirety if the Warden or her designees determine that a "genuine emergency" exists at FCI Danbury.[2] Moreover, FCI Danbury reserves the right to change the foregoing protocols based on significant operational needs or presently unforeseen events or conditions, including but not limited to substantial changes in established infection control practices or the standard of care for treatment of COVID-19 infection.

This letter is being provided to you for informational purposes only, and is not intended as any sort of consideration for, nor should it be construed as forming any part of, the Settlement Agreement.

[2] "Genuine emergency" means any special circumstances under which it is reasonable to conclude that there is any actual or potential threat to the security of FCI Danbury, or to the safety of the staff, prisoners or other persons within any one of the institution's facilities.

Very truly yours,

JOHN H. DURHAM
UNITED STATES ATTORNEY

John B. Hughes, Chief Civil Division
Assistant United States Attorney

# Exhibit B

**EXHIBIT B**

Below we identify the individuals referenced in the letter who are awaiting urgently-needed consultation and procedures in the community

- An urgent surgery consultation has been pending for more than three months for a woman with a history of cancer who has masses growing on her genital region. **[M[redacted] B[redacted], Reg. No. [redacted])**
- A man suffering from congestive heart failure has required urgent evaluation and treatment by a cardiologist for many months (in January 2020, an X-ray showed cardiac enlargement and an EKG had critically abnormal findings). **[T[redacted] S[redacted], Reg. No. [redacted]]**
- A man in urgent need of a colonoscopy has been waiting for the procedure since 2019. **[M[redacted] S[redacted], Reg. No. [redacted]]**
- A man is awaiting urgently needed orthopedic, podiatry, and pulmonology consultations that were ordered many months ago. His condition has deteriorated in the interim and he is now confined to a wheelchair. **[J[redacted] W[redacted], Reg. No. [redacted]]**
- A man with cerebrovascular disease and uncontrolled diabetes is suffering from severe retinopathy in both eyes. In January 2020 an ophthalmologist said he needed a "consult with a vitreoretinal specialist/surgeon ASAP." In June 2020, Dr. Schindler, noting that the man had still not been seen for the condition by a specialist, said: "It is felt this pt. will be better served in the community where he can receive the treatment he desperately needs to prevent blindness." Yet this man remains at FCI Danbury, going blind, and still awaiting consultation and treatment from a specialist. **[R[redacted] F[redacted], Reg. No. [redacted]-[redacted]]**

Quinnipiac
School of Law

Legal Clinics

November 23, 2020

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about Conditions at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write to follow up on our October 30, 2020 letter expressing concern that FCI Danbury is not taking certain actions that it had committed to take to meet the medical needs of prisoners during the COVID-19 pandemic and to mitigate and control the spread of the virus. On November 4, you indicated in response to our letter that you planned to visit the facility this past week (week of November 16-November 20) and could speak with us about conditions after your visit.

We are eager and await your response as soon as possible regarding the matters that we raised in our letter. In the three weeks since we wrote, the rates of COVID infection in the state have grown exponentially, raising additional concerns and reaffirming some outstanding ones. Below, we outline concerns about conditions at the facility, in addition to the ones raised in our October 30, 2020 letter, that we want to bring to your attention and discuss with you.

- *Detection of COVID-19: Symptom Screenings, Temperature Checks, and Testing:* In our letter of October 30, we expressed concern that daily symptom screenings were not being performed, temperature checks were not being conducted properly and consistently, and no facility-wide testing had been done since May. We continue to hear that temperatures are not being taken daily in all locations and are often conducted by correctional officers rather than medical staff or lieutenants. We understand that a wall-mounted thermometer is now being used in the dining hall to test the men's temperatures, but that staff are seldom recording any temperatures. Individuals from all three facilities report that symptom checks are not being conducted. Facility-wide testing has still not been accomplished. As you know, individuals with COVID frequently do not present with a fever. As COVID rates continue to rise in the community, we are concerned that that the facility is not taking appropriate steps to detect those infected with the disease.

- *Isolation and quarantine*: Inappropriate locations continue to be used for quarantining women. We understand that the education rooms at FSL are being used to quarantine women coming

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into the Camp and FSL. The women placed in these rooms are kept in a locked room with no way to alert staff to any medical needs or emergencies and with no heat overnight. There are no bathroom facilities in these rooms, so women have to wait for staff to let them out to use the bathroom, or they have to use a bucket left in the room to relieve themselves.

- *Sanitation, Heat:* We understand that units in the men's facility as well as the Camp have been without heat or hot water for multiple days this month. In the FSL, women are frequently without hand soap or paper towels in the bathroom and without readily accessible cleaning solution to clean the common areas.

- *Rash and other medical issues:*
    - Numerous men continue to express alarm and extreme discomfort from the rash, which has been present at the men's facility since spring 2020. Men continue to suffer from the rash despite being treated for scabies or receiving medication intended to treat their itching. The rash is described as red, raised, and incredibly itchy. Some sufferers report feeling as though their skin is on fire, that they have open wounds from itching, and that the rash makes it uncomfortable to walk and impossible to sleep. The men report that they have not had skin or blood samples taken to determine the cause of the rash. Some have also expressed concern that they are being treated with oral ivermectin, which is not FDA approved for the treatment of scabies, and which has made the rash worse in some instances. One of the men who took the medication now has the rash covering his entire body and has many open sores. (*See* Ex. A for additional details). We seek an update on the facility's treatment plan for this persistent condition and ask that samples be analyzed by a specialist to verify the cause of the rash—including a determination of whether it is indeed related to COVID-19—and to develop a treatment plan.
    - Countless individuals incarcerated at FCI Danbury continue to wait for urgently-needed visits with medical staff at the facility, as well as consultations and procedures in the community. For example, a woman at the Camp is pregnant and has yet to receive an ultrasound—despite being 6 months along in the pregnancy. She has been told by medical staff that she will not be receiving an ultrasound during the pregnancy. (*See* Ex. A). One man has been experiencing blood in his stool since this summer. In early October, Dr. Greene evaluated him and expressed concern that he may have colon cancer. A consultation confirmed he urgently needs a colonoscopy. In mid-November, the man learned the procedure had still not been scheduled and may take another 90 days to be performed.
    - We are also still awaiting a response to the urgent medical concerns we raised with respect to other individuals on October 30.

We look forward to hearing from you soon regarding these concerns, as well as the other issues we raised in our October 30, 2020 letter.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Alexis Farkash, *Law Student Intern*
Abigail Mason, *Law Student Intern*
George Morgan, *Law Student Intern*
Krista Notarfrancesco, *Law Student Intern*
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Ariadne Ellsworth, *Law Student Intern*
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# Exhibit A

**EXHIBIT A**

Below we identify the individuals referenced in the letter who are awaiting urgently-needed medical treatment:

- **J[redacted] G[redacted] (Reg. No. [redacted])** requires immediate medical attention. He has a severe rash that went untreated for two months. A week ago, he was given ivermectin and had a severe reaction: the rash got much worse and is now covering most of his body—with open sores that are weeping pus and soaking his clothes. He urgently needs to see a specialist. In addition to having a BMI of 62.5 (he weighs 461 pounds), Mr. G[redacted] suffers from severe asthma, obstructive sleep apnea, and peripheral vascular disease/deep vein thrombosis. He was hospitalized in 2018 for cellulitis and sepsis and has been hospitalized multiple times in 2020 for breathing difficulties and chest pains. Mr. G[redacted] is on blood thinners because of his past DVTs and he is in grave risk of infection given his open sores and medical history.

- **S[redacted] J[redacted] (Reg. No. [redacted])**, a woman at the Camp, is pregnant and has yet to receive an ultrasound—despite being 6 months along in the pregnancy. She has been told by medical staff that she will not be receiving an ultrasound during the pregnancy. (See Ex. A).

- **K[redacted] D[redacted] (Reg. No. [redacted])** has been experiencing blood in his stool since this summer. In early October, Dr. Greene evaluated him and expressed concern that he may have colon cancer. A consultation confirmed he urgently needs a colonoscopy. In mid-November, Mr. D[redacted] learned the procedure had still not been scheduled and may take another 90 days to be performed.

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December 7, 2020

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about Conditions at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write to follow up on our letters of October 30, 2020 and November 23, 2020 expressing concern that FCI Danbury is not taking certain actions that it had committed to take to meet the medical needs of prisoners during the COVID-19 pandemic and to mitigate and control the spread of the virus. On November 24, 2020, you informed us that you had met with staff at the institution the week before and had "been assured that FCI Danbury remains in substantial compliance with the July 24, 2020 side letter (the 'comfort letter') and is dedicated to striving to meet each assurance made in that letter."

Unfortunately, since we last wrote, we have continued to learn of concerning failures at the facility to control the spread of the disease. We understand there are now a number of positive COVID-19 cases in the general population of the prison in both the men's and women's facilities. As of today, the Warden reported to prisoners that there were 10 positive cases among them at the facility. (The BOP website reports that 3 staff members have also tested positive at the facility). In the past few days, we have learned that many individuals are experiencing symptoms of the disease. We are concerned that the facility is not taking appropriate steps to prevent COVID from further spreading within the facility. We are also concerned about access to medical care for medically vulnerable individuals at the institution.

Given the severity of the outbreak, we ask that BOP (1) immediately test everyone at the facility through both rapid and PCR testing and retest as needed; (2) halt the transfer of any new prisoners into the facility until the outbreak is contained; and (3) implement appropriate screening and quarantine procedures.

**Extent of the Outbreak**

We understand that there have been positive cases in the past week in at least three of the units of the men's facility—units C, J, and F. Each of these units is a dorm, containing between 55 and 80 men housed in bunk beds.

Our understanding is that after a man in C unit tested positive for COVID on 12/2, the remainder of the unit was tested that day. Three more men from C unit were informed they were positive on 12/6. A man from J unit also tested positive on 12/2, though it is unclear if the rest of that unit has been tested. On 12/4 it appears there was another positive test out of F unit.

We understand that there are also positive cases in FSL as of yesterday. It appears that two women tested positive yesterday and that another may have tested positive earlier today. As of this writing, our understanding is that there has not been unit-wide testing in the FSL, despite more than 100 women living together in a single room.

**Failure to Detect COVID-19 through Temperature Checks and Symptom Screening**

The BOP committed in July that medical staff or a lieutenant would do daily temperature checks and daily screening of all prisoners for COVID symptoms. Yet there have been many missed days of temperatures checks and it appears that COVID symptom screening is not happening at any of the facilities within the prison. For example, in the Camp, as of this morning, the women's temperatures have not been taken and symptoms screening has not been performed since November 23. In the FSL, temperatures have been checked only once in the past two weeks (a week ago), and symptom screening is not occurring. Men from multiple units have also reported there is no symptom screening occurring. We are concerned that the lack of temperature checks and symptom screening have contributed to the spread of COVID within the general population.

**Failure to Properly Quarantine and Test Those Exposed**

As noted, there are COVID cases now in at least three units of the men's facility. The individual to first test positive in C unit was working in the kitchen and had previously been housed in G unit. He interacted with people from units outside his own, and we are concerned that the other units at FCI who may have been exposed to the virus are not being tested. We understand that another man from the C unit (described in more detail below) had been feeling unwell for days and fainted in the unit on December 1. He was seen by medical that day and complained of a sore throat, cough, and difficulty breathing. He was returned to his unit. On December 6, he tested positive for COVID and was removed from the unit. Men in the units who have been exposed to individuals who tested positive may develop COVID in the coming days and will need to continue to be screened and retested. We want to ensure that people who are testing positive or who are displaying symptoms are appropriately evaluated, monitored, and quarantined/isolated. All of the men's units should be tested at this time and those with symptoms should be properly quarantined while awaiting test results.

In the FSL, despite two women testing positive yesterday, we understand that as of early this afternoon the unit as a whole has not been tested. Indeed, not even the women who were sleeping in the same bunk or cubicle as the positive women have been tested or removed from the dorm. One woman in the FSL who reported to medical yesterday because she was feeling unwell and experiencing severe body aches and chills was returned to her unit before being quarantined in the library pending testing. These issues increase the possibility that women in the unit who are currently uninfected may become infected and

that the virus may continue to spread. We urge the facility to conduct testing on the entire unit and to screen the women in the unit for COVID symptoms.

Meanwhile, women in the Camp are experiencing COVID symptoms and have been told they will not be tested unless they have a fever, because there aren't enough tests for everyone. Women who are reporting symptoms must be evaluated and tested, and, if necessary, quarantined/isolated. Because of the outbreak in the rest of the facility, the entire Camp population should be tested.

**Other Serious Medical Issues**

We wanted to bring two particular issues to your attention regarding medical care.

There is a medically vulnerable class member who has tested positive for COVID-19 and for whom we have grave concerns about his health and treatment. [redacted] is the man referenced above who tested positive on December 6 and was removed from C unit. Mr. [redacted] is 69 years old and has black lung disease from three decades of working in [redacted] coal mines. He also suffers from diabetes, atrial fibrillation, and hypertension. We urge you to ensure that he receives appropriate monitoring and treatment while in medical isolation. His numerous medical conditions and his advanced age combined, according to the CDC, put him at serious risk for severe illness or death from COVID. He should be closely monitored by medical staff and provided with appropriate treatment, including removal to the local hospital as necessary, to ensure that he does not further deteriorate.

We are also concerned that another class member with numerous medical issues is not getting the treatment she requires because of issues in transferring her for outside consultations. [redacted] has a history of cancer and has had two masses [redacted] since November of last year. These masses were confirmed by BOP medical staff in early 2020 and an outside consultation was scheduled in March. That consultation was cancelled because of the pandemic. However, since that date the masses have been growing and have spread to her [redacted], as confirmed by Dr. Greene. Dr. Greene has twice in the past couple of months scheduled Ms. [redacted] for an outside consultation with an oncologist—most recently for an appointment on 12/4—and both times Ms. [redacted] was not taken to these appointments, apparently because the facility neglected to arrange for her transport. Our understanding is that medical staff have indicated that she needs immediate biopsies to determine a course of treatment. We are seriously concerned that BOP is not able to provide Ms. [redacted] with the treatment that she needs and that she is potentially suffering from cancer that has now gone months without diagnosis because of the failure to arrange for her transfer to outside appointments. We request that arrangements be made for the outside consultation to be rescheduled immediately and for Ms. [redacted] to be transported to that appointment. Ms. [redacted] is currently under reconsideration for home confinement, and given her urgent medical needs, would be better able to obtain the medical care she needs in the community.

We look forward to hearing from you soon regarding these concerns.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Alexis Farkash, *Law Student Intern*
Abigail Mason, *Law Student Intern*
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Legal Clinics

December 8, 2020

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about Conditions at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write to follow up on our letters of October 30, 2020, November 23, 2020, and December 7, 2020 expressing concern that FCI Danbury is not taking certain actions that it had committed to take to meet the medical needs of prisoners during the COVID-19 pandemic and to mitigate and control the spread of the virus.

We have continued to hear that there are individuals with COVID symptoms in units throughout the three facilities. Temperature checks and symptom screening must scrupulously be performed by medical staff. Individuals with symptoms must immediately be tested and appropriately isolated/quarantined. If FCI Danbury does not have sufficient medical staff to perform these duties, the Warden should seek emergency assistance from BOP. Individuals in medical isolation and who are quarantined with symptoms should be closely monitored and provided with appropriate medical care. If FCI Danbury does not have sufficient space to safely isolate and quarantine people, BOP must immediately remedy this problem so that the people committed to their care stay safe. Significantly, at least half of people incarcerated at FCI Danbury are at increased risk for severe illness or death from COVID-19 because of their medical conditions.

**Camp Update**

We understand that four women in the Camp received positive results for COVID-19 yesterday. One woman, [redacted], is 69 years old, suffers from obesity, and has a history of pneumonia. As of this morning, there had not been facility-wide testing in the Camp. We understand that there are women experiencing symptoms who, as of this morning, had not been tested and remain in the dorm. We fear for the safety of the women in the Camp. The population includes at least seven women in their 60s, a woman who is six-months pregnant, and many people with high risk conditions such as diabetes, heart conditions, and history of smoking.

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We ask for immediate COVID testing of all women in the Camp (via rapid test and PCR), screening for symptoms by medical staff, and appropriate isolation/quarantine of those with symptoms pending test results. As we have noted, daily temperature checks and symptom screening did not occur in the Camp from November 23 through December 6, which allowed the spread of the virus among this vulnerable population. During this time period, women who reported symptoms were told they would not be tested because they did not have fevers.

We reiterate our request for **immediate release**, via furlough if necessary, of the women who have been approved for home confinement who are in the Camp. Continuing to hold these women in close proximity to the outbreak subjects them to unjustifiable risk. The following women are already in quarantine, have family within driving distance, and should be released **today**:

| Reg. No. | Last Name | First Name | Facility | Date Home Confinement (HC) Approved | Days Waiting | Status per BOP |
|---|---|---|---|---|---|---|
| [redacted] | F[redacted] | L[redacted] | Camp | 9/14/20 | 83 | HC date 1/19/20 |
| [redacted] | F[redacted] | C[redacted] | Camp | 10/6/20* | 61 | HC date 12/22 |
| [redacted] | G[redacted] | R[redacted] A[redacted] | Camp | 10/23/20* | 44 | HC date 12/15 |
| [redacted] | L[redacted] | N[redacted] | Camp | 10/5/20 | 62 | Awaiting date from RRM (RRM seeking HC under a contract facility) |
| [redacted] | M[redacted] | D[redacted] | Camp | 10/16/20 | 51 | HC date 12/15 (was delayed from 12/2) |
| [redacted] | R[redacted] | M[redacted] | Camp | 10/5/20 | 62 | RRM awaiting response from probation re electronic monitoring |
| [redacted] | T[redacted] | R[redacted] | Camp | 10/23/20* | 44 | Awaiting date from RRM |

The following women need transportation to be arranged and should be released via furlough **tomorrow**:

| | | | | | | |
|---|---|---|---|---|---|---|
| [redacted] | H[redacted] | J[redacted] | Camp | 9/21/20* | 76 | Probation approved relocation on 11/10 |
| [redacted] | H[redacted] | W[redacted] | Camp | 8/24/20 | 104 | Awaiting date from RRM |

We are concerned that Corrlinks access for women in the Camp has been shut down since midday yesterday and telephones have been available only sporadically. As you know, our clients have a

constitutional right to communicate with us and we ask that their access to Corrlinks and the telephone be restored. To the extent there are health concerns with respect to use of the equipment, we ask that cleaning supplies be provided and social distancing guidelines be reiterated. Given our pressing need to speak to our clients, we ask for you to arrange **legal calls today** with the following individuals from the Camp: [redacted]

**FSL Update**

We understand that everyone was tested in the FSL yesterday afternoon via PCR test. We ask that rapid testing be used as well given the BOP's reported lag in results from the PCR testing. Appropriate space needs to be utilized for isolation and quarantine: yesterday a very ill woman was placed in the cold library with no bed.

Given the vulnerability of the women in the FSL to the COVID outbreak in that facility, we reiterate our request for **immediate release**, via furlough if necessary, of the women who have been approved for home confinement who are in the FSL. The following women, all of whom have family within driving distance, should be released **today**:

| | | | | | | |
|---|---|---|---|---|---|---|
| [redacted] | C[redacted] | H[redacted] | FSL | 9/16/20 | 81 | HC date 12/17/20 but told by case manager it will be delayed |
| [redacted] | C[redacted] | J[redacted] | FSL | 10/21/20 | 46 | HC date 1/7/21 |
| [redacted] | Y[redacted] | E[redacted] | FSL | 9/16/20 | 81 | HC date 12/15 (was delayed from 12/8) |

The following women need transportation to be arranged and should be released via furlough **tomorrow**:

| | | | | | | |
|---|---|---|---|---|---|---|
| [redacted] | C[redacted] | K[redacted] | FSL | 11/2/20 | 34 | HC date 12/7/20 but will be delayed |
| [redacted] | H[redacted] | J[redacted] | FSL | 11/2/20 | 34 | Awaiting date from RRM |

**Release of Men**

The following men, approved for home confinement and going home to New Jersey and New York, should be released via furlough **today**:

| | | | | | | |
|---|---|---|---|---|---|---|
| [redacted] | D[redacted] | M[redacted] | Men's | 11/20/20* | 16 | HC date 12/15/20 |
| [redacted] | M[redacted] | J[redacted] | Men's | 11/6/20* | 30 | Awaiting date from RRM |

We look forward to hearing from you soon regarding these concerns.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Alexis Farkash, *Law Student Intern*
Abigail Mason, *Law Student Intern*
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Marisol Orihuela, *Supervising Attorney*
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December 24, 2020

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about Monitoring Individuals with COVID in Medical Isolation

Dear Ms. McConaghy and Mr. Putnam:

We write to express again our concerns about inadequate monitoring of those with COVID who are in medical isolation at FCI Danbury. We have heard multiple reports that individuals in medical isolation are typically receiving no medical attention each day other than having their temperatures taken, and that some days even that is not occurring. Those in isolation should have a complete set of vitals taken each day by trained medical staff (including heart rate, oxygen level, respiratory rate, blood pressure). Individuals with high-risk conditions and/or symptoms may need more frequent checks of vitals and need to have their lungs listened to by someone with adequate training.

Monitoring has been inadequate for men in isolation in the A-A Unit. A review of [redacted] medical records shows the serious deficiencies in monitoring of those with COVID. Mr. [redacted] is at increased risk for severe illness and death from COVID as a result of his stage 3 renal disease/chronic kidney disease, asthma, hypertension, and BMI over 25. He was placed in isolation on December 10, 2020 after testing positive for COVID and experiencing symptoms. An EMT took his vitals on December 10 and an RN checked vitals on December 11. It appears that no trained medical staff saw Mr. [redacted] during his first weekend in medical isolation. On Saturday, December 12, a social worker noted Mr. [redacted] had a normal temperature and had a sore throat but recorded no other vitals (as a social worker, she would have lacked the training to take vitals). On Sunday, December 13, the social worker noted that Mr. [redacted] had lost his sense of smell and taste and had a normal temperature. Again, no other vitals were taken. On December 14, 2020, an RN noted that Mr. [redacted] had a "dry cough for the past 3-4 days" and recorded his temperature but no other vitals. That same day, Mr. [redacted] wrote to staff on a sick call slip: "my chest is killing me" and "I can barely breath [sic] at night because it feels like someone is sitting on my chest." He requested his inhaler and asked for his blood pressure to be checked per a previous request from Dr. Greene for weekly monitoring. A written response to his sick call slips was provided four days later on December 18, stating that his pump was filled that day and noting: "Dr. Greene in his encounter did not mention weekly b/p monitoring." Following his submission of sick call slips, Mr. [redacted] temperature was taken on December 16, 17, 18, and 19 but his records show no other

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vitals recorded and no clinical encounters with a doctor. Angelica R. Angiulli, MD, an attending at Jack D. Weiler Hospital and an Instructor in the Department of Emergency Medicine of Albert Einstein College of Medicine, reviewed Mr. [redacted] records and concluded:

> On 14 Dec 2020 in 2 separate requests to staff, Mr. [redacted] wrote "I can barely breathe at night because it feels like someone is sitting on my chest" and "my chest is killing me". Given his diagnosis of COVID-19 and other underlying medical conditions, these symptoms may indicate that the he has had a myocardial infarction, pulmonary embolism, new onset heart failure, or is in impending respiratory failure all of which I have seen too often in COVID-19 patients. From my review, I do not see vital signs other than temperature documented. Mr. [redacted] should at least have his oxygen level and respiratory rate checked, as well as a physical exam and more thorough history to evaluate for these potentially life-threatening conditions.

*See* Ex. A.

Another man who tested positive and is in isolation told an RN on December 23 that he was having chest pains and pressure. The RN told him to drink water but did not otherwise intervene. A group of women in medical isolation from the Camp did not see a doctor from when they entered isolation on December 7 until December 12.

We ask that you help ensure adequate monitoring for those in medical isolation.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Alexis Farkash, *Law Student Intern*
Abigail Mason, *Law Student Intern*
George Morgan, *Law Student Intern*
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# EXHIBIT A

**Declaration of Angelica R. Angiulli, MD**

1. I am a physician board certified in emergency medicine and work as an attending at Jack D. Weiler Hospital and as an Instructor in the Department of Emergency Medicine of Albert Einstein College of Medicine. I am a graduate of Albert Einstein College of Medicine and of the Jacobi/Montefiore Emergency Medicine Residency Program. I have reviewed the Bureau of Prisons medical records of [redacted] I have cared for hundreds if not thousands of patients afflicted by COVID-19 and the other medical conditions discussed below.

2. Mr. [redacted] is a 43-year-old man incarcerated at FCI Danbury. He has multiple significant health issues, many of which make him particularly vulnerable to COVID-19. In particular, he suffers from chronic kidney disease, hypertension, asthma, and he is overweight.

3. Mr. [redacted] was diagnosed w/ COVID-19 on 10 Dec 2020. His most recent medical records indicate that he is potentially very ill. On 14 Dec 2020 in 2 separate requests to staff, Mr. [redacted] wrote "I can barely breathe at night because it feels like someone is sitting on my chest" and "my chest is killing me". Given his diagnosis of COVID-19 and other underlying medical conditions, these symptoms may indicate that the he has had a myocardial infarction, pulmonary embolism, new onset heart failure, or is in impending respiratory failure all of which I have seen too often in COVID-19 patients. From my review, I do not see vital signs other than temperature documented. Mr. [redacted] should at least have his oxygen level and respiratory rate checked, as well as a physical exam and more thorough history to evaluate for these potentially life-threatening conditions.

4. Apart from his current acute condition, Mr. [redacted] primary medically vulnerable condition is his chronic kidney disease (CKD). While under care of the DOC he has been diagnosed with stage 3 CKD (stage 1 being the lowest and stage 5 encompassing patients who often develop signs and symptoms that require initiation of dialysis). CKD is known to put patients at increased risk of severe illness from COVID-19[1]. Patients with more severe illness have higher risk of death and other serious complications. I have observed that a percentage of CKD patients with COVID-19 go on to have progression of kidney disease requiring dialysis during the course of their illness and from which their kidney function may never recover. Additionally, the patient's work-up for his CKD is incomplete. He was scheduled for a renal ultrasound on 27 July 2020, however this was cancelled due to a quarantine requirement prior to a transfer, and still has yet to be completed. An ultrasound could identify an obstruction in the urinary tract and therefore a potentially reversible cause of his disease. Because treatment of obstruction can actually salvage kidney function it is crucial to recognize it as early as possible in the course of the disease. Several other tests have not been conducted that I consider standard in the initial evaluation of CKD including urine microscopy, urine

protein-to-creatinine and albumin-to-creatinine ratios, hemoglobin A1C level, lipid panel, and hepatitis B and C screening. His evaluation should also include a thorough family history. None of this appears to have been included in his work-up to date.

5. The CDC recognizes that hypertension may put patients at increased risk of severe illness from COVID-19[1]. Mr. [redacted] was diagnosed with hypertension and started on a drug called carvedilol. Carvedilol is not considered first or second line therapy for hypertension in patients with CKD. To determine the correct antihypertensive for Mr. [redacted] further testing to evaluate for proteinuria would need to be performed. As noted above, he has not had these tests. Carvedilol is in a class of drugs known as beta blockers, which based on their mechanism of action may slow a patient's heart rate. Mr. [redacted] has numerous visits with his heart rate lower than the threshold of normal (normal range being 60-100 beats per minute (bpm)). Notably on 3 Dec 2020 his dose of carvedilol was doubled though his heart rate was documented as 53bpm. No electrocardiogram is noted in the record to address this abnormal heart rate. Giving a beta blocker to a patient who already has a slow heart rate is dangerous and could result in a life-threatening heart rhythm. Finally, beta blockers can cause bronchial obstruction and airway reactivity as well as decrease the effectiveness of the asthma medications used to treat these conditions. For these reasons, beta blockers should be used with extreme caution in asthma patients, and are considered contraindicated by some[2].

6. Mr. [redacted] suffers from asthma that has not been fully characterized in his records. He takes a daily inhaled steroid, mometasone, at a dose that is consistent with at least moderate disease. In his records at one time he was noted to be using his "rescue" albuterol inhaler 3-4 times per day, which likely should have been treated with a course of oral steroids, and prompted further evaluation to determine if his daily inhaled steroid was sufficient. CDC recognizes that patients with moderate to severe asthma might be at an increased risk of severe illness from COVID-19[1].

7. Mr. [redacted] has a body mass index (BMI) of 29.7, classifying him as overweight on the threshold of obese (BMI 30). CDC recognizes that pts who are overweight might be at an increased risk of severe illness from COVID-19[1].

8. Mr. [redacted] diagnosis with COVID-19 put him at high risk for complications from COVID-19, including but not limited to worsening kidney function, respiratory failure, and death. From our review of the record, we feel that the evaluation of his CKD is incomplete, and that he should have additional blood and urine testing and a renal ultrasound as soon as possible. Additionally, he is not on the best medication to treat his hypertension, and in fact is on a medication that puts him at risk of both heart rhythm abnormalities as well as severe consequences of asthma (including respiratory failure and death). With the above noted cancellation/delay in diagnostic imaging, neglecting to perform necessary blood and urine tests, as well incorrect medication

administration, he seems to be at unnecessary risk of medical harm due to his being incarcerated.

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

Angelica R. Angiulli, MD

Executed on 22 December 2020

Quinnipiac School of Law

Legal Clinics

December 30, 2020

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about the Safety of Individuals Incarcerated at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write again regarding our concerns about the safety of those incarcerated at FCI Danbury during this pandemic.

## I. Gas Leak at the Camp

Since at least the middle of November 2020, the facility has been aware of gas leaks at the Camp. Late last week, the gas smell became unbearable and women began experiencing headaches, dizziness, nausea, and fatigue. They complained repeatedly to staff and were told to keep the windows open. We understand that both the City of Danbury Fire Department and the gas company tried to access the Camp on December 26 after concerned family members called to inform them of the crisis. Both the fire department and the gas company were turned away by FCI Danbury staff. On December 27, the fire department finally gained access to the Camp and shut off the gas for safety reasons. Turning off the gas meant losing heat and hot water, so staff moved all 47 women from the Camp to the visiting rooms at the men's facility and the FSL.

The women have now been returned to the Camp. We understand that prior to this incident, there were no working smoke or carbon monoxide detectors at the Camp, and no functional sprinkler system. We ask that you investigate why FCI Danbury responded so slowly to the gas leak crisis and turned away emergency responders. We also ask for your help in ensuring that adequate fire and gas safety systems are put in place immediately.

## II. Positive Tests and Safety of those in Medical Isolation

At least 11 Camp women were told on December 28 that they were positive for COVID—based on tests performed last Tuesday, 12/22. During this long wait for the results, these women were

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living in close quarters with other women from the Camp. We understand that two women from the FSL also tested positive on December 28 after tests conducted a week earlier.

The women who tested positive have now been moved to isolation. We are gravely concerned for the wellbeing of these women, as well as the wellbeing of others in medical isolation at FCI Danbury.

You will recall that five women tested positive for COVID in the Camp the week of December 7, and an additional nine the week after, following a two-week period where staff failed to check temperatures or screen for COVID symptoms at the Camp. Indeed, several women had complained of COVID symptoms to medical staff the week of November 30 and staff did not test them or remove them from the dorms.

The women who tested positive the week of December 7 and the week that followed were placed in the FSL visiting room and the FCI men's visiting room. In the men's visiting room, the women had no access to a phone or computer to contact family members or legal representatives from when they entered quarantine (on December 7 or 8) until December 22. Their temperatures were taken daily on weekdays by an EMT, but on weekends they received no medical attention whatsoever. While the women were in isolation, even on weekdays, medical staff did not check their oxygen levels or listen to their lungs—despite women experiencing serious COVID symptoms. A doctor or nurse did not visit the women regularly, and one woman reported not seeing a doctor or nurse until the final day when the women were released from isolation. Women experiencing symptoms were told that the facility had run out of Tylenol. After the first three days, officers no longer staffed the visiting room and the women were told that if they needed assistance they should "yell out the window." Heat was turned off at night and extra blankets were not provided. The blankets that were provided were dirty. After three days without a shower, a shower was installed—but the wooden steps were slippery and several women fell, and there was no privacy for changing. One woman with severe allergies was not properly fed while in isolation and it took three days for women to get menstrual products.

The experience of the women housed in the FSL visiting room was similar. One woman with asthma had to wait four days for her asthma pump despite experiencing a cough and chest pain. That woman repeatedly asked for her medication and for her asthma pump, without a response from staff. The only medical attention these women in medical isolation received were daily temperature checks. There was no way to contact staff except by banging on windows.

Our serious concerns arise not only because of the past treatment of women in isolation, but also the experience of the 11 Camp women who were placed in isolation starting on December 28. We have learned that they have been wearing the same clothes since they were evacuated from the Camp on December 27 because of the gas leak. They have had no temperature checks or medical attention since they entered medical isolation. They are sleeping in cots with no mattresses provided. Many are without their medications. One woman, who repeatedly asked for her anti-seizure medication, received it only late on 12/29.

We have heard similar experiences of men in isolation. Medical staff are only checking temperatures for men as well—and not monitoring other vital signs despite high-risk men experiencing serious symptoms. One individual who tested positive for COVID has put in multiple sick call slips complaining of difficulty breathing and has not been seen by medical staff. He was told he would likely be seen after the holidays. Some of the individuals in isolation suffer from other conditions that are not being properly managed or monitored while they are in isolation. One man, [redacted], who suffers from poorly controlled diabetes and who is COVID positive has not been provided with a diabetic-appropriate diet during his time in isolation—he reports only receiving the required diabetic snack three times during the 18 days he has been in isolation—and is only receiving two insulin shots per day, which have been given later than the time they are to be administered, and which are fewer than the four prescribed by his doctor. He was recently hospitalized with blood sugar levels over 600, and we are concerned for his safety if he continues not to receive the appropriate treatment and monitoring.

As you know, FCI Danbury's medical department has been severely understaffed since before the pandemic began. It is clear that the facility is struggling to provide the necessary monitoring and care to those in medical isolation. As we have pointed out previously, the Warden can make a request that BOP provide a Medical Asset Support Team (MAST) to assist the facility and we renew our request that she do so immediately.

## III. Testing, PPE, and Cleaning Supplies

The facility needs to access PCR testing that does not take 5-7 days for results, and PCR and rapid testing should be conducted more regularly. For example, women were tested at the Camp on 12/8 and then not again for 14 days—via a PCR test that then took another 6 days for results. In the meantime, the virus spread and at least 11 more women are now infected. Similarly, in the FSL, women were tested on 12/7 and then not again until 12/21. Since then at least two more women have tested positive. Women in the FSL who tested positive from the tests done on 12/21 were not removed from the unit until 12/28. Other individuals who report to medical with symptoms are not being tested and are being kept in the unit. Our expert, Dr. Jaimie Meyer (an infectious disease specialist at Yale School of Medicine), would be happy to consult on the development of an appropriate testing plan.

In addition, FCI Danbury needs to provide appropriate PPE and cleaning supplies. The paper masks being issued are extremely thin, and we regularly hear reports of lack of soap, paper towels, and cleaning supplies for people incarcerated in all three facilities at Danbury. For example, we understand that the women at the FSL have been without hand soap in the bathrooms for a week.

## IV. Additional Medical Concerns

We continue to be concerned that urgently needed medical care is not being provided to individuals at FCI Danbury.

Mr. [redacted], has a history of Barrett's Disease of the esophagus. Last year he was sent for an outside consultation with a gastroenterologist to have an

endoscopy performed. The medical staff at the facility told him the endoscopy result was normal. However, at a follow-up gastroenterologist appointment on November 10, he was informed that the endoscopy actually showed pre-cancerous cells, which required him to undergo three sessions to have his esophagus "burned." The specialist at that appointment advised that the treatment needed to be performed as soon as possible and should have already been scheduled. However, as of December, medical staff at BOP advised Mr. [redacted] they were unaware of the recommended procedures to treat his esophagus, and that no follow-up endoscopy was in the system. Medical staff are apparently working to schedule the required procedure, but have told Mr. [redacted] that the wait time may be 6-9 months. We are concerned that the precancerous condition may further develop if he is left to wait months for the required treatment and request that the required appointments be scheduled as soon as possible. Mr. [redacted] has also been recommended by an outside optometrist for cataract surgery for his left eye. He is losing vision and seeing double, but has not had the prescribed surgery scheduled.

Mr. [redacted], has a history of bladder cancer. On October 18, Mr. [redacted] was put in the SHU overnight in anticipation of an MRI of his lower abdomen, which was scheduled for the next day—he has been complaining about recurring abdominal pain for more than three years. But, the next day, upon arriving at the hospital for the MRI, he was told that the test could not be performed because BOP failed to administer a required prep medication prior to the scheduled appointment. The test was cancelled for that day. This is apparently the second time that the required medication has not been administered to Mr. [redacted] in advance of a lower abdominal scan, resulting in a cancelled test; he reports that this has also happened three times before post-cancer bladder scopes, resulting in cancelled scans on each of those occasions, too. On December 17, Mr. [redacted] saw Dr. Schindler for other medical issues, and he asked her when he would be rescheduled for the MRI of his lower abdomen. She looked at his chart and informed him that he had been scheduled for the day prior, December 16. He has not been taken to the appointment.

Finally, we again reiterate our concerns regarding the treatment of Ms. [redacted]. As we wrote on December 7, Ms. [redacted] has had masses growing on her body for over a year now. She has missed three outside oncology or mammogram appointments in the past two months because the facility failed to transport her. She needs immediate biopsy to determine a course of treatment. The facility has indicated to her a plan to transfer her to the BOP medical facility in Carswell, TX. We understand that Carswell will, just as Danbury must, schedule outside consultations in order for Ms. [redacted] to receive her biopsies and mammograms. We are concerned, meanwhile, that she will be exposed to other individuals and vulnerable to COVID-19 during the course of her transport to that facility. Ms. [redacted] is currently under reconsideration for home confinement, and would be better served to obtain the medical care she urgently needs in the community from her own oncologist, rather than to be transported miles away to another facility only to wait for more outside consultations to be scheduled. Ms. [redacted] is serving a sentence for a non-violent offense, has no history of violence, and no disciplinary incidents; her multiple CDC COVID risk factors include COPD, history of smoking, hypertension, and heart conditions.

Sincerely,

/s/ Sarah French Russell,
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Quinnipiac School of Law

Legal Clinics

February 28, 2021

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter,* Concerns about the Health and Safety of Individuals Incarcerated at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write again on behalf of class counsel regarding our concerns about the safety of those incarcerated at FCI Danbury during this pandemic.

## I. COVID-19 Testing and Screening

We are concerned that the facility is not conducting testing or adequate screening for individuals who may have COVID-19. Units that included positive COVID-19 test results as of the latest test in December 2020 have not been tested again since late December or early January 2021. Individuals in other units report that they have not been tested since October or November 2020. Individuals housed in two men's units report they have not been tested since May 2020.

Some people experiencing COVID-19 symptoms, including shortness of breath and other respiratory issues, have reported them to medical but have not been tested, and in some cases have not even received a response from medical. One man was treated for serious lung ailments at a medical examination on January 13, 2021 but was told when he reported respiratory symptoms and requested testing that COVID-19 testing was not being conducted at that time.

Temperature checks are sporadic. Checks appear to be occurring at mealtime or after an announcement to report for temperature checks and are usually conducted by corrections officers using a handheld digital thermometer. Class counsel have received many reports of days passing between temperature checks, or checks that do not capture everyone in the unit. Many people also report that these temperature checks are often not being logged. Additional concerns are that staff, upon recording a temperature over 100°F, make repeated attempts to get a "normal" reading and do nothing to follow up with people who register as having higher temperatures.

Similarly, daily symptom screening checks for COVID-19 in the units are not being performed regularly, or—in many cases—at all. When individuals do make a complaint of COVID-symptoms, they are typically encouraged to write a medical slip, but responses to these are routinely slow.

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## II. Medical Care for Individuals Who Have Tested Positive for COVID-19

In December 2020, approximately 100 people incarcerated at FCI Danbury fell ill with COVID-19. Many have experienced long-lasting symptoms but are not receiving appropriate medical care. Many people who have recovered from COVID-19 have submitted sick call slips reporting lingering symptoms to medical, including difficulty breathing, chest pains and pressure, and fatigue. However, medical has failed to respond promptly or, in some cases, at all, to those suffering lingering symptoms. For example, as of mid-late February 2021, a group of five women who since contracting COVID-19 in December had reported symptoms—including loss of taste, loss of smell, coughing, difficulty breathing, burning lungs, night sweats, and fatigue—had been told by medical that such symptoms can occur after contracting the disease, but received no follow-up care.

The lack of adequate follow up care has extended to individuals who were severely ill with COVID-19 and who have serious lingering symptoms. For example, [redacted] was diagnosed with COVID-19 in December 2020. As of January 21, 2021, Mr. [redacted] was still suffering severe chest pain, and had also been diagnosed with congestive heart failure, with fluid building up around his heart and lungs. Medical staff provided Mr. [redacted] with hydrochlorothiazide, but he has yet to be seen by a cardiologist. Another example is [redacted], who was diagnosed with COVID-19 in the Spring of 2020 and who has since suffered multiple episodes of near-loss of consciousness secondary to difficulty breathing. He also struggles with coughing fits, wheezing, and dizziness as a result of his difficulty breathing. Mr. [redacted] was finally seen in early February regarding these breathing issues after submitting 10 requests to be seen by medical. After testing, he was informed by medical staff that his lung capacity was seriously diminished. Medical indicated they would order a CPAP machine to assist Mr. [redacted] breathing while asleep, but Mr. [redacted] has yet to receive the CPAP machine.

## III. Additional Non-COVID-19 Medical Concerns

We continue to be concerned that urgently needed medical care is not being provided to individuals at FCI Danbury. Many clients report urgent medical concerns in repeated sick call slips to medical but are not seen, sometimes for weeks or months. Clients report waiting weeks before even receiving a response to their requests. Once clients are seen, they are often told that there is no doctor available at the time, and that the available staff can only take the individual's vitals. Individuals who need specialized treatment that requires outside consultations have been left to wait months for care. Some have been waiting for more than a year for consultations or procedures marked by FCI Danbury medical staff as "urgent." Below are examples of individuals with serious medical needs that have gone unattended. We have raised most of these examples in earlier correspondence to you, and individuals continue to wait for care.

[redacted] (Reg. No. [redacted])
[redacted] is a 56-year-old man who suffers from uncontrolled diabetes, chronic kidney disease (stage 4 renal failure), and severe retinopathy in both of his eyes. He urgently needs to be seen by a nephrologist, neurologist, and a retinal surgeon. Mr. [redacted] is in desperate need of vitreoretinal surgery. **If he does not get this surgery immediately, Mr. [redacted] will go blind**. More than a year ago, in January 2020, an ophthalmologist said Mr. [redacted] needed a "consult

with a vitreoretinal specialist/surgeon ASAP." An urgent consultation request for the surgeon was made by FCI Danbury's doctor in February 2020. In June 2020, this doctor noted that Mr. [redacted] had still not been seen for the condition by a specialist and said: "It is felt this pt. will be better served in the community where he can receive the treatment he desperately needs to prevent blindness." Mr. [redacted] eyesight has continued to decline and is making it difficult for him to navigate taking his medication (he is unable to read at this point). The ophthalmologist confirmed again in January 2021—a full year later—that Mr. [redacted] urgently needs surgery. In addition, Mr. [redacted] renal function has declined to Stage 4 renal disease. In September 2020, the prison doctor submitted an urgent request that Mr. [redacted] have a consultation with a nephrologist. He has still not been seen. Mr. [redacted] suffers from hypertension and cerebrovascular disease, and had two strokes in March 2020, with little follow up. He is now confined to a wheelchair given swelling from edema and is experiencing shortness of breath. We request that he immediately receive the surgery he needs to preserve what remains of his eyesight and that he see the other specialists necessary.

[redacted] (Reg. No. [redacted])
Ms. [redacted] is a 65-year-old woman who arrived at FCI Danbury in August 2020. Since her arrival, Ms. [redacted] blood pressure readings have been dangerously high, with many of the readings indicating she was in the hypertensive crisis level. Multiple readings were over 200 or in the 190s. Medicine prescribed by medical staff did not work to reduce her blood pressure; the readings continued to be high and she experienced pain in her chest. Ms. [redacted] requested on multiple occasions prior to December 2020 to see a cardiologist. After a request was finally put in on December 2020, FCI Danbury staff informed Ms. [redacted] that outside cardiologists were not seeing inmates. In December 2020, Ms. [redacted] was also hospitalized with severe COVID-19, and on her return spent weeks in isolation in what is normally used as a suicide observation room at the FSL. Ms. [redacted] continued to have chest pressure through January and, on February 8, while in the pill line, reported to the medic on duty that she was experiencing chest pain unlike she had ever experienced before. Medical staff advised Ms. [redacted] to put in a sick call request. Medical did not run an EKG or check Ms. [redacted] blood pressure. The following day, on February 9, Ms. [redacted] suffered a full-blown heart attack and was hospitalized. Danbury staff have since told her that her scheduled follow-up cardiology appointment is unlikely to take place. We are seriously concerned for Ms. [redacted] health and request that Ms. [redacted] be seen by a cardiologist as soon as possible for follow-up care.

[redacted] (Reg. No. [redacted])
[redacted] is a 68-year-old man who suffers from bladder cancer, obesity, type 2 diabetes, COPD, emphysema, numerous ongoing cardiac issues (including 5 stents), hypertension, and a history of strokes. In February 2020, Mr. [redacted] saw a specialist who noted his diagnosis of bladder cancer and said he needed a CT scan and IVP, followed by cystoscopy. Orders for these procedures were entered by the prison doctor a few days later and marked "urgent." Yet more than a year later, these procedures have still not been conducted. Mr. [redacted] has been informed of at least two appointments that were missed because FCI Danbury staff failed to

make the necessary arrangements. We request that Mr. [redacted] be immediately scheduled for the ordered procedures.

[redacted] (Reg. No. [redacted])
[redacted] has Type II diabetes and coronary artery disease as well as hypertension, asthma, severe obesity, and chronic embolisms in lower extremities and lungs. Within the last year, Mr. [redacted] has been hospitalized four times for respiratory complications, including blood clots in his lungs, which left his left lung damaged. Mr. [redacted] is currently in urgent need of a colonoscopy to diagnose a serious bowel issue that he has been suffering from for three years (mucus in stool, 6 to 7 bowel movements a day). In March 2019, a GI doctor recommended a colonoscopy to evaluate for colitis and rule out a tumor. In December 2019, a GI consult and colonoscopy were ordered by the doctor at FCI Danbury and marked "urgent." The procedure has still not occurred. This doctor in June 2020 opined that Mr. [redacted] condition could be "better managed outside the facility." Also in June, the BOP's Home Confinement Committee approved Mr. [redacted] for transfer to an "appropriate institution." But the transfer never occurred. We request that Mr. [redacted] be scheduled for a GI consult and colonoscopy immediately.

[redacted] (Reg. No. [redacted])
Mr. [redacted] has a history of hypertension and an abnormal electrocardiogram, in addition to obesity, bilateral leg edema, albuminuria, abnormal liver function tests, and hyperlipidemia. He has a family history of cardiovascular mortality. His medical records indicate that he is suffering from congestive heart failure and urgently needs to undergo evaluation and treatment. In January 2020, Mr. [redacted] underwent an EKG and x-ray of his chest. The EKG showed "critically abnormal findings." The chest x-ray was also abnormal, and demonstrated cardiac enlargement. His blood pressure is also not being monitored appropriately. We request that Mr. [redacted] be seen by a cardiologist as soon as possible to address these urgent issues.

[redacted] (Reg. No. [redacted])
Mr. [redacted] age 77, has a history of Barrett's Disease of the esophagus. Last year he was sent for an outside consultation with a gastroenterologist to have an endoscopy performed. Although he was originally told that the endoscopy result was normal, at a follow-up gastroenterologist appointment on November 10 of 2020, he learned that the endoscopy actually showed pre-cancerous cells, which required him to undergo three sessions as soon as possible to have pre-cancerous cells treated with radiofrequency ablation. In December, he learned that medical had not yet requested that the procedures be scheduled. More recently, medical staff have told Mr. [redacted] that the wait time for his procedure may be 6-9 months. We are concerned that the precancerous condition may further develop if he is left to wait months for the required treatment. We request that the required appointments be scheduled as soon as possible. Mr. [redacted] has also been recommended by an outside optometrist for cataract surgery for his left eye. He is losing vision and seeing double.

[redacted] **(**Reg. No. [redacted])
Mr. [redacted] has had digestive issues and blood in his stool since summer 2020. On October 2, 2020, he saw a gastroenterologist, who recommended colonoscopy and

esophagogastroduodenoscopy (EGD), out of concern for cancer. On November 4, 2020, medical staff at FCI Danbury requested the procedures and marked the request as urgent. But the procedures have not been conducted. If there is a cancer, expedient diagnosis and treatment is of the utmost importance. Mr. [redacted] is also still waiting for a neurosurgery consult requested in September 2020 (after a CT of the lumber spine revealed disc pathology) and a renal ultrasound to assess a partially cystic mass of the left kidney, which was revealed by the CT scan as well. We ask that Mr. [redacted] colonoscopy and rental ultrasound be scheduled immediately, and that he receive his neurosurgery consult in the near future.

[redacted] (Reg. No. [redacted])
Mr. [redacted] suffers from obesity, poorly controlled type 2 diabetes, liver disease, hypertension, and possible cerebrovascular disease. He uses a wheelchair and has very little ability to walk (with a walker). He has and has had extremely low platelet counts and anemia that may result from a problem with his bone marrow. An MRI on 12/24/18 suggests his bone marrow may have an infiltrative process, which could represent a cancer of the bone marrow. His spleen is very large, possibly because it is sequestering his platelets. His low platelets are the result of inadequate production by the bone marrow and/or sequestration by the spleen. This must be evaluated by a hematologist. Mr. [redacted] did have some hematologic evaluation at the University of New Mexico Cancer Center in 2017 before his sentencing but there had been no follow-up since he has been in BOP custody. Mr. [redacted] presented to the emergency room at Danbury Hospital on 12/22/18 with numbness of the right side of his face, facial droop, and right hand and foot weakness. With the provisional diagnosis of a CVA (cerebral vascular accident, or stroke) he was evaluated with an MRI and CT which did not reveal any acute changes at that time. Because of that, he was given the diagnosis of Bell's Palsy. Mr. [redacted] saw a neurologist in August 2020 who wanted to see him back in 3 months; that follow-up visit has not occurred. Since June 2020, a request marked urgent has been pending for "CT scan of abdomen due to increasing jaundice and liver/ spleen enlargement." Mr. [redacted] has a history of Gilbert syndrome, a genetic disorder of the liver. He also has had occult blood in his stool. He saw a gastroenterologist in August 2020 who ordered a number of tests and an MRI; there has been no follow up. A urology consult is also pending for voiding difficulty. Mr. [redacted] had spinal cord surgery in November 2019. In early February 2020, the prison doctor submitted an "urgent" request for physical therapy for Mr. [redacted] noting: "Patient had cervical laminectomy last month. He was walking in the hospital, but has decompensated since his return. He is currently wheelchair bound and needs PT to return to independence." It appears he had only one PT appointment, in March 2020. In June 2020, the doctor wrote: "He is unable to ambulate long distances, as he did not have sufficient formal rehab. He decompensated significantly since his hospital return. His physical therapy needs cannot be met in this setting." We ask that Mr. [redacted] be scheduled immediately to see a hematologist, neurologist, gastroenterologist, and urologist, that he get the tests and procedures that have been ordered, and that he receive needed physical therapy.

[redacted] (Reg. No. [redacted])
Ms. [redacted] has had chemotherapy and surgery for skin cancer three times while incarcerated. Ms. [redacted] is concerned that her cancer may have returned, but she has not received

treatment. FCI Danbury medical staff requested that she been seen by a dermatologist after she arrived at the facility in August 2020. In January 2021 medical staff again recommended an outside consultation and expressed concern that she has not yet been seen. We request that Ms. [redacted] is seen by an appropriate outside specialist as soon as possible.

[redacted] (Reg. No. [redacted])
Mr. [redacted] has been having kidney issues and severe pain since March 2020. He was approved to have a CT scan in July 2020, because he had crystals in his urine "consistent with renal calculus" (kidney stones). He has still not received the CT scan after almost a year of severe pain. He submits daily electronic call slips to receive care. His kidney pain is so bad, he often cannot sleep. We request that Mr. [redacted] receive a CT scan immediately and any additional treatment required.

[redacted] (Reg. No. [redacted])
Ms. [redacted] is suffering excruciating pain in her left knee and her right arm, which broke in October 2020 after a fall. Her mobility and use of her arm are very limited. Medical staff told her she would require surgery because of the way her arm had healed. There is a large lump on Ms. [redacted] right arm and it is numb from wrist to elbow. After making numerous requests to be evaluated by medical, Ms. [redacted] was seen near the end of January 2021. The examination indicated she may have a torn tendon in her knee. She was given a knee brace and is now awaiting an x-ray. We request that Ms. [redacted] receive appropriate treatment for her left knee and her right arm as soon as possible.

[redacted] (Reg. No. [redacted])
Ms. [redacted] has had masses growing on her body for over a year now. Ms. [redacted] was not taken to three scheduled medical appointments in recent months while at FCI Danbury. She was transferred in mid-January 2021 to Carswell, Texas for the explicit purpose of receiving appropriate medical care. After an initial medical examination upon intake, she has not been seen by medical staff at the facility since. She has not yet been taken to an oncologist.

## IV. Rash and Facility-Conditions Concerns

In addition to these urgent medical issues, there are reports of additional concerns related to a rash in the men's facility. We are also concerned that the facility conditions are exacerbating these medical issues and failing to create a safe environment for individuals at Danbury.

Numerous men at Danbury have reported a horribly painful rash that has been present at the institution for a year. Since January 2021, several men have again raised concerns about a persistent rash. Many of the affected individuals have had the rash consistently for as long as seven months. The rash has caused tremendous discomfort. Many have described it as feeling like their skin is on fire and have reported extreme itching on their arms, legs, backs, groin, and in some cases, on their faces as well. Some men have been left with bloody wounds and open sores from itching. Men have reported submitting multiple sick call slips to see medical staff about the rash, with delays of several weeks for a response. The facility's treatment has not been effective in eliminating the rash. Some men who are

suffering from the rash have been placed in isolation where they were kept in-cell for 23.5 hours every day. Medical staff did not perform check-ups on these men during the period of isolation, despite several requests.

Furthermore, the facilities at FCI Danbury are not conducive to ensuring that future medical outbreaks are prevented. For example, in one of the men's units, only three of the five bathroom stalls are functioning, only two of approximately 5 faucets in the unit's bathroom work, and only two of four showers function. Many clients report lack of soap, which means that people are unable to properly wash their hands. Commissary often does not have any soap for individuals to purchase. Paper towels and disinfectant are not plentiful enough to keep up with cleaning common areas. Clients also report days without hot water or heat. In one instance, the heat and hot water in at least one unit were out for about 10 days, and individuals had to be moved elsewhere in the facility. Earlier in February, the hot water in one unit was out for the two days, after which the unit lost heat. Most recently, on February 17, sewage covered the floor of three men's units.

We hope that you will share these concerns with the facility and urge them to take measures to protect the individuals incarcerated at Danbury.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Lauren Austin, *Law Student Intern*
Nooram Mumtaz, *Law Student Intern*
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March 24, 2021

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about the Health and Safety of Individuals Incarcerated at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write to bring to your attention two individuals, in addition to those highlighted in our February 28, 2021 letter. We are concerned that they are not receiving urgently needed medical care.

[redacted] (Register No [redacted])
Mr. [redacted] has a history of heart problems and hypertension, which are noted in his medical records. He has had several EKGs done during his time at Danbury. More than one of the EKGs had abnormal readings, including an EKG on December 8, 2020 and a more recent EKG earlier this month. In December, Dr. Schindler noted the irregularity, specifically writing that his EKG "remains abnormal with inverted T waves" and put in an urgent request for him to see a cardiologist with a target date of March 8. To date he has not been seen by a cardiologist.

After having the first dose of the COVID vaccine on February 23, Mr. [redacted] has been experiencing chest pain. He has contacted medical about his concerns about this chest pain—he submitted sick call requests on at least two occasions on February 26 and March 8 but had not heard back until last week. He was told at his most recent visit to medical that he should notify the duty officer if the chest pains occur again. His chest pains continue and occur throughout all hours of the day and night. We understand that a cardiology appointment is pending, but we are concerned that he might be experiencing serious cardiac issues that require attention from a cardiologist immediately, and we request that he receive appropriate medical evaluation and treatment as soon as possible.

[redacted] (Reg. No. [redacted])
Mr. [redacted] has had a lumpy mass on his right testicle for at least six months. Mr. [redacted] has a family history of cancer. He reported the mass to Dr. Schindler on Sept. 3, 2020. At the time, he also reported that he was losing weight, despite efforts to the contrary. The mass was causing intense throbbing and shooting pain, and difficulty urinating. Dr. Schindler noted at the time that Mr. [redacted] needed an ultrasound as soon as possible to evaluate the mass and scheduled a urology consultation. The mass was again noted on a follow-up on Sept. 30, 2020. We understand Mr. [redacted] has received an ultrasound, which ruled out the possibility that the mass is a benign cyst. Mr. [redacted] is awaiting a

consultation with specialist and a determination as to whether the mass is cancerous. According to Mr. [redacted], the mass is growing in size and he continues to lose weight.

We hope that you will share these concerns with the facility and urge them to address these individuals' medical concerns.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Lauren Austin, *Law Student Intern*
Nooram Mumtaz, *Law Student Intern*
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June 4, 2021

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about the Health and Safety of Individuals Incarcerated at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write to bring to your attention serious medical concerns relating to 11 individuals. We have written previously about most of these individuals, most recently in our February 28, 2021 and March 24, 2021 letters. We are concerned that they are still not receiving urgently needed medical care.

[redacted] (Reg. No. [redacted])
In early May of 2021, Mr. [redacted] was informed by medical staff at FCI Danbury that his recent colonoscopy revealed that he has colon cancer. This diagnosis came seven months after a gastroenterologist first referred Mr. [redacted] for a colonoscopy and esophagogastroduodenoscopy (EGD) because of concern he may have cancer. Since Mr. [redacted] has received his cancer diagnosis in early May, no further appointments have been scheduled. And Mr. [redacted] has still not had any tests or exams done on the mass on his kidney which was discovered in September 2020. We ask that Mr. [redacted] begin immediate treatment for his cancer and that an ultrasound be scheduled for his kidney.

[redacted] Reg. No. [redacted]-[redacted]
Mr. [redacted] is a 31-year-old man who arrived at FCI Danbury on May 5, 2021. Since his arrival, Mr. [redacted] has had at least five seizures. Before arriving at FCI Danbury, Mr. [redacted] was prescribed medication for his seizures and typically had seizures no more than once every few months. The medication Mr. [redacted] is receiving at FCI Danbury is different from the medication he was previously taking that greatly reduced the frequency of his seizures. We ask that Mr. [redacted] receive the necessary medical evaluation for his more frequently occurring seizures and that medical staff ensure that Mr. [redacted] has access to his medication.

[redacted] (Reg. No. [redacted])
[redacted] is a 68-year-old man who suffers from bladder cancer, obesity, type-2 diabetes, COPD, emphysema, numerous ongoing cardiac issues (including 5 stents), hypertension, and a history of strokes. In February 2020, Mr. [redacted] saw a specialist who noted his diagnosis of bladder cancer and

indicated that he urgently needed a CT scan and IVP. In April 2021, he had an appointment for a CT scan with contrast dye to check his kidneys and the status of his bladder cancer. However, he was not given the proper pre-test preparation at FCI Danbury so that he could safety take the contrast dye given his iodine allergy. Because of a risk of a serious allergic reaction and because of his history of such reactions, Mr. [redacted] did not have the scan. He has not yet been taken for a rescheduled appointment with the proper pre-test preparation. At least two previous appointments were missed because FCI Danbury staff failed to make the necessary pre-test arrangements. Further, at an April 2021 medical visit at FCI Danbury, Mr. [redacted] learned that results from a recent ER visit for chest pains revealed that he has a blockage in his heart that may need to be treated with a pacemaker and that must be monitored by a cardiologist. We request the Mr. [redacted] be immediately scheduled to see the necessary specialists for monitoring of his kidneys and bladder cancer as well as his heart condition.

[redacted] (Reg. No. [redacted])
Mr. [redacted] has a history of hypertension and an abnormal electrocardiogram, in addition to obesity, bilateral leg edema, albuminuria, abnormal liver function tests, and hyperlipidemia. He has a family history of cardiovascular mortality. Since receiving in January 2020 an abnormal chest x-ray that demonstrated cardiac enlargement and an EKG that showed "critical abnormal findings," Mr. [redacted] finally saw a cardiologist in March 2021. The cardiologist told Mr. [redacted] that his blood pressure needed to be monitored regularly. Mr. [redacted] did not get his blood pressure checked at the facility until almost a month after his cardiology visit. His blood pressure at that time showed a reading of 149/110, which would put him in the stage 2 hypertensive range. He also continues to experience leg swelling and has recently been diagnosed with sleep apnea, and put on a waiting list for a CPAP machine. We request the Mr. [redacted] be seen by a cardiologist for follow-up and necessary testing, that his blood pressure be regularly monitored, and that he receive his CPAP machine.

[redacted] (Reg. No. [redacted])
Mr. [redacted] is a 77-year-old man with a history of Barrett's Disease of the esophagus. In November of 2020, a gastroenterologist indicated that Mr. [redacted] urgently needed to have pre-cancerous cells treated with radiofrequency ablation. He has still not been scheduled for his urgently needed ablation. Nor has he been seen by an optometrist for cataract surgery. He is losing his vision, which continues to deteriorate. We request that the required appointments be scheduled as soon as possible.

[redacted] (Reg. No.[redacted])
Mr. [redacted] has been having kidney issues and severe pain since March 2020. He was approved to have a CT scan in July 2020, because he had crystals in is urine "consistent with renal calculus" (kidney stones). As of May 2021, Mr. [redacted] has still not received a CT scan for his kidney issues. We reiterate our request that Mr. [redacted] receive a CT scan immediately and any additional treatment required.

[redacted] (Reg. No. [redacted])
Mr. [redacted] has a history of heart problems and hypertension. Since December of 2020, he has had more than one abnormal EKG, and a doctor at FCI Danbury put in an urgent request for him to see a cardiologist with a target date of March 8, 2021. In April of 2021, Mr. [redacted] was seen by medical at FCI Danbury and told that he has Ischemia, which is reduced blood flow to the heart. He was told that he was scheduled to see a cardiologist and a hematologist due to a flare in sickle cell. As of May 2021, he has still not been seen by a cardiologist or hematologist. We again ask that Mr. [redacted] be scheduled to see these specialists as soon as possible.

[redacted] (Reg. No. [redacted])
Mr. [redacted] is a 43-year-old man with hypertension and stage three chronic kidney disease. Over a year ago, BOP medical staff indicated that he needed to see a kidney specialist and have an ultrasound. His kidney disease continues to progress, and, as of May 2021, he still has not seen a specialist. We ask that Mr. [redacted] be scheduled to see a specialist and receives the treatment he needs for his kidney disease as soon as possible.

[redacted] (Reg. No. [redacted]
Ms. [redacted] has been suffering from severe pain in her left knee and her right arm. She broke her arm in October 2020 and was told she would need surgery because of the way it healed. She was diagnosed with a possible torn tendon in her left knee in January of 2021. As of April 2021, Ms. [redacted] has received an x-ray of her knee but has received no further follow up. We reiterate our request for Ms. [redacted] to receive the necessary treatment for her left knee and right arm.

[redacted] (Reg No. [redacted])
Ms. [redacted] is 43-year-old woman who suffers from diabetes. As of May 2021, she has been experiencing concerning side effects to her medication including blurred vision, extreme nausea, exhaustion, and night sweats and terrors. She also has not been given the proper diet to better manage her diabetes. We ask that Ms. [redacted] receives the appropriate medical care for her diabetes.

[redacted] (Reg. No. [redacted])
In addition to the medical concerns raised in earlier letters, Ms. [redacted] has been experiencing a concerning loss of circulation to her extremities. Her hands and feet have been turning purple or red, have been numb, and have been ice cold to the touch. When she approached a doctor in the pill line about the problem, he told her that this was a serious issue and could result in an emergency situation where she goes into anaphylactic shock because of lack of circulation. She has put in sick call slips to be seen by a doctor so that she can receive treatment, but as of our last communication with her had only been able to see a nurse or physician's assistant who told her that she needed to see a physician, but couldn't tell her when that would happen. She is also in need of an appointment with a cardiologist to monitor her heart medication; she was forced to stop taking her most recent prescription in mid-May because of a persistent adverse reaction. Ms. [redacted] is currently housed at FMC Carswell.

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*
Hannah Snow, *Law Student Intern*

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October 28, 2021

Michelle McConaghy
Nathaniel M. Putnam
United States Attorney's Office
District of Connecticut
157 Church Street, 25th Floor
New Haven, CT 06510
*Via e-mail correspondence*

Re: *Whitted v. Easter*, Concerns about the Health and Safety of Individuals Incarcerated at FCI Danbury

Dear Ms. McConaghy and Mr. Putnam:

We write to express concern regarding the health of several individuals at FCI Danbury. We have previously written to you about some of these individuals, but we are concerned that they are still not receiving the urgent medical care that they need.

[redacted]

We last wrote to you about Ms. [redacted] on October 13, 2021. Since then, Ms. [redacted] breast condition has worsened. She is in extreme pain. She is weak and has lost weight. Most of her breast has turned black and she has open wounds on it. We understand Ms. [redacted] saw Dr. Greene on October 14 and he told her he did not know what her condition was. We understand that a nurse who saw Ms. [redacted] on the weekend of October 16/17 was so concerned that she sought to send Ms. [redacted] to the hospital (the request was denied). Dr. Greene has not examined Ms. [redacted] since October 14. We recently received medical records from the breast surgeon who saw Ms. [redacted] prior to her incarceration. (Ms. [redacted] has provided these records to the medical department at FCI Danbury; we also attach them here). The records note: "At high risk for breast cancer. Tyrer-Cuzick v8 lifetime risk 35.1%." The records indicate an extensive family history of breast cancer including "multiple paternal aunts and first cousins with breast cancer, several whom were under 50 and died in their young 30s." The surgeon planned to proceed with "left breast sub-areolar lumpectomy with intraoperative nipple exploration." However, for COVID-related reasons, the surgery did not proceed before Ms. [redacted] was incarcerated. Genetic testing for BRCA also had been recommended but not completed. Given this history, we are extremely concerned that Ms. [redacted] is suffering from breast cancer that has worsened considerably since she arrived at FCI Danbury. **Ms. [redacted] is in need of emergency care. She urgently needs to see a breast surgeon. She has been pursuing the administrative remedy process to no avail.**

[redacted]

Mr. [redacted] is a 63-year-old man who had retinal surgery in May 2021 after retinal detachment (he suffers from vitreous degeneration). Mr. [redacted] was instructed to follow up twice a month with the specialist and notify the doctor immediately of any vision changes. He has not been seen by an eye

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doctor since he arrived at FCI Danbury in July 2021. His eyesight has worsened and he is experiencing vertigo. We are concerned that Mr. [redacted] has another detached retina. Retinal detachment can cause blindness if not treated right away. Mr. [redacted] urgently needs to see a retina specialist to diagnose the issues with his retina. Mr. [redacted] has made multiple requests to BOP to be seen for this issue.

[redacted]

Mr. [redacted] is a 57-year-old man who suffers from diabetes, kidney disease, and severe issues in both of his eyes. This past spring, Mr. [redacted] had surgery addressing his retinopathy. We understand that he has not seen his specialist to follow-up from the surgery. Despite the surgery, Mr. [redacted] eyesight is severely diminished and he is still unable to read. Mr. [redacted] recently saw an eye doctor at Danbury FCI who informed him he needed cataract eye surgery. Mr. [redacted] continues to suffer from chronic kidney disease, and has been told by FCI Danbury staff that he has kidney failure. We understand that although BOP has sent Mr. [redacted] to a kidney specialist twice, both times BOP failed to provide Mr. [redacted] medical records to the specialist and therefore he could not be properly evaluated. We request that BOP bring Mr. [redacted] back to the kidney specialist as soon as possible (with his records supplied) and that he see the eye specialist to follow up on his retinopathy and address his cataracts.

[redacted]

Mr. [redacted] is a 32-year-old man who continues to suffer with seizures since arriving at FCI Danbury in May of 2021. Prior to arriving at the facility, Mr. [redacted] was on medication (Gabapentin) that greatly reduced the number of seizures he had. We requested in June 2021 that Mr. [redacted] be evaluated for his seizures and have access to the medication that helped his condition. To date, Mr. [redacted] has not been prescribed medication he needs and is still having frequent seizures.

We ask that you help ensure that these individuals receive the care they urgently need.

Sincerely,

/s/ Sarah French Russell,
Sarah French Russell, *Supervising Attorney*
Tessa Bialek, *Supervising Attorney*

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/s/ Alexandra Harrington,
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May 13, 2022

Warden Timethea Pullen
Federal Correctional Institution, Danbury
33 1/2 Pembroke Station
Route 37
Danbury, CT 06811
Via email: DAN-ExecAssistant@bop.gov
CC: Regional Counsel, Darrin Howard , d3howard@bop.gov

Re: Concerns about the Health and Safety of Individuals Incarcerated at FCI Danbury

Dear Warden Pullen:

We are writing to bring your attention to five individuals with serious medical issues. We are concerned that they are not receiving urgently needed medical care.

[redacted] is a 68-year-old man who suffers from bladder cancer, prostate cancer, obesity, type-2 diabetes, COPD, emphysema, numerous ongoing cardiac issues (including 5 stents), hypertension, and a history of strokes. In 2018 Mr. [redacted] had surgery to remove cancer from his bladder. After this procedure, doctors told Mr. [redacted] that he would need a cystoscopy every three months to ensure there was no tumor regrowth. Since that procedure, the monitoring of his condition has been inconsistent.

A CT scan of Mr. [redacted] abdomen in December of 2019 revealed abnormal results. Due to his history of bladder cancer, it was noted that he needed urgent follow-up. In February 2020 he was seen by a specialist and told he needed a CT scan, an IVP and a cystoscopy. The facility's doctor ordered these procedures and marked them as urgent. However, Mr. [redacted] waited for these procedures for over a year.

Finally in July of 2021, Mr. [redacted] received a cystoscopy that revealed a return of advanced bladder cancer. In October of 2021 Mr. [redacted] had a urology consultation to screen him for prostate cancer. The results of the screening were abnormal, and he was referred for a biopsy of his prostate. In November of 2021 he was diagnosed with advanced prostate cancer. A January 2022 PET scan revealed evidence that the cancer has spread beyond his prostate to other lymph nodes.

Since that date, Mr. [redacted] has not seen a physician or received appropriate follow up care at the facility. He is not receiving care for his symptoms, even ones that, according to doctors require immediate attention. And he is experiencing significant pain and side effects from his current treatment. Due to both his bladder cancer and prostate cancer, an outside reviewing physician has confirmed that Mr. [redacted] needs radiation or surgery followed by chemotherapy, as well as consistent follow-up care to monitor his conditions and treatment side-effects. We request that

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Mr. [redacted] be immediately scheduled for follow-up with specialists to obtain a proper treatment plan for his cancer.

[redacted] is a 56-year-old man who has been diagnosed with Benign Prostatic Hyperplasia (BPH) since 2014. This is the enlargement of the prostate gland, which can lead to bladder and urination problems. As a result, Mr. [redacted] must use catheters to urinate and has suffered from frequent urinary tract infections. Urologists have told Mr. [redacted] that in order to alleviate his urinary problems he needs transurethral resection of the prostate (TURP) surgery. This surgery was originally scheduled for February of 2020 but was delayed due to the pandemic. In December 2020, Mr. [redacted] went to an outside consultation with a urologist. At this consultation he was again told that he urgently needed TURP surgery to remedy his prostate condition. To date he has yet to receive the procedure. We are requesting that Mr. [redacted] be immediately scheduled for his urgently needed TURP surgery.

[redacted] is a 44-year-old man who has a history of heart problems and hypertension. He has been experiencing chest pain since February 2021. Several EKGs revealed an abnormality. After an outside consultation with a cardiologist in April 2021, the cardiologist determined that he had Ischemia. The cardiologist told him that he needed a stress test and a CT scan. For almost a year he was not seen again for follow-up or for these procedures. He was taken to Danbury hospital in March 2022 for chest pain. He has requested to see medical and to follow-up with a cardiologist, neither of which have occurred. We are requesting that Mr. [redacted] be immediately scheduled for a follow-up appointment with a cardiologist to monitor his condition.

[redacted] Mr. [redacted] is a 44-year-old man who has a bad valve in his upper leg causing poor circulation and ulcerated veins. These ulcerated veins have burst on multiple occasions causing painful open wounds, which often become infected and make it difficult for Mr. [redacted] to walk. In August 2021 Mr. [redacted] was taken to a vascular surgeon. The surgeon planned to do an ultrasound in anticipation of surgery and reported that Mr. [redacted] needed the valve in his leg repaired and a laser procedure to address his ulcerated veins. Although he is told he is scheduled for follow-up with the vascular surgeon, this appointment has yet to occur almost a year later. We are requesting that Mr. [redacted] be seen by the vascular surgeon for his valve surgery immediately to prevent further open wounds and infections.

[redacted] is a 40-year-old man who requires a CPAP machine to sleep every night. CPAP machines can mean the difference between someone breathing while they sleep, and not. Mr. [redacted] requires distilled water for his machine. This type of water is strongly recommended for many reasons: (a) to prevent bacteria from entering a person's airways by maintaining a sterile breathing environment; (b) to prolong the life of the machine by not causing mineral build up or damage to the machine itself from tap or even bottled water; and (c) because without it the machine requires special cleaning procedures. The water in a CPAP machine needs to be replaced daily to protect the sterility of the machine. Mr. [redacted] has only been allowed to get distilled water for his machine at a certain hour on Tuesdays. The amount of water

he is given only lasts two days. This leaves him forced to purchase Dasani water from commissary at a great expense, or to not use any clean water at all. This risks harm to the machine, and more importantly to Mr. [redacted] We are requesting he be provided with distilled water in adequate amounts and at adequate intervals to supply his CPAP machine.

Thank you for your attention to these issues.

Sincerely,

Kerry Conner, Student Attorney

Karen Lillie, Student Attorney

Alexandra Harrington, Supervising Attorney
Criminal Justice Advocacy Clinic
University at Buffalo School of Law

# ATTACHMENT 4

# *FCI Danbury sees 'really large numbers' of COVID cases amid accusations of 'inadequate practices'*

The News-Times (Danbury, Connecticut)

January 9, 2022 Sunday



**Section:** STATE AND REGIONAL NEWS

**Length:** 1420 words

**Byline:** Currie Engel, The News-Times, Danbury, Conn.

## Body

Jan. 9—DANBURY — An increasing number of incarcerated people at the Federal Correctional Institute in Danbury are testing positive for COVID-19 amid calls for an investigation into allegations that they aren't receiving proper care.

Currently, 89 incarcerated people have tested positive at FCI Danbury, the fifth highest of all federal correctional facilities. Fourteen staff there have also tested positive, according to the agency's website. The facility is a low security federal correctional institution with a low security satellite prison and a minimum security satellite camp.

Sarah Russell, director of the Legal Clinic at Quinnipiac University School of Law and a Quinnipiac law professor representing the incarcerated individuals, reported that 80 men being housed in the auditorium at the facility to make room for people who are positive have only 20 cots, one toilet, and two portable showers. The men do not have access to phone, but they have access to email, she said. Staff allegedly told the men they are trying to get more cots from another facility.

"The latest information I have coming out of the men's facility is just really large numbers of people testing positive," Russell added.

She said thinks the number of positive cases listed on the DOP website is likely an undercount.

This past week, reports from the facility alleged that more than half of the women at FCI Danbury Camp tested positive on Dec. 27, but weren't isolated or initially told whether they had the virus.

The Bureau of Prisons has refused to confirm or deny the allegations, saying it follows protocol outlined by the Centers for Disease Control and Prevention.

"COVID-19 transmission rates among staff and inmates in the BOP's correctional institutions generally mirror those found in local communities," the bureau said in a statement. "The BOP is using critical testing tools to help mitigate the spread of the virus and continues to provide testing for COVID-19

symptomatic inmates, as well as mass testing or serial testing when indicated, as recommended by the Centers for Disease Control and Prevention (CDC)."

A 46-year-old Rhode Island woman at the prison has sued FCI Danbury and the warden, alleging the facility has failed to take COVID precautions and seeking to be released to home confinement because she says she cannot received the COVID vaccination due to her medical condition. The BOP said it would not comment on pending litigation.

On Monday, U.S. Sen. Richard Blumenthal, D-Conn., and his colleagues called for an investigation into allegations that the facility failed to follow COVID-19 isolation guidelines. By Thursday, Blumenthal said he had received further news of "questionable" quarantine practices at the men's facility.

In the men's prison, unit-wide COVID testing was not done in Units D, F, H, L, and M until Thursday, Russell said, and at that time, all five units reported positive cases.

Before being tested, some men from Unit F had been brought to work in the kitchen which serves food to the whole men's prison. When staff later tested the men, some were positive, Russell said.

She also received a report that more women were still being brought into the facility after lockdown began on Dec. 28, but has had very little access to information from the women's camp because of their limited access to email and phone calls since lockdown. At least four women have tested positive in the women's satellite prison so far, according to Russell's communications.

The facility is under "level three" operations due to the COVID outbreak, which entail the agency's tightest restrictions, including face coverings and social distancing.

"Right now, we have more questions than answers, and the questions are deeply serious," Blumenthal said.

Blumenthal added that legislators are going to continue demanding answers from the U.S. Attorney General. He spoke with Murphy and Hayes on Friday but has not announced further action so far.

The U.S. Attorney General's office did not return request for comment throughout the week.

Danbury's health director Kara Prunty said she had not specifically discussed the outbreak with the prison's administrators, but was aware of the situation and has been in conversation and had planning sessions with the facility.

Despite the outbreak, the facility's census is higher than it was at the start of the pandemic, with 1,103 incarcerated people now housed there. The men's facility went from a population of 728 in April of 2020 to 648 in September, and is now up to 897, according to Russell and the BOP dashboard.

Russell called the increase in the men's population "particularly striking."

Shaun Boylan, an FCI Danbury employee and executive vice president with AFGE Local 1661, independently stated that the agency continues to send the facility more inmates.

Staff shortage and medical care

Staffing shortages have had more serious implications during this COVID wave than just overworked, burnt-out employees at the facility: the staff is bringing COVID to work with them, Boylan said.

As the Danbury area hits record-high levels of COVID infection this week, and testing remains difficult to come by, those coming in to work at FCI Danbury are testing positive.

The agency originally offered two weeks of administrative leave during the pandemic, but that policy has since ended, and employees are showing up to work sick, Boylan said.

Union members held a protest in December, asking Congress to take measures to address the staffing problems.

"People are at the point now where they're so burnt out — and that's the best way to put it — they're like, 'You know what? I'm going to take my chances, because I don't have time. I can't afford to take leave without pay,'" Boylan said.

"I know this is happening, I hear the coughs," he added.

On top of that, staff members have had difficulty finding protective N95 masks and adequate testing, Boylan said, which they have to seek outside of the facility and which can take days to return. The union received guidance that they could just wear surgical masks in isolation units where those who test positive are being housed.

Boylan said the staffing shortages extended to "bureau-wide" issues with retaining essential medical staff like nurses, doctors and emergency medical technicians. During a COVID outbreak, this has caused legislators concern.

Caring for the ill

Blumenthal has heard reports of just one physician on staff to serve the entire facility for many months.

"There's no way that the regular medical staff at that facility can address the current outbreak," he said. "Throughout the pandemic, the medical department has reportedly been severely understaffed and has been unable to respond appropriately to urgent medical issues, even when there is no outbreak."

The Bureau of Prisons stated Danbury's facility has an "ample number" of trained medical personnel providing "essential medical, dental, and mental health" services.

"All inmates have daily and regular access to medical care and appointments, and medical staff conduct daily rounds throughout each facility," the statement read.

Boylan said the COVID response is better this time around for the population housed at FCI Danbury than it was the first time an outbreak occurred.

Yet Russell said she also remains extremely concerned about the population's access to medical care and appropriate monitoring for those in isolation from COVID-19.

"During past outbreaks at FCI Danbury, there were major lapses in care for people sick with COVID," she said.

A way forward

Following the resignation of Bureau of Prisons Director Michael Carvajal this week, Blumenthal said he's focused on ensuring new leadership sets more rigorous COVID-19 oversight for federal correctional facilities.

"I'm not only hopeful, I'm insistent," he said. "I will be asking tough questions during the confirmation process."

Carvajal has been criticized by lawmakers for the agency's response to COVID-19 outbreaks in facilities over the past two years. FCI Danbury itself is under new leadership, according to Boylan. The new warden comes from FCI Elkton, another low-security federal men's prison in Ohio. Boylan said she has already been communicating with the union.

"This issue, it's really a system wide issue," Blumenthal said. "If there are inadequate practices at FCI Danbury, the same is likely happening elsewhere around the country."



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# *Staff shortage and double shifts: Danbury prison union workers decry conditions*

The News-Times (Danbury, Connecticut)

December 15, 2021 Wednesday



**Section:** STATE AND REGIONAL NEWS

**Length:** 1128 words

**Byline:** Julia Perkins, The News-Times, Danbury, Conn.

## Body

Dec. 15—DANBURY — Shaun Boylan goes into work hoping he's not on the list.

If he is, he'll have to spend at least part of his shift filling in as a correctional officer at the low-security federal prison in Danbury.

FCI Danbury, where Boylan has worked since February 2017 in accounting, is so short staffed that it's common for non-officer employees, including cooks, teachers, nurses and maintenance staff to be forced to fill in as correctional officers, he said. Employees are also mandated to work 16-hour shifts when the prison is short staffed, he said.

"We've lost so many people, it's insane," said Boylan, executive vice president with AFGE Local 1661. "They just say, 'I'd rather go work at McDonald's than work here because at least I know what my schedule is.'"

The union has installed a billboard in the city that states "Dangerously understaffed federal prison ahead. Are you safe?"

Union members plans to protest Wednesday morning at the intersection of Hayestown Avenue and North Street to call on Congress to increase prison staffing levels, provide recruitment bonuses and take other measures to address the problem.

The Bureau of Prisons and FCI Danbury are "committed to ensuring appropriate staffing levels to maintain the safety and security of staff, inmates, and the institution," a spokesman stated.

"We are actively seeking to fill vacant positions with particular focus on Correctional Officer vacancies, and we continue to evaluate and use a breadth of employment incentives to attract and retain staff," spokesman Donald Murphy wrote.

The prison is staffed over over 94 percent with 112 correctional services staff, he said.

U.S. Sens. Richard Blumenthal and Chris Murphy, D-Conn., as well as U.S. Rep. Jahana Hayes, D-Conn., wrote a letter to the director of the Bureau of Prisons on Tuesday urging the bureau to address FCI Danbury's staffing challenges and to meet the BOP's staffing guidelines.

"We are concerned that the large number of vacancies and staffing issues has led to many issues at FCI Danbury," they wrote. "While we recognize that the COVID-19 pandemic may have exacerbated some of these issues, the safety and security of staff and inmates must be prioritized at all times. The ongoing staffing issues have led to low morale, fatigue and exhaustion among staff, which exacerbates the potential for incidents or injuries to staff and inmates."

The Congress members called on the bureau to support the staff's "requests and recommendations" for hiring and retaining staff.

"Without substantial changes, we are concerned that FCI Danbury's staffing issues will put inmates, staff, and the greater community at risk," the letter states. "Increasing staffing levels to meet BOP staffing guidelines would no doubt require aggressive recruiting of new hires and diligent efforts to retain existing staff."

The inmate to correctional officers ratio at FCI Danbury was 6.8 as of Sept. 30, 2020, according to the Bureau of Prisons' latest available report. The bureau must provide a more detailed explanation to the U.S. Senate if there are more than 15 inmates to one officer.

The number of individuals in FCI Danbury declined during COVID-19 and has risen again, Boylan said. The bureau reports 1,078 individuals at FCI Danbury, compared to 763 in April.

Mayor Dean Esposito plans to attend the protest, which comes a week after City Council approved renewing agreements between FCI Danbury and police, firefighters and emergency management to provide mutual assistance during natural disasters and law enforcement emergencies.

"As far as I'm concerned, we work very closely with them," Esposito said. "We always have. We're going to try to provide as much support as we can."

'Our vigilance is gone'

The staffing shortage is a problem nationwide in the Bureau of Prisons, the union said. The bureau budgeted for about 20,400 correctional officers in 2020, but the Associated Press reported in May that the bureau employed less than 13,800.

In other parts of the country, the bureau has held career fairs and offered recruitment incentives. The bureau advertises job postings through social media and other platforms, including billboards and virtual recruitment events, the spokesman said. This includes recruiting through various professional organizations, such as the military.

The union says the coronavirus pandemic exacerbated shortages. Officers are routinely required to work double shifts two to five times per week, often without prior notice, according to the union.

Over Thanksgiving weekend, an entire shift was mandated to work 16 hours for two days in a row, Boylan said. Shifts are typically eight hours.

On average, 10 to 15 administrative or programming staff members per day are asked to perform correctional officer duties, according to the union. On some days, the list of employees who will have to become correctional officers is two pages long, Boylan said. Other days, the list is shorter.

"This causes programs to cease that reduce recidivism, prepare soon to be released inmates the opportunities to prepare for a productive life outside of prison, and neglects all other tasks that are needed to maintain the facility, pay our debts, and conduct regular business," the union stated.

Boylan has worked in prisons for 12 years, previously serving as a correctional officer, but he said it's still hard to jump back into the job he hasn't done regularly for years.

All new staff members, including non-correctional officers, receive the same three-week training program at an academy in Georgia, he said. But employees haven't been traveling there due to COVID-19, he said.

Boylan said staff members are reprimanded for not completing their regular duties, even when they've been assigned as correctional officers. Even maintenance of the facility has fallen behind, he said.

"We have an aging facility that's ready to crumble, and we can't take care of it because we're too busy filling in (for) officers," he said.

He said eight staff members who previously worked at the closing Metropolitan Correctional Center in New York are supposed to move to FCI Danbury.

Due to rising COVID cases in the community, FCI Danbury is under code red, which means "intense modifications" to "operations such as inmate programming and services" to prevent the spread of the virus, according to the BOP.

This makes it harder for prison staff, Boylan said.

"The inmates are idle and irritable," he said. "When you have idle inmates they become aggressive, either verbally or physically."

No staff members have been assaulted, he said. But they're exhausted, he said.

"Our vigilance is gone," Boylan said.



**Load-Date:** December 15, 2021

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