

TABLE OF CONTENTS

Exhibits

- A. Affidavit of Dr. Yonatan Grad and Emma Accorsi
- B. Affidavit of Dr. Monik C. Jiménez
- C. Affidavit of Daniel Jaffe
- D. Department of Correction COVID Testing Protocols
- E. Affidavit of Jacqueline Dutton
- F. Affidavit of Tommy Fears
- G. Affidavit of Tracy Magdalene
- H. Affidavit of James J. Vita, III
- I. Affidavit of Rebecca Whitehill
- J. Affidavit of Thomas Mello
- K. Affidavit of John Nolen
- L. Affidavit of Carlos Brito
- M. Affidavit of Kevin Chapman
- N. Affidavit of Nicholas J. Morris
- O. Affidavit of Timothy Noonan
- P. Affidavit of Jake Hasson
- Q. Affidavit of Joel Arce
- R. Affidavit of Anthony Hill
- S. Department of Public Health, Nursing Home Testing Policy, December 7, 2020

EXHIBIT A

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT and others,
Respondents.

AFFIDAVIT OF DR. YONATAN GRAD (MD, PhD) AND EMMA ACCORSI (BS)

I, Dr. Yonatan Grad, and I, Ms. Emma Accorsi, state that the following is a true and accurate statement to the best of our knowledge and belief:

Background (Yonatan Grad)

1. I, Yonatan Grad, am the Melvin J. and Geraldine L. Glimcher Associate Professor in the Department of Immunology and Infectious Diseases at the Harvard T.H. Chan School of Public Health, and associate physician in the Division of Infectious Diseases at Brigham and Women's Hospital (BWH) and Harvard Medical School. I earned my MD and PhD at Harvard Medical School, completed my internal medicine residency at BWH and clinical infectious diseases fellowship in the Massachusetts General Hospital/BWH combined program, and performed postdoctoral work in the Center for Communicable Disease Dynamics at the Harvard T.H. Chan School of Public Health.
2. My research investigates how pathogens evolve and spread through populations with the motivation of improving clinical and public health strategies to decrease the burden of disease. I use a variety of methods, including genomics, epidemiological tools, and microbiology, to define the dynamics of spread and investigate pathogen genotypic and phenotypic diversity.
3. I am the author of more than 90 peer-reviewed articles in epidemiology, infectious diseases, and other areas that have been cited over 5,500 times. Most recently, I am the author of 5 peer-reviewed papers, 5 submitted manuscripts available as pre-prints, and several op-eds covering the COVID-19 pandemic. Among these, I am co-senior author on the recent *Science* paper "Projecting the transmission dynamics of SARS-CoV-2 through the postpandemic period," in which we built a mathematical model for SARS-CoV-2 transmission incorporating viral, environmental, and immunologic factors and evaluated

the impact of social distancing efforts on curbing the COVID-19 pandemic. In that paper, we explored multiple scenarios, including on and off again social distancing so as not to overwhelm the critical care capacity of health care systems. In addition, I am one of the science advisors for the National Basketball Association, and I worked with the team of advisors and members of the NBA and NBA Players Association to implement, oversee, and monitor the resumption of the 2019-20 season in the “bubble.” I have also been interviewed, quoted, and featured in multiple media outlets, including CNN, MSNBC, the New York Times, the Atlantic, the Washington Post, and the Boston Globe.

4. A copy of my curriculum vitae is attached as Exhibit A.

Background (Emma Accorsi)

5. I, Emma Accorsi, am a fifth-year PhD candidate in the Department of Epidemiology at the Harvard T.H. Chan School of Public Health with a focus on infectious disease epidemiology. I am the author of four peer-reviewed papers, and four manuscripts currently under scientific review, and have been an instructor for one course in quantitative methods, and a teaching fellow for six courses in epidemiology. I completed my B.S. in Applied Mathematics at Emory University where I was an Emory Scholar and a Barry M. Goldwater Scholar.
6. A copy of my curriculum vitae is attached as Exhibit B.

SARS-CoV-2 (the virus that causes the disease “COVID-19”) is a highly transmissible pathogen and can spread easily in crowded jails and prisons where physical distancing is not possible.

7. COVID-19 is a contagious, dangerous and sometimes deadly disease, which can damage the lungs, heart, and brain.¹
8. The Centers for Disease Control and Prevention (CDC) stresses the necessity of physical distancing to reduce SARS-CoV-2 transmission. As the news website STAT recently summarized, “the closer you are to someone infectious and the longer you are in contact with them, the more likely you are to contract the virus.”² Furthermore, the virus may spread through shared spaces such as toilets, showers, and eating areas because it can remain on surfaces for hours or days.³
9. Due to these characteristics, COVID-19 transmission is especially problematic in communal living environments such as colleges and universities, nursing homes, and jails and prisons.

¹ Andrew Joseph et al., *Seven Months Later, What We Know About Covid-19 — and the Pressing Questions that Remain*, STAT (Aug. 17, 2020), <https://www.statnews.com/2020/08/17/what-we-now-know-about-covid19-and-what-questions-remain-to-be-answered>.

² *Id.*

³ Centers for Disease Control and Prevention, *COVID-19: Cleaning and Disinfection for Households*, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html> (last visited Dec. 12, 2020) (“Current evidence suggests that SARS-CoV-2 may remain viable for hours to days on surfaces made from a variety of materials.”)

10. Jails and prisons in particular can act as reservoirs of infection and facilitate transmission. Without reducing the incarcerated population, it is impossible to practice physical distancing in jails and prisons. It is therefore not surprising that as of August 2020, 90 of the largest 100 cluster outbreaks in the United States had occurred in prisons and jails.⁴ These outbreaks can cause infections to spill over into surrounding communities.⁵
11. As one group of Stanford researchers explains, jails are “an epicenter of COVID-19 transmission in the United States,” where the virus can spread 3.6 times faster than aboard the Princess Diamond Cruise ship or over 4 times faster than it spread in Wuhan.⁶
12. Indeed, across the United States, jails and prisons have higher rates of infection and mortality compared to the general public. As of December 8, at least 249, 883 incarcerated individuals have contracted COVID-19 nationwide and at least 1,657 have died from the virus.⁷
13. These concerns are magnified as the number of new daily COVID-19 infections in Massachusetts has risen to its highest levels yet.⁸
14. According to the Department of Public Health’s December 10th weekly report, every county in Massachusetts reported a higher relative change in case counts and change in percent positivity.⁹ Seven counties reported a positivity rate of 5% or higher.¹⁰ As of December 10, 158 Massachusetts communities are now considered high risk.¹¹
15. In another troubling sign, surveillance for SARS-CoV-2 genetic material in the wastewater from Boston and the surrounding towns shows that community spread of SARS-CoV-2 in eastern Massachusetts is substantially higher currently than at any other point during the pandemic (**Fig. 1**).¹² This wastewater data is especially useful because unlike case counts it is not influenced by trends in testing or test availability. In particular, both the towns to the south and to the north of Boston recently had peaks in detected viral RNA levels on December 4, 2020. Wastewater surveillance anticipates

⁴ Nayanah Siva, *Experts Call to Include Prisons in COVID-19 Vaccine Plans*, The Lancet (Dec. 12, 2020), <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2932663-5>.

⁵ American Civil Liberties Union, *Flattening the Curve: Why Reducing Jail Populations is Key to Beating COVID-19*, <https://www.aclu.org/report/flattening-curve-why-reducing-jail-populations-key-beating-covid-19?redirect=covidinjails>; <https://www.medrxiv.org/content/10.1101/2020.04.08.20058842v2.full.pdf>.

⁶ Edmund L. Andrews, *Stanford Researchers Find COVID-19 Spreads Faster in American Jails Than on Cruise Ships*, Stanford News (Sept. 24, 2020), <https://news.stanford.edu/2020/09/24/covid-19-spread-american-prisons>.

⁷ The Marshall Project, *A State-by-State Look at Coronavirus in Prisons*, <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons> (last checked December 14, 2020).

⁸ Massachusetts Department of Public Health, *COVID-19 Daily Dashboard*, 5 (Dec. 13, 2020), <https://www.mass.gov/doc/covid-19-dashboard-december-13-2020/download>.

⁹ Massachusetts Department of Public Health, *COVID-19 Weekly Public Health Report*, 25 (Dec. 10, 2020), <https://www.mass.gov/doc/weekly-covid-19-public-health-report-december-10-2020/download>.

¹⁰ *Id.*

¹¹ Amanda Kaufman and Peter Bailey-Wells, *These 158 Mass. Communities Are at High Risk for COVID-19*, Boston Globe (Dec. 10, 2020), <https://www.bostonglobe.com/2020/11/19/nation/these-62-mass-communities-are-high-risk-covid-19/?p1=Article Inline Related Link>.

¹² Massachusetts Water Resources Authority, *Wastewater COVID-19 Tracking*, <https://www.mwra.com/biobot/biobotdata.htm> (last visited Dec. 15, 2020).

hospitalizations by a few weeks, and hospitalizations precede deaths by a few weeks as well, meaning that the full effect of this peak on hospitals and mortality hasn't been seen yet. While SARS-CoV-2 transmission in Massachusetts is already worse now than during the spring or summer, it is likely to continue to intensify, as the full effects of Thanksgiving gatherings are felt, and both cold weather and the holiday season continues.

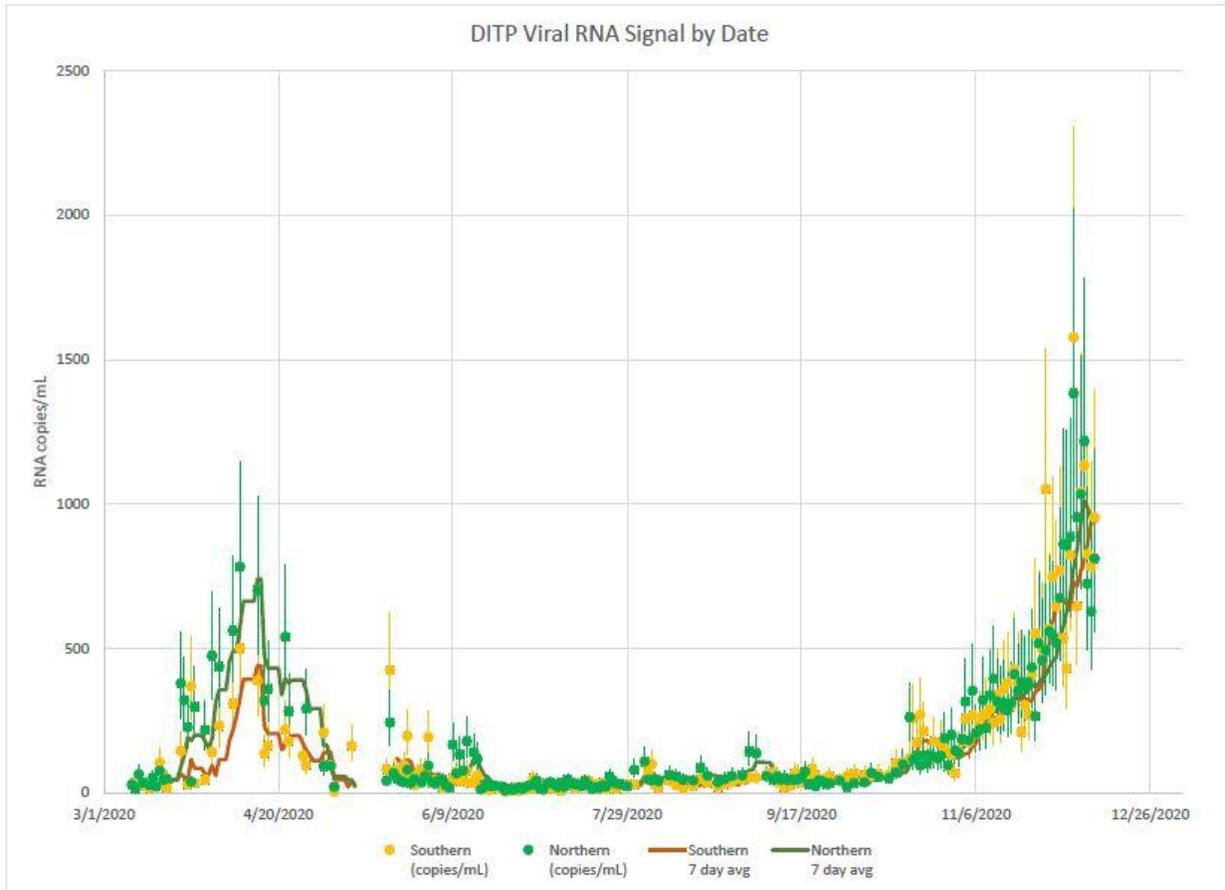


Figure 1: SARS-CoV-2 wastewater surveillance data for Boston and the surrounding towns through 12/10/2020 shows an absolute maximum on 12/4/2020.¹³

16. Compared to two weeks ago, statewide availability of ICU and non-ICU beds has dropped 23 and 20 percentage points, respectively.¹⁴ Additionally, the field hospital at the DCU Center in Worcester, which re-opened on Sunday, December 6, 2020, reported having already exceeded their planned capacity for the first week only four days after opening and is seeking more staff to be able to expand field hospital capacity.¹⁵

¹³ *Id.*

¹⁴ Massachusetts Department of Health, COVID-19 Response Reporting - COVID-19 Daily Dashboard, (Dec. 13 and Dec. 29) 16-17, <https://www.mass.gov/doc/covid-19-dashboard-december-13-2020/download>, <https://www.mass.gov/doc/covid-19-dashboard-november-29-2020/download>.

¹⁵ Melissa Hanson, *Worcester DCU Center COVID Field Hospital Already Exceeding Capacity Planned for First Week, Seeing High Demand*, Masslive (Dec. 9, 2020), <https://www.masslive.com/worcester/2020/12/worcester-dcu-center-covid-field-hospital-already-exceeding-capacity-planned-for-first-week-seeing-high-demand.html>.

17. In the absence of the introduction of new interventions locally, regionally and nationally, we will continue to see case numbers rise, along with hospitalizations and deaths.

Testing of individuals without symptoms is necessary to stem the tide of COVID-19 infections in Massachusetts jails and prisons.

18. It is well recognized that SARS-CoV-2 infected individuals are infectious before they develop symptoms and even if they never develop recognizable symptoms. These pre-symptomatic and asymptomatic infected individuals are important contributors to transmission.¹⁶

19. For example, after a skilled nursing facility in Washington screened all residents for COVID-19 - of positive residents, 56% did not have symptoms when tested. Researchers found that the majority of these pre-symptomatic individuals shed infectious virus one to six days before symptom development.¹⁷

20. Mass testing that is conducted only after a symptomatic case has been detected is too delayed to contain outbreaks in a prison setting. A Montgomery County, PA facility that tested all incarcerated individuals found that 177 of 948 were positive with 171 (97%) having no symptoms at the time of testing,¹⁸ while a Goldsboro, NC facility found 444 of 723 total incarcerated individuals were positive, 98% of whom were asymptomatic.¹⁹ Similar findings have been reported by facilities across the United States in Arkansas, Ohio, Virginia, Michigan, and Tennessee,²⁰ and an August CDC Report demonstrated “that mass testing in 16 U.S. prisons and jails found a 12-fold increase over the number of cases identified through symptoms alone.”²¹

21. Pre-symptomatic and asymptomatic cases play an important role in transmission,²² and

¹⁶ Seyed M. Moghadas et al., *The Implications of Silent Transmission for the Control Of COVID19 Outbreaks*, Proc. Natl. Acad. Sci. U. S. A. (July 6, 2020); Anne Kimball et al., *Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility - King County, Washington*, 69 MMWR Morb. Mortal. Wkly. Rep. 377–81 (Apr. 3, 2020); Melissa M. Arons et al., *Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility*, N. Engl. J. Med. (Apr. 24, 2020); W.E. Wei et al., *Presymptomatic Transmission of SARS-CoV-2 - Singapore, January 23-March 16, 2020*, 69 MMWR Morb. Mortal. Wkly. Rep. 411–15 (June 27, 2020); Zhanwei Du et al., *Serial Interval of COVID-19 among Publicly Reported Confirmed Cases*, 26 Emerging Infectious Disease 1341–43 (Mar. 19, 2020); Xi He et al. *Temporal Dynamics in Viral Shedding and Transmissibility of COVID-19*, Nature Medicine (Apr. 15, 2020).

¹⁷ Melissa M. Arons et al., *Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility*, N. Engl. J. Med. (Apr. 24, 2020).

¹⁸ Jeremy Roebuck and Allison Steele, *Montgomery County’s Jail Tested Every Inmate for COVID-19 — and Found 30 Times More Cases than Previously Known*, Philadelphia Inquirer (Apr. 28, 2020).

¹⁹ Linda So and Grant Smith, *In Four U.S. State Prisons, Nearly 3,300 Inmates Test Positive for Coronavirus -- 96% Without Symptoms*, Reuters (Apr. 25, 2020).

²⁰ *Id.*

²¹ Cid Standifer and Frances Stead Sellers, *Prisons and Jails Have Become a ‘Public Health Threat’ During the Pandemic, Advocates Say*, Washington Post (Nov. 11, 2020), https://www.washingtonpost.com/national/coronavirus-outbreaks-prisons/2020/11/11/b8c3a90c-d8d6-11ea-930e-d88518c57dcc_story.html.

²² Seyed M. Moghadas et al., *The Implications of Silent Transmission for the Control Of COVID19 Outbreaks*, Proc. Natl. Acad. Sci. U. S. A. (July 6, 2020); Anne Kimball et al., *Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility - King County, Washington*, 69 MMWR Morb. Mortal. Wkly. Rep. 377–81 (Apr. 3, 2020); Melissa M. Arons et al., *Presymptomatic SARS-CoV-2 Infections and*

research suggests that outbreaks occur even with the immediate isolation of all symptomatic cases.²³

22. Thus, public health and infectious diseases researchers and officials recognize that, particularly in vulnerable communal living environments, the frequent testing of individuals without symptoms is necessary to contain the pandemic.²⁴
23. Recent research from Larremore, *et al.* compared different testing strategies in simulated populations, including varying testing frequency, test sensitivity, and the amount of time from sample collection to result return.²⁵ They assumed that 35% of infected individuals would self-isolate due to symptoms around the time of their peak viral load without testing, while 65% would not be detected without testing. The authors found that total infectiousness was reduced by 62-66% for weekly testing, and 45-57% under biweekly testing, although some of this reduction was due to self-isolation (**Fig. 2**). The authors determined that symptom-based screening alone was insufficient to control case numbers and that surveillance testing should emphasize frequency and the time from obtaining the sample to receiving results. In simulations of a large university setting, the authors conclude “direct examination of simulations showed that ... screening weekly with either [test] effectively attenuated surges of infections”.
24. A similar study used modeling to compare testing strategies in a college population and found that symptom-based screening alone did not control dormitory outbreaks under any of the considered scenarios.²⁶

Transmission in a Skilled Nursing Facility, N. Engl. J. Med. (Apr. 24, 2020); W.E. Wei et al., *Presymptomatic Transmission of SARS-CoV-2 - Singapore, January 23-March 16, 2020*, 69 MMWR Morb. Mortal. Wkly. Rep. 411–15 (June 27, 2020); Zhanwei Du et al., *Serial Interval of COVID-19 among Publicly Reported Confirmed Cases*, 26 Emerging Infectious Disease 1341–43 (Mar. 19, 2020); Xi He et al. *Temporal Dynamics in Viral Shedding and Transmissibility of COVID-19*, Nature Medicine (Apr. 15, 2020).

²³ Seyed M. Moghadas et al., *The Implications of Silent Transmission for the Control Of COVID19 Outbreaks*, Proc. Natl. Acad. Sci. U. S. A. (July 6, 2020).

²⁴ Daniel B. Larremore, et al, *Test Sensitivity Is Secondary to Frequency and Turnaround Time for COVID-19 Screening*, Science Advances (Nov. 20, 2020).

²⁵ *Id.*

²⁶ A. David Paltiel et al., *Assessment of SARS-Cov-2 Screening Strategies to Permit the Safe Reopening of College Campuses in The United States*, 3 JAMA Open Network (July 31, 2020).

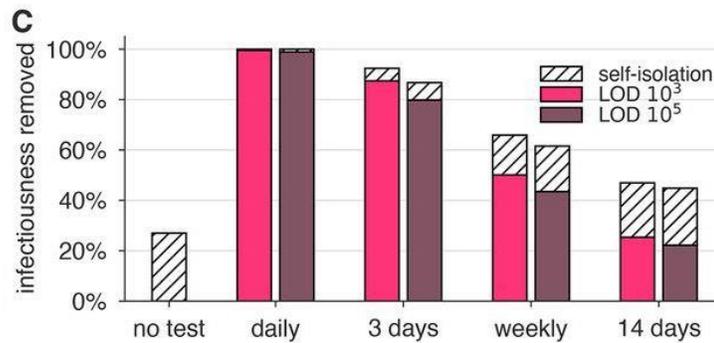


Figure 2: Figure 1c from Larremore, et al.²⁷ shows that the total infectiousness of 10,000 simulated individuals was reduced by 62-66% and 45-57% for weekly and biweekly testing, respectively, although some of the reduction occurred due to self-isolation after symptom development (shown by the cross-hatch pattern). More frequent testing resulted in additional dramatic decreases in total infectiousness. The pink and maroon colors represent two different SARS-CoV-2 tests with different limits of detection (LOD) for the virus, and the cross-hatch pattern represents reductions in total infectiousness from self-isolation due to symptom development.

25. Slovakia performed mass testing of their population (combined with isolation of identified cases with their family members). A study of Slovakia's mass testing strategy found that in counties with two rounds of weekly mass testing, the prevalence of detected infections dropped approximately 60% between rounds.²⁸
26. For prisons, failing to conduct regular testing of asymptomatic individuals decreases the likelihood of identifying cases, preventing outbreaks, and limiting the number of individuals who develop symptomatic disease, including those that manifest in severe disease and death. Simulations of a university setting showed that weekly testing with prompt return of results effectively controlled case numbers,²⁹ while symptom-based screening only did not prevent outbreaks.³⁰ To the extent that testing frequency decreases and test results are delayed, testing will be less effective for controlling outbreaks because infected individuals cannot be identified and isolated. Testing non-symptomatic individuals only at intake, or only once every few months, is not an effective strategy to prevent disease transmission. Because individuals can be infected once they are incarcerated, such infrequent testing will not identify non-symptomatic cases before the virus can spread broadly amongst incarcerated individuals and staff.
27. Testing that only targets symptomatic individuals is useful for diagnosis and identifying the cause of death, but testing must be frequent and target asymptomatics as well if it is to prevent disease transmission. Testing non-symptomatic individuals only after a

²⁷ Larremore, *supra* n.24.

²⁸ Martin Pavelka et al., *The Effectiveness of Population-Wide, Rapid Antigen Test Based Screening in Reducing SARS-Cov-2 Infection Prevalence in Slovakia*, medRxiv (Dec. 4, 2020).

²⁹ Larremore, *supra* n.24.

³⁰ Larremore, *supra* n.24; Paltiel, A. D., Zheng, A. & Walensky, R. P. Assessment of SARS-CoV-2 Screening Strategies to Permit the Safe Reopening of College Campuses in the United States. *JAMA Netw Open* **3**, e2016818 (2020).

symptomatic case is discovered similarly will not prevent the virus from spreading broadly amongst incarcerated individuals and staff.

28. In situations in which the prevalence of infection is anticipated to be low, it is possible to pool samples to monitor a facility for cases. In such “batch testing,” further individual testing is required only in the event of a positive result.³¹
29. Testing protocols at congregate facilities in Massachusetts and throughout the country reflect the reality that regular testing of pre-symptomatic and asymptomatic people is central to public health.
30. For example, ICE protocols now recognize that “expanded testing strategies are a critical tool in the prevention and management of COVID-19 infections,” and mandates that “all new admissions to ICE detention facilities require COVID-19 testing within 12 hours of arrival.”³² The speed with which testing should be done underscores as well the importance of the speed of returning the results, so that appropriate measures can be taken if the results return positive.
31. At the same time, the Executive Office of Health and Human Safety now requires nursing homes in counties with a positivity rate below 5% to test half of its staff every two weeks, while nursing homes in counties with a higher positivity rate must test all of its staff every two weeks.³³ Any positive result triggers testing of all residents and staff in the same physical space.
32. Similarly, more than 100 New England colleges have tested all of their students once or twice a week.³⁴ According to Stacey Gabriel at the Broad Institute, “schools that have done frequent testing of asymptomatic students have kept their rates at well below 1% positivity, whereas schools that use another approach of only testing symptomatic or only contacts of positives, have a rate at least tenfold higher.”³⁵
33. Routine and large-scale testing was a core element of the safe resumption of the 2019-20 NBA season, demonstrating the utility of testing to promote an environment in which individuals engage safely in high-risk activities, such as playing basketball while unmasked.
34. Regular testing in jails and prisons for individuals who are not symptomatic is similarly an important factor to interrupt transmission chains in these facilities, thereby preventing

³¹ Centers for Disease Control and Prevention, *Interim Guidance for Use of Pooling Procedures in SARS-CoV-2 Diagnostic, Screening, and Surveillance Testing* (2020), <https://www.cdc.gov/coronavirus/2019-ncov/lab/pooling-procedures.html>.

³² U.S. Immigration and Customs Enforcement, Enforcement and Removal Operations, *COVID-19 Pandemic Response Requirements*, 33 (Oct. 27, 2020), <https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf>.

³³ Mass. Dep’t of Health and Human Servs., *Residential and Congregate Care Programs: 2019 Novel Coronavirus (COVID-19) Surveillance Testing Guidance 2-3* (Nov. 2, 2020), <https://www.mass.gov/doc/eohhs-congregate-care-surveillance-testing-guidance>.

³⁴ Carey Goldberg, *Initial Results from a Massive Experiment: Over 3 Million Coronavirus Tests at New England Colleges*, WBUR (Nov. 25, 2020), <https://www.wbur.org/commonhealth/2020/11/25/on-campus-testing-colleges-broad>.

³⁵ *Id.*

outbreaks and helping our state to contain the pandemic.

35. An editorial in the New England Journal of Medicine called for regular testing of asymptomatic individuals in correctional facilities, writing “this recommendation for SARS-CoV-2 testing of asymptomatic persons...should most likely be expanded to other congregate living situations, such as prisons and jails.”³⁶
36. The CDC itself acknowledges that broad testing is a key part of an infection control program.³⁷
37. Based on our expert opinion, and as reflected in the policies and protocols described above, routine testing of pre-symptomatic and asymptomatic individuals in jails and prisons is the medical standard of care to protect the public health of prisoners, staff and the surrounding community.

The Houses of Correction failure to conduct routine, comprehensive testing of asymptomatic and pre-Symptomatic prisoners and staff means that they cannot take effective action to protect the incarcerated population from COVID-19.

38. The fact that many cases are initially pre-symptomatic or asymptomatic but can still be infectious means that the vast majority of cases among incarcerated individuals cannot be identified in time if there is no regular testing of prisoners without symptoms. If infections are not identified due to a lack of testing, the facility cannot take effective action to protect the rest of its incarcerated population from exposure and infection.
39. It is our understanding that the Houses of Correction are not conducting routine, comprehensive testing of non-symptomatic prisoners and staff. It is our expert opinion that the Houses of Correction are not conducting the level of testing necessary to identify infected prisoners and staff and that the Houses of Correction therefore lack the information necessary to take steps to protect uninfected people in the facilities.
40. The positive impact of quarantining, masking, distancing and hygiene is severely limited if the facilities do not first identify infectious individuals through routine testing. Sufficient testing of the incarcerated individuals and staff is a fundamental and necessary predicate to preventing the spread of COVID-19 in a communal living facility. Because asymptomatic and pre-symptomatic individual can be infectious, relying only on symptom screening is insufficient to prevent introductions of COVID-19 and to keep prisoners and staff safe.
41. There is no medical or scientific reason to avoid conducting more tests of prisoners and staff. If the discovery of more cases through sufficient testing leads to a logistical burden on the Houses of Correction, the proper medical answer is not to stop looking for cases,

³⁶ Monica Gandhi et al., *Asymptomatic Transmission, the Achilles' Heel of Current Strategies to Control Covid-19*, N. Engl. J. Med. (May 28, 2020).

³⁷ Centers for Disease Control and Prevention, *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html> (last visited Dec. 12, 2020); Centers for Disease Control and Prevention, *CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2*, <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html> (last visited Dec. 12, 2020).

but rather to make other changes —such as decarceration—to ease the logistical burden of properly addressing any positive cases.

42. The failure of the Houses of Correction to regularly test individuals without symptoms means that their reported number of confirmed positive cases are not meaningful indicators of how many people are actually infected with COVID-19 at each facility, given the incidence of asymptomatic and pre-symptomatic infections.

The release of detained and incarcerated individuals is key to slowing the spread of COVID-19 within Massachusetts Houses of Correction, reducing strain on the healthcare infrastructure, and limiting the number of cases and deaths from COVID-19.

43. Slowing the spread of COVID-19 in jails is important to reduce the overall number of people infected, reduce the strain on the healthcare system, and provide time for the development of new therapies and interventions. This has become all the more important now that widespread availability of a vaccine is on the horizon within the next 6-12 months that could help save the lives that have not already been lost by that point.
44. It is our understanding that jails have an even higher turnover of individuals than prisons, as pre-trial admissions routinely enter the facilities. With more individuals coming and going, and more interactions among individuals, the risk of an outbreak increases as does the speed at which any outbreak would spread.
45. This is especially true because physical distancing, a cornerstone of reducing COVID-19 transmission, is exceptionally difficult within jails. Decreasing the incarcerated population is the only way to increase the ability of the remaining individuals to physically distance.
46. It is therefore particularly concerning that numerous Houses of Correction are currently at 89% or more of their population as of April 4, 2020.³⁸
47. Release has the dual advantage of allowing for more space between people and reducing the overall number of individuals contacted by each person. For example, a person isolating at home can prepare meals, administer medications, and engage in most other activities of daily living without interacting with others. By reducing the contact rate and the number of contacts, the spread of COVID-19 will be limited.
48. Releasing prisoners whenever it is safe to do so is a key public health objective. In a piece published in the *New England Journal of Medicine*, Drs. Akiyama, Spaulding and Rich emphasized that jails and prisons need to decarcerate “as many people as possible” to “limit the impact of COVID-19 transmission,” noting that “[e]ach person needlessly infected in the correctional setting who develops severe illness will be one too many.”³⁹
49. Similarly, a recent National Academies of Science, Engineering, and Medicine (NASEM)

³⁸ Tracking COVID-19 in Massachusetts Prisons & Jails, ACLU of Massachusetts, <https://data.aclum.org/sjc-12926-tracker> (last visited Dec. 15 2020).

³⁹ Matthew J. Akiyama et al., *Flattening the Curve for Incarcerated Populations — Covid-19 in Jails and Prisons*, *New England Journal of Medicine* (May 28, 2020), <https://www.nejm.org/doi/full/10.1056/NEJMp2005687>.

report concluded, “decarceration is an appropriate and necessary mitigation strategy to include in the COVID-19 response in correctional facilities” and would improve “the safety of incarcerated and detained people and correctional staff.”⁴⁰

50. It is our expert opinion that in the absence of decarceration efforts and extensive testing accompanied by case identification and isolation to block transmission, the ability of the virus to spread from asymptomatic and pre-symptomatic infected individuals means that outbreaks in the Houses of Correction increase in likelihood with rising community spread throughout the Commonwealth.

From an epidemiological perspective, COVID-19 vaccination of incarcerated and detained individuals is an efficient public health strategy and must be prioritized.

51. Numerous medical and public health authorities in the United States have emphasized the importance of vaccination for incarcerated individuals, including Dr. Anthony Fauci⁴¹ and the American Medical Association.⁴²
52. On December 9, Governor Baker announced that staff and residents of congregate settings, including correctional facilities, will receive the newly approved COVID-19 vaccine in phase one of the Commonwealth’s vaccine rollout.⁴³ Residents and staff in prisons and jails are fourth in line in phase one, behind health-care workers doing COVID-facing care; residents and staff of long-term care facilities; and police, fire, and emergency medical services.⁴⁴ Because there are not enough doses of the vaccine to inoculate everyone in phase one in the short term, phase one will likely stretch through February 2021.⁴⁵
53. December 2020 through February 2021 will likely be the most dangerous period of the COVID-19 pandemic. The CDC estimates that 12,600 to 23,400 new deaths are likely to be reported in the week ending January 2, 2021 alone.⁴⁶
54. Incarcerated people must remain alive and COVID-free if they are to benefit from the vaccine. It is therefore critically important that correctional facilities protect incarcerated people, including through decarceration and surveillance testing, while they await vaccination.

[signatures on next page]

⁴⁰ National Academies of Sciences, Engineering, and Medicine, *Decarcerating Correctional Facilities during COVID-19: Advancing Health, Equity, and Safety* (2020), S-2, <https://www.nap.edu/catalog/25945/decarcerating-correctional-facilities-during-covid-19-advancing-health-equity-and>.

⁴¹ Harvard Public Health (@HarvardChanSPH), Twitter (Dec. 10, 2020, 1:46 PM), <https://twitter.com/HarvardChanSPH/status/1337106410929270786?s=20>.

⁴² Nayanah Siva, *Experts Call to Include Prisons in COVID-19 Vaccine Plans*, *The Lancet* (Dec. 12, 2020), <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2932663-5>.

⁴³ Martha Bebinger, *Mass. Vaccine Rollout Plan Will Be In 3 Phases. Here’s When You Could Get Yours.*, *WBUR* (Dec. 9, 2020), <https://www.wbur.org/commonhealth/2020/12/09/massachusetts-vaccine-rollout-plan> (2020).

⁴⁴ Mass. Dept. of Public Health, *When Can I Get the COVID-19 Vaccine?*, <https://www.mass.gov/info-details/when-can-i-get-the-covid-19-vaccine> (last visited Dec. 12, 2020).

⁴⁵ *Id.*

⁴⁶ Centers for Disease Control & Prevention, *COVID-19 Forecasts: Deaths* (updated Dec. 9, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/forecasting-us.html>.

Signed under the pains and penalties of perjury on December 16, 2020.



Dr. Yonatan Grad, MD, PhD

Signed under the pains and penalties of perjury on December 16, 2020.



Emma Accorsi, BS

Grad & Accorsi Affidavit

Exhibit A

YONATAN H. GRAD CURRICULUM VITAE

Date Prepared: 19 November 2020

NAME: Yonatan H. Grad

ACADEMIC TITLE: Melvin J. and Geraldine L. Glimcher Associate Professor of Immunology and Infectious Diseases

WORK ADDRESS: 665 Huntington Avenue
Building 1, Room 715
Boston, Mass. 02115

EMAIL: ygrad@hsph.harvard.edu

EDUCATION:

1996	Chemistry	B.A.	Johns Hopkins University
1997	Biological Sciences	M.Phil	Cambridge University
2004	Genetics	Ph.D.	Harvard Medical School
2006	Medicine	M.D.	Harvard Medical School

POSTDOCTORAL TRAINING:

Research Fellowships:

2010-2014	Dept of Epidemiology	Research Fellow	Harvard TH Chan School of Public Health
-----------	----------------------	-----------------	---

Internships and Residencies:

2006-2007	Internal Medicine	Intern	Brigham and Women's Hospital
2007-2009	Internal Medicine	Resident	Brigham and Women's Hospital
11/2008-2/2009	Internal Medicine	Chief Medical Resident	Faulkner Hospital
2009-2011	Infectious Diseases	Clinical Fellow	Brigham and Women's Hospital Massachusetts General Hospital

ACADEMIC APPOINTMENTS:

2012-Present	Instructor	Department of Medicine	Harvard Medical School
2015-2020	Assistant Professor	Department of Immunology and Infectious Diseases	Harvard T.H. Chan School of Public Health
2020-present	Associate Professor	Department of Immunology and Infectious Diseases	Harvard T.H. Chan School of Public Health

HOSPITAL/AFFILIATED INSTITUTIONAL APPOINTMENTS:

2011- Present	Associate Physician	Brigham and Women's Hospital
2011- 2013	Associate Medical Staff	MIT Medical

LICENSURE AND CERTIFICATION:

2009	Massachusetts Medical License
2010	ABIM Board Certification in Internal Medicine
2011	ABIM Board Certification in Infectious Diseases

OTHER PROFESSIONAL APPOINTMENTS

2015- Present	Associate Member	Broad Institute of Harvard and MIT
------------------	------------------	------------------------------------

COMMITTEE SERVICE:

DEPARTMENTAL/SCHOOL AND UNIVERSITY SERVICE:

1998 – 2001	Admissions Committee, Harvard-MIT Division of Health Science and Technology, Harvard Medical School
2008 - 2009	MD-PhD Grand Rounds, Brigham and Women's Hospital – Harvard Medical School, Resident organizer / Presenter
2013	Review of HST040 “Mechanisms of Microbial Pathogenesis”, HST Curriculum Committee
2014 – Present	Interviewer, HMS MD-PhD Admissions Committee
2015 – Present	PQE Committee, Departments of Systems Biology and Immunology and Infectious Diseases
2015 – Present	Immunology and Infectious Diseases Department Dissertation Defense Committee
2015 – Present	Dissertation Advisory Committees for students at MIT (Biological Engineering) and Harvard (both Systems Biology and Biological Sciences in Public Health graduate programs)
2016 – Present	Biological Sciences in Public Health PhD Program Admissions Committee
2016 – 2018	Biological Sciences in Public Health Retreat Committee
2018 – Present	Harvard College Postgraduate Public Service Selection Committee
2018 – Present	Harvard College Evaluation Committee for the Fulbright Program
2018	Executive Committee of the Leadership Council presentation

2019 – Present	HSPH Faculty Council
2020 – Present	Committee on Microbiologic Safety

REGIONAL COMMITTEE SERVICE:

2020	Commonwealth of Massachusetts COVID-19 Task Force
------	---

NATIONAL COMMITTEE SERVICE:

2013 – Present	Infectious Disease Laboratory Working Group of the Board of Scientific Counselors, Office of Infectious Diseases, Centers for Disease Control and Prevention
2016	External review panel, Advanced Molecular Detection program of the US Centers for Disease Control and Prevention
2017	Invited member, US Centers for Disease Control and Prevention-Association for Public Health Laboratories “Gono-caucus 2017: Defining Multi-drug Resistant <i>Neisseria gonorrhoeae</i> ”
2019 – 2020	Invited member, 2020 STD Prevention Conference Scientific Program committee (Clinical & Laboratory Domain)
2020 – 2024	NIH Study Section MIDS-B Standing Member

PROFESSIONAL SOCIETIES:

2011 – Present	Infectious Diseases Society of America
2012 – Present	American Society of Microbiology

HONORS AND DISTINCTIONS:

1994	Barry Goldwater Scholar	National
1995	Kilpatrick Prize	Johns Hopkins University
1995	Phi Beta Kappa	Johns Hopkins University
1996	Churchill Scholar	Winston Churchill Foundation
1997-2006	Medical Scientist Training Program Award	National Institutes of Health

2007	Resident/Mentor Teaching Award, Department of Medicine	BWH
2010	Fellowship Teaching Award, Department of Medicine	BWH
2012	Developmental Award	American Sexually Transmitted Diseases Association
2014	The Maxwell Finland Award for Excellence in Research	Massachusetts Infectious Disease Society
2016	ICAAC Young Investigator Award	American Society for Microbiology
2016	Clinical Scientist Development Award	Doris Duke Foundation
2016	Milton Fund Award	Harvard University
2019	ASTDA Young Investigator Award	American Sexually Transmitted Diseases Association

FUNDED GRANTS AND PROJECTS:

Completed Grants:

07/01/2013 – 09/30/2016

NIH

K08AI104767 (Grad)

Role: Principle Investigator

Total Direct Cost: \$305,671

Genomic epidemiology of Neisseria gonorrhoeae with elevated MICs to cefixime

In this project, I aim to study the rising prevalence of gonococcal isolates with reduced susceptibility to the oral extended spectrum cephalosporin cefixime in the US.

05/01/2016 – 10/31/2017

Bill & Melinda Gates Foundation

OPP1151010 (Hanage)

Role: Principle Investigator

Total Direct Cost: \$8,222

From Clinic to Cloud: Crowdsourcing resistance surveillance

The goal of this project is to develop a “clinic to cloud” approach for directly sequencing patient samples, inferring the presence of antibiotic resistance-associated sequencing, and collating that information for use in patient care and molecular epidemiology.

01/01/2016 – 12/31/2017

NIH (Broad Institute)

R21AI121932 (Blainey/Grad)

Role: Principle Investigator

Total Direct Cost: \$49,641

Microfluidic sample preparation for genomic sequencing of clinical pathogen isolates

Our goal is to demonstrate the utility of a microfluidic device in pipelines for pathogen genome sequencing. To do so, we will sequence and analyze MRSA genomes obtained from Project CLEAR, a clinical trial investigating the impact of *S. aureus* decolonization protocols on *S. aureus*-associated morbidity and mortality.

07/01/16–06/30/19

CDC (Harvard Pilgrim Health Care Institute)

U54CK000484 (PI: Platt)

Role: Site PI

Total Direct Cost: \$220,961 (subaward)

Epicenter IV: CLUSTER Trial for Outbreak Detection and Response

This project compares two approaches to predicting nosocomial pathogen outbreaks. We will use genome sequencing and analysis to quantify the mean pairwise genetic distance between outbreak isolates predicted by both methods and thereby assess the relative accuracy of the methods.

09/30/14–09/29/19

CDC (Stanford University)

NU38PS004644 (PI: Salomon)

Role: Co-Investigator

Total Direct Cost: \$42,061 (subaward)

Prevention Policy Modeling Lab

Dr. Grad will contribute expertise in bioinformatics and genomics, particularly relating to gonorrhea projects. Responsibilities will include contribution to development of study questions, modeling strategies, data acquisition, parameterization of models, and interpretation of the results. He will contribute to preparation of manuscripts and modeling tools and dissemination of results and tools at scientific meetings, meetings with other stakeholders, and public release of modeling tools.

01/01/16 – 09/30/19

Richard and Susan Smith Family Foundation

No award No. (Grad)

Role: Principle Investigator

Total Direct Cost: \$285,714

*Genetic networks of antibiotic resistance in *Neisseria gonorrhoeae**

This project focuses on understanding the mechanisms of how strains of resistant bacteria emerge and spread, with the aim of developing novel strategies to prevent and treat resistant infections.

Active Grants:

07/01/18-01/07/2021

CDC (Social & Scientific System, Inc.)

Contract HHSN2722013000141, Task Order # HHSN27200011 (PI: Morris)

Role: Co-Investigator

Total Direct Cost: \$171,834 (subaward)

Pilot Study of Whole Genomic Sequencing to Detect Reduced Antibiotic Susceptibility in Neisseria gonorrhoeae

For this proposal, the lab plans to culture isolates, and either generate the sequencing libraries in house or use local core facilities for library construction and sequencing. We will then analyze the results, linking the antibiotic susceptibility data (tests performed in another laboratory collaborating on this study) together with the genome sequences to define whether genetic elements known or suspected to contribute to resistance are present, and to determine the positive and negative predictive values of these elements.

07/01/16 – 12/31/20

Doris Duke Charitable Foundation – Clinical Scientist Development Award

Grant No. 2016092 (Grad)

Role: Principle Investigator

Total Direct Cost: \$450,000

Using pathogen genomics and patient data to define determinants of persistent MRSA colonization and of success of decolonization

We aim to create a framework that considers factors from the patient and the colonizing MRSA strain to predict who is likely to benefit from decolonization protocols. To do so, we will analyze data from a randomized controlled clinical trial of decolonization that is unprecedented in its size and simultaneously examine host and pathogen attributes, including MRSA whole genome sequences and phenotypes. We will develop risk models for persistent MRSA carriage and MRSA infections and provide a framework to develop tools to assess and modify the factors that contribute to persistent colonization.

08/01/17 – 07/31/20

CDC (University of Utah)

U01CK000538 (Lipsitch)

Role: Co-Investigator

Total Direct Cost: \$42,192 (subaward)

Modeling and Simulation to Support Antibiotic Stewardship and Epidemiological Decision-Making in Healthcare Settings

For project 1, we propose to obtain one or more data sets to estimate each quantity in the Bystander Selection Model, and will perform the analyses specified in the proposal. For project 2, working with Dr. Samore, we propose to define the most appropriate data sets from the VA database for analysis, and to select the alert threshold algorithms of greatest practical and clinical interest.

01/15/20 – 01/14/21

Harvard T.H. Chan School of Public Health

No award No. (Grad)

Role: Principle Investigator

Total Direct Cost: \$100,000

Harvard Chan School of Public Health Acceleration Award

The two aims of this proposal are to define the drivers of the decline in outpatient antibiotic prescribing in a national dataset and to determine the drivers of geographic heterogeneity in antibiotic prescribing in the US.

03/01/20 – 02/28/22

Wellcome Trust

219812/Z/19/Z (Grad)

Role: Principle Investigator

Total Direct Cost: \$300,517

Reducing antibiotic prescribing through a prioritized vaccination strategy

In this proposal, we will evaluate the association of PCV13 uptake on the recent declines in outpatient antibiotic prescribing in the US and estimate the antibiotic prescribing attributable to the most common pathogens and variation by age, demographic, and geography.

07/01/17 – 6/30/22

NIH/NIAID

R01AI132606 (Grad)

Role: Principle Investigator

Total Direct Cost: \$1,250,000

Genomics approaches to elucidating pathways to antibiotic resistance in Neisseria gonorrhoeae

This project focuses on understanding the compensatory and enabling mutations that facilitate acquisition and maintenance of antibiotic resistance in the common pathogen *Neisseria gonorrhoeae*, the cause of the sexually transmitted disease gonorrhea.

07/01/20 – 6/30/25

NIH/NIAID

R01AI153521 (Grad)

Role: Principle Investigator

Total Direct Cost: \$748,235

Identification and analysis of compensatory mutations that support the evolution of antibiotic resistance in Neisseria gonorrhoeae

This proposal will apply a synergistic combination of approaches to identify and characterize mutations that compensate for resistance mutations, using competitive co-infections in the mouse model of gonorrhea, application of systematic population genomics-informed methods to identify compensatory mutations in human isolates, and comprehensive experimental analysis to define their mechanisms.

07/01/20 – 05/31/25

NIH/NIAID (Yale University)

R01AI153351 (Yaesoubi)

Role: Co-Investigator

Total Direct Cost: \$154,315 (subaward)

Enhancing surveillance systems to slow the spread of antimicrobial-resistant gonorrhea in the United States

This project aims to address the timely challenge of how to optimize surveillance for clinical and public health decision-making for gonorrhea.

03/25/17-04/30/22

Pfizer Pharmaceutical, Inc.

A31316 (Lipsitch/Grad)

Role: Co-PI

Total Direct Costs: \$144,348

Quantifying pneumococcal conjugate vaccine impact against otitis media

This project will analyze epidemiological datasets of bacterial carriage and disease incidence to characterize changes in the relationship between disease and carriage that suggest vaccine impact on OM vaccine-targeted pneumococcal serotypes and other agents. The study assess whether early-life infection may be a causal factor in subsequent susceptibility based on epidemiological data, and model how this mechanism could impact OM burden under vaccination and serotype replacement scenarios.

08/15/20-08/14/21

Harvard T.H. Chan School of Public Health

No award # (Huttenhower)

Role: Co-Investigator

Total Direct Costs: \$5,973

Dean's Fund for Scientific Advancement: Incubation Award

This project aims to provide first-in-kind discovery of DNA and RNA viruses throughout the human microbiome using the resources of the Harvard Chan Center for the Microbiome in Public Health, including over 10,000 existing human metagenomes and ~1,500 metatranscriptomes. These have been uniformly processed and curated by our standardized bioBakery computational platform, and here we will develop and apply new bioinformatic capabilities to detect and analyze viral members of the respiratory and gastrointestinal microbiome, including phage and eukaryotic viruses of relevance in population health.

*12/01/20-11/30/22

Richard and Susan Smith Family Foundation – Odyssey Award

No Award # (PI: Grad)

Role: Principal Investigator

Total Direct Costs: \$285,714

Mechanisms of host-pathogen interactions from conditionally essential and deleterious genes

Our central hypothesis is that host niche-specific factors select for conditionally essential and against conditionally deleterious genes in *N. gonorrhoeae*. This project will leverage our large dataset of genome sequences from >12,000 clinical isolates and (1) use statistical association methods as the equivalent of a “natural screen” to identify conditionally essential and deleterious genes and use experimental methods to define the growth conditions that favor the loss-of-function and the wildtype forms, and (2) use these variants to learn the host selective pressures shaping *N. gonorrhoeae* evolution, starting with the pressures from cervical site of infection.

**Note: the sponsor allows award recipients to delay the project start-date; Dr. Grad officially delayed his start-date.*

TEACHING AND TRAINING:

TEACHING IN HARVARD CHAN SCHOOL COURSES:

2015-16	Epi519 – Evolutionary Epidemiology of Infectious Diseases	Guest Lecturer
2016-17	Epi260 – Mathematical Modeling of Infectious Diseases	Guest Lecturer
2014 -	Epi502 – Antibiotic Resistance	Guest Lecturer
2019 -	IID207 – Infectious Disease Outbreaks of the 20 th and 21 st Centuries: Strategies for Investigation and Control	Guest Lecturer
2019 -	MPH100e Essential Concepts in Infectious Disease	Guest Lecturer
2019 -	IID220 Topics in Immunology and Infectious Diseases	Course Director

TEACHING IN OTHER HARVARD COURSES:

2000	Computational Biology	Teaching Fellow
2008	Introduction to the Profession	Teaching Fellow
2011	Immunology, Microbiology, and Pathology	Instructor
2010-2012	The Impact of Infectious Diseases on History and Society	Instructor
2014-2016	Infectious Diseases Bootcamp	Instructor
2014-	Models of Diseases Bootcamp	Instructor
2014	MD-PhD Lunchtime Series	Instructor
2014-	HST040 – Mechanisms of Microbial Pathogenesis	Instructor

INVITED PRESENTATIONS:

2011	Genomic epidemiology of the <i>E. coli</i> O104:H4 Outbreaks in Europe	Boston, MA
2012	Comparative Genomics of <i>E. coli</i> O104:H4: Short-Term Evolution of an Emerging Pathogen	Newport, RI
2012	Technical Consultation of the Working Group on the Formation and Use of an Oral Cholera Vaccine Stockpile, World Health Organization	Geneva, Switzerland
2012	Chemotherapies: Common Challenges in Infectious Diseases and Cancer Biology, Broad Institute Retreat	Boston, MA
2013	Comparative Genomics of <i>E. coli</i> O104:H4: short-term evolution of an emerging Pathogen	Seattle, WA
2013	Two Stories of Pathogen Genomic, CDC	Atlanta, GA
2013	Genomic Epidemiology of <i>N. gonorrhoeae</i> with Reduced Susceptibility to Cefixime, CDC Division of Sexually Transmitted Diseases	Atlanta, GA
2014	Using Genomics to Study the Evolution and Spread of Pathogens: Examples from <i>N. gonorrhoeae</i> and RSV	Cambridge, MA
2014	Genomic Epidemiology of <i>N. gonorrhoeae</i> with Reduced Susceptibility to Cefixime, STD Prevention Conference / 15 th IUSTI World Congress	Atlanta, GA

2014	Evolution and Spread of Pathogens, Wadsworth Center	Albany, NY
2015	Successful Lineages of Multidrug Resistant <i>N. gonorrhoeae</i> , IDWeek	San Diego, CA
2015	Worcester Polytechnic Institute	Worcester, MA
2015	Within-Host Deep Sequencing and Diversity Analysis of RSV Infection Reveals Dynamics of Genomic Diversity, RSV Vaccines for the World	La Jolla, CA
2015	Umass Medical School Invited Presentation	Boston, MA
2016	Society for Molecular Biology and Evolution	Japan
2016	The emergence and Spread of Antibiotic Resistant <i>N. gonorrhoeae</i> in the US	LAMG
2016	Invited Lecture, Ragon Institute and Center for AIDS Research at Harvard University 2016 Workshop on Microbial Genomics	Cambridge, MA
2016	Talk, 12 th Annual Broad Institute Scientific Retreat	Boston, MA
2017	Invited seminar, Center for AIDS Research, Brigham and Women's Hospital,	Boston, MA
2017	Invited talk, United States Japan Cooperative Medical Sciences Program 19 th International Conference on Emerging Infectious Diseases in the Pacific Rim	Seoul, S. Korea
2017	Invited talk, STAR STI CTG 2017 Programmatic Meeting on Antimicrobial Resistance in <i>Neisseria gonorrhoeae</i>	Silver Spring, MD
2017	Invited keynote talk, ASM Conference on Rapid Applied Microbial Next-Generation Sequencing and Bioinformatic Pipelines	Washington, DC
2017	Invited talk, Vaccine waning and mumps re-emergence in the United States, 116 th International Titisee Conference: From pathogen evolution to microbiome dynamics	Titisee-Neustadt, Germany
2018	HSPH Forum panel member: The flu outbreak	Boston, MA
2018	Invited talk, Integrating genomics and epidemiology: examples of antibiotic resistant gonorrhea and the resurgence of mumps European Bioinformatics Institute	Hinxton, UK
2018	Invited talk, Integrating genomics and epidemiology: examples of antibiotic resistant gonorrhea and the	Waltham, MA

	resurgence of mumps North East section of the American Association of Clinical Chemistry / American Society for Microbiology Meeting	
2018	Invited talk, Integrating genomics and epidemiology: examples of antibiotic resistant gonorrhoea and the resurgence of mumps Yale University	New Haven, CT
2018	Invited talk, Integrating genomics and epidemiology: examples of antibiotic resistant gonorrhoea and the resurgence of mumps Brigham and Women's Hospital Clinical Pathology Conference Series	Boston, MA
2018	Invited talk, Epistasis in gonococcal antibiotic resistance, Conference – Antibiotic resistance: Evolutionary concepts versus clinical realities	Stockholm, Sweden
2018	Invited talk, Vaccine waning and the resurgence of mumps in the US Viral Genomics and Evolution conference	Hinxton, UK
2018	Invited talk, Modeling gonococcal antibiotic resistance STD Prevention Conference	Washington, DC
2018	Invited talk, Resurgence of mumps in highly vaccinated populations Massachusetts Department of Public Health Seminar series	Boston, MA
2018	Invited talk, Azithromycin resistance through interspecific acquisition of an epistasis dependent efflux pump component and transcriptional regulator in <i>Neisseria gonorrhoeae</i> International Pathogenic Neisseria Conference	Pacific Grove, CA
2018	Invited talk, Genomics and modeling to control gonococcal antibiotic resistance Microbiology Department Seminar	Indianapolis, IN
2018	Invited talk, MRSA colonization Doris Duke Charitable Foundation Meeting	New York City, NY
2018	Invited talk, Antibiotic resistance in gonococcus Society for Molecular Biology and Evolution	Kyoto, Japan
2018	Invited keynote talk, Antibiotic resistance in <i>Neisseria gonorrhoeae</i> Course on Antibiotics and Antibiotic Resistance	Hjortviken, Sweden
2018	Invited keynote talk (graduate student invitation)	Rehovot, Israel

	Integrating genomics and epidemiology to control antibiotic resistance Weizmann Institute, Systems Biology symposium	
2019	Invited talk, Addressing the challenges of antibiotic resistant <i>Neisseria gonorrhoeae</i> Institute for Microbiology and Infection, University of Birmingham	Birmingham, United Kingdom
2019	Invited keynote address, Infectious diseases genomic epidemiology and pathogen genomics Massachusetts Infectious Disease Society Spring Meeting	Boston, MA
2019	Invited talk, Genetics of development of gonococcal antimicrobial resistance at extragenital sites STI Clinical Trials Group Meeting on Extra-Genital Sexually Transmitted Infections	Washington, DC
2019	Invited talk, Selection, adaptation, and antibiotic resistance in the recombining bacterial pathogen <i>Neisseria gonorrhoeae</i> Boston Evolutionary Supergroup	Cambridge, MA
2019	Symposium talk: Quantifying the surveillance needed to sustain genetic marker- based antibiotic resistance diagnostics STI and HIV 2019 World Congress	Vancouver, Canada
2019	Conference talk: Novel pathway to ceftriaxone resistance in clinical isolates of <i>N. gonorrhoeae</i> via point mutations in the RNA polymerase STI and HIV 2019 World Congress	Vancouver, Canada
2019	Invited talk: Population genomics strategies for discovering pathways to the acquisition and maintenance of resistance in <i>Neisseria gonorrhoeae</i> IUSTI-Europe Congress 2019	Tallinn, Estonia
2019	Invited talk: Gonococcal genomics to improve surveillance and inform diagnostics IUSTI-Asia/Pacific Congress 2019	Shanghai, China
2019	Invited talk: Antibiotic use, resistance, and the example of <i>Neisseria gonorrhoeae</i> Department of Biomedical Informatics, Harvard Medical School	Boston, MA
2019	Invited talk: Discovery of modulators of antibiotic resistance in <i>Neisseria gonorrhoeae</i> through genomics National Consortium for Microbial Genomics Meeting Norwegian Institute of Public Health	Oslo, Norway
2020	Invited talk: <i>Neisseria gonorrhoeae</i> genomics and antibiotic resistance	Boston, MA

	Vincent Center for Reproductive Biology Massachusetts General Hospital	
2020	Invited webinar: <i>Neisseria gonorrhoeae</i> genomics and antibiotic resistance DMID project, NIH and international collaborators	Boston, MA
2020	Invited webinar: <i>Neisseria gonorrhoeae</i> genomics and antibiotic resistance London School of Hygiene and Tropical Medicine	London, UK
2020	Invited webinar: Navigating the Covid-19 pandemic: from life raft to dry land Broad Institute	Boston MA
2020	Invited talk: Getting to the post-pandemic period Broad-Israel Science Foundation Conference	Boston MA
2020	Invited talk: Genomics and antimicrobial resistance in <i>Neisseria gonorrhoeae</i> CDC STD Prevention Conference	Atlanta GA
2020	Invited talk: <i>Neisseria gonorrhoeae</i> Population Genomics for the Discovery of Genetic Modulators of Antimicrobial Resistance <i>N. gonorrhoeae</i> Research Society (NgoRS) Conference 2020	Chicago, IL
2020	Invited presentation: SARS-CoV-2 viral dynamics in acute infections FDA Evidence Accelerator	Washington, DC
2020	Invited talk: Using genomics to respond to antimicrobial resistant <i>N. gonorrhoeae</i> 2020 Joint Australasian HIV&AIDS and Sexual Health Conferences	Sydney, Australia
2020	Invited talk: Estimating SARS-CoV-2 seroprevalence and epidemiological parameters with uncertainty from serological surveys World Health Organization	Geneva, Switzerland
2020	Invited keynote: The challenges of antibiotic resistance in <i>Neisseria gonorrhoeae</i> CDC AMD conference	Atlanta, GA
2020	Invited panelist: COVID-19 and genome sequencing American Society for Microbiology Conference on Rapid Applied Microbial Next-Generation Sequencing and Bioinformatic Pipelines	Atlanta, GA
2020	Invited talk: Reducing antibiotic prescribing through a prioritized vaccination strategy Wellcome Trust Impact of Vaccines on AMR Researcher Meeting	London, UK
2020	Invited talk: The challenges of antibiotic resistance in <i>Neisseria gonorrhoeae</i> University of Washington Center for AIDS and STD	Seattle, WA

	Seminar Series	
--	----------------	--

BIBLIOGRAPHY:

Peer reviewed original research articles

1. Halfon MS, **Grad Y**, Church GM, and Michelson AM (2002) Computation-based discovery of related transcriptional regulatory modules and motifs from a combinatorial model. *Genome Res.* 2002 Jul;12(7):1019-28.
2. **Grad Y**, Kim J, Aach J, Hayes G, Reinhart B, Church GM, and Ruvkun G. (2003) Computational and Experimental Identification of *C. elegans* microRNAs. *Molecular Cell* May;11(5):1253-63.
3. Kim J, Kirchevsky A, **Grad Y**, Hayes GD, Kosik KS, Church GM & Ruvkun G. Identification of many microRNAs that copurify with polyribosomes in mammalian neurons. *Proc Natl Acad Sci.* 2004 Jan 6;101(1):360-5.
4. **Grad Y**, Roth F, Halfon M, and Church GM. Prediction of similarly acting cis-regulatory modules by subsequence profiling and comparative genomics in *Drosophila melanogaster* and *D.pseudoobscura*. *Bioinformatics.* 2004 Nov 1;20(16):2738-50.
5. **Grad YH**, Lipsitch M, and Aiello AE. Secular trends in *Helicobacter pylori* seroprevalence in adults in the United States: evidence for sustained race/ethnic disparities. *Am J Epidemiol.* 2012 Jan 1; 175(1):54-9.
6. **Grad YH**, Lipsitch M, Feldgarden M, *et al.* Genomic epidemiology of the *E. coli* O104:H4 outbreaks in Europe, 2011. *Proc Nat Acad Sci.* 2012 Feb 21;109(8):3065-70.
7. **Grad YH**, Miller J, Lipsitch M. Cholera Modeling: Challenges to Quantitative Analysis and Predicting the Impact of Interventions. *Epidemiology.* 2012 Jul;23(4):523-30.
8. **Grad YH**, Lipsitch M, Griggs AD, Haas BJ, Shea TP, McCowan C, Montmayeur A, FitzGerald M, Wortman JR, Krogfelt KA, Bingen E, Weill FX, Tietze E, Fliieger A, Lander ES, Nusbaum C, Birren BW, Hung DT, Hanage WP.. Reply to Guy et al: Support for a bottleneck in the 2011 *E. coli* O104:H4 outbreak in Germany. *Proc Natl Acad Sci.* 2012 Dec 26;109(52):E3629-30.
9. **Grad YH**, Godfrey P, Cerquiera GC, Mariani-Kurkdjian P, Gouali M, Bingen E, Shea TP, Haas BJ, Griggs A, Young S, Zeng Q, Lipsitch M, Waldor MK, Weill FX, Wortman JR, Hanage WP. Comparative genomics of recent Shiga toxin-producing *E. coli* O104:H4: short-term evolution of an emerging pathogen. *mBio.* 2013 Jan 22;4(1). doi:pii: e00452-12. 10.1128/mBio.00452-12.

10. **Grad YH**, Kirkcaldy RD, Trees D, Dordel J, Harris SR, Goldstein E, Weinstock H, Parkhill J, Hanage WP, Bentley S, Lipsitch M. Genomic epidemiology of *Neisseria gonorrhoeae* with reduced susceptibility to cefixime in the United States: a retrospective observational study. *Lancet Infect Dis*. 2014 Mar;14(3):220-6. doi: 10.1016/S1473-3099(13)70693-5. Epub 2014 Jan 22.
11. **Grad YH**, Newman R, Zody M, Yang X, Murphy R, Qu J, Malboeuf CM, Levin JZ, Lipsitch M, DeVincenzo J. Within-host whole genome deep sequencing and diversity analysis of human RSV infection reveals dynamics of genomic diversity in the absence and presence of immune pressure. *J Virol*. 2014 Apr 16. [Epub ahead of print] PMID: 24741088
12. Johnson S, **Grad Y**, Ganakammal S, Burroughs M, Frace M, Lipsitch M, Weil R, Trees D. In vitro selection of mutants of *Neisseria gonorrhoeae* with elevated MIC values and increased resistance to cephalosporins. *Antimicrob Agents Chemother*. 2014 Sep 8. pii: AAC.03082-14. [Epub ahead of print] PMID: 25199775
13. Watkins E, **Grad YH**, Gupta S, Buckee C. Contrasting within- and between-host immune selection shapes *Neisseria Opa* repertoires. *Sci Rep*. 2014 Oct 9;4:6554. doi: 10.1038/srep06554.
14. Hollenbeck BL, Gannon S, Qian Q, and **Grad YH**. Genome sequence and analysis of resistance and virulence determinants in a strain of *Neisseria mucosa* causing native-valve endocarditis. *JMM Case Reports*. 2015. 2. doi: 10.1099/jmmcr.0.000049
15. Pessia A, **Grad YH**, Cobey S, Puranen JS, Corander J. K-Pax2: Bayesian identification of cluster-defining amino acid positions in large sequence datasets. *Microbial Genomics*. 2015. 1. doi: 10.1099/mgen.0.000025
16. Unemo M, Golparian D, Sánchez-Busó L, **Grad Y**, Jacobsson S, Ohnishi M, Lahra M, Limnios A, Sikora A, Wi T, Harris S. The novel 2016 WHO *Neisseria gonorrhoeae* reference strains for global quality assurance of laboratory investigations – phenotypic, genetic and reference genome characterization. *J Antimicrob Chemother*. 2016
17. De Silva D, Peters J, Cole K, Cole MJ, Cresswell F, Dean G, Dave J, Thomas D Rh, Foster K, Waldram A, Wilson DJ, Didelot X, **Grad YH**, Crook DW, Peto TEA, Walker AS, Paul J, Eyre DW. Whole-genome sequencing to determine *Neisseria gonorrhoeae* transmission: an observational study. *Lancet Infect Dis*. 2016.
18. **Grad YH**, Harris SR, Kirkcaldy RD, Green A, Marks DS, Bentley SD, Trees D, Lipsitch M. Genomic epidemiology of gonococcal resistance to extended spectrum cephalosporins, macrolides, and fluoroquinolones in the US, 2000-2013. *J Inf Dis*. 2016. **Nominated for the CDC's Charles C. Shepard Science Award.**
19. Harrison OB, Clemence M, Dillard JP, Tang CM, Trees D, **Grad YH**, Maiden MC. Genomic analyses of *Neisseria gonorrhoeae* reveal an association of the gonococcal genetic island with antimicrobial resistance. *J Infect*. 2016 Aug 26. pii: S0163-4453(16)30214-6. doi: 10.1016/j.jinf.2016.08.010. [Epub ahead of print]

20. Chang HH, Huber RG, Bond PJ, **Grad YH**, Camerini D, Maurer-Stroh S, Lipsitch M. Systematic analysis of protein identity between Zika virus and other arthropod-borne viruses. *Bull World Health Organ*. 2017 Jul 1;95(7):517-525I. doi: 10.2471/BLT.16.182105
21. **Grad YH**, Lipsitch M. Reply to Allan-Blitz and Klausner. *J Infect Dis*. 2016 Dec 21. pii: jiw552. doi: 10.1093/infdis/jiw552.
22. Johnson SR, **Grad Y**, Abrams AJ, Pettus K, Trees DL. Use of whole-genome sequencing data to analyze 23S rRNA-mediated azithromycin resistance. *Int J Antimicrob Agents*. 2016. Dec 19
23. Cerqueira GC, Earl AM, Ernst CM, **Grad YH**, Dekker JP, Feldgarden M, Chapman SB, Reis-Cunha JL, Shea TP, Young S, Zeng Q, Delaney ML, Kim D, Peterson EM, O'Brien TF, Ferraro MJ, Hooper DC, Huang SS, Kirby JE, Onderdonk AB, Birren BW, Hung DT, Cosimi LA, Wortman JR, Murphy CI, Hanage WP. Multi-institute analysis of carbapenem resistance reveals remarkable diversity, unexplained mechanisms, and limited clonal outbreaks. *Proc Natl Acad Sci*. 2017 Jan 17. pii: 201616248. doi: 10.1073/pnas.1616248114
24. Eyre DW, De Silva D, Cole K, Peters J, Cole MJ, **Grad YH**, Demczuk W, Martin I, Mulvey MR, Crook DW, Walker AS, Peto TEA, Paul J. WGS to predict antibiotic MICs for *Neisseria gonorrhoeae*. *J. Antimicrob. Chemother*. 2017. 2017 Mar 10. doi: 10.1093/jac/dkx067. [Epub ahead of print]
25. Peak C, Childs L, **Grad Y**, Buckee CO. A Quantitative Comparison of Non-Pharmaceutical Interventions for Containing Emerging Epidemics. *Proc Natl Acad Sci*. 2017. published ahead of print March 28, 2017, doi:10.1073/pnas.1616438114.
26. Piantadosi A, Mukerji SS, Chitneni P, Cho TA, Cosimi LA, Hung DT, Goldberg MB, Sabeti PC, Kuritzkes DR, **Grad YH**. Metagenomic sequencing of an echovirus 30 genome from cerebrospinal fluid of a patient with aseptic meningitis and orchitis. *Open Forum Infect Dis*. 2017 Jul 28;4(3):ofx138.
27. Lau JW, Kim YI, Murphy R, Newman R, Yang X, Zody M, DeVincenzo J, **Grad YH**. Deep sequencing of RSV from an adult challenge study and from naturally infected infants reveals heterogeneous diversification dynamics. *Virology*. 2017 Oct;510:289-296.
28. Tuite AR, Gift TL, Chesson HW, Hsu K, Salomon JA, **Grad YH**. Impact of rapid susceptibility testing and antibiotic selection strategy on the emergence and spread of antibiotic resistance in gonorrhea. *J Infect Dis*. 2017. Nov 27;216(9):1141-1149.
29. Ma KC, Unemo M, Jeverica S, Kirkcaldy RD, Takahashi H, Ohnishi M, **Grad YH**. Genomic characterization of urethritis-associated *Neisseria meningitidis* shows that a wide range of *N. meningitidis* strains can cause urethritis. *J Clin Micro*. 2017. Dec;55(12):3374-3383.

30. Kanjilal S, Sater M, Thayer M, Lagoudas G, Kim S, Blainey P, **Grad YH**. Increasing Antibiotic Susceptibility In *Staphylococcus aureus* In Boston, Massachusetts, 2000-2014: An Observational Study. *J Clin Micro*. 2017. Nov 1. pii: JCM.01160-17.
31. Arnold BJ, Gutmann MU, **Grad YH**, Sheppard SK, Corander J, Lipsitch M, Hanage WP. Weak Epistasis May Drive Adaptation in Recombining Bacteria. *Genetics*. 2018 Jan 12. pii: genetics.300662.2017. doi: 10.1534/genetics.117.300662.
32. Cobey S, Gouma S, Parkhouse K, Chambers BS, Ertl HC, Schmader KE, Halpin RA, Lin X, Stockwell TB, Das S, Landon E, Tesic V, Youngster I, Pinsky BA, Wentworth DE, Hensley SE, **Grad YH**. Poor immunogenicity, not vaccine strain egg adaptation, may explain the low H3N2 influenza vaccine effectiveness in 2012-13. *Clinical Infectious Diseases*. 2018 Feb 20. doi: 10.1093/cid/ciy097.
33. Lewnard JA and **Grad YH**. Vaccine waning and mumps re-emergence in the United States. *Science Translational Medicine*. 2018 Mar 21;10(433). pii: eao5945. doi: 10.1126/scitranslmed.aao5945
34. Olesen SW, Barnett M, MacFadden D, Lipsitch M, **Grad YH**. Trends in outpatient antibiotic prescribing practice among older adults in the US, 2011-2015. *BMJ*. 2018 Jul 27;362:k3155.
35. Wadsworth CB, Arnold BJ, Abdul Sater MR, **Grad YH**. Azithromycin resistance through interspecific acquisition of an epistasis dependent efflux pump component and transcriptional regulator in *Neisseria gonorrhoeae*. *mBio*. 2018 Aug 7;9(4). pii: e01419-18. doi: 10.1128/mBio.01419-18.
36. Hicks N, Yang J, Zhang X, Zhao B, **Grad YH**, Liu L, Ou X, Chang Z, Xia H, Zhou Y, Wang S, Dong J, Sun L, Zhu Y, Zhao Y, Jin Q, Fortune S. Clinically prevalent mutations in *Mycobacterium tuberculosis* alter propionate metabolism and mediate multidrug tolerance. *Nature microbiology*. 2018 Aug 6. doi: 10.1038/s41564-018-0218-3.
37. Olesen SW, **Grad YH**. Racial/ethnic disparities in antibiotic use. *Emerging Infectious Diseases*. 2018. DOI: 10.3201/eid2411.180762.
38. Olesen SW, Torrone EA, Papp JR, Kirkcaldy RD, Lipsitch M, **Grad YH**. Azithromycin susceptibility in *Neisseria gonorrhoeae* and seasonal macrolide use. *Journal of Infectious Diseases*. 2018 Sep 15. doi: 10.1093/infdis/jiy551.
39. Tedijanto C, Olesen SW, **Grad YH**, Lipsitch M. Estimating the proportion of bystander selection for antibiotic resistance in the US. *PNAS*. 2018. 201810840; DOI: 10.1073/pnas.1810840115.
40. Olesen SW, Barnett M, MacFadden D, Brownstein JS, Hernández-Díaz S, Lipsitch M, **Grad YH**. The distribution of antibiotic use and its effect on antibiotic resistance. *eLife*. 2018. 7:e39435 DOI: 10.7554/eLife.39435

41. Wang Y, Ferrer-Espada R, Baglo Y, Goh XS, Held KD, **Grad YH**, Gu Y, Gelfand JA, Dai T. Photo-inactivation of *Neisseria gonorrhoeae*: A paradigm changing approach for combating antibiotic-resistant gonococcal infection. *J Infect Dis*. 2019 Jan 9. doi: 10.1093/infdis/jiz018.
42. Olesen SW, MacFadden D, **Grad YH**. Cumulative risk of receiving an antibiotic prescription. *New England Journal of Medicine*. 2019; 380:1872-1873. DOI: 10.1056/NEJMc1816699.
43. Järvenpää M, Sater M, Lagoudas G, Blainey P, Miller L, McKinnell J, Huang S, **Grad YH***, Marttinen P*. A Bayesian model of acquisition and clearance of bacterial colonization incorporating within-host variation. *PLOS Computational Biology* 15(4): e1006534. <https://doi.org/10.1371/journal.pcbi.1006534>
*=co-senior authors
44. Klevens M, Caten E, Olesen SW, DeMaria A Jr, Troppy S, **Grad YH**. Outpatient antibiotic prescribing in Massachusetts, 2011-2015. *Open Forum Infectious Diseases*. 2019. Apr 8;6(5):ofz169. doi: 10.1093/ofid/ofz169.
45. Wadsworth CB, Sater MRA, Bhattacharyya RP, **Grad YH**. Impact of population structure on the design of RNA-based diagnostics for antibiotic resistance in *Neisseria gonorrhoeae*. *Antimicrob Agents Chemother*. 2019 May 28. pii: AAC.00549-19. doi: 10.1128/AAC.00549-19.
46. Sanchez-Buso L, Golparian D, Corander J, **Grad YH**, Ohnishi M, Flemming R, Parkhill J, Bentley SD, Unemo M, Harris SR. The impact of antimicrobials on gonococcal evolution. *Nature Microbiology*. 2019 Jul 29. doi: 10.1038/s41564-019-0501-y.
47. Abuelezam NN, Reshef YA, Novak D, **Grad YH**, Seage GR, Mayer K, Lipsitch M. Interaction patterns of men who have sex with men on a geosocial networking phone application in seven U.S. metropolitan areas. *J Med Internet Res*. 2019; 21(8):e13766 doi 10.2196/13766
48. Williamson D, Chow E, Gorrie C, Seemann, T, Ingle D, Higgins N, Easton M, Tairaoa G, **Grad YH**, Kwong J, Fairley C, Chen M, Howden B. Bridging of *Neisseria gonorrhoeae* across diverse sexual networks in the HIV pre-exposure prophylaxis (PrEP) era: A clinical and molecular epidemiological study. *Nature Communications*. 2019. 2019 Sep 5;10(1):3988. doi: 10.1038/s41467-019-12053-4.
49. Hicks AL, Wheeler N, Sanchez-Buso L, Rakeman JL, Harris SR, **Grad YH**. Evaluation of parameters affecting performance and reliability of machine learning-based antibiotic susceptibility testing from whole genome sequencing data. *PLOS Computational Biology*. 2019. 15(9): e1007349. <https://doi.org/10.1371/journal.pcbi.1007349>.
50. Arnold B, Sohail M, Wadsworth C, Corander J, Hanage WP, Sunyaev S, **Grad YH**. Fine-scale haplotype structure reveals strong signatures of positive selection in a recombining bacterial pathogen. *Molecular Biology and Evolution*. 2019 Oct 7. pii: msz225. doi: 10.1093/molbev/msz225.

51. Coe KA, Lee W, Komazin-Meredith G, Meredith TC, **Grad YH**, Walker S. Comparative Tn-Seq reveals common daptomycin resistance determinants in *Staphylococcus aureus* despite strain-dependent differences in essentiality of shared cell envelope genes. *PLOS Pathogens*. 2019 Nov 18;15(11):e1007862.
52. Hicks AL, Kissler SM, Lipsitch M*, **Grad YH***. Surveillance to maintain the sensitivity of genotype-based antibiotic resistance diagnostics. *PLOS Biology*. 2019 Nov 12;17(11):e3000547. *=co-senior authors
53. Ryu S, Cowling B, Wu P, Olesen S, Fraser C, Sun DS, Lipsitch M, **Grad YH**. Case-based surveillance of antimicrobial resistance with full susceptibility profiles. *JAC Antimicrob Resist*. 2019. doi:10.1093/jacamr/dlz070
54. Hadjineophytou C, Anonsen JH, Wang N, Ma KC, Viburiene R, Vik Å, **Grad YH**, Koomey JM. Genetic determinants of genus-wide glycan diversity in a bacterial protein glycosylation system. *PLOS Genetics*. 2019 Dec 23;15(12):e1008532. doi: 10.1371/journal.pgen.1008532.
55. Wohl S, Metsky HC, Schaffner SF, Piantadosi A, Burns M, Lewnard JA, Chak B, Krasilnikova LA, Siddle KJ, Matranga CB, Bankamp B, Bennigan S, Sabina B, Byrne EH, McNall RJ, Park DJ, Gharib S, Fitzgerald S, Berriera P, Fleming S, Lett S, Rota PA, Madoff LC, MacInnis BL, Yozwiak NL, Smole S, **Grad YH**, Sabeti PC. Co-circulating mumps lineages at multiple geographic scales. *PLOS Biology*. 2020. 18(2): e3000611.
56. Tedijano C, **Grad YH**, Lipsitch M. Potential impact of outpatient stewardship interventions on antibiotic exposures of bacterial pathogens. *eLife*. 2020 Feb 5;9. pii: e52307. doi: 10.7554/eLife.52307.
57. Volz EM, Wiuf C, **Grad YH**, Frost SDW, Dennis AM, Didelot X. Identification of hidden population structure in time-scaled phylogenies. *Systematic Biology*. 2020. Feb 12. pii: syaa009. doi: 10.1093/sysbio/syaa009.
58. Palace SG, Wang Y, Rubin DHF, Welsh MA, Mortimer TD, Cole K, Eyre DW, Walker S, **Grad YH**. RNA polymerase mutations explain cephalosporin resistance in clinical *Neisseria gonorrhoeae* isolates lacking mosaic *penA* alleles. *eLife*. 2020 9:e51407 DOI: 10.7554/eLife.51407.
59. Břinda K, Callendrello A, Ma KC, MacFadden DR, Charalampous T, Lee RS, Cowley L, Wadsworth CB, **Grad YH**, Kucherov G, O'Grady J, Baym M, and Hanage WP. Rapid heuristic inference of antibiotic resistance and susceptibility by genomic neighbor typing. *Nature Microbiology*. 2020. <https://doi.org/10.1038/s41564-019-0656-6>
60. Yaesoubi R, Cohen T, Hsu K, Gift TL, Chesson H, Salomon JA, **Grad YH**. Adaptive guidelines for the treatment of gonorrhea to increase the effective lifespan of antibiotics: A mathematical modeling study. *PLOS Medicine*. 2020. 17(4):e1003077.

61. Kissler SM, Klevens M, Barnett ML, **Grad YH**. Dissecting the mechanisms of a 5-year decline in antibiotic prescribing. *Clinical Infectious Diseases*. 2020 Mar 16. pii: ciaa269. doi: 10.1093/cid/ciaa269.
62. Kissler SM, Tedijanto C, Goldstein E, **Grad YH***, Lipsitch M*. Projecting the transmission dynamics of SARS-CoV-2 through the post-pandemic period. *Science*. 2020. May 22;368(6493):860-868. doi: 10.1126/science.abb5793. *co-senior authors
63. Peak CM, Kahn R, **Grad YH**, Childs LM, Li R, Lipsitch M, Buckee CO. Modeling the comparative impact of individual quarantine vs active monitoring of contacts for the mitigation of COVID-19. *Lancet Infectious Diseases*. 2020. May 20:S1473-3099(20)30361-3.
64. Vegvari C, **Grad YH**, White PJ, Didelot X, Whittles LK, Scangarella-Oman NE, Mitrani-Gold FS, Dumont E, Perry CR, Gilchrist K, Hossain M, Mortimer TD, Anderson RM, Gardiner D. Using rapid point-of-care tests to inform antibiotic choice to mitigate drug resistance in gonorrhoea. *Eurosurveillance*. 2020;25(43):pii=1900210. <https://doi.org/10.2807/1560-7917.ES.2020.25.43.1900210>
65. Hicks AL, Kissler SM, Mortimer TD, Ma KC, Tairaoa G, Ashcroft M, Williamson DA, Lipsitch M, **Grad YH**. Targeted surveillance strategies for efficient detection of novel antibiotic resistance variants. *eLife*. 2020;9:e56367. DOI: <https://doi.org/10.7554/eLife.56367>. Accompanied by a commentary: <https://elifesciences.org/articles/59379>
66. Ma KC, Mortimer TD, Hicks AL, Wheeler NE, Sánchez-Busó L, Golparian D, Tairaoa G, Rubin DHF, Wang Y, Williamson DA, Unemo M, Harris SR, **Grad YH**. Adaptation to the cervical environment is associated with increased antibiotic susceptibility in *Neisseria gonorrhoeae*. *Nature Communications*. 2020. 11:4126 <https://doi.org/10.1038/s41467-020-17980-1>.
67. Larremore DB, Bubar KM, **Grad YH**. Implications of test characteristics and population seroprevalence on ‘immune passport’ strategies. *Clinical Infectious Diseases*. 2020. Jul 20:ciaa1019. doi: 10.1093/cid/ciaa1019.
68. Ma KC, Mortimer TD, **Grad YH**. Efflux pump antibiotic binding site mutations are associated with azithromycin nonsusceptibility in clinical *Neisseria gonorrhoeae* isolates. *mBio*. 2020. 11:e01509-20.
69. Kissler SM, Kishore N, Prabhu M, Goffman D, Beilin Y, Landau R, Gyamfi-Bannerman C, Bateman BT, Katz D, Gal J, Bianco A, Stone J, Larremore D, Buckee CO, **Grad YH**. Reductions in commuting mobility predict geographic differences in SARS-CoV-2 prevalence in New York City. *Nature Communications*. 11:4674 doi.org/10.1038/s41467-020-18271
70. Mortimer TD, Pathela P, Crawley A, Rakeman JL, Lin Y, Harris SR, Blank S, Schillinger JA*, **Grad YH***. The distribution and spread of susceptible and resistant *Neisseria gonorrhoeae* across demographic groups in a major metropolitan center. *Clinical Infectious Diseases*. 2020. ciaa1229, <https://doi.org/10.1093/cid/ciaa1229>. *co-senior authors.

71. Kahn R, Kennedy-Shaffer L, **Grad YH**, Robins JM, Lipsitch M. Potential biases arising from epidemic dynamics in observational seroprotection studies. *American Journal of Epidemiology*. 2020 Sep 1:kwaa188. doi: 10.1093/aje/kwaa188

72. Ma KC, Mortimer TD, Duckett MA, Hicks AL, Wheeler NE, Sánchez-Busó, L, **Grad YH**. Increased power from conditional bacterial genome-wide association identifies *Neisseria gonorrhoeae* macrolide resistance mutations. *Nature Communications*. 2020. 11:5374 | <https://doi.org/10.1038/s41467-020-19250-6>.

73. Olesen SW, Lipsitch M, **Grad YH**. The role of "spillover" in antibiotic resistance. *Proc Nat Acad Sci*. 2020. doi.org/10.1073/pnas.2013694117.

Pre-print, submitted, and in-review manuscripts

1. Larremore DB, Fosdick BK, Bubar KM, Kissler SM, Buckee CO, **Grad YH**. Estimating SARS-CoV-2 seroprevalence and epidemiological parameters with uncertainty from serological surveys. *medRxiv*. 2020. In revision.

2. Kissler SM, Klevens M, Barnett ML*, **Grad YH***. The roles of stewardship and socioeconomic status in geographic variation in antibiotic prescribing: an observational study. *medRxiv*. 2020. In review. *co-senior authors.

3. Yaesoubi R, Cohen T, Hsu K, St Cyr SB, Salomon JA, **Grad YH**. Evaluating spatially adaptive guidelines for the treatment of gonorrhea to increase the effective lifespan of antibiotics. 2020. Submitted.

4. Neprash HT, Sheridan B, Jena AB, **Grad YH**, Barnett ML. Within office transmission of influenza-like illness. 2020. In revision.

5. Ashcroft MA, Chow EPF, Lee DYJ, De Petra V, Soumilas M, Tschaepe M, Zhang L, Ingle DJ, Taiaroa G, Hicks AL, **Grad YH**, Howden BP, Fairley CK, Williamson DA. Genomic assessment of within-host population variation in *Neisseria gonorrhoeae*: Implications for gonorrhoea transmission. 2020. Submitted.

6. Bubar KM, Kissler SM, Lipsitch M, Cobey S, **Grad YH**, Larremore DB. Model-informed COVID-19 vaccine prioritization strategies by age and serostatus. *medRxiv*. 2020. In revision.

7. Brynildsrud OB, Osnes MN, Ma KC, **Grad YH**, Koomey JM, Caugant DA, Eldholm V. High-frequency phase-switching of *modB* methylase is associated with phenotypic ceftriaxone susceptibility in *Neisseria gonorrhoeae*. *bioRxiv*. 2020.

8. Sánchez-Busó L, Yeats CA, Taylor B, Goater R, Underwood A, Abudahab K, Argimon S, Ma KC, Mortimer TD, Cole MJ, **Grad YH**, Martin I, Raphael BH, Shafer WM, Spiteri G, Town K, Wi T, Harris SR, Unemo M, Aanensen D. A community-driven resource for genomic surveillance of *Neisseria gonorrhoeae* at Pathogenwatch. *bioRxiv*. 2020.

9. Yahara K, Ma KC, Mortimer TD, Shimuta K, Nakayama S, Hirabayashi A, Suzuki M, Jinnai M, Ohya H, Kuroki T, Watanabe Y, Yasuda M, Deguchi T, Eldholm V, Harrison OB, Maiden MCJ, **Grad YH**, Ohnishi M. Emergence and evolution of antimicrobial resistance genes and mutations in *Neisseria gonorrhoeae*. *bioRxiv*. 2020.
10. Ogbemor O, Mortimer TD, Fryling K, Zhang JJ, Bhanot N, **Grad YH**. Disseminated gonococcal infection complicated by prosthetic joint infection: case report and genomic and phylogenetic analysis. 2020. In review.
11. Kissler SM, Fauver JR, Mack C, Tai C, Shiue KY, Kalinich CC, Jednak S, Ott IM, Vogels CBF, Wohlgenuth J, Weisberger J, DiFiori J, Anderson DJ, Mancell J, Ho DD, Grubaugh ND*, **Grad YH***. Viral dynamics of SARS-CoV-2 infection and the predictive value of repeat testing. *medRxiv*. 2020. *co-senior authors.
12. Brown TS, Martinez de Salazar Munoz P, Bhatia A, Bunda B, Williams WK, Bor D, Miller JS, Mohareb A, Naranbai V, Beltran WG, Miller TE, Thierauf J, Yang W, Kress D, Stelljes K, Johnson K, Larremore D, Lennerz J, Iafrate AJ, Balsari S, Buckee CO*, **Grad YH***. GPS-estimated foot traffic data and venue selection for COVID-19 serosurveillance studies. *medRxiv*. 2020. *co-senior authors
13. Poyraz O, Sater MRA, Miller LG, McKinnell JA, Huang SS, **Grad YH***, Marttinen P*. The impact of site-specific clearance on Methicillin-resistant *Staphylococcus aureus* decolonization. *medRxiv*. 2020. *co-senior authors.

Other peer reviewed publications

1. **Grad YH**, Seifter JL, Levy B, and Loscalzo J. Clinical problem-solving. Bitter Pills. *N Engl J Med*. 2010. Nov 4;363(19):1847-51.
2. Schaffer A, **Grad Y**, and Ross J. Interactive medical case. Bitter Pills. *N Engl J Med*. 2010. Oct 14; 363(16):e26.
3. Croucher NJ, Harris SR, **Grad YH**, Hanage WP. Bacterial genomes in epidemiology--present and future. *Philos Trans R Soc Lond B Biol Sci*. 2013 Feb 4;368(1614):20120202. doi: 10.1098/rstb.2012.0202. Print 2013.
4. Wei K, Vaidya A, Rohloff PJ, Sun Y-P, **Grad YH**. A patient with fevers and fatigue. *N Engl J Med*. 2013 Feb 14;368(7):e9. doi: 10.1056/NEJMimc1208059.
5. **Grad YH**, Waldor MK. Deciphering the origins and tracking the evolution of cholera epidemics with whole-genome-based molecular epidemiology. *MBio*. 2013 Sep 10;4(5). doi:pii: e00670-13. 10.1128/mBio.00670-13.

6. **Grad YH**, Lipsitch M. Epidemiologic data and pathogen genome sequences: a powerful synergy for public health. *Genome Biol.* 2014 Nov 18;15(11):538
7. Chang H, Cohen T, **Grad YH**, Hanage WP, O'Brien TF, Lipsitch M. Origin and proliferation of multiple drug resistance in bacterial pathogens. *Microbiol Mol Biol Rev.* 2015 Mar;79(1):101-116.
8. **Grad YH**, Goldstein E, Lipsitch M, White P. Improving control of antibiotic resistant gonorrhea by integrating research agendas across disciplines: key questions arising from mathematical modeling. *J Infect Dis.* 2015.
9. **Grad YH**, Fortune SM. Biodiversity and hypervirulence of *Listeria monocytogenes*. *Nat Genet.* 2016. Mar 15
10. Mortimer T, **Grad YH**. Applications of genomics to slow the spread of MDR *Neisseria gonorrhoeae*. Antimicrobial Therapeutics Reviews. *Annals of the New York Academy of Sciences.* 2018.
11. Olesen SW and **Grad YH**. Deciphering the impact of bystander selection for antibiotic resistance in *Neisseria gonorrhoeae*. *Journal of Infectious Diseases.* 2019. 2019 Apr 8. pii: jiz156. doi: 10.1093/infdis/jiz156.
12. Rubin DHF, Ross JDC, **Grad YH**. The frontiers of addressing antibiotic resistance in *Neisseria gonorrhoeae*. *Translational Research.* 2020. 2020 Feb 28. pii: S1931-5244(20)30031-1. doi: 10.1016/j.trsl.2020.02.002.
13. Buckee CO, Balsari S, Chan J, Crosas M, Dominici F, Gasser U, **Grad YH**, Grenfell B, Halloran ME, Kraemer MUG, Lipsitch M, Metcalf CJE, Meyers LA, Perkins TA, Santillana M, Scarpino SV, Viboud C, Wesolowski A, Schroeder A. Aggregated mobility data could help fight COVID-19. *Science.* 23 Mar 2020: DOI: 10.1126/science.abb8021
14. Segal E, Zhang F, Lin X, King G, Shalem O, Shilo S, Allen WE, **Grad YH**, Greene CS, Alquaddoomi F, Anders S, Balicer R, Bauman T, Bonilla X, Booman G, Chan AT, Cohen O, Coletti S, Davidson N, Dor Y, Drew DA, Elemento O, Evans, G, Ewels P, Gale J, Gavrieli A, Geiger B, Hajirasouliha I, Jerala R, Kahles A, Kallioniemi O, Keshet A, Landau G, Meir T, Muller A, Nguyen LH, Oresic M, Ovchinnikova S, Peterson H, Rajagopal J, Ratsch G, Rossman H, Rung J, Sboner A, Sigaras A, Spector T, Steinherz R, Stevens I, Vilo J, Wilmes P. Building an international consortium for tracking coronavirus health status. *Nature Medicine.* 2020 Jun 2. doi: 10.1038/s41591-020-0929-x.
15. Lipsitch M, **Grad YH**, Sette A, Crotty S. Memory T cells and herd immunity to SARS-CoV-2. *Nature Reviews Immunology.* 2020. <https://doi.org/10.1038/s41577-020-00460-4>

Book Chapters

1. **Grad YH** and Ross J. Osteomyelitis and Septic Arthritis. In Principles and Practice of Hospital Medicine. McKean S, Ross J, Dressler D, Brotman D, and Ginsberg J, eds. New York: McGraw-Hill. 2012

2. Certain LK and **Grad YH**. Osteomyelitis and Septic Arthritis. In Principles and Practice of Hospital Medicine, 2nd Ed. McKean S, Ross J, Dressler D, Brotman D, and Ginsberg J, eds. New York: McGraw-Hill. 2017

3. Bhattacharyya RP, **Grad YH**, Hung DT. Chapter 146: Microbial genomics and infectious diseases. In Longo DL, Fauci AS, Kasper DL et al., eds. Harrison's Principles of Internal Medicine (19th edition). 2015. Updates 2018 and 2021.

Non-peer reviewed publications

1. **Grad Y**, Miller JC, Lipsitch M. Challenges to quantitative modeling of cholera disease transmission. SACEMA (South African Centre for Epidemiological Modelling and Analysis) Quarterly. Sept 2012.

Media and public engagement

Podcast interview, ThinkResearch, March 2020

Op-Ed, Washington Post, March 2020

Op-Ed, STAT, March 2020

Interview/podcast, Innovation Hub, April 2020

Podcast interview, "Deep Background" with Noah Feldman, May 2020

Podcast interview, ThinkResearch, September 2020

Op-Ed, Washington Post, September 2020

Thesis

1. **Grad Y**. (2004). *Computational analysis and prediction of regulatory sequences in bilaterians*. Ph.D. Thesis. Harvard University: Cambridge, MA, USA.

Grad & Accorsi Affidavit

Exhibit B

E. K. Accorsi

eaccorsi@g.harvard.edu • (860) 942-4239

EDUCATION	Harvard University , Cambridge, Massachusetts Doctor of Philosophy in Infectious Disease Epidemiology • Advisors: Dr. Marc Lipsitch, Dr. Curtis Huttenhower • Cumulative GPA: 4.0/4.0 Sep 2016 – Present
	Emory University , Atlanta, Georgia Bachelor of Science in Applied Mathematics • Cumulative GPA: 4.0/4.0 Sep 2009 – May 2013
ACADEMIC HONORS & AWARDS	Barry M. Goldwater Scholar Nationally competitive award for excellence in research in science, mathematics, and engineering. 2012
	Jocelyn B. Taylor Scholar, Emory Scholars Program • One of Emory's premier merit awards, offered to 40 of 15,600 Emory applicants. • Provides full tuition scholarship for undergraduate studies. 2009 – 2013
	Deborah Jackson Award, Emory Department of Math/CS Awarded to the most outstanding juniors and seniors in the Math and Computer Science Department. 2013
	Additional Awards: National Merit Scholar, Robert C. Byrd Honor Scholar, Phi Beta Kappa
PROFESSIONAL EXPERIENCE	Epic Systems Corporation , Verona, WI Technical Services Engineer, EpicCare Inpatient Team Advised large health care organizations on how to configure and optimize Epic's electronic medical record software to improve patient outcomes and clinician efficiency; led large software install, upgrade, and optimization projects; handled customer relationships; liaised with software developers and clinicians to improve software quality. Aug 2013 – Sep 2015
RESEARCH EXPERIENCE	Harvard T.H. Chan School of Public Health , Boston, MA Graduate Research Assistant to Drs Marc Lipsitch & Curtis Huttenhower Conduct computational research on the human microbiome. My current project aims to benchmark statistical techniques for mediation analysis in microbiome data. My first project identifies species and genes associated with patterns of <i>S. aureus</i> carriage in the early infant nasal microbiome. Oct 2016 – Present
	NASA Ames Research Center DEVELOP Program , Moffet Field, CA Team Member, Contractor with SSAI Worked collaboratively on a team using GIS and satellite remote sensing to study <i>Sargassum</i> seaweed over-proliferation in the Caribbean Sea, which causes both environmental and economic problems. Jan 2016 – Aug 2016
	Emory Center for Mathematics & Computing in Medicine , Atlanta, GA Research Assistant to Dr. Alessandro Veneziani Used computational fluid dynamics simulations to understand cerebral aneurysm pathogenesis and identify predictors of rupture in real patients and to study the long term effects of bicuspid aortic valve disease. Jan 2013 – Jun 2013
	Centers for Disease Control (CDC) , Atlanta, GA Guest Researcher, CDC Insectary Conducted two independent research projects focusing on the fitness of transgenic mosquitoes and the implications of mosquito mating for genetic control strategies. Jan 2011 – Dec 2012
	West Nile Virus Lab , Atlanta, GA Research Assistant to Dr. Uriel Kitron Performed field work studying the transmission dynamics of West Nile virus in urban Atlanta, including bird mist-netting, creek surveillance, and collection and identification of mosquitos. Sep 2010 – Dec 2012
	NASA Student Airborne Research Program , Palmdale, CA Research Assistant to Dr. Raphael Kudela Conducted remote sensing research on harmful algal bloom detection. Developed an algorithm that can be applied to satellite data to predict when blooms will become toxic based on their algal species composition. Jun 2012 – Aug 2012
	Emory Undergraduate Research Programs , Atlanta, GA Grant Recipient & Program Participant Received competitive fellowships and grants (SIRE, SURE) in support of my research. Gained experience writing grant proposals, designing experiments, conducting literature reviews, creating posters, and presenting research. Sep 2010 – Dec 2011

PUBLICATIONS

- 1) Accorsi, E.K., Franzosa, E.A., Hsu, T., Joice Cordy, R., Maayan-Metzger, A., et al. (2020). Determinants of *Staphylococcus aureus* Carriage in the Developing Infant Nasal Microbiome. *Genome Biology*, 21(1), 301. <https://doi.org/10.1186/s13059-020-02209-7>
- 2) Accorsi, E.K., Samples, J., McCauley, L.A., & Shadbeh, N. (2020). Sleeping Within Six Feet: Challenging Oregon’s Labor Housing COVID-19 Guidelines. *Journal of Agromedicine*, 1–4.
- 3) Kudela, R., Palacios, S., Austerberry, D., Accorsi, E.K., Guild, L., & Torres, J. (2015). Application of Hyperspectral Remote Sensing to Cyanobacterial Blooms in Inland Waters. *Remote Sensing of Environment*, 167: 196-205. <http://dx.doi.org/10.1016/j.rse.2015.01.025>
- 4) Henin, J., Accorsi, E.K., Cho, P., & Tabor, W. (2009). Extraordinary Natural Ability: Anagram Solution as an Extension of Normal Reading Ability. In the Proceedings of the 31st Annual Meeting of the Cognitive Science Society. Mahwah, New Jersey: Lawrence Erlbaum Associates.

**MANUSCRIPTS
IN REVIEW**

- 1) Accorsi, E.K., Qiu, X., Rumpler, E., Kennedy-Shaffer, L., Kahn, R., et al. (2020). How to Detect and Reduce Potential Sources of Biases in Epidemiologic Studies of SARS-CoV-2. <https://osf.io/46am5/> [In review at *European Journal of Epidemiology*]
- 2) Zhang, Y., Bhosle, A., Bae, S., McIver, L., Accorsi, E.K., et al. (2020) Identifying Novel Bioactive Microbial Gene Products in Inflammatory Bowel Disease. [In review at *Nature*]
- 3) Wang, Y., Yan, Y., Thompson, K. N., Bae, S., Accorsi, E.K., et al. (2020). Whole Microbial Community Viability is Not Quantitatively Reflected by Propidium Monoazide Sequencing Approach. <https://doi.org/10.21203/rs.3.rs-59563/v1> [In review at *Microbiome*]
- 4) Lopez, L., Nguyen, T., Weber, G., Kleimola, K., Bereda, M., Liu, Y., Accorsi, E.K., et al. (2020). Seroprevalence of anti-SARS-CoV-2 IgG Antibodies in the Staff of a Public School System in the Midwestern United States. <https://doi.org/10.1101/2020.10.23.20218651> [In review at *PLOS ONE*]

PRESENTATIONS

Cold Spring Harbor Laboratory Microbiome Meeting – Virtual	2020
Harvard Chan Center for the Microbiome in Public Health Symposium – Virtual	2020
Harvard Chan Center for the Microbiome in Public Health Symposium – Boston, MA	2019
17 th Annual Jonathan Freeman Symposium – Boston, MA	2019
Keystone Microbiome Symposium – Montreal, CA	2019
4 th Annual MIT-Harvard Microbiome Symposium – Cambridge, MA	2019
NASA Annual Earth Science Application Showcase – Washington, DC	2016
Society for Conservation GIS Annual Conference – Monterey, CA	2016
11 th Regular Session of CiiMAR-GoMC – Villahermosa, MX	2016
Association of American Geographers – San Francisco, CA	2016
Association for the Sciences of Limnology and Oceanography – New Orleans, LA	2013
American Geophysical Union Fall Meeting – San Francisco, CA	2013
Emory Fall 2012 Undergraduate Research Symposium – Atlanta, GA	2012
UF-HHMI Science for Life Creativity in the Arts and Science Event – Gainesville, FL	2012
60 th Annual Meeting of the American Society of Tropical Medicine and Hygiene – Phil., PA	2011

	Emory SURE Poster Symposium – Atlanta, GA • 3 rd place poster (of 103)	2011
	Emory Spring 2011 Undergraduate Research Symposium – Atlanta, GA • Best Poster, Natural Sciences	2011
	31 st Annual Meeting of the Cognitive Science Society – Amsterdam, NL	2009
TEACHING EXPERIENCE	Physalia Courses , Berlin, Germany Course Instructor Co-taught a week-long intensive workshop for 40 PhD students and postdoctoral researchers entitled “Metagenomics, metatranscriptomics, and multi’omics for microbial community studies”.	May 2019
	Harvard T.H. Chan School of Public Health , Boston, MA Teaching Fellow Ran daily or weekly discussion sections and held office hours. Graded and provided feedback on homework assignments and exams. • EPI 207: Advanced Epidemiologic Methods (Fall 2018, Fall 2019) • EPI 203: Study Design in Epidemiologic Research (Spring 2019) • EPI 201: Introduction to Epidemiology: Methods I (Fall 2017) • EPI 202: Introduction to Epidemiology: Methods II (Fall 2017) • EPI 500: Fundamentals of Epidemiology (Summer 2017)	Jul 2017 – Oct 2019
	Harvard T.H. Chan School of Public Health , Boston, MA Tutor • EPI 201: Introduction to Epidemiology: Methods I (Fall 2018) • EPI 202: Introduction to Epidemiology: Methods II (Fall 2018)	Sep 2018 – Dec 2018
WORKSHOPS	Alan Turing Institute EpiRecipes – London, UK	2018
	Marine Biological Laboratory STAMPS – Woods Hole, MA	2017
LEADERSHIP EXPERIENCE	COVID-19 and Health Inequities: Seminar Series , Virtual Organizer and moderator Organized and moderated five-part seminar series focused on the factors driving inequalities in COVID-19 infection and mortality rates in the U.S. See: https://ccdd.hsph.harvard.edu/health-inequities-seminar-series/	Sep 2020 – Oct 2020
	CCDD Student Journal Club , Boston, MA Organizer Organized, and facilitated discussions for weekly graduate student journal club.	Jan 2019 – May 2019
	Emory Undergraduate Research Journal , Atlanta, GA Editor-in-Chief (Jan 2012 - May 2013), Social Sciences Section Head (Sep 2009 - Dec 2011) Rebuilt and expanded the journal after it became inactive under previous leadership. Recruited, trained and managed a new 47 student staff. Increased student submissions to the journal, secured club funding, identified new ways to partner with faculty and staff, and produced a high-quality, peer-reviewed publication.	Sep 2009 – May 2013
	Emory Global Health Case Competition , Atlanta, GA Competition Co-Director (Sep 2010 - May 2011), Planning Committee (Sep 2011 - May 2013) Led the group that organized the first global-health focused case competition to be held at a national level. Thirteen U.S. universities (120 students) competed, and full sponsorship (\$70,000) was provided by General Electric. Coordinated all areas of the competition including case writing, funding, logistics and marketing.	Sep 2010 – May 2013
ADDITIONAL SKILLS	Programming: R, SAS Data Management: SQL, Excel GIS and Remote Sensing: ArcGIS, TerrSet Able to learn new languages quickly as needed.	

EXHIBIT B

EXHIBIT B

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT and others,
Respondents.

AFFIDAVIT OF DR. MONIK C. JIMÉNEZ (ScD, SM, FAHA)

I, Dr. Monik C. Jiménez, state that the following is a true and accurate statement to the best of my knowledge and belief:

1. I am an Assistant Professor of Epidemiology at the Harvard T.H. Chan School of Public Health, an associate epidemiologist at Brigham and Women's Hospital (BWH), and an Assistant Professor of Medicine at Harvard Medical School. I received my SM and ScD, both in epidemiology, from the Harvard Chan School. I completed my post-doctoral research in cardiovascular epidemiology at BWH, prior to becoming faculty in 2013.
2. My research investigates factors that impact the cardiovascular health of patients who have experienced incarceration, identifies ways to support respectful patient-clinician communication about incarceration and inform future policy to support health care equity. Additionally, I am engaged in work to track COVID-19 in US carceral facilities and have published on the impact of COVID-19 in Massachusetts prisons and jails. In partnership with community advocacy groups, I am Principal Investigator of the INdividuals Speak: Incarcerated during the COVID-19 Epidemic (INSIDE) study to examine the lived experience of conditions of confinement experienced by those incarcerated or detained during COVID-19. I am also a collaborator of the Pregnancy In Prisons Statistics study to examine medical comorbidities of pregnant women experiencing incarceration. In addition, I was funded by the National Institutes of Health to examine the intersection of race/ethnicity and sex on inequities in stroke. I am Course Director of "Mass Incarceration and

Health in the US” and “Cardiovascular Epidemiology” at Harvard T.H. Chan School of Public Health.

3. I am the author of more than 40 peer-reviewed articles on the impact of COVID-19 on incarcerated populations, racial/ethnic and sex inequities in cardiovascular disease, cardiovascular disease, epidemiology, oral epidemiology, stroke, and oral health. Most recently, I am a senior author on the recent paper *Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons*, which assessed the COVID-19 burden in Massachusetts prisons and jails.
4. A copy of my curriculum vitae is attached as Exhibit A.

Massachusetts is entering the most dangerous phase of the pandemic.

5. People may have gained a false sense of security after months of living with the pandemic, but the Commonwealth is in the midst of the most dangerous period of the pandemic so far. From an epidemiological perspective, the COVID-19 risks are higher now than at any other point, including the first surge in the spring.
6. Massachusetts now regularly reports thousands of new confirmed cases each day, and the total COVID-19 deaths in Massachusetts have already topped 11,000.¹ Based on data from the CDC, the number of new cases of COVID-19 has increased by 66% in the past two weeks alone.² And according to the dean of Brown University School of Public Health, hospitalizations and deaths in Massachusetts have risen 100% in the past three weeks.³ To deal with the surge of hospitalizations, the state has re-opened field hospitals, and the Department of Health and Human Services has curtailed inpatient elective surgeries.⁴ Forecasting by the CDC predicts the number of weekly cases of

¹ See generally, Mass. Dep’t of Public Health, COVID-19 Dashboard: Dec. 11, 2020, <https://www.mass.gov/doc/covid-19-dashboard-december-11-2020/download>.

² Centers for Disease Control and Prevention, *United States COVID-19 Cases and Deaths by State over Time*, <https://data.cdc.gov/Case-Surveillance/United-States-COVID-19-Cases-and-Deaths-by-State-o/9mfq-cb36/data> (last visited Dec. 15, 2020).

³ Shirley Leung, *Public Health Experts and Some Boston-Area Mayors Urge More Action On COVID-19*, Boston Globe (Dec. 6, 2020), <https://www.bostonglobe.com/2020/12/06/business/with-no-new-covid-19-restrictions-state-top-health-expert-some-boston-area-mayors-urge-more-action>.

⁴ See Matt Murphy, *Mass. Curbing Some Elective Inpatient Procedures, Expanding Test Sites*, WBUR (Dec. 7, 2020), <https://www.wbur.org/commonhealth/2020/12/07/massachusetts-covid-coronavirus-elective-inpatient-procedures>.

COVID-19 in Massachusetts between December 12, 2020 and January 2, 2021 will increase by 23% and related deaths will increase by 57%.⁵

7. A similar surge of COVID-19 is gripping the entire nation. Last week, the United States recorded its most COVID-related deaths over a weeklong period, with a seven-day average of 2,249 deaths.⁶ The nation is averaging nearly 200,000 cases per day.⁷ Nationwide rates of hospitalizations are at levels seen early on in the pandemic and demonstrate the continued burden on our health care system.⁸

Prisons and jails are high-risk environments for COVID-19.

8. Compared to the general population, people who are held in prisons and jails are more vulnerable to contracting COVID-19 and more likely to become seriously ill or die from the virus.
9. The SARS-CoV-2 virus, which causes the disease COVID-19, spreads in three main ways.⁹ People who live and work in prisons and jails are more susceptible to all three forms of transmission.
10. First, the virus primarily spreads through inhalation of respiratory droplets expelled when an infected person exhales, talks, coughs, or sneezes.¹⁰ Because this form of transmission is most likely to occur when someone is physically close to the infectious person, generally within about six feet, people who live and work in congregate-living environments like prisons and jails are more likely to contract the virus.¹¹

⁵ See Centers for Disease Control and Prevention, COVID Data Tracker: Forecasting, https://covid.cdc.gov/covid-data-tracker/#forecasting_weeklydeaths (last visited Dec. 16, 2020).

⁶ See Will Wright, *The U.S. Has Recorded its Most COVID-19 Deaths in a Week*, N.Y. Times (Dec. 11, 2020), <https://www.nytimes.com/live/2020/12/07/world/covid-19-coronavirus/the-us-has-recorded-its-most-covid-19-deaths-in-a-week>.

⁷ *Id.*

⁸ See Centers for Disease Control and Prevention, *COVID-19: Key Updates for Week 49, ending December 5, 2020*, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>.

⁹ See Centers for Disease Control and Prevention, *COVID-19 Frequently Asked Questions, Spread*, <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Spread> (last visited Dec. 12, 2020).

¹⁰ *See id.*

¹¹ *See generally* Centers for Disease Control and Prevention, *COVID-19 Guidance for Shared or Congregate Housing*, <https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html> (last visited Dec. 12, 2020).

11. Second, people can contract COVID-19 through contact with objects and surfaces contaminated with the virus.¹² Current evidence suggests that SARS-CoV-2 may survive for hours to days on surfaces.¹³ People living in congregate environments like prisons and jails are more susceptible to contracting the virus from contaminated surfaces because they share spaces such as toilets, showers, cells, and eating areas.
12. Third, we now know that the SARS-CoV-2 virus spreads through airborne transmission. Once expelled into the air, droplets containing the virus can remain suspended for hours.¹⁴ Airborne transmission of SARS-CoV-2 is more likely to occur in closed environments and spaces with poor ventilation.¹⁵ Because prisons and jails are enclosed, congregate spaces that often have poor airflow, people living and working in prisons and jails are likely at higher risk of airborne transmission of SARS-CoV-2 than the general population.
13. Because the SARS-CoV-2 virus generally spreads person-to-person, physical distancing is the cornerstone of COVID-19 prevention. Thus, in environments where physical distancing is impossible without significant decreases in population, like prisons and jails, COVID-19 transmission is especially widespread.
14. The high risk of outbreaks in correctional settings is not merely theoretical; as of August 2020, 90 of the largest 100 cluster outbreaks in the United States

¹² See Centers for Disease Control and Prevention, *COVID-19 Frequently Asked Questions, Spread*, <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Spread> (last visited Dec. 12, 2020) (“A person may get COVID-19 by touching the surface or object that has the virus on it and then touching their own mouth, nose, or eyes.”).

¹³ See Centers for Disease Control and Prevention, *COVID-19: Cleaning and Disinfection for Households*, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html> (last visited Dec. 12, 2020) (“Current evidence suggests that SARS-CoV-2 may remain viable for hours to days on surfaces made from a variety of materials.”).

¹⁴ Dyani Lewis, *Mounting Evidence Suggests Coronavirus Is Airborne — But Health Advice Has Not Caught Up*, *Nature* (July 8, 2020), <https://www.nature.com/articles/d41586-020-02058-1>.

¹⁵ See Centers for Disease Control and Prevention, *Scientific Brief: SARS-CoV-2 and Potential Airborne Transmission* (Oct. 5, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html> (last visited Dec. 12, 2020) (noting that airborne transmission appears to have occurred in enclosed spaces, with prolonged exposure to respiratory particles, and in spaces with inadequate ventilation).

had occurred in prisons and jails.¹⁶ As of December 10, there have been 1,644 reported deaths of incarcerated individuals due to COVID-19.¹⁷

15. A recent article in the *Annals of Epidemiology* provides the first estimate of the reproduction ratio of COVID-19 in a large jail.¹⁸ The basic reproductive ratio, R_0 , is defined as the expected number of secondary infections arising from a single individual during his or her entire infectious period. The study found that, in a large jail in the United States, the R_0 was 8.44, meaning a single infectious individual could be expected to spread the virus more than eight additional people.¹⁹ Notably, this R_0 is of higher magnitude than those reported for other congregate settings, such as the Diamond Princess cruise ship, despite the younger age of those incarcerated.²⁰
16. What is more, there is evidence that incarcerated people are not only more susceptible to contracting COVID-19, but also more likely to die from the disease. As of August, the nationwide COVID-19-related death rate in the prison population was an estimated three times higher than in the U.S. population, adjusting for the fact that incarcerated people are younger on average than the general population.²¹
17. A recent article in pre-print based on data from prisons across the United States demonstrated that the age and sex adjusted mortality rate from COVID-19 among incarcerated people was 2.75 times higher than the general population.

¹⁶ Nayanah Siva, *Experts Call to Include Prisons in COVID-19 Vaccine Plans*, The Lancet (Dec. 12, 2020), <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2932663-5>.

¹⁷ See Homepage, The Covid Prison Project, <https://covidprisonproject.com> (last visited Dec. 12, 2020).

¹⁸ Lisa B. Puglisi et al., *Estimation of COVID-19 basic reproduction ratio in a large urban jail in the United States*, 53 *Annals of Epidemiology* 103 (2021), [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7480336/#:~:text=The%20basic%20reproduction%20ratio%20\(R,the%20spread%20of%20infectious%20diseases](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7480336/#:~:text=The%20basic%20reproduction%20ratio%20(R,the%20spread%20of%20infectious%20diseases).

¹⁹ See *id.* at 104.

²⁰ See *id.* at 105.

²¹ See National Academies of Sciences, Engineering, and Medicine, *Decarcerating Correctional Facilities during COVID-19: Advancing Health, Equity, and Safety* (2020), 1-1 [“NASEM Report”], <https://www.nap.edu/catalog/25945/decarcerating-correctional-facilities-during-covid-19-advancing-health-equity-and>.

People who live and work in Massachusetts prisons and jails face a serious risk of contracting COVID-19.

18. I recently co-authored a paper titled *Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons*, which was published in JAMA Network Open on August 21, 2020. The paper is attached as Exhibit B.
19. In the study, my co-authors and I analyzed data reported by the Massachusetts Department of Correction and Houses of Corrections from April 5 through July 8, 2020, which was produced pursuant to this Court's order in *Comm. for Pub. Counsel Servs. v. Chief Justice of Trial Court*, 484 Mass. 431, 456, *aff'd as modified*, 484 Mass. 1029 (2020).²²
20. We calculated cumulative testing and laboratory-confirmed case rates for Massachusetts prisons and jails. We found that, as of July 8, 2020, 1,032 confirmed cases of COVID-19 were reported among incarcerated individuals. The rate of COVID-19 was 44.3 cases per 1000 persons—nearly three times higher than the Massachusetts general population and nearly five times the U.S. general population. For the Houses of Correction, this is likely an underestimate because the facilities had low testing rates.²³ Importantly, the percent of positive tests among those tested was 55% higher among people incarcerated in Houses of Corrections compared to the general population of the state.
21. We also analyzed the relationship between COVID-19 case rates and changes in facilities' incarcerated populations. Among the thirteen Houses of Correction, those with greater reductions in population also had lower rates of COVID-19 infections.²⁴ Limited and inconsistent testing data make it difficult to estimate exactly how much decarceration helped prevent infections.
22. We concluded that rates of COVID-19 in Massachusetts jails and prisons are alarmingly high, and that increased testing, decarceration, and contact tracing are necessary to decrease harm from COVID-19 to incarcerated people and their communities.²⁵
23. Given the current rates of community transmission, the low testing rates at the Houses of Correction, and the high populations of the Houses of Correction, the present rate of infection among people incarcerated in those facilities is almost certainly higher than reported in our study.

²² See Exhibit B at 1.

²³ See *id.*

²⁴ See *id.* at 3.

²⁵ See *id.*

Outbreaks of COVID-19 in prisons and jails can drive community transmission of the virus.

24. As the National Academies of Science, Engineering, and Medicine has reported, “because correctional facilities are not isolated settings—incarcerated individuals move between facility and community and staff return home at night—the outbreaks in correctional facilities are associated with community infection rates.”²⁶
25. Research has confirmed that jail and prison outbreaks are major drivers of community infection. A new report from the Prison Policy Initiative and Professor Gregory Hooks estimates how prisons and jails added to COVID-19 caseloads on the county, state, and national levels. Hooks compared the population density of incarcerated people in U.S. counties to the growth in COVID-19 cases in those counties over the summer of 2020. To get a more direct measure of community spread across county lines, he also measured the impact on county caseloads from prison and jail populations held in nearby counties located within the same multi-county economic areas. The study concludes that over half a million COVID-19 cases this summer were directly linked to mass incarceration. The report concluded that “[i]f the cases linked to mass incarceration over the summer of 2020 were the reported caseload of a country, that country would rank 5th in the world.”²⁷ Although these data were not collected at the individual level, they are among the most robust data to date on the impact of COVID-19 in carceral settings on the local community.
26. In another study conducted by Prof. Daniel L. Chen and Eric Reinhart, data from Cook County, Illinois, were used to examine the association between arrests and cases of COVID-19 at the community level based on ZIP code. As of late April, cycling people through Cook County Jail was associated with an estimated 15.9% of COVID-19 cases in Chicago and 15.7% in the state as a whole.²⁸ The largest proportion of the variability in case rates in zip codes across Chicago (55%) was explained by jail to community cycling ($R^2=0.55$) and such cycling explained 37% of the variability in case rates in zip codes across the state of Illinois ($R^2=0.37$). Moreover, jail cycling explained more of

²⁶ See NASEM Report at S-1.

²⁷ Gregory Hooks and Wendy Sawyer, *Mass Incarceration, COVID-19, and Community Spread*, Prison Policy Initiative (Dec. 15, 2020), <https://www.prisonpolicy.org/reports/covidsread.html>.

²⁸ See generally Eric Reinhart and Daniel L. Chen, *Incarceration and Its Disseminations: COVID-19 Pandemic Lessons From Chicago’s Cook County Jail*, Health Affairs (June 4, 2020), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00652>.

the variability in case rates than race (Chicago: 41%, Illinois: 30%), poverty (Chicago: 26%, Illinois: 9%), public transportation use (Chicago: 0.6%, Illinois: 26%), and population density (Chicago: 4%, Illinois: 21%).²⁹ Although these data were not collected at the individual level, they are among the most robust data to date on the impact of COVID-19 in carceral settings on the local community.

Asymptomatic testing is a necessary component of any effective strategy to curb COVID-19 infections in Massachusetts prisons and jails.

27. People with asymptomatic and pre-symptomatic infection are significant contributors to SARS-CoV-2 transmission.³⁰ According to current best estimates from the Centers for Disease Control and Prevention (CDC), 40% of COVID-19 cases are asymptomatic, or never show symptoms, but can still transmit the virus. Moreover, among symptomatic cases, 50% of transmissions occur before symptom onset.³¹ Another review of the scientific literature suggests that nearly 62% of transmission is expected to occur prior to symptom onset.³²

28. When a COVID-19 patient starts showing symptoms – which is typically an average of 5 days after exposure – they have already been infectious for upwards of 2 days.³³ This means that, in a congregate living environment, outbreaks of COVID-19 will occur even if symptomatic individuals are immediately isolated.

29. Research demonstrates that, without broad-based testing, many cases of COVID-19 go undetected in correctional facilities. In August 2020, the CDC published a report describing the results of broad-based testing events in

²⁹ Eric Reinhart and Daniel L. Chen, *Incarceration And Its Disseminations: COVID-19 Pandemic Lessons From Chicago's Cook County Jail*, Health Affairs (Aug. 2020), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00652>.

³⁰ See Centers for Disease Control and Prevention, *CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2*, (Dec. 3, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html>.

³¹ Centers for Disease Control and Prevention, *COVID-19 Pandemic Planning Scenarios*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html> (last visited Dec. 10, 2020);

³² See W. Joost Wiersinga et al., *Pathophysiology, Transmission, Diagnosis, and Treatment of Coronavirus Disease 2019 (COVID-19)*, JAMA Network (July 10, 2020), <https://jamanetwork.com/journals/jama/fullarticle/2768391>.

³³ Centers for Disease Control and Prevention, *Clinical Questions about COVID-19: Questions and Answers: Infection Control*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html> (last visited Dec. 16, 2020).

sixteen correctional facilities between April and May of 2020.³⁴ The comprehensive testing resulted in a median 12.1-fold increase in the number of known infections among incarcerated people in these facilities. The study concluded that “[b]road-based testing can provide a more accurate assessment of prevalence and generate data to help control transmission.”³⁵

30. Because of the prevalence of asymptomatic and pre-symptomatic transmission, it is my expert opinion that, in congregate living environments like prisons and jails, any reasonable response to the COVID-19 pandemic includes routine, comprehensive testing of residents and staff without symptoms.
31. Research shows that broad-based testing is a necessary part of any effective strategy to protect incarcerated people from COVID-19. A June 2020 study by Yale and Stanford researchers estimates the impact of various mitigation strategies on COVID-19 transmission in a U.S. jail.³⁶ The researchers started observing the facility when its mitigation efforts were limited to quarantining upon intake, screening for symptoms, and suspending visitations. They then estimated, among other things, the virus’s transmission after three phased interventions: (1) the start of depopulation efforts, (2) increased single celling, and (3) large-scale asymptomatic testing of incarcerated individuals. Compared to the baseline, the transmission rate decreased by 56% after the initiation of depopulation strategies; an additional 51% after single celling; and an additional 73% after the adoption of surveillance testing.
32. In a prison or jail, in order to be effective, a testing policy must be both comprehensive—meaning it includes non-symptomatic testing—and routine. That is because prisons and jails are not closed environments; staff members, contractors, and incarcerated people cycle in and out of correctional facilities, all potentially bringing SARS-CoV-2 in with them. As a result, a one-time test or a test offered every few months offers little information about whether someone will become infected after a potential exposure. Likewise, because individuals could be exposed to the virus after entering the facility, testing prisoners only upon intake is not sufficient. Instead, individuals in high-risk

³⁴ See generally, Liesl M. Hagan et al., *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails — Six Jurisdictions, United States, April–May 2020*, Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (Aug. 21, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm#suggestedcitation>.

³⁵ *Id.*

³⁶ Giovanni S.P. Malloy et al., *The Effectiveness of Interventions to Reduce COVID-19 Transmission in a Large Urban Jail* (June 18, 2020), <https://doi.org/10.1101/2020.06.16.20133280>.

settings like prisons and jails must be tested frequently in order to detect infections and prevent spread.³⁷

33. In order to mitigate outbreaks of COVID-19, correctional facilities must isolate infectious individuals and identify their close contacts.³⁸ But isolation and contact tracing are only possible once an individual has been identified as infected with COVID-19. As discussed above, without routine, comprehensive testing, prisons and jails cannot identify pre-symptomatic or asymptomatic individuals. Therefore, in prisons and jails, the efficacy of isolation and contact tracing depend upon the routine testing of staff and residents who are not yet experiencing symptoms.
34. Reflecting this scientific consensus, the CDC recommends that certain institutions, including congregate settings such as correctional institutions, implement “an expanded screening testing strategy to rapidly identify people without symptoms (i.e., asymptotically or presymptomatically infected with SARS-CoV-2) who are contributing to the silent spread of infection, because they are unaware that they are infectious.”³⁹
35. Under the CDC’s guidance, the recommended cadence of testing depends upon two indicators in the surrounding county: (1) the cumulative number of new positive cases per 100,000 people in the last seven days; and (2) the percentage of viral tests that are positive within the last seven days.⁴⁰ As of December 17, nine Massachusetts counties’ indicators placed them in the high infection tier, for which weekly or twice-weekly screening is recommended; the other five counties were in the moderate infection tier, for which weekly screening testing is recommended.⁴¹

³⁷ Daniel B. Larremore, et al, *Test Sensitivity Is Secondary to Frequency and Turnaround Time for COVID-19 Screening*, Science Advances (Dec. 12, 2020), <https://pubmed.ncbi.nlm.nih.gov/33219112> (Simulations of a university setting showed that weekly testing with prompt return of results effectively controlled positive cases of COVID-19).

³⁸ See generally Centers for Disease Control and Prevention, *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html> (last visited Dec. 12, 2020).

³⁹ See Centers for Disease Control and Prevention, *CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2*, <https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/expanded-screening-testing.html> (last visited Dec. 12, 2020).

⁴⁰ See *id.*

⁴¹ See *id.*; Massachusetts Department of Public Health, *Weekly COVID-19 Public Health Report* (Dec. 17, 2020), <https://www.mass.gov/doc/weekly-covid-19-public-health-report->

36. It is my understanding that none of the Massachusetts Houses of Correction conduct routine, comprehensive COVID-19 testing of prisoners or staff members. It is my expert opinion that the Houses of Correction are not conducting the level of testing necessary to identify infected prisoners and staff, and therefore that the Houses of Correction are not taking the necessary steps to protect the people who live and work in their facilities. Based upon the CDC's guidance and the foregoing research, it is my expert opinion that testing in Massachusetts jails and prisons should happen at the very least weekly or biweekly.

Decarceration is a necessary component of any effective strategy to curb COVID-19 infections in Massachusetts prisons and jails.

37. As discussed above, physical distancing is paramount to combating COVID-19 transmission. Reducing the incarcerated population is the only way to increase the ability of the remaining individuals to physically distance from one another. Thus, decarceration is a necessary component of any effective strategy to protect people who live and work in carceral settings from COVID-19.

38. Indeed, as discussed above, the research demonstrates that decarceration is a central part of an effective mitigation strategy. In a large U.S. jail, the transmission rate decreased by 56% after the jail employed decarceration strategies of reducing intakes and releasing incarcerated people, and another 51% when detained people were able to live in single-occupancy cells.⁴² Depopulation efforts must therefore be a primary strategy for COVID-19 mitigation in jails, especially given that increasing access to single-occupancy cells will not be feasible without depopulation efforts.

39. In addition, the study I co-authored on COVID-19 rates in Massachusetts prisons and jails found that, among the Houses of Correction, those with greater reductions in their incarcerated populations also had lower COVID-19 positivity rates.⁴³

[december-17-2020/download](#) (Barnstable, Berkshire, Franklin, Hampshire, and Norfolk had average daily incidents rates of between 27.9 and 47.3, thus falling into the CDC's definition of moderate infection tier; Bristol, Dukes & Nantucket, Essex, Hampden, Middlesex, Plymouth, Suffolk, and Worcester Counties had average daily incidents rates of 54.3 to 101.5, thus falling into the CDC's definition of high infection tier.).

⁴² Giovanni S.P. Malloy et al., *The Effectiveness of Interventions to Reduce COVID-19 Transmission in a Large Urban Jail* (June 18, 2020),

<https://doi.org/10.1101/2020.06.16.20133280>.

⁴³ See Exhibit B at 2-3.

40. After reviewing the research on the most effective COVID-19 mitigation measures in prisons and jails, a consensus report of the National Academies of Science, Engineering, and Medicine recently concluded that “decarceration is an appropriate and necessary mitigation strategy to include in the COVID-19 response in correctional facilities and would reduce risks of exposure to and transmission of the disease within correctional facilities.”⁴⁴
41. It is my expert opinion that decarceration is a necessary component of any reasonable strategy to combat the spread of COVID-19 in Massachusetts prisons and jails. If the Houses of Correction have not made meaningful use of the tools at their disposal to reduce their incarcerated populations, they have failed to take the reasonable steps necessary to protect the people who live and work in their facilities from COVID-19.

Prevention strategies such as decarceration and routine, comprehensive testing are necessary while incarcerated people await the COVID-19 vaccine.

42. On December 11, the FDA issued emergency authorization to approve the use of the first COVID-19 vaccine.⁴⁵ In the Commonwealth, as nationwide, vaccine distribution will occur in a phased approach, with prioritization reflecting the need to protect the most vulnerable, maintain health-care system capacity, and address inequities in health care access and COVID-19 burden.⁴⁶
43. Recognizing the fact that incarcerated people are among the most vulnerable to COVID-19, the Governor and the Massachusetts Department of Public Health have decided to vaccinate people living and working in congregate settings, including correctional institutions, in the first phase, immediately after health-care workers doing COVID-facing care, long-term care facilities, and emergency personnel.⁴⁷

⁴⁴ See NASEM Report at S-2.

⁴⁵ See FDA News Release, *FDA Takes Key Action in Fight Against COVID-19 By Issuing Emergency Use Authorization for First COVID-19 Vaccine* (Dec. 11, 2020), <https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19>.

⁴⁶ See Mass. Dept. of Public Health, *When can I get the COVID-19 vaccine?*, <https://www.mass.gov/info-details/when-can-i-get-the-covid-19-vaccine> (last visited Dec. 12, 2020); Robert Weisman et al., *Mass. Lays Out COVID-19 Vaccine Timeline, But Most Will Have to Wait Till Spring*, Boston Globe (Dec. 9, 2020), <https://www.bostonglobe.com/2020/12/09/metro/state-lays-out-covid-19-vaccination-priorities>.

⁴⁷ See Mass. Dept. of Public Health, *When Can I Get the COVID-19 Vaccine?*, <https://www.mass.gov/info-details/when-can-i-get-the-covid-19-vaccine> (last visited Dec. 12, 2020).

44. Although incarcerated people are prioritized for the vaccine, the Commonwealth will not have enough doses of the vaccine to inoculate all of the populations in the first phase in the near future. The state's current vaccine timeline suggests that it will not finish vaccinating the populations in Phase One until February 2021.⁴⁸
45. As discussed above, soaring rates of community infection suggest that December 2020 through February 2021 might be the most devastating period of the COVID-19 pandemic. Indeed, the head of the CDC recently warned that the upcoming months could be “the most difficult in the public health history of this nation.”⁴⁹
46. In order to benefit from the vaccine, people living and working in the Houses of Correction must be alive and uninfected. Therefore, to protect the health and safety of incarcerated people before the vaccine becomes available, the Houses of Correction should adopt the preventative measures of routine, comprehensive testing and decarceration. Indeed, the Commonwealth's prioritization of incarcerated people alongside residents of long-term care facilities⁵⁰ suggests that—until the vaccine is available—incarcerated people should benefit from the same preventative measures taken in long-term care facilities, including surveillance testing.

Signed under the pains and penalties of perjury on December 18, 2020.



Dr. Monik C. Jiménez, ScD, SM, FAHA

⁴⁸ See *id.*

⁴⁹ Sheila Kaplan, *Redfield Warns this Winter May Be 'the Most Difficult Time in the Public Health History' of the U.S.*, N.Y. Times (Dec. 2, 2020), <https://www.nytimes.com/live/2020/12/02/world/covid-19-coronavirus/redfield-warns-this-winter-may-be-the-most-difficult-time-in-the-public-health-history-of-the-us>.

⁵⁰ See Mass. Dept. of Public Health, *When Can I Get the COVID-19 Vaccine?*, <https://www.mass.gov/info-details/when-can-i-get-the-covid-19-vaccine> (last visited Dec. 12, 2020).

Jiménez Affidavit

Exhibit A

**Harvard Medical School
Curriculum Vitae**

Date Prepared: December 17, 2020

Name: Monik C. Jiménez

Office Address: Division of Women's Health, Brigham and Women's Hospital
1620 Tremont St., 3-034
Boston, MA 02120

Home Address: 76 Old Palmer Rd, Brimfield, MA 01010

Work Phone: 617-525-7516

Work Email: mjimenez11@partners.org

Work FAX: 617-525-7746

Place of Birth: Los Angeles, CA

Education

2004	BA (<i>magna cum laude</i>)	Biology	Whittier College, Whittier, CA
2004-2009	Certificate	Oral Epidemiology	Harvard School of Dental Medicine, Boston, MA
2006	SM	Epidemiology	Harvard School of Public Health, Boston, MA (now Harvard T.H. Chan School of Public Health)
2009	ScD	Epidemiology Kaumudi Joshipura, BDS, SM, ScD	Harvard School of Public Health

Postdoctoral Training

12/09-6/13	Research Fellow	Cardiovascular Epidemiology Kathryn M. Rexrode, MD, MPH	Brigham and Women's Hospital, Boston, MA
------------	-----------------	--	---

Faculty Academic Appointments

09/09-	Adjunct Teaching Associate (no voting privileges)	Graduate Studies	Forsyth School of Dental Hygiene, Massachusetts College of Pharmacy and Health Sciences, Boston, MA
02/11-	Adjunct Lecturer (no voting privileges)	Department of Nursing	Simmons College, School of Nursing and Health Sciences, Boston, MA
07/13-9/17	Instructor in Medicine	Department of Medicine	Harvard Medical School, Boston, MA
10/17-	Assistant Professor	Department of Medicine	Harvard Medical School

10/19- Assistant Professor Department of Epidemiology Harvard T.H. Chan School of Public Health

Appointments at Hospitals/Affiliated Institutions

2013- Associate Epidemiologist Department of Medicine Brigham and Women's Hospital

Other Professional Positions

2000-2003 Undergraduate Intern Harvard School of Dental Medicine
Harvard T.H. Chan School of Public Health

2004-2005 Research Assistant Harvard School of Dental Medicine

2005 Research Assistant Harvard T.H. Chan School of Public Health

2006-2010 Research Assistant Boston University Henry M. Goldman School of Dental Medicine, Boston, MA

2007-2009 Investigator University of Puerto Rico, School of Dentistry, San Juan, Puerto Rico

2008-2009 Research Assistant Beth Israel Deaconess Medical Center, Boston, MA

2009-2011 Consultant University of Michigan, Ann Arbor, MI

2010-2015 Consultant Colgate Oral Care Report, Boston, MA

2011-2013 Summer Fellow National Heart, Lung, and Blood Institute Programs to Increase Diversity among Individuals Engaged in Health-Related Research (NHLBI PRIDE) Summer Institute on Mentoring Researchers in Latino Health Disparities, San Diego State University, San Diego, CA (sole compensation was payment of travel expenses).

2015-2016 Summer Fellow New York University School of Medicine, Center for Stroke Disparities Solutions Training and Mentoring Institute, New York, NY (sole compensation was payment of travel expenses).

2018- Board Member Partakers – College Behind Bars, Newton, MA

2020- Faculty Director BWH STARS, Brigham and Women's Hospital

Major Administrative Leadership Positions

Local

2009-2013 Co-director, Advanced Graduate Education (AGE) Course in Biostatistics
Harvard School of Dental Medicine

2014-2016 Co-director, Peer Networking
Division of Preventive Medicine

Regional

2009- Co-director, Biostatistics
Forsyth School of Dental Hygiene, Massachusetts College of Pharmacy and Health Sciences

Committee Service

Local

2009-2014 Member, Curriculum Advisory Board
Clinical Epidemiology & Population Health (AC511.0)
First-year medical students

2013-2016 Alumni Representative, Dean's Advisory Committee on Diversity and Inclusion
Harvard T.H. Chan School of Public Health

2018- Member, Health Equity Committee
Department of Medicine, Brigham and Women's Hospital

2018- Wellness Champion
Department of Medicine, Brigham and Women's Hospital

2019- Member, Health Equity Data Committee
Department of Medicine, Brigham and Women's Hospital

Professional Societies

2004-2010 International Association for Dental Research

2004-2010 American Association for Dental Research

2005-2010 Society for the Advancement of Chicanos/Hispanics and Native Americans in Science
2005-2006 Chapter President

2008-2011 Society for Epidemiology Research

2009- American Heart Association (AHA)

2010- Member, Epidemiology Council

2014- Appointed Member, AHA Epidemiology Council
Early Career Committee
Program Committee

2014- Appointed Member, AHA Stroke Statistics Committee

2017- Chair, AHA Epidemiology Council Early Career Committee

2019- Appointed Member, AHA, Council Operations Committee

2019- Appointed Member, AHA Epidemiology Council Social Determinants of Health
Committee

2020- Chair, AHA Council Operations Committee, Mid-Career Committee

Editorial Activities

Ad hoc Reviewer

Circulation
Diabetes Care
European Journal of Epidemiology
Hypertension
Journal of Dental Public Health Dentistry
Neurology
PLoS
Social Science & Medicine
Stroke

Honors and Prizes

- 2002-2004 John Greenleaf Whittier Merit Scholarship, Whittier College
- 2002-2004 Whittier College Dean's List, Whittier College
- 2004 John Stauffer Trust Science Scholarship, Whittier College
- 2004 Outstanding Biology Major, Whittier College
- 2004-2006 Presidential Scholar, Harvard T.H. Chan School of Public Health
- 2006 Honorable Mention, Harvard School of Public Health Student Research Day
Harvard T.H. Chan School of Public Health
- 2006 Outstanding Student Abstract Award, International Association for Dental Research
- 2006-2008, Conference Travel Award, American Association for Dental Research
2009
- 2010 Travel Award to 36th Ten-Day Seminar on the Epidemiology and Prevention of
Cardiovascular Disease, Centers for Disease Control and Prevention
- 2012 Epidemiology and Prevention Minority Travel Grant, American Heart Association
Travel award to Cardiovascular Disease Epidemiology & Prevention Scientific Sessions 2012
- 2013 Award for Excellence in Tutoring, Harvard Medical School
- 2014 Selected participant for the Research Leadership Program, Brigham and Women's Hospital
- 2014 Selected for participation in the Grant Review and Support Program, The Harvard Clinical
and Translational Science Center (Harvard Catalyst)
- 2015 Chair's Research Award, Brigham and Women's Hospital, Department of Medicine
- 2018 PRIDE Peer Mentorship Program, New York University School of Medicine

- 2018 Elected Fellow of the American Heart Association, Council on Epidemiology and Prevention
- 2020 Mentoring Award, Harvard T.H. Chan School of Public Health

REPORT OF FUNDED AND UNFUNDED PROJECTS

Funding Information

Past

- 2009-2013 National Institutes of Health (NIH)/National Heart, Lung, and Blood Institute (NHLBI) 3R01HL088521-S1
Diversity Supplement to Risk Factors for Ischemic Stroke in Women
Postdoctoral Research Fellow (PI: Kathryn M. Rexrode)
This study evaluated the association between adipokines, sex hormones, and risk of stroke among women. Furthermore, it provided career development support to progress towards an independent research career as a cardiovascular epidemiologist.
- 2010 NIH/National Institute of Dental and Craniofacial Research (NIDCR) 1F32DE020227
(Award declined) Metabolic Syndrome as a Predictor of Periodontitis and Tooth Loss
PI (\$152,982)
This study evaluated the association between metabolic syndrome and its components in relation to incident tooth loss. This award was declined to pursue expanded cardiovascular post-doctoral training.
- 2011-2013 NIH Loan Repayment Program Recipient
Award recipient
This award provided student loan repayment for individuals engaged in research-oriented careers.
- 2013-2014 NIH/NHLBI R01 HL102122-S1
Diversity Supplement to Effect of Vitamin D and Omega-3 Fatty Acids on Blood Pressure and Hypertension
Investigator trainee (PI: Howard D. Sesso)
This innovative diversity supplement examined racial/ethnic and sex disparities in HTN by testing their differential impact on the effects of randomized vitamin D and omega-3 fatty acid (ω -3 FA) interventions on HTN incidence, 2-year changes in 24-hour ambulatory blood pressure (ABP) and sex steroid hormones, and the validity of self-reported HTN measures.
- 2014-2015 Brigham and Women's Hospital Faculty Career Development Award
PI
Assessing the influence of cardiovascular risk factors and gender on risk of stroke among hypertensives
This project will examine the role of clinical and lifestyle risk factors that influence stroke risk among both pre-hypertensive and hypertensive men and women of the Physicians' Health Study II and the Women's Health Study. (**Note:** The Women's Health Study was a clinical trial randomizing 39,876 female health professionals aged ≥ 45 years starting in 1992; whereas the Women's Health Initiative, mentioned elsewhere in the CV, is an ongoing prospective study of 161,808 multi-ethnic postmenopausal women aged 50-79 years starting in 1994, consisting of clinical trials and an observational study.)

- 2014-2019 Brigham and Women's Hospital Minority Faculty Career Development Award
Examining the role of social and biologic determinants of sex and racial/ethnic disparities in stroke
PI (\$100,000)
This award will provide career development and research support to facilitate the transition to independence.
- 2014-2019 NIH/NHLBI 1K01HL124391
Examining Racial Disparities in Stroke
PI (\$650,430)
This mentored career development award will examine stroke disparities in three large cohort studies, the Women's Health Initiative, the Southern Community Cohort Study and the Reasons for Geographic and Racial Differences in Stroke Study by evaluating the contribution of traditional and non-traditional cardiovascular risk factors for stroke among white and black populations. Furthermore, the performance of existing stroke prediction scores will be compared in blacks and whites, with a new score developed to optimize prediction in black individuals.

Current

- 2019-2021 Nesson Fellowship Brigham and Women's Hospital Center for Community Health and Health Equity
Examining the cardiovascular implications of incarceration
PI (\$180,000)
This award provides career development support to examine factors that impact the cardiovascular health of patients who have experienced incarceration, identify ways to support respectful patient-clinician communication about such experiences and inform future policy to support health care equity.
- 2019-2020 Brigham and Women's Hospital Department of Medicine Health Equity Grant
Engaging patients and health care providers in communication regarding history of incarceration
PI (\$20,000)
This award provides research support to interview patients through qualitative methods and survey provides regarding patient preferences in discussing history of incarceration.

REPORT OF LOCAL TEACHING AND TRAINING

Teaching of Students in Courses

HMS/HSDM/DMS courses

Harvard School of Dental Medicine

2007-2008	Teaching Assistant	20 two-hour lab sessions/year
	Outcomes of Treatment (OTx Block)	2 two-hour lectures
	3 rd year dental students	

Harvard Medical School

2009	Tutorial leader	1 two-hour session
	Clinical Epidemiology & Population Health (AC511.0)	
	First-year medical students	
2011-2017	Tutorial leader	7 two-hour sessions/year
	Clinical Epidemiology & Population Health (AC511.0)	
	First-year medical students	

2019	Tutorial leader Clinical Epidemiology & Population Health (AC511.0) First-year medical students	6 two-hour sessions/year
2020	Learning Studio Instructor and Tutorial leader Clinical Epidemiology & Population Health (AC511.0) First-year medical students	8 two-hour sessions/year
2020	Tutorial Leader Essentials of the Profession II (PWY120) Fourth-year medical students	6 one-hour sessions
2020	The Criminal Punishment System and Health in the US Social Medicine Fourth-year medical students	1 two-hour session

Other Harvard University Courses

Harvard T.H. Chan School of Public Health

2007	Teaching Assistant Introduction to Epidemiology (Epi 201) First-year master's students	16 two-hour sessions
2009	Teaching Assistant Introduction to Epidemiology (Epi 500) First-year year master's students	20 one-hour sessions/year
2013- 2014	DHEAS and risk of cardiovascular disease Oral presentation for undergraduate summer students Summer Program in Epidemiology and Fostering Advancement & Careers through Enrichment Training in Science (FACETS), Office of Diversity and Inclusion	1 two-hour session/year
2014	DHEAS and risk of cardiovascular disease Oral presentation for undergraduate summer students Summer Program in Quantitative Sciences, Department of Biostatistics	1 two-hour session
2019-	Course Director Cardiovascular Disease Epidemiology (Epi 223) Master's and doctoral students	16 hour and half sessions
2020	Course Director Mass Incarceration and Health (SBS 502) Master's and doctoral students	16 hour and half sessions

Other Teaching during Harvard Fellowship and Faculty Appointments

Massachusetts College of Pharmacy and Health Sciences

2009-2012	Adjunct Lecturer Biostatistics (DHY714) First-year master's students	14 one-hour online sessions/year
2012-2018	Adjunct Lecturer Statistics (MAT261) Undergraduate students	14 one-hour online sessions/year
2013-2019	Adjunct Lecturer Research Methods in Oral Health (DHY 714) First-year master's students	14 one-hour online sessions/year

Simmons College

2011	Adjunct Instructor Research Methods (PT 610) Pre-doctoral physical therapy students	14 two-hour sessions/year
2012-2020	Adjunct Instructor Research Methods (SNHS 410) Nursing students (various levels)	14 three-hour sessions/year

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs)

2006-2009,	Lecturer, Harvard School of Dental Medicine	5 two-hour lectures
2012	Advanced Graduate Education Course in Biostatistics (OHPE 751.BIO) First-year post-doctoral residents	

Laboratory and Other Research Supervisory and Training Responsibilities

2009-	Statistical advisor / peer-mentor, post-doctoral research fellows and visiting scholars	8 hours per month
-------	---	-------------------

Mentored Trainees and Faculty

2015-2019	Marcia Pescador Jiménez, MS, PhD candidate, Brown School of Public Health, Providence, RI Mentor – Conducting the analysis and literature review for a manuscript to examine the validity of the Framingham Risk Score across racial/ethnic groups.	
2018-	Nicolette Cassarino, ABL, Intern, Division of Women's Health, BWH Mentor – Conducting the analysis examining the association between social engagement and incarceration among a representative sample of men and women incarcerated in state correctional facilities.	
2019-	Lin Yuan, BS, Intern, Division of Women's Health, BWH Mentor- Conducting analysis to support ongoing work examining the association between social engagement and incarceration among a representative sample of men and women incarcerated in state correctional facilities. In addition, she is preparing a proposal to examine the prevalence of cancer among incarcerated populations.	

- 2020- Mimi Yen Li, 4th year medical student, Harvard Medical School
Mentor- Conducting data abstraction to track COVID-19 in US carceral facilities and questionnaire development of a community-based questionnaire to survey the conditions of confinement in US carceral facilities among adults incarcerated during the COVID-19 pandemic.
- 2020- Abdullah Hamad, MS student, Harvard T.H. Chan School of Public Health
Research Mentor – Conduction data analysis of prediction of atrial fibrillation among patients with cryptogenic strokes.

Formal Teaching of Peers/Harvard Medical School CME Courses

No presentations below were sponsored by outside entities.

- 2007 Lecturer, David Rockefeller Center for Latin American Studies, Harvard University
First Symposium on Health Research Methods of University Faculty Members and Researchers for Latin America & Spain
Practicing clinicians 2-hour lecture

Local Invited Presentations

No presentations below were sponsored by outside entities.

- 2010 Alcohol consumption and risk of stroke among women
Conference series for faculty and trainees
Brigham and Women’s Hospital, Division of Preventive Medicine
- 2010 Alcohol consumption and risk of stroke among women
Oral presentation and discussion
Channing Laboratory of Network Medicine, Boston, MA
- 2011 DHEAS and risk of stroke
Cardiovascular Epidemiology Seminar, Department of Nutrition
Harvard T.H. Chan School of Public Health
- 2011 Fetuin-A and risk of stroke among women
Division of Preventive Medicine conference series for faculty and trainees
Brigham and Women’s Hospital, Division of Preventive Medicine
- 2011 Cardiovascular risk factors associated with low dehydroepiandrosterone sulfate
Cardiovascular Epidemiology Seminar, Department of Nutrition
Harvard T.H. Chan School of Public Health
- 2014 High-sensitivity C-reactive Protein (hsCRP) and risk of stroke by hypertension status
Cardiovascular Epidemiology Seminar, Department of Nutrition
Harvard T.H. Chan School of Public Health
- 2015, 2016, 2017, 2018 Disparities in cardiovascular disease and cardiovascular disease research
Invited speaker, Cardiovascular Disease Epidemiology
Harvard T.H. Chan School of Public Health

2016 Disparities in Cardiovascular Disease
Invited speaker, Forum on Population Health Equity
Harvard T.H. Chan School of Public Health

2016 NIH Funding for Students of Color
Office of Diversity and Inclusion
Harvard T.H. Chan School of Public Health

2016, 2017, 2018, 2019 Dirty Little Secrets of Navigating Academia
Invited speaker, Summer Program in Epidemiology and Fostering Advancement & Careers
through Enrichment Training in Science (FACETS), Office of Diversity and Inclusion
Harvard T.H. Chan School of Public Health

2016, 2017, 2018, 2019, 2020 Imposter Syndrome
Office of Diversity and Inclusion
Harvard T.H. Chan School of Public Health

2019 Racial Inequities in Stroke Risk among Older Adults in the Southern Community Cohort
Study
Women in Medicine and Science Symposium
Brigham and Women's Hospital

2020 My Career in Epidemiology and Social Justice
Global Health Fridays and Fireside Chats
Harvard Global Health Institute
Harvard Medical School

2020 My Career in Epidemiology and Social Justice
Summer Jobs Program
Massachusetts General Hospital

2020 Overcoming Imposter Syndrome
Program in Graduate Education
Harvard Medical School

2020 Using Epidemiology to Address Community Needs
Policy and Advocacy Seminar
Division of Women's Health / Department of Medicine
Brigham and Women's Hospital

2020 Confronting Racism and Structural Inequities using Health Equity Research
Panelist
Health Equity Summit
Brigham and Women's Hospital

2020 Attempts to Achieve Health Equity: Successes, Failures, and Lessons Learned: The Impact
of COVID-19 on Incarcerated Populations
Department of Medicine, Research Seminar Series
Brigham and Women's Hospital

REPORT OF REGIONAL, NATIONAL and INTERNATIONAL TEACHING AND PRESENTATIONS

Invited Presentations and Courses

Regional

No presentations below were sponsored by outside entities.

- 2011, 2012 Epidemiology of Stroke
Invited speaker, Chronic Disease Epidemiology
Brown University, School of Public Health, Providence, RI
- 2019 Engaging patients and health care providers in communication regarding history of incarceration
Invited speaker, Health Justice Lab
Yale School of Medicine, New Haven, CT
- 2020 Using a citizen's science approach to understand conditions of confinement among incarcerated individuals the INdividuals Speak: Incarcerated During the COVID-19 Epidemic (INSIDE) study
Yale School of Medicine, New Haven, CT

National

No presentations below were sponsored by outside entities.

- 2005 Can racial disparities in oral disease be reduced?
Oral presentation and discussion
Centers for Disease Control and Prevention,
Division of Oral Health, Atlanta, GA
- 2006 Disparities in Oral Health: Racial/ethnic variations in tooth loss
Oral presentation and discussion
University of Puerto Rico, School of Dentistry
- 2014 Examining Racial Disparities in Stroke
Invited Speaker, Annual Meeting
Programs to Increase Diversity (PRIDE), Bethesda, MD
- 2014, 2015 The strength of non-traditional talents
Keynote Speaker, 2014 Midwestern Pre-Health Conference
Bowling Green State University, Bowling Green, OH
- 2015 Top 10 ideas for surviving academia (and maintaining sanity)
American Heart Association-Scientific Sessions Orlando, FL
- 2015 Examining Racial Disparities in Stroke
Invited Speaker, Center for Stroke Disparities Solutions
New York University School of Medicine
- 2017 Funding Hacks for Researchers
Invited Speaker, Elsevier Publishing Campus, Online
- 2019 Inequities in Stroke among Women of Color in the Women's Health Initiative
Invited Speaker, Women's Health Initiative Investigator's Meeting, Bethesda, MA

Abstract Oral Presentations

- 2010 Alcohol Consumption and risk of stroke in women
Oral abstract presentation
American Heart Association-Scientific Sessions, Chicago, IL
- 2010 Alcohol Consumption and risk of stroke in women
Oral abstract presentation
NHLBI Trainee Session, American Heart Association-Scientific Sessions, Chicago, IL
- 2011 DHEAS is associated with decreased risk of ischemic stroke
Moderated poster presentation
American Heart Association-Cardiovascular Disease Epidemiology and Prevention, Atlanta, GA
- 2011 Total adiponectin and risk of ischemic stroke among women
Moderated poster presentation
American Heart Association-Cardiovascular Disease Epidemiology and Prevention, Atlanta, GA
- 2012 Fetuin-A and risk of ischemic stroke among women
Moderated poster presentation
American Heart Association-Cardiovascular Disease Epidemiology and Prevention, San Diego, CA
- 2012 Fetuin-A and risk of ischemic stroke among women
Oral abstract presentation
NHLBI PRIDE Annual Meeting, Rockville, MD

International

No presentations below were sponsored by outside entities.

- 2010 Obesity, diabetes and risk of periodontitis and tooth loss
Invited lecture and discussion
University of Birmingham, School of Dental Medicine, Birmingham, United Kingdom

Abstract Oral Presentations

- 2005 Can Racial Disparities in Oral Disease be reduced?
Oral abstract presentation
International Association for Dental Research, Baltimore, MD
- 2006 Impact of socio-economic factors on residuals of tooth loss independent of dental disease
Oral abstract presentation
International Association for Dental Research, Orlando, FL
- 2007 Periodontitis and risk of cerebrovascular disease in men
Oral abstract presentation
International Association for Dental Research, New Orleans, LA
- 2008 Smoking history and incidence of tooth loss
Oral abstract presentation
International Association for Dental Research, Toronto, Canada

- 2009 Is there a prospective association between obesity and periodontal disease?
Oral abstract presentation
International Association for Dental Research, Miami, FL
- 2010 Diabetes and risk of periodontitis and tooth loss: 20-year study
Oral abstract presentation
International Association for Dental Research, Barcelona, Spain

REPORT OF EDUCATION OF PATIENTS AND SERVICE TO THE COMMUNITY

No activities or presentations below were sponsored by outside entities.

- 2005-2006 Harvard Medical School Martha Eliot After School Program, Mentor
Jamaica Plain, MA
Mentored junior high students through weekly meetings, encouraging healthy behaviors and pursuit of higher education and future careers in the biomedical sciences.
- 2005-2010 Society for the Advancement of Chicanos and Native Americans in Science, Member, mentor, Former Chapter President
Encouraged under-represented minorities and supported resiliency in academia, including establishing a culturally welcoming environment at Harvard T.H. Chan School of Public Health for Latino and Native American students.
- 2012 Academic Careers in Health Disparities: A PhD perspective
Latino Medical Student Association, Harvard Medical School
Presentation to undergraduate-level students interested in medical or graduate school.
- 2013 My life as an epidemiologist
Wellesley High School, Wellesley, MA
Presentation to high school-level students as part of their career exploration series.
- 2014, 2016 Finding your career path in the biomedical sciences
Bunker Hill Community College, Charlestown, MA
Presentation to undergraduate-level students interested in biomedical sciences careers.
- 2018- Partakers Organization, Board Member and Mentor
Auburndale, MA
Provide leadership and fundraising service to support mentorship of currently incarcerated adults in Massachusetts enrolled in higher education degree programs. Serve as a mentor to incarcerated and formerly incarcerated individuals who are current or former students of the Partakers program.
- 2019- All-Inclusive Support Services (previously After Incarceration Support Systems) –
Hampden County Sheriff's Department, Mentor
Springfield, MA
Serve as a mentor, through weekly meetings, to women who are currently in custody or formerly incarcerated. Lead group re-entry classes once a month at the Western Massachusetts Women's Correctional Center in Chicopee, MA.

2020 American Hear Association
Hispanic Heritage Month – Know your numbers campaign
National television and radio
Conducted media tour in English and Spanish to raise awareness of acute symptoms of myocardial infarction and stroke in women.

REPORT OF SCHOLARSHIP

Peer reviewed publications in print or other media

Research investigations

1. Dietrich T, **Jimenez M**, Krall Kaye EA, Vokonas PS, Garcia RI. Age-dependent associations between chronic periodontitis/edentulism and risk of coronary heart disease. *Circulation* 2008; 117(13):1668-74. PMID: PMC2582144.
2. Saeed S, **Jimenez M**, Howell H, Karimbux N, Sukotjo C. Which factors influence students' selection of advanced graduate programs? One institution's experience. *J Dent Educ.* 2008;72(6):688-97. PMID: 18519599.
3. Blissett R, Lee MC, **Jimenez M**, Sukotjo C. Differential factors that influence applicant selection of a prosthodontic residency program. *J Prosthodont.* 2009;18(3):283-8. PMID: 19141048.
4. **Jimenez M**, Dietrich T, Shih MC, Li Y, Joshipura KJ. Racial/ethnic variations in associations between socioeconomic factors and tooth loss. *Community Dent Oral Epidemiol.* 2009;37(3):267-75. PMID: PMC2758161.
5. Schrott AR, **Jimenez M**, Hwang JW, Fiorellini J, Weber HP. Five-year evaluation of the influence of keratinized mucosa on peri-implant soft-tissue health and stability around implants supporting full-arch mandibular fixed prostheses. *Clin Oral Implants Res.* 2009;20(10):1170-7. PMID: 19719741.
6. **Jimenez M**, Krall EA, Garcia RI, Vokonas PS, Dietrich T. Periodontitis and incidence of cerebrovascular disease in men. *Ann Neurol.* 2009;66(4):505-12. PMID: PMC2783821.
7. **Jimenez M**, Hu FB, Marino M, Li Y, Joshipura KJ. Prospective Associations between Measures of Adiposity and Periodontal Disease. *Obesity (Silver Spring).* 2012 Aug;20(8):1718-25. PMID: PMC3727227.
8. **Jimenez M**, Hu FB, Li Y, Joshipura KJ. Type 2 diabetes mellitus and 20 year incidence of periodontitis and tooth loss. *Diabetes Research and Clinical Practice.* 2012; 98(3):494-500. PMID: PMC3551264.
9. **Jimenez M**, Chiuve SE, Glynn RJ, Stampfer MJ, Camargo CA, Willett WC, Manson JE, Rexrode KM. Alcohol consumption and risk of stroke in women. *Stroke.* 2012;43(4):939-45. PMID: PMC3350838.
10. Sandhu R, **Jimenez M**, Chiuve SE, Kenfield SA, Tedrow UB, Albert CM. Smoking, Smoking Cessation and Risk of Sudden Cardiac Death in Women. *Circulation: Arrhythmia and Electrophysiology.* 2012;5:1091-97. PMID: PMC4025959.

11. **Jimenez M**, Sun Q, Schürks M, Chiuve SE, Hu FB, Manson JE, Rexrode KM. Low dehydroepiandrosterone sulphate is associated with increased risk of ischemic stroke among women. *Stroke*. 2013; 44: 1770-74. PMID: PMC3811081.
12. **Jimenez M**, Giovannucci E, Krall EK, Dietrich T. Predicted vitamin D status and incidence of tooth loss. *Public Health Nutr*. 2014 Apr;17(4):844-52. PMID: 23469936.
13. Muñoz Torres FJ, **Jiménez M**, Rivas-Tumanyan S, Joshipura KJ. Associations between measures of central adiposity and periodontitis among older adults. *Community Dent Oral Epidemiol*. 2014 Apr;42(2):170-7. PMID: PMC3949210.
14. Ley SH, Sun Q, **Jiménez M**, Rexrode KM, Manson JE, Jensen MK, Rimm EB, Hu FB. Alcohol consumption, plasma fetuin-A and risk of type 2 diabetes in women. *Diabetologia*. 2014 Jan;57(1):93-101. PMID: PMC3858443.
15. **Jiménez M**, Sun Q, Schürks M, Hu FB, Manson JE, Rexrode KM. Circulating fetuin-A and risk of ischemic stroke in women. *Clin Chem*. 2014 Jan;60(1):165-73. PMID: PMC3971644.
16. Sun Q, **Jiménez MC**, Townsend MK, Rimm EB, Manson JE, Albert CM, Rexrode KM. Plasma levels of fetuin-A and risk of coronary heart disease in US women: the Nurses' Health Study. *J Am Heart Assoc*. 2014 Jun;3(3):e000939. PMID: PMC4309097.
17. Sanders A, Campbell SM, Mauriello SM, Beck JD, **Jiménez M**, Kaste LM, Singer RH, Beaver SM, Finlayson TL, Badner VM. Heterogeneity in periodontitis prevalence in the Hispanic Community Health Study/Study of Latinos. *Ann Epidemiol*. 2014 Jun;24(6):455-62. PMID: PMC4050972.
18. **Jiménez MC**, Sanders AE, Mauriello SM, Kaste LM, Beck JD. Prevalence of periodontitis according to Hispanic or Latino background among study participants of the Hispanic Community Health Study/Study of Latinos. *J Am Dent Assoc*. 2014 Aug;145(8):805-16. PMID: 25082929.
19. Akarolo-Anthony SN, **Jiménez MC**, Chiuve SE, Spiegelman D, Willett WC, Rexrode KM. Plasma Magnesium and Risk of Ischemic Stroke Among Women. *Stroke*. 2014 Oct;45(10):2881-6. PMID: PMC4175301.
20. Sanders AE, Essick GK, Beck JD, Cai J, Beaver S, Finlayson TL, Zee PC, Loredó J, Ramos AR, Singer RH, **Jiménez MC**, Redline S. Periodontitis and sleep disordered breathing in the Hispanic Community Health Study/ Study of Latinos. *Sleep*. 2015 Aug 1;38(8):1195-203. PMID: PMC4507724.
21. **Jiménez MC**, Rexrode KM, Glynn R, Ridker P, Gaziano JM, Sesso HD. Association between high sensitivity C-reactive protein and total stroke by hypertensive status among men. *J Am Heart Assoc*. 2015 Sep 21; 4(9):e002073. PMID: PMC4599494.
22. Sesso HD, **Jiménez MC**, Wang L, Ridker P, Buring J, Gaziano JM. Plasma Inflammatory markers and the risk of developing hypertension. *J Am Heart Assoc*. 2015. Sep 21; 4(9):e001802. PMID: PMC4599490.
23. **Jiménez MC**, Curhan G, Choi H, Forman J. Plasma Uric Acid Concentrations and Risk of Ischemic Stroke. *Eur J Neurol*. 2016 Jul; 23(7):1158-1164. PMID: PMC4899277.

24. **Jiménez MC**, Rexrode KM, Kotler G, Everett BM, Glynn RJ, Lee IM, Buring JE, Ridker PM, Sesso HD. Association between markers of inflammation and total stroke by hypertensive status among women. *Am J Hypertens*. 2016 Sep; 29(9):1117-1124. Epub ahead of print 2016 May 28. PMID: 4978228.
25. **Jiménez MC**. Response to comment on plasma uric acid and risk of ischaemic stroke in women. *European journal of neurology*. 2017 January;24(1):e2. PMID: PMC5178970.
26. Rist PM, **Jiménez MC**, Tworoger SS, Hu FB, Manson JE, Sun Q, Rexrode KM. Plasma retinol-binding protein 4 levels and the risk of ischemic stroke among women. *J Stroke Cerebrovasc Dis*. 2017 88(23): 2176-2182. PMID: PMC5467954.
27. Rist PM, **Jiménez MC**, Rexrode KM. Prospective association between beta2-microglobulin levels and ischemic stroke risk among women. *Neurology*. 2017;88:2176-2182. PMID: PMC5467954.
28. Gall S, Phan H, Madsen TE, Reeves M, Rist P, **Jimenez M**, Lichtman J, Dong L, Lisabeth LD. Focused update of sex differences in patient reported outcome measures after stroke. *Stroke*. 2018;49:531-535. PMID: 294438078.
29. Madsen TE, Howard VJ, **Jiménez M**, Rexrode KM, Acelajado MC, Kleindorfer D, Chaturvedi S. Impact of conventional stroke risk factors on stroke in women: An update. *Stroke*. 2018;49:536-542. PMID: PMC5828997.
30. Bushnell CD, Chaturvedi S, Gage KR, Herson PS, Hurn PD, **Jiménez MC**, Kittner SJ, Madsen TE, McCullough LD, McDermott M, Reeves MJ, Rundek T, and the PROWESS Group. Sex Differences in Stroke: Challenges and Opportunities. *J Cereb Blood Flow Metab*. 2018 Dec; 38(12): 2179-2191. PMID: PMC6282222.
31. **Jiménez MC**, Wang L, Buring JE, Manson JE, Forman JP, Sesso HD. Association between sex hormones and ambulatory blood pressure. *J Hypertens*. 2018 Nov; 36(11):2237-2244. PMID: 29927841.
32. **Jiménez MC**, Tucker KL, Rodriguez F, Porneala BC, Meigs JB, López L. Cardiovascular risk factors and dehydroepiandrosterone sulfate among Latinos in the Boston Puerto Rican Health Study. *J Endo Society*. 2018 Dec; 3(1):291-303. PMID: 30623167.
33. **Jiménez MC**, Manson JE, Cook NR, Kawachi I, Wassertheil-Smoller S, Haring B, Nassir R, Rhee JJ, Seally-Jefferson S, Rexrode KM. Racial variation in stroke risk among women by stroke risk factors. *Stroke*. 2019; 50: 797-804. PMID: 30869565.
34. Hu J, Lin JH, **Jiménez MC**, Manson JE, Hankinson SE, Rexrode KM. Plasma Estradiol and Testosterone Levels and Ischemic Stroke in Postmenopausal Women. *Stroke*. 2020: STROKEAHA119028588 (*In press*).
35. Stanford FC, Cena H, Biino G, Umoren O, **Jiménez M**, Freeman MP, Shadyab AH, Wild RA, Womack CR, Banack HR, Manson JE. The association between weight promoting medication use and weight gain in postmenopausal women: findings from the Women's Health Initiative. *Menopause*. July 13, 2020 - Volume Publish Ahead of Print - Issue - doi: 10.1097/GME.0000000000001589

36. **Jiménez MC**, Cowger TL, Simon LE, Behn M, Cassarino N, Bassett MT. Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons. *JAMA Netw Open*. 2020;3(8):e2018851. doi:10.1001/jamanetworkopen.2020.18851
37. Cushman M, Shay CM, Howard VJ, **Jiménez MC**, Lewey J, McSweeney JC, Newby LK, Poudel R, Reynolds HR, Rexrode KM, Sims M, Mosca LJ; American Heart Association. Ten-Year Differences in Women's Awareness Related to Coronary Heart Disease: Results of the 2019 American Heart Association National Survey: A Special Report From the American Heart Association. *Circulation*. 2020 Sep 21:CIR0000000000000907. doi:10.1161/CIR.0000000000000907. Epub ahead of print. PMID: 32954796.

Non-peer reviewed scientific or medical publications/materials in print or other media

Reviews, chapters, monographs and editorials

1. **Jimenez M**, Dietrich T. Regression models in periodontal epidemiology: purpose, approach and interpretation. *Periodontol* 2000. 2012;58(1):121-33. PMID: 22133371.
2. Douglass CW, **Jimenez M**. Our Current Geriatric Population: Demographic and Oral Health Care Utilization. *Dent Clin North Am*. 2014 Oct;58(4):717-28.

Clinical Guidelines and Reports

1. Mozaffarian D, Benjamin EJ, Go AS, Arnett DK, Blaha MJ, Cushman M, Das SR, de Ferranti S, Despres JP, Fullerton HJ, Howard VJ, Huffman MD, Isasi CR, **Jiménez MC**, Judd SE, Kissela BM, Lichtman JH, Lisabeth LD, Liu S, Mackey RH, Magid DJ, McGuire DK, Mohler ER, 3rd, Moy CS, Muntner P, Mussolino ME, Nasir K, Neumar RW, Nichol G, Palaniappan L, Pandey DK, Reeves MJ, Rodriguez CJ, Rosamond W, Sorlie PD, Stein J, Towfighi A, Turan TN, Virani SS, Woo D, Yeh RW, Turner MB: Heart disease and stroke statistics-2016 update: A report from the American Heart Association. *Circulation*. 2016;133:e38-e360. PMID: 26811276.
2. Benjamin EJ, Blaha MJ, Chiuve SE, Cushman M, Das SR, Deo R, de Ferranti SD, Floyd J, Fornage M, Gillespie C, Isasi CR, **Jiménez MC**, Jordan LC, Judd SE, Lackland D, Lichtman JH, Lisabeth L, Liu S, Longenecker CT, Mackey RH, Matsushita K, Mozaffarian D, Mussolino ME, Nasir K, Neumar RW, Palaniappan L, Pandey DK, Thiagarajan RR, Reeves MJ, Ritchey M, Rodriguez CJ, Roth GA, Rosamond WD, Sasson C, Towfighi A, Tsao CW, Turner MB, Virani SS, Voeks JH, Willey JZ, Wilkins JT, Wu JH, Alger HM, Wong SS, Muntner P; American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart Disease and Stroke Statistics-2017 Update: A Report From the American Heart Association. *Circulation*. 2017 Mar 7;135(10):e146-e603. PMID: 28356607.
3. Benjamin EJ, Virani SS, Callaway CW, Chang AR, Cheng S, Chiuve SE, Cushman M, Delling FN, Deo R, de Ferranti SD, Ferguson JF, Fornage M, Gillespie C, Isasi CR, **Jiménez MC**, Jordan LC, Judd SE, Lackland D, Lichtman JH, Lisabeth L, Liu S, Longenecker CT, Lutsey PL, Matchar DB, Matsushita K, Mussolino ME, Nasir K, O'Flaherty M, Palaniappan LP, Pandey DK, Reeves MJ, Ritchey MD, Rodriguez CJ, Roth GA, Rosamond WD, Sampson UKA, Satou GM, Shah SH, Spartano NL, Tirschwell DL, Tsao CW, Voeks JH, Willey JZ, Wilkins JT, Wu JH, Alger HM, Wong SS, Muntner P. Heart disease and stroke statistics-2018 update: A report from the American Heart Association. *Circulation*. 2018;137(12):e67-e492. PMID: 29386200.

Thesis

Jimenez MC. Disparities in periodontitis and tooth loss: The roles of SES, obesity & diabetes [dissertation]. Boston, MA. Harvard Univer.: 2009.

Abstracts, Poster Presentations and Exhibits Presented at Professional Meetings

1. **Jiménez MC**, Tucker K, Rodriguez F, López L. Variable associations of dehydroepiandrosterone with cardiovascular risk factors in the Boston Puerto Rican Health Study. *Circulation*. 2014; 129: AP355.
2. **Jiménez MC**, Rexrode KM, Kotler G, Everett BM, Glynn RJ, Lee I, Buring JE, Ridker PM, Sesso HD. Association Between markers of inflammation and total stroke by hypertensive status among women. *Circulation*. 2016.133: AP018.
3. Adebamowo SN, Pai JK, **Jiménez MC**, Rexrode KM. Hemoglobin A1c (HbA1c) and the risk of ischemic stroke among women. *Circulation*. 2016.133: AP021.
4. Rist P, **Jiménez KM**, Rexrode KM. Prospective association between beta-2 microglobulin and the risk of ischemic stroke in women. *Circulation*. 2016.133: AP319.
5. **Jiménez MC**, Manson JE, Cook N, Kawachi I, Wassertheil-Smoller S, Haring B, Nassir R, Rhee J, Sealy-Jefferson S, Rexrode KM. Racial Variation in Stroke Risk by Stroke Risk Factors. NIH K-to-R01 Investigators Meeting. Bethesda, MD 2016
6. **Jiménez MC**, Wang L, Buring JE, Manson JE, Forman JP, Sesso HD. Association Between Sex Hormones and Ambulatory Blood Pressure. *Circulation*. 2016; 134: A20644.
7. **Jiménez MC**, Manson JE, Cook N, Kawachi I, Wassertheil-Smoller S, Haring B, Nassir R, Rhee JJ, Sealy-Jefferson S, Rexrode KM. Racial variation in stroke risk by stroke risk factors. American Heart Association Epidemiology and Prevention, Lifestyle and Cardiometabolic Health 2017 Scientific Sessions. Portland, OR. P084.
8. Wang L, Forman JP, Gold DR, Heike G, Rautiainen S, **Jiménez MC**, Buring JE, Manson JE, Sesso HD. Self-reported blood pressure is comparable to measured blood pressure in a study of general population participants. American Heart Association Epidemiology and Prevention, Lifestyle and Cardiometabolic Health 2017 Scientific Sessions. Portland, OR, P177.
9. **Jiménez MC**, Blot WJ, Manson JE, Cook N, Rexrode KM. Racial disparities in stroke risk among older adults in the Southern Community Cohort Study. International Stroke Conference 2019. Honolulu, Hawaii. WP247.
10. Cassarino NR, Rexrode KM, **Jiménez MC**. Associations between social engagement and cardiovascular disease conditions among adults incarcerated in state correctional facilities. New England Science Symposium 2019. Boston, MA.
11. **Jiménez MC**, López L, Rexrode KM. Greater Burden of Cardiovascular Disease Among Incarcerated Women of Color Compared to Whites. American Heart Association Epidemiology and Prevention, Lifestyle and Cardiometabolic Health 2019 Scientific Sessions. Houston, TX. P134.

12. Yen Li, M.*, Grebbin, S.*, Cassarino, N., Dabbara, H., Grandhi, U., Patil, A., White, S., **Jiménez, MC**. COVID-1 Inequities by Sex Between US Carceral Facilities and General Population: Lessons on Data Collection from Investigative Journalism. Discover Brigham 2020. Boston, MA.
13. Cassarino, N.*, Dabbara, H.*, Bennett, D., Bembury, A., Credle, L., Lee, J.V., Patil, A., White, S., Yen Li, M., **Jiménez, MC**. Examining Conditions of Confinement During the COVID-19 Pandemic: Individuals Speak – Incarcerated During the COVID Epidemic (INSIDE). Discover Brigham 2020. Boston, MA.

Jiménez Affidavit

Exhibit B



Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons

Monik C. Jiménez, ScD; Tori L. Cowger, MPH; Lisa E. Simon, DMD, MD; Maya Behn, BA; Nicole Cassarino, BA; Mary T. Bassett, MD, MPH

Introduction

Incarcerated populations have exceptionally high risk of coronavirus disease 2019 (COVID-19) transmission and mortality due to overcrowding, movement through facilities, and high rates of chronic illness; hence, physical distancing is not a viable mitigation strategy.¹ As of June 6, 2020, at least 42 107 cases and 510 deaths have occurred among individuals incarcerated in US prisons.² Decarceration and increased testing may reduce transmission, but their efficacy is uncertain.³ Jails confine nearly one-third of incarcerated individuals, but data on COVID-19 in jails are limited. However, Massachusetts reports data on COVID-19 in both county jails and state prisons. We describe the COVID-19 burden in these settings and its association with decarceration and testing rates.

Author affiliations and article information are listed at the end of this article.

Methods

Data used in this cohort study were reported by 16 Massachusetts Department of Corrections (MA DOC) facilities and 13 county-level systems from April 5 through July 8, 2020, pursuant to a court order.⁴ This study used publicly available, deidentified data and was deemed exempt from institutional review board approval by Partners HealthCare. We followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

We used baseline facility populations to calculate cumulative testing and laboratory-confirmed case rates per 1000 persons and changes in incarcerated population size (ie, decarceration). Case and testing rates among staff could not be calculated. We report rate ratios (RR) for individuals incarcerated in Massachusetts relative to the state and US general populations.^{5,6} Analyses were conducted in R, version 3.6.3 (R Foundation).

Results

At baseline, 14 987 individuals were incarcerated across Massachusetts facilities (MA DOC, 7735; county facilities, 7252). As of July 8, 2020, 1032 confirmed cases of COVID-19 were reported among incarcerated individuals ($n = 664$) and staff ($n = 368$). The rate of COVID-19 was 44.3 cases per 1000 persons—2.91 (95% CI, 2.69-3.14) times higher than the Massachusetts general population and 4.80 (95% CI, 4.45-5.18) times the US general population (**Table**). Reported incidence was lower in county facilities (35.71 cases per 1000 persons) than in MA DOC facilities (52.36 cases per 1000 persons); however, many county facilities had low testing rates (facilities in 5 counties tested <100 per 1000 persons).

Overall, systems with higher testing rates had higher case rates (**Figure, A**). For example, the testing rate across all county jails was 254 per 1000 persons, with a case rate of 36 cases per 1000 persons, whereas MA DOC facilities had a testing rate of 1093 per 1000 persons and a case rate of 52 cases per 1000 persons. The proportion of positive tests among incarcerated individuals in county facilities was higher (14%) than in MA DOC facilities (5%) and the general Massachusetts (9%) and US (8%) populations. Case incidence was higher among systems that released a lower proportion of their baseline population (**Figure, B**). The MA DOC case rate was 52 cases per 1000 persons with a

Open Access. This is an open access article distributed under the terms of the CC-BY License.

Table. Rates of Confirmed Cases of COVID-19 and Testing by Carceral System Compared With the General Population in Massachusetts and the United States^a

Characteristic	United States (n = 329 915 897)	Massachusetts State (n = 6 892 503)	All MA carceral facilities (n = 14 987)	MA DOC: state prison system (n = 7735)	County carceral facilities (n = 7252)
Staff					
Total cases	NA	NA	368	193	175
Proportion of staff among all cases, % ^b	NA	NA	36	32	40
Incarcerated individuals					
Total cases, No.	3 042 503	104 961	664	405	259
Total tested, No. ^c	37 395 666	1 157 023	10 298	8455	1843
Positive tests, %	8	9	6	5	14
Cumulative case rate per 1000 persons	9.22	15.23	44.31	52.36	35.71
Incarcerated population compared with state					
RD (95% CI)	NA	NA	29.08 (25.71-32.45)	37.13 (32.03-42.23)	20.49 (16.14-24.84)
RR (95% CI)	NA	NA	2.91 (2.69-3.14)	3.44 (3.11-3.79)	2.35 (2.07-2.65)
Incarcerated population compared with United States					
RD (95% CI)	NA	NA	35.08 (31.71-38.45)	43.14 (38.04-48.24)	26.49 (22.14-30.84)
RR (95% CI)	NA	NA	4.80 (4.45-5.18)	5.68 (5.14-6.26)	3.87 (3.42-4.37)

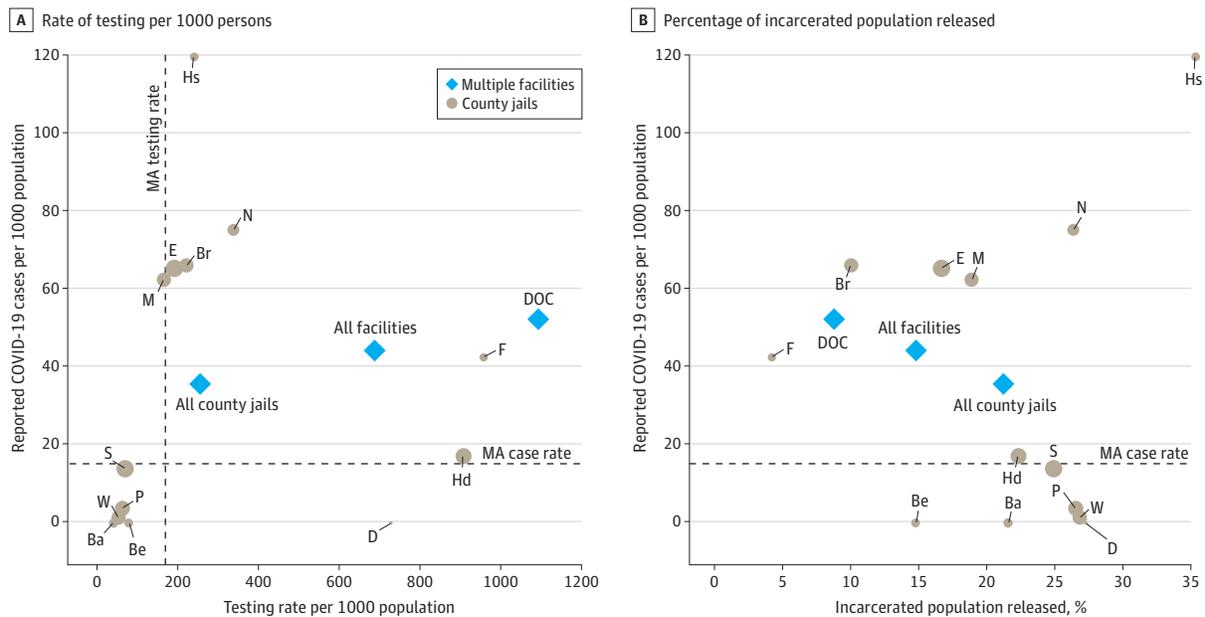
Abbreviations: DOC, Department of Corrections; MA, Massachusetts; NA, not applicable; RD, rate difference per 1000 persons; RR, rate ratio.

^a All total values are cumulative counts as of July 8, 2020; All rates reported per 1000 persons.

^b Cases among staff among all cases (including both staff and incarcerated individuals).

^c Excludes antibody tests.

Figure. Rates of COVID-19 Cases Compared With the Rates of Testing and the Percentage of the Incarcerated Population Released



Rate of (A) COVID-19 testing per 1000 persons and (B) percentage of incarcerated population released against confirmed cases per 1000 among incarcerated persons by county carceral facilities and the state prison system. Diamonds represent multiple facilities; circles, county jails. Ba indicates Barnstable County; Be, Berkshire County; Br,

Bristol County; D, Dukes County; DOC, Department of Corrections; E, Essex County; F, Franklin County; Hd, Hampden County; Hs, Hampshire County; M, Middlesex County; N, Norfolk County; P, Plymouth County; S, Suffolk County; and W, Worcester County.

population decrease of 9% compared with all county jails, which had a case rate of 36 case per 1000 persons and decreased their overall population by 21%. County jails released up to 35% of incarcerated individuals. A gradual decline in reported cases among incarcerated individuals and staff was observed, corresponding to a decrease of 15% in the incarcerated population.

Discussion

To our knowledge, this is the first examination of COVID-19 burden among incarcerated individuals and staff in both jails and prisons. The rate of COVID-19 among incarcerated individuals was nearly 3 times that of the Massachusetts general population and 5 times the US rate, consistent with recent reports in US federal and state prisons.² Systems with smaller reductions in incarcerated populations and higher testing rates demonstrated higher rates of confirmed cases. Limited testing likely underestimates the true infection rate in county jails.

These data are limited by absence of deaths and demographic characteristics. Owing to structural racism and the criminalization of poverty, COVID-19 racial/ethnic inequities may be exacerbated among incarcerated individuals. Whereas rates of COVID-19 vary nationwide, our results add to a growing body of literature emphasizing high COVID-19 rates in carceral settings and the importance of testing and decarceration.¹⁻³

Rates of COVID-19 in Massachusetts jails and prisons are alarmingly high and require urgent action. Reporting of COVID-19 data from carceral facilities is highly variable and generally excludes county jails; hence, standardization is needed. Access to testing without coercion, decarceration, and contact tracing are necessary to decrease harm from COVID-19 to incarcerated people and their communities.

ARTICLE INFORMATION

Accepted for Publication: July 18, 2020.

Published: August 21, 2020. doi:10.1001/jamanetworkopen.2020.18851

Correction: This article was corrected on August 28, 2020, to fix a sentence in the Discussion that incorrectly reported the percentage of positive COVID-19 tests in county jails. The incorrect statement was deleted.

Open Access: This is an open access article distributed under the terms of the [CC-BY License](#). © 2020 Jiménez MC et al. *JAMA Network Open*.

Corresponding Author: Monik C. Jiménez, ScD, SM, FAHA, Division of Women's Health, Brigham and Women's Hospital, Harvard Medical School, 1620 Tremont St, 3-034, Boston, MA 02120 (mjimenez11@partners.org).

Author Affiliations: Division of Women's Health, Brigham and Women's Hospital, Boston, Massachusetts (Jiménez, Behn, Cassarino); Department of Medicine, Harvard Medical School, Boston, Massachusetts (Jiménez, Simon); Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, Massachusetts (Jiménez, Cowger); François-Xavier Bagnoud Center for Health and Human Rights, Harvard T.H. Chan School of Public Health, Boston, Massachusetts (Cowger, Bassett); Department of Oral Health Policy and Epidemiology, Harvard School of Dental Medicine, Boston, Massachusetts (Simon).

Author Contributions: Dr Jiménez had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: Cowger, Simon, Cassarino.

Drafting of the manuscript: Jiménez, Cowger, Behn, Cassarino.

Critical revision of the manuscript for important intellectual content: Cowger, Simon, Behn, Cassarino, Bassett.

Statistical analysis: Jiménez, Cowger, Simon.

Obtained funding: Behn, Cassarino.

Administrative, technical, or material support: Bassett.

Conflict of Interest Disclosures: Dr Jiménez reported receiving grants from Brigham and Women's Hospital during the conduct of the study. No other disclosures were reported.

Funding/Support: Dr Jiménez is supported by grant K01HL124391 from the National Heart, Lung, and Blood Institute and the Brigham and Women's Hospital H. Richard Nesson Fellowship.

Role of the Funder/Sponsor: The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

REFERENCES

1. Wallace M, Marlow M, Simonson S, et al. Public health response to COVID-19 cases in correctional and detention facilities—Louisiana, March–April 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(19):594–598. doi:10.15585/mmwr.mm6919e3
2. Saloner B, Parish K, Ward JA, DiLaura G, Dolovich S. COVID-19 cases and deaths in federal and state prisons. *JAMA*. Published online July 8, 2020. doi:10.1001/jama.2020.12528
3. Lofgren E, Lum K, Horowitz A, Madubuonwu B, Fefferman N. The epidemiological implications of incarceration dynamics in jails for community, corrections officer, and incarcerated population risks from COVID-19. MedRxiv. Preprint posted online May 4, 2020. doi:10.1101/2020.04.08.20058842
4. ACLU Massachusetts. Tracking COVID-19 in Massachusetts prison & jails. Updated July 23, 2020. Accessed July 11, 2020. <https://data.aclum.org/sjc-12926-tracker/>
5. Mass.gov. COVID-19 updates and information. Updated July 22, 2020. Accessed July 11, 2020. <https://www.mass.gov/info-details/covid-19-updates-and-information#daily-updates->
6. The COVID Tracking Project. Accessed July 17, 2020. <https://covidtracking.com/>

EXHIBIT C

Declaration of Daniel Jaffe

I, Daniel Jaffe, do hereby state that the following information is true to the best of my knowledge and belief, under the pains and penalties of perjury:

1. I am a paralegal working with the Strategic Litigation Unit of the Committee for Public Counsel Services.
2. On October 20, 2020, I sent a public records request pursuant to G. L. c. 66, § 10 to each county's sheriff's office, with the exception of Nantucket. I requested, among other things, a list of every individual placed on home confinement since January 1, 2020, and all policies, procedures, and protocols regarding home confinement.
3. To date, every recipient except the Dukes County Sheriff's Office has responded to my October 20 public records request.
4. The attached exhibit is a true and accurate summary, as reported in the counties' responses to my public records requests, of the total number of people each facility had placed on home confinement since April 1, 2020, and the number of people each facility had on home confinement on November 5, 2020. Complete copies of the counties' responsive records can be produced upon request.
5. The attached exhibit also includes an estimate of the number of people incarcerated at each county facility who are eligible for home confinement. To create this estimate, I used a list of sentenced individuals who are eligible for early parole, which the Parole Board provides to the Committee for Public Counsel Services on a weekly basis. From this list, I subtracted (1) people who are more than eighteen months from their parole eligibility dates; (2) people who are serving sentences for the crimes listed in G. L. c. 127, § 49; and (3) people convicted of sex offenses. *See* G. L. c. 127, § 49 (listing criteria for home confinement). It is possible that this list is a bit under-inclusive because I took out everyone serving time on an offense with a mandatory minimum when people who have passed the mandatory minimum would still be eligible.

Sworn to this 18th day of December, 2020

/s/Daniel Jaffe
Daniel Jaffe
Paralegal
Strategic Litigation Unit
CPCS
100 Cambridge Street
Boston, MA 02114
djaffe@publiccounsel.net

County	Placements in home confinement since April 1, 2020ⁱ	Placements in home confinement on November 5, 2020ⁱ	Estimate of Incarcerated Individuals Eligible for Home Confinement on December 11, 2020ⁱⁱ
Barnstable	1	0	29
Berkshire	0	0	23
Bristol	No home-confinement program.		44
Dukes	No response to public records request.		2
Essex	2 ⁱⁱⁱ	0	63
Franklin	8	3	21
Hampden	10	3	36
Hampshire	8	1	9
Middlesex	26	9	47
Norfolk	0	0	28
Plymouth	No home-confinement program.		22
Suffolk	No home-confinement program.		67
Worcester	0	0	36

ⁱ These figures were reported by the counties in response to public records requests filed by the Committee for Public Counsel Services.

ⁱⁱ See Affidavit of Daniel Jaffe for a description of how this estimate was calculated.

ⁱⁱⁱ Both people released figures from the Middleton House of Correction in Essex County to home confinement were federal prisoners. Essex County reported transferring zero state prisoners to home confinement since April 1, 2020.

EXHIBIT D



October 15, 2020

Covid-19 Protocol

Covid-19 Protocol was developed in consultation with DPH epidemiologists and utilization of CDC guidelines and recommendations.

Covid-19 Testing

- 1) Process for testing all intakes from MCI-Framingham, MASAC, and Cedar Junction:
 - All intake patients will be quarantined and will be Covid-19 tested at **day 5** of their incarceration.
 - The incubation period is believed to be 2-5 days from exposure per CDC guidelines.
 - If the test result is negative and if the patient is asymptomatic, the patient will be released from quarantine.
 - If a patient tests positive, the Covid protocol would be initiated.
 - If the patient refuses testing, it is recommended that the patient remain in quarantine for the 14 days.
- 2) All patients that are symptomatic will be Covid-19 tested.
- 3) Testing of collateral contacts (roommates or other patients that came into contact with a positive patient) will be completed when applicable.
- 4) Screening (temperature check and symptom screening) of collateral contacts who are symptomatic will be completed twice daily. If a contact became symptomatic they would be isolated and tested "Covid Immediate Action Steps" protocol initiated.
- 5) Patients that will be releasing to congregate housing will be tested up to 72 hours prior to release.
- 6) Patients that are going to the hospital for a procedure will be screened and tested prior to the appointment as required by outside facility policy.
- 7) Mobile testing of targeted populations will be completed at the request of the Commissioner.

****All Covid tests must be done in consultation with Infectious Disease Manager****

Immediate Action if patient is Covid-19 Positive or Symptomatic

1. Place face mask on patient- if the patient has a roommate, they should also be housed in. If in dorm setting, the surrounding inmates will have limited movement.
2. Place in separate, closed room, with the door shut.
 - a. Healthcare worker and correctional officer should wear proper PPE while in the room.
3. Staff to contact site leadership. Site leadership will then contact the site ID Manager. The ID Manager will then contact the Department of Public Health for recommendations.

Recommendations for Patient Placement in COVID-19

In determining placement of patients in a COVID-19 environment, it is important to evaluate and weigh the following considerations:

1. Where possible, it is advisable to isolate patients who test positive from those patients who test negative, or remain asymptomatic and have not been offered COVID-19 testing.
2. If space does not permit separation of all COVID-19 positive and negative patients, patients should be prioritized and separated when:
 - a. Patients who test negative have significant risk factors that place them at high risk for contracting the COVID-19 virus (i.e. age, underlying health issues, etc.)
 - b. Patients who test positive and are symptomatic and present with priority symptoms such as cough, sneezing, temperature that place them and others at higher risk.
3. Patients who refuse to test for Covid-19 due to symptoms will be quarantined for 14 days. Patients who refuse test who are identified close contact of a positive patient will quarantine for 14 days. Patients who refuse to test for intake testing shall be quarantined for 14 days. Every effort should be made to separate this population from those who have already tested and tested negative.

Preferred cohorting of patients is as follows:

- If a person's test result is positive for COVID-19, they should be housed alone, or housed with another person who tested positive for COVID-19.
- If two roommates have different results, then the COVID-19 positive patient is to be moved, and housed with another patient who is COVID-19 positive.
- When movement of patients is not possible, every effort should be made to identify and isolate those patients with COVID-19 positive results who are coughing, have fever, or have symptoms of malaise, headache or fatigue.
- Furthermore, patients who test COVID-19 negative, who are over the age of 60, and/or have underlying health conditions (asthma, immunocompromised, cancer, obesity, etc.) are not to be housed in the same room as a person who has tested COVID-19 positive.

Clearance Protocol

1. Duration of isolation and precautions
 - For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days *after symptom onset* and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.
 - A limited number of persons with severe illness (hospitalized) may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; consider consultation with infection control experts.

- For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days *after the date of their first positive RT-PCR test for SARS-CoV-2 RNA*.
2. Role of PCR testing to discontinue isolation or precautions
 - For persons who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts.
 - For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined in Part 1, above.
 3. Role of PCR testing after discontinuation of isolation or precautions
 - For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection.
 - For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Isolation may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.
 - For persons who never developed symptoms, the date of first positive RT-PCR test for SARS-CoV-2 RNA should be used in place of the date of symptom onset.
 4. Role of serologic testing
 - Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection.

Mobile Testing Schedule

Sites	Dates	Plan	Inmate Census	Staff FTE's
MCI Concord 965 Elm Street Concord, MA 01742	5/17 -5/18	Test patients only 5/17, 5/18 rest of pts and staff testing	587	331
Northeastern Correctional Center Barretts Mill Road West Concord, MA 01742	5/18	Pts testing with staff testing at Concord	152	70
Boston Pre Release Center 430 Canterbury Street Roslindale, MA 02131 Massachusetts Alcohol and Substance Abuse Center 1 Bumps Pond Road Plymouth, MA	5/19	Staff and Patient testing for both sites spilt into two crews 2 Brewster Testers at each site 30 patients at MASAC and approx. 30 staff interested in testing thus far	72	58
Souza Baranowski Correctional Center Harvard Road Shirley, MA 01464	5/20-5/21	5/20 Patient testing only. 5/21 Rest of patient testing with staff testing.	690	525
MCI Shirley Minimum Harvard Road Shirley, MA 01464	5/21	5/21 patient testing, staff welcome to testing at SBCC. Date maybe moved to 5/22 depending cooperation with PTs at SBCC.	253	80
MCI Cedar Junction Route 1A South Walpole, MA 02071	5/27- 5/28	Patients only on 5/27 and staff testing 5/28 neighboring sites welcomed	537	422
Pondville Correctional Center One Industries Drive Norfolk, MA 02056	5/28	Patients and staff testing at CJ.	121	51
MCI Norfolk 2 Clark Street Norfolk, MA 02056	5/29-5/31	Patients only on 5/29 and 5/30. Finish patients on 5/31 with staff testing. Staff welcome to at testing on 5/28 at CJ.	1254	405

• **Inmate/Patient Testing Schedule:**

The patient testing schedule will consist of three (3) phases.

- Phase 1 will be continuation of testing for the month of June.
- Phase 2 will be testing from July 1, 2020 through August 30, 2020.
- Phase 3 will be testing from September 1, 2020 and onward for spot testing of facilities if there is a marked increase in symptomatic patients and/or confirmed positive tests.

Phase	Sites	Units	Date of Testing
1	MTC	1 CIVILC2 (62), 1 STATE N2 (67)	June 22, 2020
1	OCC MED/MIN	WORKERS	June 22, 2020
1	BSH	B 1	June 22, 2020
1	MASAC	INTAKE C Dorm in for 5 – 7 days	June 29, 2020
2	CJ/PCC	OU, WORKERS	July 13, 2020
2	NORFOLK	CSU (7) RHU (28) RHU 3 rd (17)	July 13, 2020
2	SBCC	Infirmary	July 20, 2020
2	SHIRLEY MED/MIN	OU, WORKERS	July 20, 2020
2	MCI-F/SMCC	OU, WORKERS	August 3, 2020
2	CONCORD/NECC	L Dorm, WORKERS	August 10, 2020
2	BPR	WORKERS	August 17, 2020
2	NCCI	T1 Unit	August 24, 2020
3	TBD	Ongoing spot testing	September 1, 2020 onward

MOBILE COVID TESTING UNIT PROPOSAL

Submitted by Wellpath

PROPOSAL OVERVIEW

This proposal is for the continuation (Phase 3) of the Mobile Covid-19 Testing Unit to identify individuals who are positive before they become symptomatic, perform testing on high-risk populations across the system and continue testing of identified patient population(s).

PHASE 2 OF MOBILE TESTING RECAP

Phase 2 of Mobile Testing began on June 22, 2020 and finished on August 24, 2020 with each site having identified patient populations that were tested. There were a total of 1028 patients tested and only two patients tested positive, both being previously known positive. The percent positive rate for the second phase of testing is 0.0019%.

Site	Total Tested	Positives
MTC	38	1
OCC Med/Min	122	0
BSH	12	1
MASAC	31	0
Norfolk 6/29	211	0
CJ/PCC	82	0
BPR	34	0
Fram/SMCC	40	0
Concord/NECC	181	0
SBCC	6	0
Shirley Med/Min	68	0
NCCI	203	0
Total Tested	1028	2

PHASE 3 OF MOBILE TESTING (SEPTEMBER SCHEDULE)

Phase 3 of mobile testing, per the previous proposal submitted in early June, will be for spot testing facilities if there is a marked increase in symptomatic patients and/or confirmed positive cases. To date, there has not been a marked increase of symptomatic patients or confirmed positive cases across the system.

- *****Spot testing will NOT be mandatory for patients at the facilities but would be on a voluntary basis. Since testing is on a voluntary basis, the patients opting out of testing will not be required to sign a Refusal of Treatment form. The Covid Mobile Testing Consent form will be completed for each patient who is either consenting or refusing testing.**

It is recommended that the intake facilities not be included in the Phase 3 Mobile Testing, as there is currently the Intake Covid - 19 Testing Protocol implemented at Framingham, Cedar Junction and MASAC. It is also recommended that any patient that has previously tested positive will not be tested.

Phase	Sites	Units	Date of Testing	Address
3	OCCC MIN	Workers	Sept 3, 2020	1 Administration Rd Bridgewater, MA 02324
3	Pondville	Workers	Sept 10, 2020	2405 Main Street S. Walpole, MA 02071
3	BPR	Workers	Sept 17, 2020	430 Canterbury St. Roslindale, MA 0213143
3	SMCC	Workers	Sept 22, 2020	135 Western Ave Framingham, MA 01701135
3	NECC	Workers	Sept 25, 2020	965 Elm St. Concord, MA 01742965
3	* SHIRLEY * Minimum	Workers	Sept 25, 2020	Harvard Road Shirley, MA 01464
U n i t s				

to be tested and testing schedule may be subject to change based on clinical indications and factors such as an outbreak of cases at any of the facilities.

Staff Testing Location	Dates of Testing	Time of Testing
Old Colony Correctional Center Medium	Sept 15, 2020	7A-3P
Souza-Baranowski Correctional Center	Sept 22, 2020	7A-3P

MOBILE COVID TESTING UNIT PROPOSAL

Submitted by Wellpath

PROPOSAL OVERVIEW

This proposal is for the continuation (Phase 4) of the Mobile Covid-19 Testing Unit to identify individuals who are positive before they become symptomatic, perform testing on high-risk populations across the system and continue testing of identified inmate population(s).

PHASE 3 OF MOBILE TESTING RECAP

Phase 3 of Mobile Testing was for the month of September with each site having identified inmate populations that were tested. There were a total of 251 Inmates tested and zero inmates tested positive. The percent positive rate for the third phase of testing is 0%.

Site	Total Tested	Positives
OCC Med/Min	33	0
PCC	46	0
BPR	21	0
SMCC	21	0
NECC	96	0
SBCC	6	0
Shirley Min	28	0
Total Tested	251	0

PHASE 4 OF MOBILE TESTING (OCTOBER SCHEDULE)

Phase 4 of mobile testing will be for spot testing inmates who have been identified by Commissioner's office.

Spot Testing will be highly encouraged, but will not be mandatory for inmates at facilities.

It is also recommended that any inmate that has previously tested positive will not be tested.

Phase	Sites	Units	Date of Testing	Location
4	OCCC Med	Targeted Inmates	October 13, 2020	On the unit / in cell

4	MTC	Targeted Inmates	October 13, 2020	Inmate Gym
4	SMCC	Targeted Inmates	October 16, 2020	Framingham Clinic
4	Framingham	Targeted Inmates	October 16, 2020	Clinic
4	SHIRLEY	Targeted Inmates	October 20, 2020	VR for check- and search room for test
4	SBCC	Targeted Inmates	October 20, 2020	HSU outpatient area
4	Cedar Junction	Targeted Inmates	October 21, 2020	General Pop - first cell in each housing unit DDU inmates - showers on each perspective tier
4	Norfolk	Targeted Inmates	October 21, 2020	CSD Building
4	Concord	Targeted Inmates	October 27, 2020	J Visiting Area
4	NCCI	Targeted Inmates	October 27, 2020	D building 1st floor rear holding cell

ted and testing schedule may be subject to change based on clinical indications and factors such as an outbreak of cases at any of the facilities.

If you have questions on this proposal, feel free to contact Julia Kershisnik-Sweedler at jkershisniksweedler@wellpath.us or Claudia Gonzalez at CJGonzalez@Wellpath.us .

EXHIBIT E

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF JACQUELINE DUTTON

I, Jacqueline M. Bush Dutton, state the following to be true to the best of my knowledge, information and belief:

1. I am the Attorney in Charge of the Worcester County Public Defender Division office at Committee for Public Counsel Services.
2. The Worcester House of Corrections is the primary place of incarceration for our male clients.
3. Attorneys are able to visit clients at the jail via telephone, video, non-contact and contact options. Each form of communication has significant limitations that interfere with attorneys' abilities to represent their clients. Also, the rules

about each form of communication are constantly shifting and applied inconsistently.

4. Unit Telephones: As was the policy prior to the pandemic, inmates are able to call their attorneys on Securus “tier phones” at their designated “tier times.” Due to Covid-19, inmates have had less tier time than they had prior to the pandemic. Depending on levels of lockdown, inmates may have only 20-minute periods out to use the phones to call their attorneys. Some blocks may have two 20-minute periods per day; others may have one. In those blocks of time, they must address competing interests of showering, calling their attorney or calling their family.
5. Furthermore, the Securus phones are on walls in the main area. The jail has told us that they have blocked more space between the phones and provided tables for clients to have access to their legal paperwork, but the phones are not confidential as they are in the open tier and there are no barriers separating the phone from others in the tier, including correctional officers. The jail has indicated that they endeavor to have correctional officers and others leave more space for those using the phone for privacy. This is happening in some cases, but it is not happening consistently.
6. Scheduled Telephone Calls: Throughout the last 8 months, attorneys have been able to set up a phone call with a client through the inmate support

counselors, either by asking the inmate support counselor to give a message to the client to call us, or by requesting a specific time for a call in the counselor's office. Many of the inmate support counselors are responsive and helpful and provide messages. However, it is inconsistent whether or not our clients (1) get the messages to call, (2) get the complete information about where and who to call, or (3) are able to actually call us. Furthermore, the counselor's office phones are not private and confidential. These phones allow the possibility for a client to be alone. Sometimes, however, the social worker remains in the office with the client so it is not confidential. These calls are also on recorded lines.

7. Tablets: Many clients are now given tablets to use in their cells. The introduction of the tablets has improved somewhat the ability to get calls from clients, but we are still unable to have consistent messages for clients to call at specific times; the ability to directly send messages to clients asking them to call at a certain time without going through the counselors would be helpful. Some of the clients have individual cells and thus the calls are confidential; others have cellmates and these tablet calls are not confidential.
8. Sometimes the phone app is removed from the tablets, which means they can only be used for games, music, and movies. In the last week or so, tablets

were taken away from inmates in the Mods section of the jail for updating.

Some of the tablets were returned to inmates without the phone app.

9. Video visits: In the last few months, the jail instituted attorney video visits.

Only attorneys may set this up and Social Services Advocates or Investigators

may only use this option with an attorney and cannot have a confidential

independent meeting on video with clients. Social Service Advocates or

Investigators must either work directly with the attorney to have a joint

meeting or go in person to visit at the jail. In the past, non-attorney staff at our

office was able to visit and receive confidential calls from clients as a member

of our team.

10. Attorneys may set up Zoom attorney visits 3 days a week. The attorney must

email the Superintendent's office with possible times; once confirmed, the

attorney must provide the Zoom log in information to the jail.

11. Attorneys cannot schedule a video call for the same day they request one

because the slots get booked. It usually takes about a week to get an attorney

video visit. Therefore, for cases that involve § 58A hearings or in which we

need to convey information quickly, such as a probation violation hearing, or

plea that requires substantial consultation with a client, it is extremely difficult

if not impossible to have an attorney video conference. In these instances,

attorneys are put in the position of either having to physically go to the jail or

continuing hearings in order to have time to talk to clients. Having daily video access would vastly improve the capacity issues.

12. While some video conferences are clearly confidential, there have been numerous instances in which attorneys question confidentiality due to noise of hearing correctional officers or other individuals talking in close proximity to the video room. Some attorneys have experienced others in the room and have had to ask them to leave. Others have experienced clients reporting that no one was in the room, but the level of noise and talking by staff and correctional officers is so loud that the inference is that they are close and can hear. Moreover, this noise has made it difficult in these instances to hear clients and conduct an appropriate client meeting.
13. Webex Video Calls: The jail allowed for video interpreter and expert evaluations earlier in the summer one day a week through a Webex system. Attorneys indicated that they generally could access this within an acceptable period of time, but due to it being only weekly, if an emergency need came up, they would be unable to access the video call with an interpreter or evaluator. This problem has been somewhat mitigated with the additional Zoom attorney meetings.
14. Communication with Clients in Quarantine: In addition to the fact that many of these forms of communication take several days or more to schedule,

attorneys are further thwarted from communicating with clients about court hearings that are likely to be scheduled at the beginning of a new case, such as § 58A hearings, because people facing § 58A hearings are likely to be new to the jail, every new inmate is quarantined upon entry, and counselors have informed attorneys that phone or video contact will not be facilitated for inmates who are in quarantine.

15. We have had instances over the last 8 months when we are unable to get phone calls from clients prior to quick court dates and § 58A hearings or in the first week that they are incarcerated. We have at times had to work up the chain to include the superintendent or legal counsel to try to get even telephone access to clients in emergencies for court dates. Sometimes, a cell phone or other phone contact has eventually been secured after substantial efforts by an attorney. Other times, attorneys are forced to decide between going to the jail in order to maintain a scheduled court date or moving a court date in order to have adequate time to communicate with a client.
16. In one instance in particular within the last two weeks, an attorney attempted to set up both video and phone visits with a new client. The attorney was told that a video call could not be set up due to him being in quarantine. Then the attorney was told conflicting information as to whether or not a phone call could occur. Ultimately, after failing to be able to set up a phone call and do

anything other than leave a message for a client to call during tier time, the Attorney had to contact the Superintendent's office in order to secure a phone call. In the end, it took much of a week for the attorney to make contact with a new client, which delayed the attorney's ability to seek bail review and file other motions on the client's behalf.

17. In-Person Meetings: The viability of in-person visitation at the jail depend on which building a client is housed in. The Worcester House of Corrections has three buildings where clients are housed and where attorneys visit - the Main Jail, the Mods and the Annex.
18. In the Main Jail, the non-contact option is the same space that is shared by family members who are visiting. Currently the jail has visiting times by specific tiers that run almost the entire day for family members in these non-contact areas. As a result, unless an attorney visits often before 8:30 a.m. or after 8:00 or 9:00 p.m., there is no guarantee of confidentiality because there could be others visiting. Family members visiting would be able to hear the conversations. No correctional officers are in this visiting area. There is sufficient space between the phones for non-contact visits, as long as no one is seated in the phone directly next to the attorney; however, the phones are recorded. We have been able to have the recordings off when no other visitors are there.

19. The contact option in the Main Jail does not allow for social distancing.

There are 3 possible rooms, none of which allow for a 6 foot distancing. In order to maintain client confidentiality, the door must remain closed. There are significant attorney concerns related to lack of ventilation with the small room, closed door and close quarters. This has impacted attorney willingness to visit clients who are at the Main Jail.

20. In the Mods, the non-contact visiting option is the same as it is in the Main Jail - lacking confidentiality if the public or other attorneys are visiting clients at the same time.

21. The contact visiting option in the Mods consists of three rooms - the rooms allow for close to 6 foot distancing, but not if attorneys and their clients are using tables.

22. In the Annex, attorneys are able to have a confidential non-contact visit with no problems. In the Annex, attorneys are also able to have a socially distanced and safe contact visit with no problems. The space is such that there is privacy and space with either option.

23. In no part of the jail are there portable plexiglass options for contact visiting rooms.

24. Testing: Worcester House of Corrections does not do regular testing of all inmates and does not do asymptomatic testing; the only testing that we are

aware of is that of individuals exhibiting symptoms and only in limited circumstances. Clients have informed us that they have cold-like symptoms or have asked for testing but have been denied.

25. New inmates are placed in 14-day quarantine in a separate block upon entry or re-entry into the facility and are also placed in quarantine if there is a suspected Covid-19 exposure. They are not tested before they are quarantined. While in quarantine, they are likely to experience difficulties communicating with counsel or accessing the court, as detailed herein.
26. There have been several Covid-19 related lockdowns over the course of the last 8 months during which video visits, in person visits, and video court are unavailable. When a unit is locked down for possible Covid-19 concerns, no inmate, regardless of test results, is transported anywhere in the facility. Therefore, the inmates in that unit cannot attend video court, in-person visits or attorney video visits.
27. Currently, attorneys are neither screened with Covid-specific screening questions nor experiencing temperature checks prior to entry into the facility.
28. There are significant numbers of attorneys who try to avoid at all costs going to visit clients at the jail due to concerns about Covid-19 – both concerns about their own exposure at the jail and the risk that they will inadvertently bring anything into the jail. The lack of screening of attorneys raises concerns.

The reports we hear of little to no testing raises serious concerns, particularly as attorneys become aware of lockdowns for potential Covid-19 reasons when attorneys have been visiting themselves and are unclear as to their potential for exposure and risk. While at the initial outset of the pandemic it was very clear that substantial cleaning was occurring, it is not clear that cleaning is happening between visits and the clear indicators of intense cleaning are not as prevalent (smell of cleaner, regularly seeing people cleaning). Attorneys consistently report hearing concerns of clients who are fearful of in person visits in part because of their experiences that the jail does not regularly test and concerns that they will not receive appropriate treatment if they do become sick.

29. Our office also has clients who are inmates who are at other facilities - predominately Chicopee (for women), Essex and Billerica.
30. For Chicopee, the quarantine is extremely strict. The jail provides attorneys with a new mask upon visits and will not allow people to bring in their own masks. All in person visits are currently non-contact. There is a guard directly next to the attorney which impacts confidentiality; however, the Attorney in Charge was recently informed that the jail was acquiring plexiglass and a white noise machine to create a more confidential barrier. The video visits occur in the previous attorney contact room and are confidential and

easy to set up. It is challenging to get phone calls when a client is in quarantine.

31. For Essex, many attorneys have been extremely concerned about visiting clients due to the massive Covid outbreaks as well as the failure to have any video options for visiting. Recently video options were allowed but no one has yet used these options.
32. For Billerica, attorneys report having no contact visits but feeling that the contact was confidential and safe.

Signed under the pains and penalties of perjury, this 7th day of December, 2020.

/s/ Jacqueline Dutton
Jacqueline Dutton

EXHIBIT F

AFFIDAVIT

I, Tommy D. Fears, do hereby depose and state that the following is true to the best of my knowledge, information, and belief:

- 1) I am the Attorney in Charge (AIC) of the Plymouth County Trial Office of the Committee for Public Counsel Services (“CPCS”) located at 144 Main Street, 3rd Floor, Brockton, MA 02301.
- 2) I have been AIC of this office since September 2018, managing a team of fourteen attorneys, two social services advocates (SSAs), two investigators, and three administrative assistants. Prior to becoming AIC, I was a supervising attorney in this same office for seven years after serving here for four years as a staff attorney. The only job I have ever had as a lawyer has been as a public defender for the last thirteen years in Plymouth County.
- 3) Our staff represent indigent criminal defendants in Plymouth County’s four District Courts (located in Brockton, Hingham, Plymouth, and Wareham) as well as in the Brockton and Plymouth Sessions of the Superior Court. Our clients face a wide range of charges, from misdemeanor crimes against property and low-level drug offenses to serious felony sex offenses and first degree murder. In 2019, our staff handled over 2,500 such cases.
- 4) At any given time a substantial number of our clients are held in custody without bail pending final probation surrender hearings or while awaiting trial following “dangerousness” hearings pursuant to G.L. ch. 276, sec. 58A. Many others are detained pretrial on high cash bails they are unable to post. The majority of our custody client population is held at the the Plymouth County Correctional Facility (PCCF), the main county jail operated by the Plymouth County Sheriff’s Department. PCCF is located at 26 Long Pond Road in Plymouth, a drive of approximately forty five minutes from our office in downtown Brockton.
- 5) CPCS performance guidelines require attorneys to establish and maintain effective relationships with their clients who are in custody through regular in-person visits. Attorneys are expected to visit clients who they have not previously represented within 72 hours of being assigned to their case. Attorneys are also expected to visit those clients at least once between every court date and more frequently when preparing the clients for upcoming evidentiary hearings or trials. Attorneys are expected to use in-person visits with custody clients, rather than letters or phone calls, as the primary means of communicating with them about the most important issues in a case. Similarly, SSAs, who work closely with attorneys as part of the defense team, rely on in-person visits with custody clients to do their jobs effectively. SSAs use in-person visits to assess what treatment programs, housing options, and public benefits, among other services, best meet the client’s needs and might help result in the best possible legal outcome for their case.
- 6) In my experience, all attorneys and SSAs in our office, prior to March 16, 2020, met or exceeded those performance guidelines. On that date, as the rate of COVID-19

infections began to rise across the state, CPCS began requiring employees to perform their work remotely if possible and to avoid going to physical office locations entirely. In our office, almost all staff immediately shifted to working remotely. Telephone calls to the office—including collect calls from our clients at PCCF—were forwarded indefinitely to staff members’ personal cell phones so clients could continue to reach us. Around mid-March of this year, most attorneys and SSAs in our office also began to limit their in-person visits to PCCF because of concerns—expressed to me in individual and group meetings I conducted—about whether such visits risked exposing them or their clients to infection. These staff members’ concerns were based in large part on a lack of information from PCCF about how widespread COVID-19 infections were at the facility and what measures were being taken to prevent its spread. I advised attorneys and SSAs to avoid in-person visits unless absolutely necessary and to take appropriate precautions to protect themselves and their clients if they decided an in-person visit was required.

- 7) Following the April 3, 2020, Supreme Judicial Court decision in CPCS v. Chief Justice of the Trial Court, 484 Mass. 431 (2020), I contacted PCCF staff and proposed ways that the jail could help limit unnecessary and potentially risky in-person visits by providing means for client communications with attorneys and SSAs that were more efficient and effective than collect calls. I suggested allowing our staff to be able to call the jail and reach clients on phones in their housing units instead of only permitting clients to place collect calls from the jail. I also suggested allowing clients to meet with legal staff via videoconferencing tools like Zoom. PCCF staff rejected the videoconferencing option, explaining that all of the facility’s Zoom and similar resources were tied up with court hearings resulting from the CPCS vs. Chief decision. Allowing for incoming calls to clients was also rejected but PCCF staff did agree to help facilitate attorney-client phone calls by relaying messages left by attorneys requesting that their clients call them.
- 8) Over the last seven months since the CPCS vs. Chief decision, most of the attorneys and SSAs I supervise have expressed serious concerns about visiting clients at PCCF. The primary reason is that they are not confident the jail is accurately portraying how widespread COVID-19 is among its staff and inmate population by enforcing unfairly strict criteria for administering tests for COVID-19 infection. Consequently, the jail’s number of positive cases is low simply because not enough people who might be sick are being tested. As a result, some attorneys and SSAs have delayed or altogether avoided visiting clients at the jail because they are unwilling to put themselves and their families at risk. Those who have continued to conduct in-person visits nonetheless report that fear of infection has caused their meetings to often be shorter in duration and to occur less frequently than before the pandemic began. Until mid-September of this year, when PCCF began making clients available for meetings with Zoom, phone calls had to substitute for face-to-face contact with clients. Many of the attorneys and the SSAs have told me that they have been answering client calls outside of regular business hours and on weekends and holidays, offering clients the ability to reach them almost at any time in exchange for never or rarely seeing them in person.

- 9) Most of the attorneys and SSAs have described still feeling as if they are effectively representing their clients even when they are visiting their custody clients much less frequently now or not at all. Nonetheless, staff acknowledge that fewer or no in-person visits makes it much harder to establish rapport and trust with new clients. Likewise, using phone calls instead of face-to-face meetings limits their ability to adequately prepare for 58A and other evidentiary hearings.
- 10) On or about September 17, 2020, PCCF began allowing inmates to meet with attorneys and legal staff via Zoom. Our office staff have identified some advantages to conducting client meetings this way. First, the process for scheduling such meetings is straightforward (sending an email with the name of the client and the day/time requested to a designated staff person). Second, the Zoom platform the jail currently uses allows meeting participants to feel more like they are in the same room than a phone call does. Third, there is a cost and time savings associated with not having to drive to the jail. However, in the opinion of our office staff who have described their client Zoom meetings to me, there are significant problems with how PCCF employs Zoom. At least initially, there was a serious capacity issue given that only two rooms at the jail were set up to accommodate clients' confidential discussions with their attorneys. Also, the jail will schedule the meetings for no later than 4 p.m., when attorneys and SSAs often need to speak to clients outside of those hours because in order to meet court or program deadlines. The meetings can last at most for fifty minutes (the latter limit being imposed on the jail by the terms of its Zoom license) when attorneys and SSAs often have more than 50 minutes worth of information and materials to review with their clients. And although most attorneys report that Zoom meetings are a reasonably effective way of maintaining a good relationship with clients who they have visited in-person before, the meetings are much less effective for establishing relationships with brand new clients. Furthermore, the jail does not permit SSAs to meet with clients via Zoom without the attorney also participating in the meeting, which creates a hurdle, though not an insurmountable one, to SSAs performing their important job duties in as timely a way as possible.
- 11) In my view, which aligns with what attorneys and SSAs in the office have told me, Zoom meetings alleviate some of the problems caused by their reluctance to visit clients in person at the jail, which itself can be attributed to the jail's lack of widespread, frequent testing for COVID-19.
- 12) However, given the limits of Zoom client meetings, they are an inadequate substitute for the regular, in-person meetings that PCCF can accommodate. Attorneys and SSAs have indicated to me that they would resume conducting such regular, in-person meetings if the jail restored their confidence in it being a safe meeting place by improving its testing and reporting protocols.

A handwritten signature in black ink, appearing to read "Tommy D. Fears", is centered in the upper right portion of the page.

Tommy D. Fears

Signed under the pains and penalties of perjury on this 24th day of November, 2020.

EXHIBIT G

COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES
and MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners

v.

CHIEF JUSTICE OF THE TRIAL COURT
Respondent

AFFIDAVIT OF COUNSEL

I, Tracy Magdalene, state the following to be true to the best of my knowledge, information, and belief:

1. I am a supervising attorney at the Springfield Public Defender Division of CPCS.
2. Since March 16, 2020, the first day of shutdowns in the Commonwealth because of the novel coronavirus, I have been one of two attorneys who continue to appear at the Springfield CPCS office.
3. Since March 16, 2020, the rest of the staff of approximately 45 attorneys, social services advocates, investigators, and support personnel have been working remotely.
4. Since March 16, 2020, I have been a liaison between our staff and the Hampden County House of Corrections (HOC) in Ludlow, Massachusetts.
5. I have worked extensively with HOC personnel to establish procedures for facilitating attorney/client telephone calls, videoconferencing, and visits.
6. Specifically, I have worked with Attorney Theresa Finnegan and Ms. Beth Hanna, HOC counsel and HOC Assistant Deputy Superintendent, respectively.
7. These procedures became especially significant for conducting arraignments and Section 35 hearings, routine attorney/client communications, and attorney visits.
8. At the inception of the shutdown, I was informed that the proximity of Westover Air Force Base made it nearly impossible to provide attorney/client meetings via Zoom, but that the HOC was making every effort to rectify the problem.

9. Because of the proximity of Westover Air Force Base, video-conferences via Zoom are only allowed in limited and/or exceptional circumstances such as when the need to meet with a hearing-impaired client arises.
10. As a result, the overwhelming majority of communications between attorneys and clients must take place in person or over the telephone.
11. Even though the HOC personnel sanitize the attorney/client meeting stations, (and sanitizing products remain at the stations for attorneys to do so themselves), many of the attorneys do not visit their clients in person at the jail because they do not feel it is safe and confidentiality cannot be assured. The visits are non-contact, with the attorney and the client separated by a plexiglass barrier and they speak to each other over a telephone. However, attorneys report to me that there are sometimes correctional officers near the client and they can hear the correctional officer or people in the next non-contact visiting cubicle. If the attorney can hear the other parties, then the other parties can hear the clients.
12. Since the shutdown, staff attorneys could email the HOC and ask for their clients to call them within a certain timeframe. This system has generally worked, though not always. Thus, sometimes we do not get calls from clients with time sensitive matters which impacts our ability to prepare for our clients' cases.
13. Staff attorneys also stated these calls were being made from counselors' offices and that the counselors were remaining in the office with clients during the telephone calls and, therefore, the calls were not confidential.
14. I spoke with Attorney Finnegan about this particular issue, and she had informed me that she would instruct counselors to allow clients to sit outside of their counselors' offices during attorney/client telephone calls.
15. I expressed the concern that this does not meet confidentiality requirements.
16. On October 7, 2020, I went to the HOC to meet with Attorney Finnegan and Ms. Hanna, and they gave me a tour of the facility.
17. I came to understand the various, complicated steps HOC personnel must take when facilitating client calls to attorneys.
18. During this tour, Attorney Finnegan agreed that the arrangement where clients sit outside of the counselor's office for the attorney/client communication was not viable in that she learned that the counselors would, in fact, still be able to hear the conversation.

19. Attorney Finnegan, as a result, showed to me the designated areas for clients to sit for attorney/client calls that were located away from the counselors' offices.
20. These areas were in the same locations as the telephones used by clients for attorney/client communications prior to the pandemic. These phones are in the housing unit in the area where the prisoners spend their time when they are not in their cells. As such, confidentiality cannot be assured. Moreover, sometimes calls are time-limited.
21. When these issues would arise, I would notify Attorney Finnegan who made every effort to rectify the problems.
22. Nonetheless, several staff attorneys have reported that their clients are still calling them from the counselors' offices and that, therefore, those communications are not confidential.
23. Some staff attorneys report that their symptomatic clients are making attorney telephone calls from their cell where they are housed with another symptomatic client and that, therefore, those calls are not confidential.
24. The HOC realized an outbreak of Covid-19 on or about the Thanksgiving weekend and, on December 1, 2020, reported that approximately 99 people at the facility tested positive for the virus.
25. We were not notified that the HOC was placed on medical quarantine, and attorneys who travelled to the HOC for an attorney/client visit were not allowed in due to the medical quarantine instituted at the facility.
26. I contacted Attorney Finnegan about this, and she explained that it would be best for attorneys to call the HOC prior to visiting to ensure that a particular client was off of medical quarantine.
27. On December 2, 2020, Attorney Finnegan notified us that the majority of housing units were still on medical quarantine and that "... most if not all of the housing units are likely to be off medical quarantine by next Friday December 11, 2020." Thus, in-person visits were discontinued for almost two weeks.
28. The medical quarantine has exacerbated the difficulties in obtaining attorney/client telephonic communications with two attorneys stating on December 3, 2020, that their requests for a client calls made early in the day had not met with a response by the close of business.

29. After contacting the HOC to inquire into the availability of in-person visits, the HOC began to allow attorneys to visit clients who were still on medical quarantine with visits taking place in the client's housing unit. However, it is not safe for an attorney to enter a housing unit with people who are Covid-19 positive or were exposed to and may have become infected with the virus, even if they are given full personal protective equipment.

/S/ Tracy Magdalene
Tracy A. Magdalene

EXHIBIT H

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF JAMES J. VITA, III

I, JAMES J. VITA, III, state the following to be true to the best of my knowledge,
information and belief:

1. I am an attorney employed by the Committee for Public Counsel Services Public Defender Division.
2. I work in the New Bedford office and have done so since 2012. I currently represent clients charged with crimes in New Bedford District Court and Bristol County Superior Court. I have done so since I began working in the New Bedford office in 2012.
3. Throughout those years I have represented many people held at the Bristol County House of Correction (BCHOC) in Dartmouth, MA as well as the Ash Street Jail in New Bedford, MA.
4. Those clients have included people held in lieu of cash bail; people held without bail under both s. 58A and 58B; people held without bail pending a final probation violation hearing; people held by the Department of Homeland Security pending the outcome of their immigration proceedings; and people serving sentences.
5. I have continued to represent clients held in Bristol County throughout the ongoing pandemic.

6. I currently represent six men held without bail at the Bristol County House of Correction. At the time of the writing of this affidavit, two of those six are committed to Bridgewater State Hospital, but would return to the BCHOC at the end of their commitments.
7. I continued to visit clients in person from March 2020 through this autumn. I last visited clients at the BCHOC in October of 2020.
8. I have serious concerns about going to the BCHOC right now to visit clients in person.
9. The BCSO does not conduct widespread testing of staff or incarcerated people to determine who is infected with covid-19. The BCSO only conducts testing when someone is symptomatic, despite the large number of asymptomatic cases of covid-19 that appear in every correctional setting that actually conducts widespread testing. Assistant district attorneys routinely argue in court that the low number of positive covid-19 cases demonstrates that covid-19 is not a threat in the BCHOC while ignoring the reality that if the BCSO is not testing everyone, it really has no idea how many cases there are in the BCHOC.
10. This approach—refusing to test everyone and then arguing that the low positive numbers means there are few covid-19 cases in the BCHOC—makes me extremely reluctant at this point in the pandemic to go to the BCHOC. I don't trust the BCSO to seriously its responsibility to limit transmission of covid-19 because of how insincerely it represents to the DA's office, and thus to the courts, the threat of transmission in its facilities.
11. In addition to the inadequate testing numbers, clients report horrible conditions to me. People held pretrial are still being held in dormitory-style living arrangements with bunk beds. They are still being required to line up in close proximity for medications and for meals. They are required to wear their masks while off of their bunks, but not on their bunks. Their bunks are open to the rest of the housing unit, however, so this effectively accomplishes nothing. I have at least one client who is held under such conditions.
12. When incarcerated people are symptomatic, they may be tested. However, clients are afraid of reporting symptoms because symptomatic individuals are held in restrictive housing that mirrors solitary confinement.
13. I spoke with a client yesterday, 9 December 2020, who was transferred from another facility where there was a large covid-19 outbreak. That client had been tested repeatedly at the prior facility and was negative. Instead of testing him when he arrived at the BCHOC, he was placed into a restrictive housing unit immediately, although he was not symptomatic.
14. He is only permitted 20 minutes outside of his cell per day. His meals are not nutritious, nor are enough to not leave him hungry.
15. Large clusters of covid-19 cases appear to be present every time a correctional facility conducts widespread testing. The lack of such testing by the BCSO, and their reliance on

this to demonstrate that the BCHOC has few covid-19 cases, makes me very apprehensive to go to the BCHOC to visit my clients.

16. The BCSO provides attorneys with very few alternatives to in-person visits.
17. In the spring the Bristol County Sheriff's Office (BCSO) established a method for setting up a phone call with a client by emailing a particular staff person, who would arrange a phone call with the client on the date and at the time of the attorney's choosing. This system is still in place and works well in certain respects. It is sufficient for discussing upcoming court dates or recent court dates with clients. It is adequate for answering most questions a client has about the law or about the facts of their case. However, in this situation, my client would be using the phone on his unit. It is not completely confidential because other inmates using adjacent telephones could hear what they are saying. I would not generally have clients tell me information through this format.
18. The BCSO does not offer any sort of videoconferencing for attorney-client communications.
19. There are enormous limitations to relying only on phone calls with clients.
20. I cannot go over videos with my clients that are relevant to their cases unless I go in-person. Each one of my six clients has video—whether a recorded interrogation, a police interview of a witness, or video recorded by a witness—that is relevant to their case. They obviously cannot watch such video over a phone call, the BCSO does not provide videoconferencing that would allow me to play the video for them over zoom or another program, so I am left with the option of going in-person. As I stated above, I have serious concerns about my ability to safely go to the BCHOC under the current circumstances.
21. It is much more difficult to know when a client does not understand something, or is confused, when I cannot see their face or their body language. I have learned throughout the years that many clients tell me that they understand when they don't, and for a variety of reasons. Often, it will be clear from their body language or their facial expressions that they are still confused, and thus I need to continue to explain something, or ask them questions to determine what they are still confused about. This kind of communication is best in-person, but videoconferencing would be sufficient.
22. It is necessary in many of my cases to retain an expert to evaluate for criminal responsibility or to aid in drafting a sentencing memorandum. Those experts have expressed reluctance to me about visiting clients in person at the BCHOC. All have asked about videoconferencing alternatives. The necessity of bringing a client into the New Bedford District Court for a 15a screening evaluation for competency contributed to that hearing being delayed by almost two months when combined with court closures and the large number of custody cases in New Bedford District Court. Clients who are not held have been able to be seen by a court clinician for the same evaluation over zoom, and have had much more timely and thorough evaluations.

23. I represent individuals charged with serious sex offenses. It is often inadvisable to send those clients discovery materials while they are at the BCHOC because they are unable to safely secure their belongings if they are held in the dormitory-type conditions I described earlier. Other incarcerated people may steal these materials and then try to harm the client. This is not a problem if I can go to the BCHOC to see them because I can bring the discovery in their case and we can discuss it, but that I have serious concerns about going to the BCHOC right now. Thus, it is very difficult to actually have my client go through this discovery himself unless I go in person and risk my safety, or I send the discovery to him and risk his safety.
24. Additionally, clients at BCHOC have to pay for stamps for legal mail out of their commissary account. If we send a self-addressed stamped envelope so that a client can quickly mail something back to us, it is likely to be confiscated. Commissary accounts can only be filled on Friday's, and many of my clients have not had family members routinely adding to their commissaries. Not being able to receive mail from my clients in a timely fashion has delayed the progress I can make on their cases; for example, I have had to wait to request treatment records until I received a signed release from a client. If the jail was safer, I would be able to meet the client and obtain the signed release in person.
25. These problems could be addressed if the BCSO would conduct widespread and ongoing testing to determine exactly how many covid-19 cases there are, report that information accurately to guarantee transparency, and then act according to the health needs of the people who are incarcerated. If that is not possible, providing a videoconferencing system for attorney-client communications that is secure and confidential would be sufficient for the time being.

Signed under the pains and penalties of perjury, this 11th day of December, 2020.

/s/James J. Vita, III
James J. Vita, III

EXHIBIT I

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF REBECCA WHITEHILL

I, Rebecca Whitehill, state the following to be true to the best of my
knowledge, information and belief:

1. I am the Attorney in Charge for the Salem office of the Public Defender
Division of CPCS. The Salem office is presently staffed with nine attorneys,
including me, who represent clients charged with criminal offenses in Essex
County.
2. Most of our clients that are in custody are held at the Essex County
Correctional Facility in Middleton. More than thirty(30) clients are detained

pursuant to MGL c. 276, s. 58A., some are detained on probation violations, some revoked and some simply on bail.

3. Of the clients held on bail, the vast majority are held on non-presumptive release cases.
4. Since the onset of the COVID-19 pandemic, several members of our staff have refrained from meeting with clients at the jail out of concern that the meetings rooms there are not safe.
5. On or about November 27, 2020, I was notified that attorneys would be able to schedule video calls with incarcerated clients through the Securus Connect system.
6. I reviewed information about this program which is summarized at the Essex County Sheriff's website, at https://www.essexsheriffma.org/sites/g/files/vyhlf3111/f/uploads/ecsd_attorney_-_video_connect_step_by_step.pdf. This online guidance is attached to my affidavit.
7. As the guidance indicates, attorneys with a Securus Connect account must pay a fee to schedule video calls with clients.
8. I created a Securus Connect account on December 3, 2020.
9. On December 3, 2020, after receiving a confirmatory email at about 6 a.m. that my account had been successfully set up I attempted to schedule a

meeting with a client who had a hearing the next day. The program would not allow me to schedule a meeting for any time that day.

10. As I was to be in court with the client the next day, I did not try to schedule a meeting the following day.
11. I did have a video call with a different client on December 10, 2020.
12. I have also spoken to other attorneys who have used the Securus Connect system to have video calls with clients.
13. It is my understanding that the Securus Connect system does not have a screen-sharing function. Therefore, attorneys will be unable to remotely review cases with extensive discovery.
14. According to another attorney, an interpreter is not able to join a Securus Connect call remotely, for example, through their own computer at their location, as they can do with Zoom. An interpreter would have to be with the attorney, in person, or on speakerphone with the attorney.
15. I have heard that glitches in the technology have prevented some attorneys from completing their video calls with clients.
16. Finally, an attorney in my office had two video calls scheduled for Tuesday December 15. She related to me that, on that date, she received an email from Securus that the calls were cancelled. She telephoned the jail to find out what was going on and she was told the telephone/video system was down and

that Securus would be reinstalling something that day (Tuesday). She was given to understand it would be back up that evening. She rescheduled the two calls for Wednesday, December 16. On Wednesday, she received the same sort of email regarding the cancellation of these calls. She forwarded one of these notices to me and I have attached it to this affidavit.

Signed under the pains and penalties of perjury, this 17th day of December, 2020.

/s/ Rebecca Whitehill

Rebecca Whitehill

BBO #541866

ESSEX COUNTY SHERIFF'S DEPARTMENT



ATTORNEY \ PROFESSONAL VISITS
VIDEO CONNECT INSTRUCTIONS
STEP BY STEP

Each Attorney must create their own individual account.
Shared accounts for firms, divisions or groups are prohibited

One Time Setup Per Each Attorney Video Account

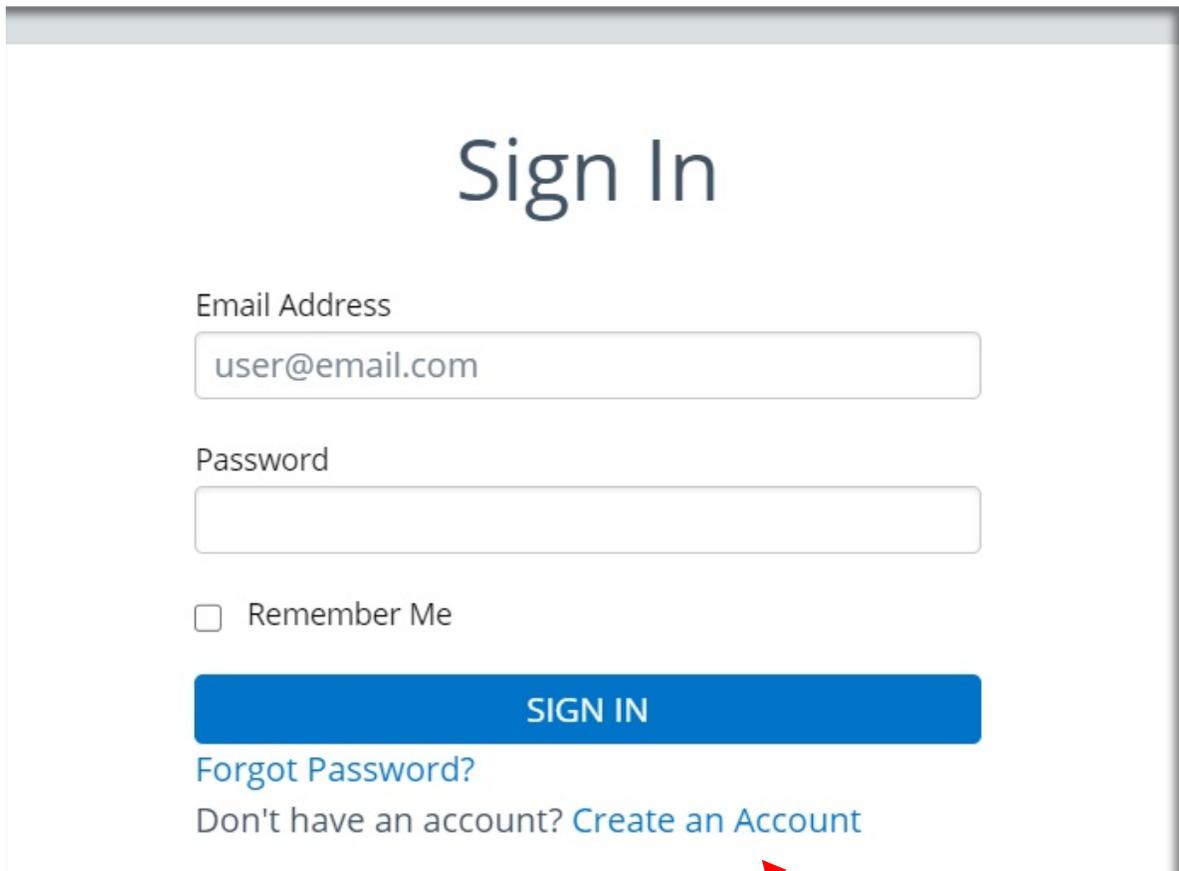
- Setting up a Securus Connect Account
- Setting Up and Configuring an Attorney Account
24 hr. Approval Process

Required Scheduling Process for Each Requested Attorney Video Connect

- Scheduling an Attorney Video Connect session

Setting up a Securus Connect Account

Using a web browser go to <https://securustech.online/#/login> to begin the sign up process



Sign In

Email Address
user@email.com

Password

Remember Me

SIGN IN

[Forgot Password?](#)
[Don't have an account? Create an Account](#)

If you do not have an account yet* click **Create an Account**

*If you already have a Securus Account, please scroll to the section
Setting Up and Configuring an Attorney Account

1 ————— 2 ————— 3

Email & Password Security Questions Contact Information

Email & Password

You will use this email address to log in to Securus Online.

Email Address

Email Confirmation

Password

Password Confirmation

Password must contain

- 8 characters
- 1 number
- 1 uppercase letter
- 1 lowercase letter

I have read and agree to the [Terms and Conditions](#).

NEXT

Fill out all necessary information as required. Once done check the **box** next to the acknowledging the Terms and Conditions and then click **NEXT**

Please keep track of your login and security question information.
ECSD staff will not be able to assist you with any account information.
You will need to contact [Securus Tech Support](#)

1

Email & Password

2

Security Questions

3

Contact Information

Security Questions

Select three security questions below. These questions will help us verify your identity should you forget your password.

Question 1

What is the name of your first pet?

Answer 1

XXXXXXXXXXXXXXXXXXXX

Question 2

What was the make of your first car?

Answer 2

XXXXXXXXXXXXXXXXXXXX

Question 3

What is the name of your favorite actor?

Answer 3

XXXXXXXXXXXXXXXXXXXX

[BACK](#)

[NEXT](#)

Fill out required Security Questions and Answers and click **NEXT**

1 ————— 2 ————— 3

Email & Password Security Questions **Contact Information**

Contact Information

Please complete the information below as it appears on your ID.

First Name

Last Name

Email Address

Country

Address

Address Line 2

City State Zip

Phone (US Only)

Create 4-Digit Passcode

Your 4-Digit Passcode is specific to your account and will be used for identification and security purposes whenever you contact our Customer Care Team. If you already have a passcode, enter it below. ⓘ

4-Digit Passcode

Confirm 4-Digit Passcode

Verification

824932

[BACK](#)

Fill out Contact information and enter the Verification code then click **SUBMIT**

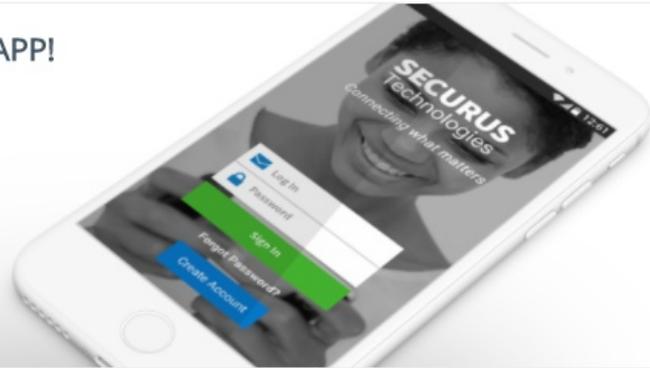
Your Securus Online Account was Created Successfully!

If your incarcerated loved one is located at a facility with Securus Video ConnectSM you can have a session from anywhere using a smartphone or tablet.

Check availability then download the Securus Mobile app.

The ALL-NEW Securus Mobile APP!

- Create a Securus Online account
- Enroll in Securus Video ConnectSM
- Fund prepaid calling account
- Enroll in AutoPay/TextPay



[CHECK AVAILABILITY](#)

Apple, the Apple logo, and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. Android, Google Play and the Google Play logo are trademarks of Google Inc.

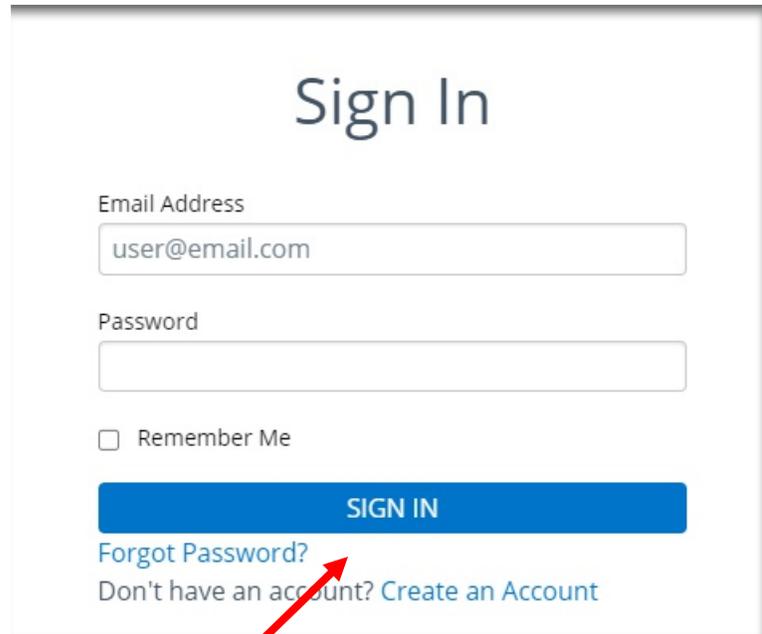
Your Securus Account is now setup. You will have the option to download apps to your smartphone, but it is recommended to use a web browser during your initial account & scheduling setup process

You will need to log back into the [Securus Site](#) before continuing to setup your video visit connect account for attorneys

*If you already have a Securus Attorney Account, please scroll to the section

Scheduling an Attorney Video Connect Session

Setting Up and Configuring an Attorney Account



Sign In

Email Address
user@email.com

Password

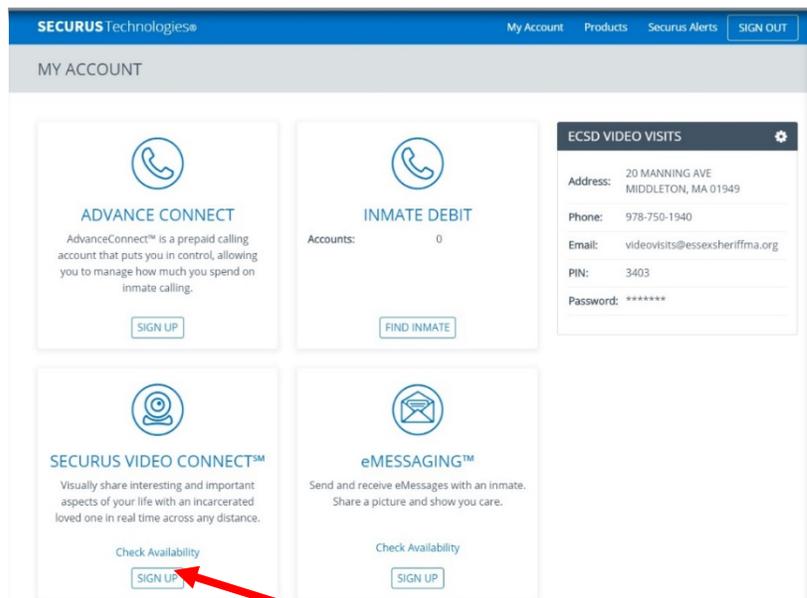
Remember Me

SIGN IN

[Forgot Password?](#)
[Don't have an account? Create an Account](#)

A red arrow points from the 'Create an Account' link to the 'SIGN IN' button.

You will need to sign back in at <https://securustech.online/#/login>



SECURUS Technologies® My Account Products Securus Alerts SIGN OUT

MY ACCOUNT

ADVANCE CONNECT
AdvanceConnect™ is a prepaid calling account that puts you in control, allowing you to manage how much you spend on inmate calling.
SIGN UP

INMATE DEBIT
Accounts: 0
FIND INMATE

SECURUS VIDEO CONNECT™
Visually share interesting and important aspects of your life with an incarcerated loved one in real time across any distance.
Check Availability
SIGN UP

eMESSAGING™
Send and receive eMessages with an inmate. Share a picture and show you care.
Check Availability
SIGN UP

ECSD VIDEO VISITS

Address: 20 MANNING AVE
MIDDLETON, MA 01949

Phone: 978-750-1940

Email: videovisits@essexsheriffma.org

PIN: 3403

Password: *****

A red arrow points to the 'SIGN UP' button under 'SECURUS VIDEO CONNECT™'.

Under **SECURUS VIDEO CONNECT** Click **SIGN UP**



SECURUS VIDEO CONNECTSM

Visually connect through video to share life events in real time from anywhere. Explore more convenient opportunities to communicate with your incarcerated loved ones with Securus Video Connect.

[Learn More](#)

[SIGN UP](#)

Click **SIGN UP**

FACILITIES WE SERVE

Securus is proud to serve over 3,400 Correctional Facilities across the United States.

To check if Securus services the facility of your incarcerated friends or family, please choose a state below.

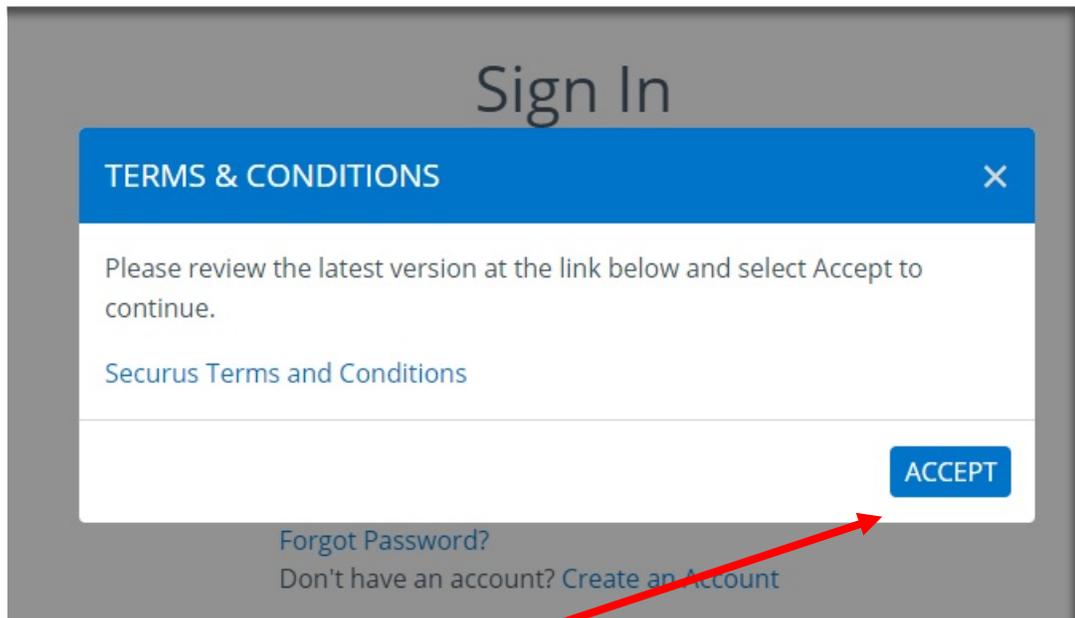
To begin using Securus products and services you will need to enroll in Securus Online, our free all-in-one account management portal.

State

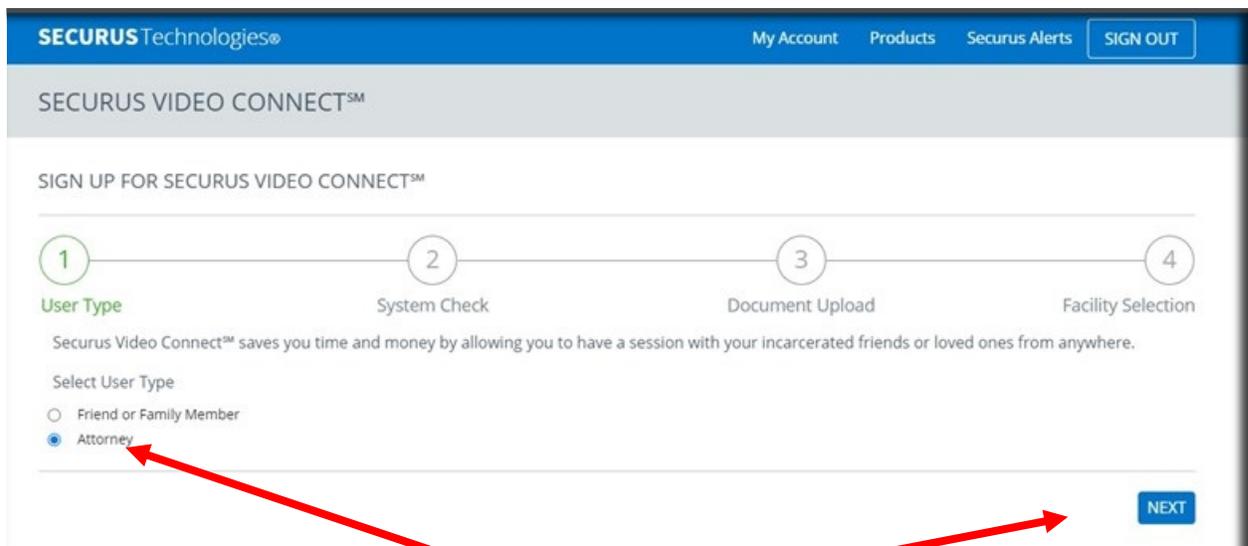
Facility

Products and Services at this Facility

Choose the ECSD Facility using the drop down menu's



Accept the **TERMS & CONDITIONS**



Choose **Attorney** then click **NEXT**

SECURUS VIDEO CONNECTSM

SIGN UP FOR SECURUS VIDEO CONNECTSM

1 User Type 2 System Check

Securus Video ConnectSM saves you time and money by allowing you to

Select User Type

Friend or Family Member

Attorney

Firm Name

Bar Card Number

Issue Date

Enter Your **FIRM Name**, **BAR Card Number** and **Issue Date** then click **NEXT**

SECURUS VIDEO CONNECTSM

SIGN UP FOR SECURUS VIDEO CONNECTSM

1 User Type 2 System Check 3 Document Upload 4 Facility Selection

Verify Your Web Camera

To finish adding Securus Video ConnectSM to your Securus Online account, you must complete a system check and provide photo identification for your account. By running the system check, you will know if your personal computer is compatible with the SECURUS VIDEO CONNECTSM service.

Please select the "Allow" button to provide access to your web camera.

CAN YOU SEE YOUR IMAGE?

NO YES

Verify your Web Camera is compatible and functioning
(Please select the "Allow" button to provide access to your web camera)

SIGN UP FOR SECURUS VIDEO CONNECT™

1 User Type 2 System Check 3 Document Upload 4 Facility Selection

SECURUS VIDEO CONNECT™

You must take two photos to submit for approval to the Correctional Facility. Click the camera image below to take your photos using your computer's web camera.

In order to add Securus Video Connect™ to your account, you are required to take a photo of your government issued photo ID and a photo of yourself. These images will be added to your Securus Online account and will be submitted to the correctional facility for approval where you would like to have a session with an inmate.

The information collected by this website, including your photograph and government-issued or other ID, is subject to our [privacy policy](#). By using Securus Video Connect™, you consent to our collection and use of this information.

Profile Photo Government ID Bar Card

CAPTURE UPLOAD CAPTURE UPLOAD CAPTURE UPLOAD

SUBMIT

Use your web camera to **CAPTURE** pictures of your **Profile Photo** , **Government ID** and **BAR Card**.

SIGN UP FOR SECURUS VIDEO CONNECT™

1 User Type 2 System Check 3 Document Upload 4 Facility Selection

SECURUS VIDEO CONNECT™

You must take two photos to submit for approval to the Correctional Facility. Click the camera image below to take your photos using your computer's web camera.

In order to add Securus Video Connect™ to your account, you are required to take a photo of your government issued photo ID and a photo of yourself. These images will be added to your Securus Online account and will be submitted to the correctional facility for approval where you would like to have a session with an inmate.

The information collected by this website, including your photograph and government-issued or other ID, is subject to our [privacy policy](#). By using Securus Video Connect™, you consent to our collection and use of this information.

Profile Photo Government ID Bar Card



CAPTURE UPLOAD CAPTURE UPLOAD CAPTURE UPLOAD

SUBMIT

Once you have all your pictures CAPTURED Click **Submit**

Note: These are example pictures. You will need to submit your Profile Photo, valid Government ID and BAR Card photos. These items must match, or you will not be approved for the video visit



Please select the state of the Correctional Facility where the Inmate is housed.
If you are unable to locate the facility, please review [Facilities We Serve](#).

State
Massachusetts

FACILITY ID	FACILITY NAME	CITY	ADDRESS
<input type="radio"/> 05494	Barnstable County Sheriffs Office, MA	BOURNE	6000 SHERIFF'S PL
<input type="radio"/> I-000609	Berkshire Co House of Corrections, MA		
<input type="radio"/> 00676	Billerica HOC, MA	BILLERICA	269 TREBLE COVE RD
<input type="radio"/> 28032	Boston Pre Release Center, MA	ROSLINDALE	430 CANTERBURY ST
<input checked="" type="radio"/> 05672A	Essex County Middleton Jail Attorney Site, MA	MIDDLETON	20 MANNING AVE
<input type="radio"/> 05672	Essex County Middleton Jail and HOC, MA	MIDDLETON	20 MANNING AVE
<input type="radio"/> 05699	Essex Cty Lawrence Corr Alt Ctr, MA	LAWRENCE	165 MARSTON ST
<input type="radio"/> 06011	Franklin County Jail, MA	GREENFIELD	160 ELM ST
<input type="radio"/> 04640	Suffolk County House Of Correction, MA	BOSTON	20 BRADSTON ST
<input type="radio"/> 04639	Suffolk County Jail, MA	BOSTON	200 NASHUA ST

SUBMIT

CHOOSE the ECSD Facility ID 05672A then Click **SUBMIT**

CONSENT [X]

By selecting "I Agree," I certify that I am uploading a photograph of myself, my government-issued ID or Bar ID, and that I am providing my express consent to the retention and use of the information in connection with Securus Video ConnectSM.

[CANCEL](#) **AGREE**

Click **AGREE**

THANK YOU FOR ENROLLING!

Thank you for adding SECURUS VIDEO CONNECTSM to your Securus Online Account. A confirmation email has been sent to the email address used during enrollment. Click on the confirmation link in the email to verify your email address. Failure to verify your email address within 48 hours of enrolling will lock your account. If you do not receive your confirmation email in 24 hours, please check your spam folder or contact [Securus Customer Care](#).

If your incarcerated loved one is located at a facility with SECURUS VIDEO CONNECTSM you can have a session from anywhere using a smartphone or tablet.

FINISH

Apple, the Apple logo, and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries.
Android, Google Play and the Google Play logo are trademarks of Google Inc.

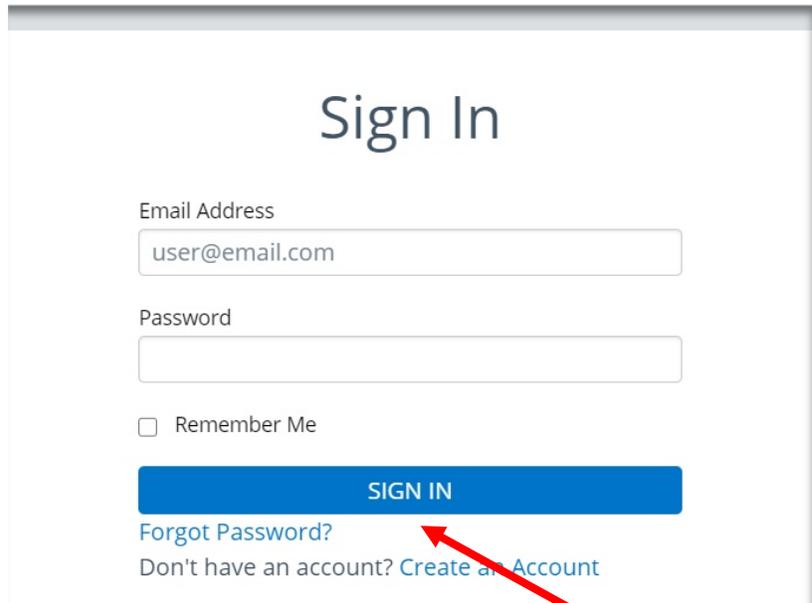


Click FINISH

**Please check your email. You will need to wait
24 hours for your account to be processed**

Scheduling an Attorney Video Connect Session

Once your account has met the requirements and been approved please log back in



Sign In

Email Address
user@email.com

Password

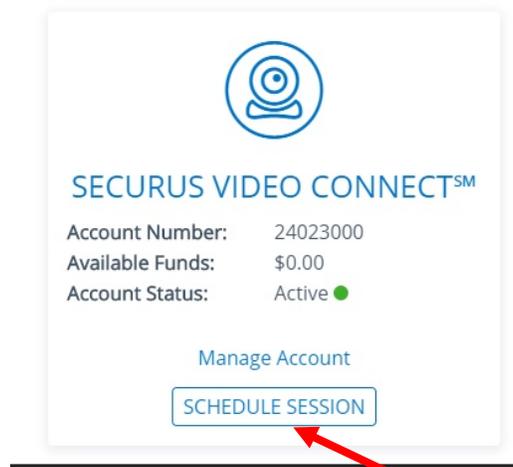
Remember Me

SIGN IN

[Forgot Password?](#)
Don't have an account? [Create an Account](#)

A red arrow points from the 'SIGN IN' button to the 'Create an Account' link.

Enter your account information and **SIGN IN**





SECURUS VIDEO CONNECTSM

Account Number: 24023000
Available Funds: \$0.00
Account Status: Active ●

[Manage Account](#)

SCHEDULE SESSION

A red arrow points from the 'SCHEDULE SESSION' button to the 'Manage Account' link.

CLICK **SECURUS VIDEO CONNECT** → **SCHEDULE SESSION**

My Future Sessions
Account Statements
Transaction Details
Unlimited Subscription
My Past Sessions
Schedule A Session
Add a New Facility
Block/Unblock
Credit Card Information

SCHEDULE A SESSION

SITE NAME
ESSEX COUNTY MIDDLETON...

REMOTE SESSION

ⓘ

Click **SCHEDULE SESSION**

1 Inmate 2 Appointment 3 Checkout

Search For Inmate

Search by Inmate Name Inmate ID

First Name Last Name

Appointment Summary

Session Type: Remote
Site: ESSEX COUN...
State: MA
Inmate:
Duration:
Date:
Time:

Search for **Inmate Name** or **Inmate ID #**
Enter inmate name or ID# and click **FIND INMATE**

1 Inmate 2 Appointment 3 Checkout

Search For Inmate

Search by Inmate Name Inmate ID

First Name Last Name

FIND INMATE

Appointment Summary

Session Type: Remote
 Site: ESSEX COUN...
 State: MA
 Inmate: [REDACTED]
 Duration:
 Date:
 Time:

Select Inmate
 If the inmate you were looking for is not listed, please verify the inmate information and try again.

SEARCH RESULTS

INMATE	INMATE ID	STATE	FACILITY
<input checked="" type="radio"/> [REDACTED]	[REDACTED]	MA	ESSEX COUN...

[Cancel](#) **NEXT**

Verify in the **SEARCH RESULTS** this is the inmate you are looking for and click **NEXT**

1 Inmate 2 Appointment 3 Checkout

Appointment Summary

Session Type: Remote
 Site: ESSEX COUN...
 State: MA
 Inmate: [REDACTED]
 Duration: 30 Minutes
 Date: Dec 1, 2020
 Time:

Current Promotions

Schedule (1) Session

- Schedule and pay for (1) session

Relationship To Inmate

Relationship
 Attorney

Appointment Details

Duration
 30 Minute Session for \$5.00

Date
 12/01/2020

Time
 10:00 AM ET

I have read and agree to the [Terms and Conditions](#).

[Back](#) **NEXT**

Enter the session **Relationship ,Duration, Date & Time** requested using the drop-down menus . Note **Attorneys will have an option of 30- or 60-minute sessions.**

Check the box that you have Read & Agree to the **Terms and Conditions**. Click **NEXT**

1 Inmate 2 Appointment 3 Checkout

You have 2:27 to complete this transaction

Appointment Summary

Session Type:	Remote
Site:	ESSEX COUN...
State:	MA
Inmate:	
Duration:	30 Minutes
Date:	Nov 25, 2020
Time:	10:00 AM ET

Billing Address

Your billing address must match your credit card. To avoid failed payments, please update the billing address to match the credit card.

First Name: Last Name:

Address: Address Line 2:

City: State: Zip:

Payment Details

Credit Card Type: Credit Card Number:

Month: Year: CVV #:

Coupon Code

Please enter coupon code and apply.

APPLY

Payment Amount

Price	\$5.00
Sales Tax	\$0.31
Sub Total	\$5.31
Total Amount	\$5.31

Save Credit Card

[BACK](#) **SUBMIT**

15 MINUTES TO COMPLETE AND SUBMIT THE PAYMENT INFORMATION

Enter payment Information and Click **SUBMIT**

You will have 15 minutes to complete this section or it will time out and the session will no longer be reserved for you & your client

Verify your appointment information and click **Finish**

SCHEDULE A SESSION



CONFIRMATION

Thank you for scheduling a SECURUS VIDEO CONNECT™ Session. You will receive a confirmation email with the details of this session. If you do not receive this email within 24 hours please check your spam folder or contact Securus Customer Care.

Session Type: Remote
Name: [REDACTED]
Email: [REDACTED]
Contact Number: [REDACTED]
Site: Essex County Middleton Jail & Hoc, MA
Inmate: [REDACTED]
Duration: 30
Date: Dec 1, 2020
Time: 10:00 AM ET
Total Paid: \$5.31

FINISH

You will receive an email with your appointment confirmation

SECURUS Technologies
connecting what matters®

[Phone Products](#) [Video Products](#) [Emessaging](#) [Facilities We Serve](#)

Dear ECSD,

The following Securus Video Connect was successfully scheduled!

Did you know that you can easily communicate from your Android™ or Apple smartphone, tablet, or computer that has internet access?* Download the Securus Video Connect app today on Google Play™, the App Store or go to www.videovisitananywhere.com to conduct your conversation. For best results and to reduce echo, use a headset or earbuds with a microphone.

Appointment ID: [REDACTED]
Date: 2020-12-01
Time: 10:00:00
With: [REDACTED]
Duration: 30minutes
Prepaid Securus Video Connect Session Cost:

Session Price: \$5.00
Tax: \$0.31
LESS: Credit Used: \$(0.00)
Transaction Fee: \$0.00

Total: \$5.31 using card ending [REDACTED]

* Includes all applicable state and local taxes, including but not limited to sales, use and other transaction taxes

Reminder: All Securus Video Connects are subject to the rules, regulations, and [terms and conditions](#) of the hosting facility and of Securus Technologies. Sessions must be canceled with at least 1440 minnotice in order to receive a credit.

Sincerely,
Securus Technologies, Inc.
Connecting What Matters

SECURUS VIDEO CONNECT TECHNICAL SPECIFICATIONS \ REQUIREMENTS

Technical Specifications

Note: Securus is not responsible for the quality of your Internet connection or for the setup and operation of your computer, web camera, or other hardware. Problems related to your Internet connection or hardware should be directed to your Internet service provider or a qualified computer repair technician.

Internet (DSL, Cable, Fiber) Speed

- 256KB minimum upstream and downstream speed
- To test network speed, go to speedtest.net.

Configurations Supported by Securus Online

- Windows (XP, 7, 8, 10) with Firefox or IE 9, 9, 10, or 11
 - To optimize performance for IE 9, 10, and 11, add "securustech.net" to Compatibility view settings.
 - Verify the latest Java software is installed – get it at www.java.com. Only one version is needed.
 - If the camera doesn't work, uninstall all Java versions, reboot your PC, and install the latest version of Java.
 - Add <https://securusvideovisitation.securustech.net> to the exception list under the security tab in the Windows "Control Panel" under Java control panel.
- MacOS 10.9+ with Firefox or Safari.

Supported Smart Phones (running the Securus Video Visit application)

- Android 4.0+
- Apple iOS 8.0+

Notes about video and sound

- Most built-in cameras on laptops, tablets, and smartphones provide sufficient picture quality.
- Visit is being monitored and recorded.
- Do **NOT** use while driving.
- Headset or earbuds with microphone recommended.

 2 messages

Phone Services

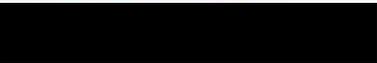
Video Services

Email Services

Facilities We Serve

VIDEO SESSION CANCELED

Please be advised that Essex County Middleton Jail Attorney Site, MA has canceled the following Securus Video ConnectSM session:

- Appointment ID: **21761431**
- Date: [2020-12-16](#)
- Time: [10:00 AM EDT](#)
- With: 

This decision is solely that of Essex County Middleton Jail Attorney Site, MA and Securus is unfortunately unable to intervene on your behalf.

Please call Essex County Middleton Jail Attorney Site, MA with any questions or concerns you have about this cancellation.

Your account has been provided with a credit of the session cost which is usable towards future sessions.

Note: This cancellation applies only to this specific video session; other sessions are not affected by this notice.



CONNECTING WHAT **MATTERS**

This message was sent by Securus Technologies, LLC.

P.O. Box 1109, Dallas, Texas 75001-1109

[1-877-578-3658](tel:1-877-578-3658)

See our [Terms & Conditions](#) and [Privacy Policy](#).



EXHIBIT J

I, Thomas J. Mello, do state the following to be true to the best of my knowledge, information, and belief:

1. I am the Attorney in Charge for the New Bedford Trial Court PDD office of the Committee for Public Counsel Services.
2. The New Bedford office is staffed with eight attorneys, including me, who represent clients charged with criminal offenses in the New Bedford District Court and Fall River Superior Court.
3. Many of our clients who are in custody are housed at the Bristol County House of Correction in North Dartmouth MA or at the Ash Street jail in New Bedford MA.
4. Prior to the Covid-19 pandemic, all staff attorneys had “in person” visits at both the Bristol County House of Correction and the Ash Street Jail.
5. Currently, no staff attorneys in the New Bedford office visit their Bristol County custody clients “in person” due to concerns associated with the Covid-19 pandemic, instead relying on telephone calls to communicate with their clients.
6. Attorneys in the New Bedford office report the following problems with client communication via telephone:
 - a. In order to schedule a phone call attorneys must contact the house of correction between the hours of 10am and 2pm one day in advance and all scheduled calls must occur between the hours of 10am and 2pm no sooner than the following day.
 - b. The scheduling parameters make it difficult to address issues that require immediate client access.
 - c. Phone calls do not always happen during their scheduled time.
 - d. Phone calls are limited to 30 minutes but are often cut short at 15 or 20 minutes with no prior warning.
 - e. The client makes the scheduled call from the unit phone in a common area where confidentiality cannot be guaranteed, and lawyers sometime report hearing other voices in the background.
7. Attorneys in the New Bedford office agree that phone calls are an insufficient replacement for face to face meetings with clients held in custody:

- a. Face to face interaction is a necessary component to building a strong attorney client relationship rooted in trust, and crucial for effective advocacy throughout every stage of litigation.
 - b. Face to face interaction is necessary for lawyers to thoroughly review with our clients indictments, statutes, motions, and discovery, which may be detailed and fact specific (i.e.. pictures, maps, audio/video recordings, expert analysis of DNA, etc...).
 - c. Face to face interaction is necessary for parties to observe crucial non-verbal cues that reveal misunderstanding, confusion, frustration, acquiesce, error, and other obstacles to effective and accurate communication.
8. Attorneys in the New Bedford office believe video conferencing is a viable solution to address some of these concerns; however, the Bristol County House of Correction does not allow attorneys to video conference cases with their clients.
 9. The Bristol County House of Correction does provide video conferencing for scheduled court dates in the New Bedford District Court but only on Tuesday and Friday mornings.

Signed, this day, December 9, 2020 under the pains and penalties of perjury,

/s/ Thomas J. Mello

Thomas J. Mello

EXHIBIT K

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF JOHN NOLEN

I, John Nolen, state the following to be true to the best of my knowledge,
information and belief:

1. My true name is John W. Nolen.
2. I am an attorney licensed and admitted to practice in the Commonwealth of Massachusetts.
3. I am currently employed by the Committee for Public Counsel Services as a staff attorney in the Springfield office.
4. I represent a client who is incarcerated at Hampden County House of Correction. During a telephone call with this client on December 3, 2020, he told me the following:
 - a. On November 24, my client was given a COVID-19 test.

- b. On November 27, while awaiting test results, he developed symptoms consistent with COVID-19, including shortness of breath and a deep, rattling cough.
 - c. Despite his symptoms, he was not given a second test. Instead, he was placed in isolation, which means that he must be in his cell 23 hours per day, with just one hour of recreation at 10:00pm.
 - d. On November 30, this client asked for an attorney call. The jail did not bring him a cordless phone to facilitate the call until five days later.
 - e. On December 1, the COVID-19 test came back negative.
 - f. On December 3, 2020, when the jail finally brought him a cordless phone to call me, I spoke to my client to learn this information.
 - g. On December 7, 2020, my client took a second COVID-19 test. He has not received any results as of today, December 10, 2020. However, he was moved to a quarantine pod in close proximity to people who are confirmed positive.
5. While he was in isolation and before he was moved to quarantine, this client did not have a physical check up from the jail's medical unit, and was not given any medication to treat any COVID-19 symptoms, though he had chills and felt like he had a fever. He had his temperature checked just one time.
 6. On the quarantine unit, he has his temperature checked more frequently, but he still is not given any additional medication for his symptoms.
 7. My inability to have contact with my client between November 30 and December 3 significantly slowed down any litigation I could do on his behalf.
 8. To file a motion, I have to leave my home office, use the printer at the CPCS office, and walk to Hampden County Superior Court to leave the motion in a drop-box at the courthouse. I was unable to file any emergency motions on his behalf during the week of November 30 because I didn't find out about his situation until the end of the week.
 9. I will struggle to be able to file an emergency motion the week of December 7 because it is so hard to communicate with him while he is in isolation: I can't

visit him in person, and while I can schedule calls, it is not reliable that I will get a call back.

10. In a similar situation, I had placed a request to talk to a different client on December 2, 2020. This was to discuss a possible motion to review his bail.
11. Late that afternoon, I got a call from this client, who immediately told me he had tested positive for COVID-19.
12. He explained he had been given a test on November 30, 2020 and been given his test results the following day.
13. He was then moved to a quarantine pod at 8:00 at night.
14. In the quarantine pod, he is in a mixed population of pretrial and sentenced inmates, with 2 or 3 cell mates depending on how many people are coming into the pod.
15. He has not had a medical checkup since he was moved to the quarantine pod, and has not been given any medication besides his usual prescriptions.
16. This means he has not received any medication for his cough, shortness of breath, fever, diarrhea and joint pain.
17. He has not had a temperature check since being moved to quarantine.
18. To the best of my knowledge, because he is in quarantine, he will not be able to participate in a zoom hearing on any motion for review of bail that I file.
19. I had a follow-up phone call with this client on December 10, 2020. He told me that the unit he was in previously had been locked down because an inmate there tested positive and had enemy restrictions that prevented him from being moved to the quarantine unit. Therefore, that unit is currently housing people who have tested positive along with people who have not tested positive.
20. Finally, I went to the jail to conduct an in-person visit with a third client on Wednesday October 14, 2020. I had a non-contact visit with the client. As per usual, correctional officers checked me in, cleaned the phone I used, and prepared my visiting booth.

21. On Friday October 17, 2020, I was told by my Supervising Attorney that there had been at least two positive COVID-19 cases among correctional officers. I did not know whether I had interacted with them during my client visit.
22. My spouse was 4 and a half months pregnant at the time, so I made the decision to self-isolate at home until I could get a negative COVID-19 test result.
23. This meant expending sick time to do my testing and using personal time to set up a spare room and isolate my office. During this time, I was unable to go to the courthouse or the CPCS office for documents or for printing supplies.
24. I have not felt comfortable returning to the jail since this incident. My concerns have been reinforced by the current outbreak of cases there.

Signed under the pains and penalties of perjury this 11th day of December, 2020.

/s/ John Nolen
John W. Nolen

EXHIBIT L

AFFIDAVIT OF ATTORNEY CARLOS BRITO REGARDING COMMUNICATIONS WITH
INCARCERATED CLIENTS IN BRISTOL COUNTY

I hereby state under oath that the following is true to the best of my knowledge information and belief:

1. I have been employed as an attorney with the Committee for Public Counsel Services (CPCS) for approximately twenty eight years.
2. I have been employed in the capacity of Attorney in Charge of the Fall River office of CPCS for approximately fourteen years.
3. My office comprises a staff of thirteen attorneys, including myself, all of whom have had clients incarcerated at the Bristol County House of Corrections in Dartmouth, Massachusetts, and at the Ash Street Jail in New Bedford, Massachusetts, during the covid-19 pandemic.
4. Some of the members of my staff have abstained from visiting clients at the two above mentioned facilities during the pandemic due to what they perceive as a lack of conditions that insure their and their clients' health and safety.
5. The reluctance to conduct in person visits stems from our own observations of the conditions at the jails early on, and the Sheriff's lack of transparency and out right misrepresentations regarding testing and safety procedures at the jail. For instance, the Sheriff's office had issued an affidavit in March in which they averred that since February they had been screening visitors by asking "questions related to COVID-19 symptoms and by body temperature assessment", when we knew from our experience visiting clients at both facilities that these measures were not implemented until mid-March. The affidavit also misrepresented the fact that staff or inmates had already tested positive at the Dartmouth facility, which I believe we found out through press releases.
6. Although no-contact visits are allowed at the Dartmouth House of Corrections (DHC), the small booth –approximately 5' by 5'- used for that purpose does not have a door, and is located within earshot of the visiting room officer's desk. As far as I know, the Ash Street Jail does not provide any private rooms for no-contact visits.
7. Attorneys who do not conduct in person visits at DHC and the Ash Street Jail, communicate with their incarcerated clients by telephone, following a protocol which has been created specifically for this purpose.

8. These attorneys have reported to me that based on background noise that they hear during the calls, and statements made by their clients, they believe that clients do not have adequate privacy during the telephone calls. For instance, one attorney reported that one client charged with sexual assault offenses told her that he could not discuss details of the case by telephone. During the call the attorney could hear other voices, and assumed that the client could not talk about the case because there were other inmates in the room. The attorney complained that she was only able to obtain limited information about the facts of the case by asking leading questions and limiting the client's responses to either yes or no.

Signed under the pains and penalties of perjury this 25 of November, 2020.



Carlos Brito

EXHIBIT M

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF KEVIN CHAPMAN

I, Kevin Chapman, state the following to be true to the best of my knowledge, information and belief:

1. I am an attorney employed by the Committee for Public Counsel Services. I work in the Salem office of the Public Defender Division of CPCS.
2. During the COVID-19 pandemic, I have represented many people who were incarcerated at the Middleton Jail.
3. It has been difficult to stay in contact with clients, even those in general population. Until very recently, the jail did not have any system for video calls with clients. Inmates could call from me from a bank of telephones in the

unit, or from tablets that they have in their cells. Neither form of communication is confidential.

4. To have confidential communication with clients, it has been necessary for me to go to the jail during the pandemic. When I go to the jail, my client and I meet in visiting rooms about eight feet long by eight feet wide, without ventilation or air filters. We sit on either side of a table, attached to which is a plexiglass divider about two or three feet high.
5. During the pandemic, I have spoken to my clients and employees of the jail about what happens when there is a positive case of COVID-19.
6. Based on these conversations, I learned that if someone is exposed to COVID-19, they are considered “presumptively positive” and the entire unit is placed in quarantine. While in quarantine status, the jail will not transport clients for in-person court appearances, nor will they allow clients to leave their respective housing units to go to the video conference area to participate in video court appearances. Therefore, when my clients have been placed in quarantine, I have had to either waive their presence in court or reschedule the court event.
7. Officials at the Middleton Jail have provided conflicting information regarding attorney access to clients who are on quarantine. For example, today I learned that a client’s unit had been placed in quarantine and my client’s COVID-19

test results were pending. I called the jail and a correctional officer told me that I could come to the jail and visit my client in person in the “no-contact” area. No-contact visits take place over a phone, with multiple inmates sitting next to one another on one side of a screen, and their visitors sitting on the other side of the screen. Therefore, no-contact visits are not confidential. The officer also invited me to schedule a video meeting with my client. I did not actually attempt to schedule the video meeting so I don’t know if the jail would have facilitated the video meeting. The Attorney-in-Charge of my office, on the other hand, was told today by a correctional officer that a client who is housed in the same unit as my client could not participate in a video meeting with a social worker from our office which was previously scheduled to take place this morning. According to that correctional officer, no one on the quarantined unit would be permitted to move from the unit.

8. My clients who have been placed in quarantine have expressed concern about the fact that they are housed in close proximity to people who are actually positive for the virus, which puts them at great risk for contracting it.
9. It has been very difficult for me to communicate with clients who are COVID-19 positive. For those clients, I am only permitted to receive collect calls from clients. The calls can be made either by tablet or telephones on the unit.

Because neither method of phone contact is private or confidential, I cannot have any meaningful discussions with my clients who are COVID-19 positive.

10. I have also had difficulty scheduling in-person court events, such as motions to suppress and bench trials, in a timely fashion. Because of restrictions on the number of people that can be transported to court from jails each day, I have had to schedule in-person court events about sixty days in advance. For example, one client appeared virtually in Lynn District Court on December 2, 2020. The earliest date he could schedule an in-person bench trial was February 8, 2021.

Signed under the pains and penalties of perjury, this 14th day of December, 2020.

/s/ Kevin Chapman
Kevin Chapman
BBO # 672662

EXHIBIT N

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF NICHOLAS J. MORRIS

I, Nicholas J. Morris, Esq., state the following to be true to the best of my knowledge, information and belief:

1. I have been licensed to practice law in the Commonwealth of Massachusetts since November 2011. My BBO No. is 681912 and my office address is 60 Washington Street, Suite 201, Salem, MA 01970.
2. Since being sworn into the bar, the vast majority of my practice has been devoted to criminal defense.
3. I have been a member of the Essex County bar advocate program since approximately February 2012 and I currently accept court-appointed bind-

over felony cases likely to be indicted to Essex Superior Court. Because of this, I represent clients in almost every district court in Essex County, the majority of whom are held in lieu of bail at the Essex County Correctional Facility (“ECCF”).

4. In many, if not most, of the bind-over felony cases on which I am appointed to represent clients, the Commonwealth files a motion to detain the client without bail under G. L. c. 276, § 58A, and a hearing on that motion is scheduled seven days from the arraignment date.
5. I have also been a supervising attorney in the Essex County bar advocate program since February 2020, and in that capacity I am responsible for overseeing the bar advocates who accept appointed cases in Lawrence District Court and Newburyport District Court.
6. Because of my personal circumstances I have been unable to visit clients held at ECCF in person since March 16, 2020, except for one in-person visit on August 25, 2020 (I visited two clients that day).
7. Other than the August 25 meeting, the exclusive means through which I have been able to communicate with clients from March 16 through November 30, 2020 has been by letter or through telephone calls.
8. Whenever I speak with a client held at ECCF on the phone, either because the client chooses to call me or because I am able to get a message to the

client to call me by using an email address set up by staff at ECCF, the client is either calling me from a shared phone on their housing tier or using a tablet inside the client's cell.

9. Neither the tier phone nor the client's use of a tablet inside the cell are confidential means of communication because neither the client nor I can control who is listening nearby on the client's side of the call. Further, I cannot share documents or videos pertinent to the client's case through the phone.
10. The one exception to the lack of confidential communication with the client via telephone calls are occasions where the client has a video conference appearance scheduled with the court (and to a much lesser extent an in-person court appearance).
11. The Essex County Sheriff's Department ("ECSD") maintains that counsel are permitted to call into the video conference area thirty minutes prior to the client's scheduled video conference appearance in court to speak with the client by phone where the client is in a room alone.
12. In practice, however, it has been my experience in almost every case that when I call into the video conferencing area thirty minutes before the scheduled hearing time, I am told to call back because the client is still being brought down from his unit (typically I am told to call back in five to ten

minutes at which point the client is in the video conferencing area) which makes the time available to speak with the client less than thirty minutes.

13. Even if the full thirty minute block were available, speaking with the client immediately prior to a court appearance is inadequate to address any substantive issues. For example, if a client were to provide new information pertinent to the hearing I would have no ability to verify or follow up on that information in the short amount of time before the client appears in court by video (this is especially problematic in situations where bail or other release conditions would be argued). Also, in my experience, much of the time spent on the call is used answering the client's last minute questions about the proceedings and there is not enough time to have a substantive discussion about the case. Further, many times, but not always, these phone calls take place on my cellphone inside the courthouse in the hallways, stairwells, etc., so my side of the conversation is not confidential (I have seen my fellow attorneys in the same situation countless times).
14. If a client were in-person in the courthouse, the client's case would not be called until I were ready after having spoken with the client. Additionally, in all the courthouses in which I have practiced, I am able to request that the court officers move my client somewhere more private so that I can have a confidential conversation with the client.

15. As stated above, because I accept appointments on bind-over felony cases, almost all those cases are scheduled for a hearing pursuant to G.L. c. 276 § 58A at the time I receive the case from the bar advocate administrator.
16. Prior to the implementation by the ECSD of the Securus video meeting system, my entire preparation and meeting with a client for a § 58A hearing took place by telephone. Typically, I would receive the case from the bar advocate program the day of or the day after arraignment; I would immediately submit a request to ECCF by email to notify the client to call my office collect; I would then send a letter to the client informing him I would be representing the client on the case and to call my office collect immediately upon receipt of the letter. Normally, the business day following my email request to ECCF to notify the client to call me I would get a response email from unnamed staff at ECCF that my request had been received and the client would be notified.
17. Usually the client would then call me within one to three days so we could discuss the allegations and prepare for the § 58A hearing. All of this would be done over the phone. When the client calls me, the client is either on the shared phone on the tier or calling me from a tablet in the client's cell. Neither of these types of calls are private on the client's side because anyone can listen to what the client is saying aloud into the phone.

18. Beginning on November 30, ECSD implemented video meeting capabilities with clients held at ECCF through Securus, and I have used this service on four occasions.
19. The first occasion I used the Securus video meeting with a client held at ECCF was on December 4, 2020.
20. On December 4 I had a meeting scheduled at 9:00 A.M. When I logged onto the website and the jail connected, I immediately noticed that the connection was atrocious and the client (“Client 1”) and I could barely hear one another.
21. Client 1 was able to get a staff member to come into the video conferencing room to check the system at ECCF, but could not resolve the connection issue. A staff member then called me on my cellphone and offered to reschedule the meeting at a later time on the same date and to let me speak with the client privately by telephone for the hour block I had scheduled for the meeting. The staff member also rescheduled the video meeting for 12:00 P.M. that day. When I hung up with the staff member, the client called me and we were able to speak at length in private.
22. At 12:00 P.M. I logged back into the Securus website to meet with Client 1. Immediately upon connecting, I noted that the client and I could again barely hear one another and the client got a staff member. The staff member called

me on my cellphone and offered to refund the money I paid for the video meeting and to have the client call me again, which the client did a short time later. The staff at ECCF did not refund the money I paid for the meeting, but instead gave me a credit in that amount to my account on the Securus video meeting website.

23. The meeting with Client 1 was essential because the client had a bench trial scheduled for December 7, 2020 in Lawrence Superior Court (which went forward that day). Instead of speaking with my client face to face prior to the trial I had to rely on phone calls where we could not look at transcripts, photographs, or maps pertinent to the case together. Client 1 was convicted of three of the five indictments (one felony and two misdemeanors) and is awaiting sentencing. Based on my experience, I expect Client 1 to receive a state prison sentence.
24. On December 15, 2020. I had a meeting scheduled with a client (“Client 2”) at 2:00 P.M. At approximately 2:00 P.M. I logged into the Securus website, but ECCF never connected to the video meeting. Eventually, I was disconnected from the Securus website. A few minutes later I got an email from Securus stating that the video meeting had been cancelled and “[t]his decision is solely that of Essex County Middleton Jail Attorney Site, MA and Securus is unfortunately unable to intervene on your behalf.” The email from

Securus also stated that my Securus account would be credited for amount I paid for the meeting, which did occur.

25. Client 2 called me a short time later and told me that a correctional officer on the client's unit told the client that I never logged in and that was the reason why the video meeting was cancelled. A short time later I received information that a staff attorney in the CPCS Salem office also had a scheduled video meeting cancelled that had been scheduled around the same time as my meeting with Client 2.
26. Client 2 is charged with numerous bind-over felony charges and requires an interpreter. I communicated with an unnamed representative of ECSD on December 2 and 3, 2020 by email about the use of an interpreter for a Securus video meeting. The ECSD employee did not have an answer for how to use an interpreter on the video meeting on December 2 and had to get back to me. The employee responded on December 3 stating "[w]e did confirm with Securus personnel that you may have an interpreter either in the office with you, or on speakerphone, and you may conduct the video visit without issue. Our suggestion is to schedule a visit and host your interpreter in person or via phone, and if you have any issues to let us know."
27. I made arraignments with my administrative assistant, who is a native Spanish speaker, to be available by telephone on December 15 for this video meeting

so that I could speak with Client 2. Luckily, my assistant can serve as an interpreter and I did not need to hire an outside interpreter for this meeting, which would have added time and expense to a meeting that the ECSD canceled unilaterally without explanation.

28. On December 17, 2020, I had a meeting scheduled at 11:00 A.M. The client (“Client 3”) was brought down to the video meeting area and connected at the scheduled time. However, just as it was on December 4, the connection was atrocious and I could barely hear Client 3. The audio from Client 3’s connection at ECCF broke up constantly and I could hear no more than one syllable at a time before the audio broke up then came back in. Eventually I was able to determine that Client 3 could hear me much more clearly than I could hear what Client 3 was trying to tell me. I did my best to walk Client 3 through the status of his case, without any opportunity for Client 3 to ask me questions or comment on the specifics. I had to have Client 3 use hand signals to answer questions I posed (i.e. I would ask Client 3 to raise Client 3’s hand if he received copies of the discovery I had mailed to him). We could not have any discussion about the factual allegations of the case, other than me reading the police reports to Client 3, because I could not hear any questions Client 3 would have asked and Client 3 could not provide me any information or comments (i.e. witnesses to be interviewed, disputes with the

sequence of events as documented by the investigating officers, etc.). My discussion with Client 3 merely walked Client through the procedural status of Client 3's case and lasted only approximately fifteen minutes. Client 3 was unable to get an ECCF staff member to assist Client 3, to see if the staff member could resolve the connection issue.

29. Client 3 is facing a serious felony charge and the assigned prosecutor has informed me that his case is scheduled to be presented to the grand jury for indictment in the next few weeks.
30. On December 17, 2020, I had a meeting scheduled at 2:05 P.M. with a client ("Client 4"). I logged on to the Securus website at approximately 2:05 P.M. and a short time later ECCF connected to the call. When the call connected I could see Client 4, but as before, every time Client 4 spoke the audio broke up. I was able to tell Client 4 to ask a staff member for assistance.
31. Client 4 was able to get a staff member to come into the video meeting room and I could see that the staff member assisting Client 4 was a uniformed correctional officer. From what I could make out through the spotty audio connection, Client 4 and the uniformed correctional officer were trying to tell me that because I was using a laptop to connect to the video meeting that was causing the audio connection problems.

32. Eventually, I was able to make out through the intermittent audio connection that Client 4 spoke with the correctional officer. The correctional officer asked me to log out of Securus and log back in so Client 4 could be moved to a different video conference room to see if that improved the connection. I did as the correctional officer requested.
33. When I logged out and logged back in I was reconnected with Client 4 at ECCF. However, the audio connection did not improve and I could not readily make out what Client 4 was saying (the audio connection continually went in and out). Like the prior clients, Client 4 was able to hear what I was saying, and I told Client 4 to ask the correctional officer if Client 4 could call me on the telephone in a private room in the video conferencing area so we could speak confidentially. The correctional officer inquired with a supervising officer about my request.
34. Client 4 was eventually able to communicate to me through the intermittent audio connection that the correctional officer would attempt to reconnect one more time before allowing Client 4 to call me by telephone in a private room in the video conferencing area. This entire exchange took approximately thirty minutes.
35. I reconnected a third time and waited for ECCF to reconnect. At 3:05 P.M. Securus logged me off the website because the hour I had reserved had

expired. Client 4 called me at 3:09 P.M. from a tablet in Client 4's cell. When asked Client 4 told me that Client 4's "cellie" was also in the room. While speaking with Client 4 I knew, therefore, that our conversation was not private and had to speak in vague and general terms. I could also not ask Client 4 what transpired prior to Client 4's arrest because I knew someone else was listening. In fact, at the end of the call I heard Client 4's cellmate ask Client 4 to have me answer a legal question about bail revocations under G. L. c. 276, § 58B.

36. Any suggestion that Client 4 could have asked Client 4's cellmate to leave the cell so Client 4 could speak to me in private fails to appreciate the realities of incarceration and that normal society's norms and niceties do not apply in a jail setting. Even if Client 4's cellmate left the room, that does not extinguish the possibility that Client 4's cellmate, or any other inmate on the unit, could stand just outside the cell door and listen every word spoken by Client 4 to me over the phone.
37. On December 16, 2020, I received word from a client's ("Client 5") sister that the client is positive and symptomatic for COVID-19 (I requested Client 5's medical records from ECCF per the ECSD's written policy and I am waiting for a response). Client 5 told his sister that the client is currently locked into his cell.

38. I had a video meeting scheduled with Client 5 today, on December 17, 2020 at 3:00 P.M. However, on December 15, Client 5 told his sister by phone that Client 5 will not be allowed to leave Client 5's cell for the meeting because Client 5's unit is locked down. Because of the information given to me by Client 5's sister, I cancelled the meeting scheduled for 3:00 P.M. on December 17. I cancelled the meeting at 10:45 A.M. on December 17. After I cancelled the meeting, I received an email from Securus stating that I would not be refunded for the prepaid hour rate because the cancellation was less than twelve hours in advance.
39. The December 17 meeting with Client 5 was particularly important because the client has a contested probation violation hearing on December 28, 2020 at which the probation department will be requesting that the court impose an eighteen month suspended sentence.
40. Because Client 5 has tested positive for, or is presumed positive for, COVID-19, I am personally unable to visit Client 5 at ECCF or have a video call with him prior to the scheduled probation violation hearing on December 28.
41. Additionally, it has been my experience with prior clients at ECCF who have tested positive, or were presumptively positive, for COVID-19 are not transported to court or brought to the video conference area for court appearances. It is unclear at this time, therefore, whether Client 5 will even be

present by video for his December 28 court appearance or if it will have to be rescheduled.

42. It seems clear to me the issue is with ECCF equipment or Securus itself because I have used the same computer setup and internet connection on numerous occasions for court hearings by Zoom in multiple courts and for other Zoom meetings, without incident. Also, I have used the same computer setup and internet connection to have Zoom meetings with my clients in three different Department of Correction facilities (MCI-Cedar Junction, MCI-Shirley, and Bridgewater State Hospital), without incident.

Signed under the pains and penalties of perjury, this 17th day of December, 2020.

/s/ Nicholas J. Morris, Esq.
Nicholas J. Morris, Esq.

EXHIBIT O

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF TIMOTHY NOONAN

I, Timothy Noonan, state the following to be true to the best of my
knowledge, information and belief:

1. My name is Timothy Noonan and my date of birth is 3/12/80.
2. I am an attorney in the Public Defender Division of the Committee for Public Counsel Services. My bar number is 601169.
3. My office is located at 101 State St. 3rd Floor, Springfield, MA 01103.
4. I currently have six clients held in the Hampden County House of Corrections. Three of them have tested positive for COVID, but five of them are housed with COVID positive people.

5. Since November 23, 2020, all of these clients have reported difficulties in trying to call me on the telephone. They have reported that there are a few staff members who are extremely helpful but if those particular staff are not working, they will not be getting a phone call.
6. For clients in the general population, I can send an email to a specific email address to request a phone call. Usually, a member of the jail staff calls me within an hour to a day. They ask if I have time to talk, and if I do, they transfer the call into the inmate's pod and bring the cordless phone into the cell. I can hear my clients speaking to people while I'm on the phone with them. I cannot have confidential conversations with my clients.
7. I have not had timely calls back from clients who are housed in COVID positive pods, medical quarantine pods, or the orientation pod, which is where new inmates are housed upon entering the jail.
8. One of my clients (Unnamed #1) who is currently under sentence was transferred from a minimum-security facility to the main facility shortly before the current outbreak. He was in the orientation pod for 18 days.
9. After 18 days, he tested negative for COVID-19 and was placed in general population.

10. The same day Unnamed #1 was moved to general population, he put in a sick call for some Tylenol because he had a headache. He was immediately moved to different pod. No test was performed.
11. I was later informed, by a member of the jail staff, that that pod was for inmates displaying symptoms but before they have a positive test.
12. After 11 days in that pod, Unnamed #1 tested positive for COVID-19 and was moved to a pod for COVID positive inmates.
13. While he was in the orientation pod, the pod for inmates displaying symptoms, and the pod for COVID positive inmates, Unnamed #1 could only initiate a call with me by calling his mother during rec time, which was just 30 minutes per day, and having her try to patch me into the call.
14. Another client, Carlos Garcia, DOB 9/21/80, called on December 2, 2020 to inform me that he had been diagnosed with COVID-19 and was placed in medical quarantine.
15. He is only allowed out of his cell for one half hour a day.
16. He is receiving only three meals and no commissary. The meals consist of cereal or oatmeal for breakfast, some form of "patty" for lunch, and either a ham and cheese or turkey and cheese sandwich with three cookies for dinner.
17. All meals are eaten in the cell. Trash is not picked up regularly and will sometimes sit in the cell for a day or more.

18. On December 7, 2020, I requested a call from a client who is COVID positive and symptomatic. I have not received a call from that client. Since that time, I have received requested and unrequested calls from other clients.
19. Today, December 10, 2020, I received a call from a member of the jail staff on behalf of a client. They were not able to transfer the call into the pod because of an apparent phone glitch and I was not able to speak to that client.

Signed under the pains and penalties of perjury, this 11th day of December, 2020.

/s/ Timothy Noonan
Timothy Noonan
BBO #601169

EXHIBIT P

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF JAKE HASSON

I, Jake Hasson, state the following to be true to the best of my knowledge,
information and belief:

1. I am a staff attorney in the Springfield office of the Committee for Public Counsel Services (CPCS). I represent criminal defendants in Springfield District Court, Holyoke District Court, and Chicopee District Court.
2. Many of my clients are held at the Hampden County Jail.
3. On April 14 and 28, 2020, I received memoranda attached to e-mails from Hampden County Sheriff Department's General Counsel, Theresa Finnegan, indicating that I would be able to request telephone calls with my clients at the

Hampden County Jail by e-mailing attorneycontact@sdh.state.ma.us and that, if requested by 3:00 p.m., the jail would have the client call me on the same day. These e-mails and memoranda are attached to my affidavit.

4. In this affidavit, I will provide two examples of some of the problems I have encountered trying to ensure confidential client communication with incarcerated clients during the pandemic.

A.M.

5. On October 9, I requested a telephone call with my client, A.M., by sending an e-mail to attorneycontact@sdh.state.ma.us, as I had been instructed to do.
6. On October 13, I had not been contacted by A.M. There were time-sensitive matters that I had to discuss with him, with the assistance of a Spanish interpreter. Therefore, I was forced to attempt to visit A.M. in person. Over the phone on October 13 and in person on October 14, I was informed by correctional officers that I could not visit A.M. because his unit, "C3," was on "lockdown." Four other units, which the jail refers to as "pods," were also on lockdown on October 14.
7. When I left the jail on October 14, I updated my supervisor, Attorney Tracy Magdalene. Attorney Magdalene corresponded with Hampden County Sheriff Department's General Counsel, Theresa Finnegan, via e-mail over the next several days. Attorney Magdalene was initially misinformed by Attorney

Finnegan that I had been able to speak with my client. I clarified to Attorney Magdalene that, in fact, I had not been able to speak with my client.

8. On October 16, Attorney Finnegan relayed a message to A.M. that I had to speak with him. A.M. called me on October 16, a full seven days after I initially tried to reach him.

J.G.

9. On October 14, I attempted to meet with my client, J.G., in person. I was refused entry and informed that his unit was on lockdown.
10. On October 17, I received a telephone call from J.G., asking about the status of his case. Specifically, J.G. asked me which of his open charges were felonies. Before I had a chance to answer him, an employee of the jail stated “they’re all felonies. I went to law school.” The employee, who I deduce to be J.G.’s counselor, had not announced her presence at the beginning of the call. She never identified herself by name.
11. At my request, J.G. told his counselor that she should not listen to the conversation. Nevertheless, she continued to make comments that indicated that she was listening and that our communication was not confidential. Therefore, I was forced to end the call.
12. After experiencing this breach of confidentiality, I immediately informed my supervisor, Attorney Magdalene. She informed me that she would talk to

General Counsel Theresa Finnegan about this breach of confidentiality, as she had done with similar situations in the past.

13. On November 27, I received another call from J.G. During the conversation, I asked J.G. whether his counselor could hear what he was saying. He said that the counselor could hear what he was saying to me. Therefore, I was again forced to end the call.

Signed under the pains and penalties of perjury this 3rd day of December, 2020.

/s/ Jake Hasson
Jake Hasson

From: finnegan, theresa [mailto:theresa.finnegan@SDH.state.ma.us]

Sent: Tuesday, April 14, 2020 12:12 PM

To: Tracy Magdalene <tmagdalene@publiccounsel.net>

Cc: hanna, beth <beth.hanna@SDH.state.ma.us>

Subject: questions regarding attorney contact

Good afternoon Tracy,

I am attaching our latest notice regarding attorney-client contact info. I hope this helps clarify some of the issues you raised in your email to Assistant Deputy Superintendent Beth Hanna. With regard to your suggestions related to ZOOM, we would love to be able to facilitate something like that for attorneys to communicate in that manner, however, we cannot make that happen at this time. We are operating with very limited staff due to the Governor's orders regarding non-essential employees. The staff and resources we have right now are strained beyond belief with video conferencing for the courts. At this time, other than non-contact visits at the jail with precautions, the email system in place is the best we can do at this time.

I am following up on your inquiry related to your communication with Maureen Lauzon and will get back to you as soon as possible. Thank you for your feedback, and please feel free to reach out to me directly.

Kind regards,

Theresa

Theresa S. Finnegan
General Counsel
Hampden County Sheriff's Department
627 Randall Rd.
Ludlow, MA 01056
Tel. (413) 858-0164
Fax (413) 589-1851

The information contained in this e-mail is intended solely for the person or entity to which it is addressed and may contain confidential and/or legally privileged material. Any use, disclosure, or taking of any action in reliance upon this information by person or entities other than the

intended recipient is prohibited and may be unlawful. If you have received this e-mail in error, please notify the sender by return e-mail and delete it from your computer.

<http://hcsdma.org>

HCS D Process for Contacting Clients By Telephone

I know there has been some confusion surrounding the process for attorneys to contact their clients. We had to make temporary changes to the process last week, as Lisa Deliz was out. Going forward please direct all requests to arrange to speak with your clients at Ludlow or Chicopee facilities to:

AttorneyContact@sdh.state.ma.us

Please provide them with your client's name, D.O.B and person number if you have it. They will get back to you by email with times that you can expect a call from your clients. We have limited staff right now due to the Governor's order regarding non-essential employees. Please be patient. Our staff will do the best that they can in getting back to you in a timely manner.

A few important things to know to ensure the smooth operation of this process and that you will be able to maintain confidentiality with your clients:

1. If you need your client to call you at a number that is not already in our system you should send an email with your phone number and BBO number to ICS@sdh.state.ma.us . Please do not email this link unless you are fairly certain your phone number is not already registered.
2. It is best to have your clients contact you from the blue phones on the housing units as opposed to using a counselor's phone. Neither would be recorded, but more privacy and time for the phone call will be afforded to your clients if they use the housing unit phones. If they need to use a counselor's phone, time is limited as they cannot have their phones tied up for large periods of time. Additionally, those calls have to occur with the staff member either in the office or in the doorway for security reasons.
3. Please make every effort to send your emails prior to 3 p.m. so that the call times can be set up for you on the day requested.

Thank you for your patience as we all navigate these highly unusual and difficult times.

From: finnegan, theresa <theresa.finnegan@SDH.state.ma.us>

Sent: Tuesday, April 28, 2020 4:26 PM

To: HCLJ (hampdenba@hclji.org) <hampdenba@hclji.org>; dchoose@strhlaw.com <dchoose@strhlaw.com>; Larry Madden <lmadden@publiccounsel.net>; Tracy Magdalene <tmagdalene@publiccounsel.net>; Caitlin Glenn (caitlin@hcbare.org) <caitlin@hcbare.org>

Cc: Sheriff Nick Cocchi <Nick.Cocchi@SDH.state.ma.us>; crowley, kevin <kevin.crowley@SDH.state.ma.us>; colbert, mike <mike.colbert@sdh.state.ma.us>

Subject: Attorney Client Communications

Good afternoon everyone,

I am sending this out again, as we are still receiving some inquiries on our process. The Sheriff and our entire staff are so grateful for how polite and kind you have been to our staff who are working very hard to make sure you can communicate with your clients. We ask that you continue to exercise patience during this very challenging time. I made a few edits to the memo to clarify a few things, and a reminder that we remain willing to accommodate attorney visits at our facilities provided attorneys are willing to undergo a brief medical screening and wear a mask.

Kind regards,
Theresa

Theresa S. Finnegan
General Counsel
Hampden County Sheriff's Department
627 Randall Rd.
Ludlow, MA 01056
Tel. (413) 858-0164
Fax (413) 589-1851

The information contained in this e-mail is intended solely for the person or entity to which it is addressed and may contain confidential and/or legally privileged material. Any use, disclosure, or taking of any action in reliance upon this information by person or entities other than the intended recipient is prohibited and may be unlawful. If you have received this e-mail in error, please notify the sender by return e-mail and delete it from your computer.

<http://hcsdma.org>

This email and any files transmitted with it are the property of HAMPDEN COUNTY SHERIFF'S DEPARTMENT, are confidential, and are intended solely for the use of the individual or entity to which this e-mail is addressed. This email may contain FOR OFFICIAL USE ONLY and/or LAW ENFORCEMENT SENSITIVE information. This email, including any attachments, is covered by the Electronic Communications Privacy Act, 18 USC 2510-2521. If you are not one of the named recipient(s), or otherwise have reason to believe that you have received this message in error, please notify the sender at the number above and destroy this message by properly disposing/shredding the documents received. Any other use, retention, dissemination, forwarding, printing or copying of this email is strictly prohibited. Please notify this office immediately if you have received this message in error.

HCSD Process for Contacting Clients By Telephone
UPDATED 4/28/20

PLEASE BE AWARE THAT THE HCSD DOES NOT PROHIBIT ATTORNEY VISITS DURING THIS PANDEMIC. ATTORNEY VISITS DO REQUIRE A BRIEF MEDICAL SCREENING AND ATTORNEYS MUST WEAR MASKS. CLIENTS WILL HAVE MASKS ON AS WELL.

For those attorneys who do not wish to visit their clients at our facilities we have a process in place for attorneys to contact their clients in the event that the attorney does not wish to visit a client at the facilities. Please direct all requests to arrange to speak with your clients at Ludlow or Chicopee facilities to: AttorneyContact@sdh.state.ma.us

Please provide them with your client's name, D.O.B and person number if you have it. They will get back to you by email with times that you can expect a call from your clients. We have limited staff right now due to the Governor's order regarding non-essential employees. Please be patient. Our staff will do the best that they can in getting back to you in a timely manner.

A few important things to know to ensure the smooth operation of this process and that you will be able to maintain confidentiality with your clients:

1. If you need your client to call you at a number that is not already in our system you should send an email with your phone number and BBO number to ICS@sdh.state.ma.us . Please do not email this link unless you are fairly certain your phone number is not already registered.
2. It is best to have your clients contact you from the housing unit phones on the housing units as opposed to using a counselor's phone. Neither would be recorded, but more privacy and time for the phone call will be afforded to your clients if they use the housing unit phones. If they need to use a counselor's phone, time is limited as they cannot have their phones tied up for large periods of time. Additionally, those calls have to occur with the staff member either in the office or in the doorway for security reasons.

3. Please make every effort to send your emails prior to 3 p.m. so that the call times can be set up for you on the day requested. If you know you are covering arraignments on Monday morning, please try to reach your clients over the weekend if possible so as to ensure you can speak with them prior to the proceeding.
4. If you have special circumstances which you believe require a different type of arrangement than what is in place currently, please feel free to reach out.
5. As you are all aware, these are challenging times for all of us, but please try to communicate by email as described above unless it is necessary to make a phone call to the staff. We are very shorthanded and our staff are trying to be as responsive as possible. If you have concerns about not being able to communicate with your clients, please contact theresa.finnegan@sdh.state.ma.us . As always, everything is changing and evolving and we will continue to keep you advised of those changes.

Thank you for your patience as we all navigate these highly unusual and difficult times.

EXHIBIT Q

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF JOEL ARCE

I, Joel Arce, state the following to be true to the best of my knowledge,
information and belief:

1. My name is Joel Arce and my date of birth is 5/8/83.
2. I am an inmate at the Hampden County Correctional Center. The address is 627 Randall Rd., Ludlow, MA 01056.
3. I was detained on November 9, 2020 on a warrant for a probation violation.
4. I have been in the B1 pod for the entire time. The B1 pod is the orientation pod where new arrivals are placed for 14 days before moving to general population.

5. Since I arrived, I have been on medical quarantine. I have been confined to my cell for 23.5 hours a day.
6. I am allowed out of my cell for a half hour a day. During that time I have to choose between using the phone and taking a shower.
7. I have been allowed my half hour of rec time at varying times throughout the day, sometimes as late as 9:00 pm. My mother, the main person I call, is not awake at that time.
8. I have requested attorney calls every day. These requests are not honored.
9. I have only been able to speak with my attorneys when they make a request to speak with me.
10. When I do get an attorney call, a member of the jail staff calls my attorney and then brings the phone to my cell. The staff member stays outside the door.
11. These calls are not confidential. Staff members can hear what I am saying as well as other inmates.
12. I suffer from migraines and have requested Excedrin. As of December 4th, 2020, I had not received any.
13. Shortly after reviewing an initial draft of this affidavit with my attorney, I was given Excedrin the next day. I suspect that staff overheard my conversation.

14. When I came to this jail, I had a splint on my finger. I had torn two tendons and my doctor recommended the splint to aid in proper healing. The splint was removed and has not been returned.
15. For the last few days, we've only been getting cold sandwiches for dinner.
16. The room is cold. I sleep with my shoes on and I've put plastic wrap over the windows.
17. I can hear coughing and sneezing through the vents.
18. In the same pod, there is a guy I know from the streets. While walking past my cell, he informed me that he was positive for COVID-19. He appeared to be sweating and seemed to have trouble breathing.
19. I have been tested for COVID three times and all have been negative.
20. As a result of the COVID-19 pandemic, this affidavit was read to me over the phone by my attorney and I assent to having my signature affixed below.

Signed under the pains and penalties of perjury, this 9th day of December, 2020.

/s/ Joel Arce
Joel Arce

Signed with Approval

/s/ Timothy Noonan
Timothy Noonan
BBO #601169

EXHIBIT R

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss.

SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES and
MASSACHUSETTS ASSOCIATION OF
CRIMINAL DEFENSE LAWYERS,
Petitioners,

v.

CHIEF JUSTICE OF THE TRIAL COURT,
Respondent.

AFFIDAVIT OF ANTHONY HILL

I, Anthony Hill, state the following to be true to the best of my knowledge,
information and belief:

1. My name is Anthony Hill and my date of birth is 3/22/82.
2. I am an inmate at the Hampden County Correctional Center. The address is
627 Randall Rd., Ludlow, MA 01056.
3. I was detained on November 21, 2020 on a Fugitive from Justice Charge.
4. Since I arrived, I have been in medical quarantine because I was new to the
jail. I never tested positive or showed symptoms of COVID-19.
5. I have been confined to my cell for 23.5 hours a day.

6. I can hear people coughing and sneezing through the vents. I sleep with my mask on.
7. Jail staff attempted to place me in a cell next to person who had tested positive for COVID-19. I found out about the diagnosis through another inmate who knew the COVID positive inmate.
8. I was not given toilet paper for the first three days.
9. I was not given anything drink except the water from my sink and at mealtimes. Meals are eaten in the cell.
10. I am allowed out of my cell for a half hour a day. During that time I have to choose between using the phone and taking a shower.
11. I have been allowed my half hour of rec time at varying times throughout the day, sometimes as late as 9:00 pm.
12. When I get an attorney call, a member of the jail staff calls my attorney and then brings the phone to my cell. The staff member stays outside the door.
13. These calls are not confidential. Staff members can hear what I am saying as well as other inmates.
14. I suffer from severe back pain, including multiple herniated discs. I have requested medication and been denied. As of today, I can barely touch my toes and only with great pain.

15. It was only today that a nurse took me through the steps necessary to get my medication.

16. As a result of the COVID-19 pandemic, this affidavit was read to me over the phone by my attorney and I assent to having my signature affixed below.

Signed under the pains and penalties of perjury, this 9th day of December, 2020.

/s/ Anthony Hill

Anthony Hill

Signed with Approval

/s/ Timothy Noonan

Timothy Noonan

BBO #601169

EXHIBIT S



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street
Boston, MA 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

Tel: (617) 983-6550
Fax: (617) 983-6925
www.mass.gov/dph

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

To: Skilled Nursing Facilities, Rest Homes, Assisted Living Residences
From: Kevin Cranston, MDiv, Director, BIDLS
Elizabeth Daake Kelley, MPH, MBA, BHCSQ
Date: December 7, 2020
RE: Updates to Long-Term Care Surveillance Testing

A. Overview

This memorandum applies to all long-term care settings including nursing homes, rest homes and assisted living residences (ALRs) and shall take effect on December 7, 2020. To align with the Centers for Medicare and Medicaid Services (CMS) surveillance testing recommendations and due to increased rates of community transmission, the Department of Public Health (DPH) is updating this surveillance testing memorandum to require long-term care facilities to conduct weekly testing of all staff. Compliance with the testing program is required in nursing homes and rest homes. Compliance with the testing program is recommended in ALRs.

To protect the health and safety of long-term care residents and staff against the spread of COVID-19, all long-term care settings must continue to implement the surveillance testing program that began with baseline staff testing completed no later than July 19, 2020, in accordance with this updated memorandum and, with respect to nursing homes participating in MassHealth, with accompanying MassHealth guidance. Any test conducted in accordance with this guidance must be able to detect SARS-CoV-2 virus, with a polymerase chain reaction (PCR) of greater than 95 percent sensitivity and greater than 90 percent specificity.

For the purposes of a provider's surveillance testing program, a "week" means from 7:00 AM Thursday morning through 6:59 AM the following Thursday morning.

This testing program may be updated as more is learned about the COVID-19 virus.

B. Surveillance Testing Program

Long-term care facilities must conduct weekly testing of all staff.

If the staff testing results indicate a positive COVID-19 staff member(s), then the provider must conduct outbreak testing of all residents and staff to ensure there are no resident cases and to

assist in proper cohorting of residents. Testing must take place as soon as possible and within 48 hours.

For purposes of this memorandum, CDC and CMS define a close contact as while they were symptomatic or within the 48 hours before symptom onset or, if asymptomatic, the 48 hours before the test was completed to the 10 days after the test was completed. Symptoms of COVID-19 include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.

C. Previously Positive Individuals Cleared from Isolation:

Individuals previously diagnosed with COVID-19 infection confirmed by molecular diagnostic testing may continue to have PCR detection of viral RNA for many weeks. This does not correlate with the presence or transmissibility of live virus.

Accordingly, for the purposes of the surveillance testing program, recovered or previously COVID-19 positive residents and staff do not need to be re-tested and will not be included as part of total staff when determining if the facility met the required staff surveillance testing thresholds. However, it is clinically recommended for individuals previously diagnosed with COVID-19 to be retested under the following circumstances:

- i. Individuals who were previously diagnosed with COVID-19, and who develop clinically compatible symptoms, should be retested if they are more than 3 months past the date of original infection. If viral RNA is detected by PCR testing, the patient must be isolated and considered to be possibly re-infected. Consult the DPH epidemiologist for guidance.
- ii. Individuals who were previously diagnosed with COVID-19 and who are identified as a close contact of a confirmed case should be retested and subject to quarantine if they are more than 6 months from their date of original infection. It may be appropriate to allow these individuals to quarantine in place.

E. Staff Definition:

For purposes of conducting testing and implementing a surveillance testing program and, in accordance with CMS and CDC guidance, long-term care staff includes: employees, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions reporting to the facility during the relevant testing period. For the purposes of a long-term care provider's surveillance testing program, staff does not include: persons who work entirely remotely or off-site, employees on leave, such as paid family medical leave, or staffing provided at the Commonwealth's expense (such as those provided by EOHHS through a clinical rapid response team or the Massachusetts National Guard). Any testing completed by the provider must capture required Department of Public Health information about each staff person including but not limited to gender, age, race, ethnicity, primary city/town of residence, disability, primary language and occupation.

Long-term care providers in Massachusetts are encouraged to monitor the CMS and CDC website for up-to-date information and resources:

- CMS website: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>
- CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>

Additionally, please visit DPH's website that provides up-to-date information on COVID-19 in Massachusetts: <https://www.mass.gov/2019coronavirus>.