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To Judge Gerdes:

As of November 30, 2020, the State of Colorado has 232,905 cases of COVID-19 with 3,037 deaths. Colorado is currently seeing levels of COVID-19 many times greater than experienced during the first peak. Despite the reductions in mortality observed after the initial wave, the death rates associated with COVID-19 are near the levels observed during the initial peak. Seven of the ten largest outbreaks in the state are in state prisons, with the outbreaks at Arkansas Correctional Facility, Fremont Correctional Facility and Sterling Correctional Facility each exceeding 700 cases. 368 CDOC staff and 4,300 incarcerated people – almost one quarter of CDOC's entire prisoner population – have tested positive, there are more than 1,500 active cases in CDOC right now, and seven prisoners have died.

The epidemic of COVID-19 has been unprecedented in recent history due to the combination of a completely novel to which there is no immunity in the community, a highly transmissible virus that can be spread both through respiratory droplets and contact with fomites on surfaces, and an attributable mortality an order of magnitude greater than that of seasonal influenza. Medically vulnerable individuals are at a substantial risk of contracting, spreading and becoming seriously ill or dying from COVID-19 in any carceral setting. It is important to remember also, though the death rates are higher in patients with identifiable risk factors, severe illness and death have occurred in those who have been previously healthy. Those with milder illness, can spread the illness to those who may become severely ill or die from their infection.

CDC guidance and experience with this virus to date make clear that social distancing is the best way to prevent infection. This is especially important in Congregate settings such as correctional facilities in which the inability to maintain recommended social distancing combined with the large population of persons at high risk for severe COVID-19 disease can lead to the rapid transmission of COVID-19. Adequate social distancing requires maintaining, at a very minimum, at least six feet between people in all settings. This is especially important given the current awareness of the role of asymptomatic spreaders of the illness. It is estimated that 50% of transmission occurs from individuals who are pre-symptomatic (24-48 hours before the onset of symptoms or asymptomatic. Prevention protocols must take into account that individuals who would not be identified by symptoms screens or temperature checks may be transmitting the virus. Policies that rely on isolation of individuals with symptoms will not be sufficient to constrain spread of the virus. It is now recognized that airborne transmission of

SARS-CoV-2 can occur in enclosed spaces, spaces with inadequate ventilation or air handling, and in the context of prolonged exposure. Because many of these situations are frequent in correctional settings, as cases rise, reducing the population is a critically needed to reduce the number of cases and prevent COVID associated complications and deaths. To the greatest extent possible, medically vulnerable individuals should be released. To the extent medically vulnerable people cannot be released, they should be housed in single-person cells to mitigate the risk of serious illness or death to this population.

Experience

I am an Associated Professor of Medicine in the Division of Infections Disease at the University of Colorado School of Medicine. I am board certified in Internal Medicine and Infectious Disease. I serve as the Medical Director for Occupational Health for the University of Colorado Denver Campus and as a medical consult for infectious to UC Health Employee Health for the University of Colorado Hospital. In this capacity I have served on multiple committees addressing policies related to COVID-19 related infection control in the workplace.

Prior to joining the University of Colorado, I was part of the Infectious Disease division at the Warren Alpert School of Medicine at Brown University. As part of my work there, I was part of multiple initiatives supporting care delivery following reentry for persons with HIV in corrections. I additionally supported the Rhode Island Department of Corrections in their efforts to expand hepatitis C testing and treatment in corrections. I have written and been a coauthor on multiple publications addressing HIV and hepatitis C care in corrections and on reentry.

Gary Winston, John Peckham, Matthew Aldaz, Dean Carbajal and William Stevenson

I have reviewed the declarations of the named plaintiffs in this case. Based on their declarations, each of the named plaintiffs have a medical condition that places them at high risk of death or serious illness from COVID-19.

These plaintiffs and the class definition track the CDC guidelines on high risk people. While the CDC generally says 65 or older is the cut off for high risk, the WHO lists ages 60 and the CDC acknowledges that incarcerated populations are in poorer health than the general public, even at younger ages, and so I believe the class definition of 60 and older is more accurate in this population than 65 years.

Since the time of my last declaration, I have had the opportunity to review documents provided by the CDOC (such as single celling plans, number of high risk people in single cells and numbers of high risk people for whom there are no available single cells) and have also visited three CDOC prisons, Sterling, Arrowhead and Crowley. According to documents I have seen, conversations I have had with prisoners, and my own visits to the prison, I can tell the Court that the necessary social distancing and separation of prisoners from each other is not possible given the current occupancy and the constraints of the correctional setting,

I understand that it is the policy of CDOC not to mingle prisoners who are positive for COVID-19 with prisoners who are not, but I also understand that prisoners at CTCF, Arrowhead, Trinidad, Fourmile and Freemont are all reporting that this is happening. I understand it is the

policy of CDOC to cohort prisoners and avoid comingling cohorts, but I also understand that this is not always possible and the sheer number of prisoners combined with the lay outs of the prisons means that people are mixing between units.

I also understand that, while there is a list of medically vulnerable prisoners, and while that list is likely to be amended with changes proposed by the Independent Expert hired by the parties, there are simply not enough single cells to accommodate all of the people at high risk of serious harm.

Now that we are in the midst of this spike in cases, and seven of the ten biggest outbreaks in Colorado are in correctional facilities, it is critical that people at higher risk of death or serious illness be able to separate themselves from others and that simply can't happen in Colorado's prisons given the population. The priority list for single cells is important, and changes to that priority list to better protect those at greatest risk will be important, but for many this will not be sufficient as single cells will not become available for them.

The transfer of prisoners around facilities, the use of prisoners from one unit to work in the kitchen or other locations from another unit, described in the original affidavits and that I have learned about during the work on the consent decree violate the public health understandings of what has to happen to stave off preventable deaths among incarcerated people, staff and the public.

I agree with Governor Polis that we are about to hit a major shortage of hospital capacity. ICUs around some jails have already reportedly had to start to turn away patients. Prevention of contracting the illness in the first place is critical for higher risk individuals, and it cannot happen for many of them in the Department of Corrections.

As I said in my previous letter, I have also reviewed several expert declarations, including by Dr. Carlos-Franco-Paredes, Dr. Jamie Meyer, Dr. Marc Stern. These declarations have been prepared at various stages in the pandemic and, while more information is available, these are a good resource and I agree with the descriptions of the pandemic and the recommendations made in these declarations.

Based on the information provided by incarcerated plaintiffs CDOC, my visits to the prisons, my understanding of the situation there as an expert in the field, and review of other carceral settings, I believe that the only way to help mitigate the rapidly rising outbreaks in Colorado's prisons is to reduce the prison population such that high risk persons can be appropriately distanced and housed and fewer people are at risk to contract the virus. In order to more fully advise the Court, I believe it would be most helpful to obtain updated numbers related to population, single celling, staffing, and outbreak patterns, which I have been told that Plaintiffs' counsel believe are currently being tracked by the Governor's COVID task forces, before a hearing.

I am willing to assist the Court as necessary in evaluating the level of population that can be sustained safely during this crisis.

Sincerely,

Brian Montague D.O.