

**SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX**

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In the Matter of the Application of
CHARLES HOLDEN and ALBERTO FRIAS on
behalf of themselves and all others similarly situated,

Index No.

Petitioner,

**JOINT AFFIRMATION OF
VICTORIA ADEWUNMI, M.D.
AND MARK FENIG, M.D.**

For a Judgment Pursuant to Article 78
of the Civil Practice Law and Rules,

- against -

HOWARD A. ZUCKER, as Commissioner of Health for New
York State, and ANDREW M. CUOMO, as Governor of the
State of New York,

Respondents.

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We, Victoria Adewunmi, M.D., and Mark Fenig, M.D., hereby affirm as follows:

Qualifications of Victoria Adewunmi, M.D.

1. I, Victoria Adewunmi, M.D., am over the age of eighteen and am competent to make this Affirmation.
2. I am a physician duly licensed to practice medicine in the State of New York. I have over 10 years of experience working as a full-time attending in the Bronx, NY..
3. I received my medical degree from SUNY Health Science Center in Brooklyn, NY. I completed my residency training in Emergency Medicine at Jacobi-Montefiore Medical Center in the Bronx, where I served as chief resident in my final year of training in 2007. After completing this specialty training, I served as a full time attending at the Moses Campus of Montefiore Medical Center from September 2007 - June 2013, and continued

on to the Jack D. Weiler Campus of the Montefiore Medical Center in July 2013, where I am still currently employed as a full time attending.

4. I have been an Assistant Professor of Emergency Medicine at the Albert Einstein College of Medicine since November 2010 to present, where my clinical work includes ongoing preceptorship and lecturing of emergency medicine residents, physician assistants and nurse practitioners on a variety of emergency medicine topics. I was a clinical Instructor of Emergency Medicine from October 2007 - October 2010, and Clinical Preceptor for the medical students of the Albert Einstein School of Medicine from October 2008 - June 2013.
5. As an emergency medicine physician in the Bronx, New York, a region that was particularly hard hit with severe COVID-19 infection, I have treated and continue to treat many patients infected with COVID-19.
6. As part of my clinical work, it is my responsibility to remain current on much of the relevant COVID-19 scientific literature and guidance from public health authorities including the CDC in order to educate patients about their individual risk factors for severe COVID-19 illness, methods of infection prevention, and risks and benefits of approved vaccines. By ensuring that I am updated on relevant literature and public health guidance, I ensure I am likewise knowledgeable on the COVID-19 transmission risks of particular settings and populations, as well as the criteria that should inform how vaccinations are prioritized.
7. I am an Associate of the Medical Justice Alliance, an organization made up of volunteer physicians in the public interest. I have contributed my medical expertise to efforts evaluating COVID-19 responses in correctional settings in Oregon and New York, which

include interviews and affidavits of personal knowledge of people confined in those settings. I am also familiar with the relevant medical literature about carceral settings.

Qualifications of Mark Fenig, M.D.

8. I, Mark Fenig, M.D., am over the age of eighteen and am competent to make this Affirmation.
9. I am a physician duly licensed to practice medicine in the State of New York. I have over 10 years of experience working as a full-time attending emergency medicine physician in the Bronx, New York.
10. I received my medical degree from the Sackler School of Medicine in 2007 and completed my Emergency Medicine residency training at Emory University School of Medicine in 2010. After completing my specialty training I served as a full time attending physician in Montefiore Medical Center's Department of Emergency Medicine – Weiler Division from August 2010 until August 2012. I was then a full time attending physician for NYC-HHC Lincoln Medical and Mental Health Center from August 2012 until August 2017. I then returned to the Montefiore Medical Center's Weiler Division where I resumed my full-time duties as an attending physician and where I am presently employed.
11. I have also held academic appointments at both Weill Cornell Medical School and the Albert Einstein College of Medicine. I am an Assistant Professor of Emergency Medicine at the Albert Einstein College of Medicine (November 2010 – 2014 and again from August 2017 – present). I was a clinical Instructor of Emergency Medicine at Weill Cornell Medical College (November 2012 – August 2017).

12. I am a Diplomate of the American Board of Emergency Medicine (certification valid from June 2011 to December 2021). I was a Fellow of the American Academy of Emergency Medicine (FAAEM 2012 – 2016), and a Fellow of the American College of Emergency Physicians (FACEP 2007 – 2012; 2017).
13. As an emergency medicine physician in the Bronx, New York, a region that was particularly hard hit with severe COVID-19 infection, I have treated and continue to treat many patients infected with COVID-19.
14. As part of my clinical work, it is my responsibility to remain current on much of the relevant COVID-19 scientific literature and guidance from public health authorities including the Centers for Disease Control and Prevention (“CDC”) in order to educate patients about their individual risk factors for severe COVID-19 illness, methods of infection prevention, and risks and benefits of approved vaccines. By ensuring that I am updated on relevant literature and public health guidance, I ensure I am likewise knowledgeable on the COVID-19 transmission risks of particular settings and populations, as well as the criteria that should inform how vaccinations are prioritized.
15. I am the Executive Director of the Medical Justice Alliance, an organization made up of volunteer physicians in the public interest. I have contributed my medical expertise to efforts evaluating COVID-19 responses in correctional settings in Oregon and New York. As part of my duties as Executive Director, I have both interviewed and reviewed affidavits of personal knowledge of people confined in those settings. I am also familiar with the relevant medical literature about carceral settings.

We, Drs. Fenig, and Adewunmi, jointly affirm the following:

The COVID-19 Emergency is Ongoing in New York City

16. New York City is fighting a resurgence of COVID-19 infections as we continue into winter. In November, positivity rates began rising after a summer of lower case and hospitalization numbers.¹ As of January 14, 2021, the New York City Department of Health reported an 8.30% weekly average positivity rate and increasing trends in confirmed cases, hospitalizations, and deaths.²
17. As the second wave in continues in New York City and statewide, the medical community is increasingly concerned about new variants of COVID-19 emerging globally. As of January 28, 2021, New York State has positively identified 22 cases of the new COVID-19 variant strain, B.1.1.7, first identified in the United Kingdom—and New York City has also identified presence of the variant in multiple boroughs.³ Though we are still learning about B.1.1.7, initial evidence suggests that it is more transmissible than the original strain.⁴
18. Other strains identified in South Africa, B.1.351, and Brazil, P.1, may also be more easily transmissible.⁵ P.1, perhaps the most concerning of all of the emerging variants, has

¹ Goldstein, Joseph. *This Is How The Outbreak Is Surging Across New York City*, THE NEW YORK TIMES, November 20, 2020, available at <https://www.nytimes.com/2020/11/20/nyregion/covid-19-nyc.html> (last visited January 15, 2021).

² COVID-19: Latest Data, NEW YORK CITY DEPARTMENT OF HEALTH, available at <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>.

³ *U.S. COVID-19 Cases Caused by Variants*, CENTERS FOR DISEASE CONTROL AND PREVENTION (January 28, 2021), available at <https://www.cdc.gov/coronavirus/2019-ncov/transmission/variant-cases.html>; see also O’Connell-Domenech, *Two NYC residents reported to have new COVID-19 variant first identified in the UK*, AMNY, January 13, 2021, available at <https://www.amny.com/news/two-nyc-residents-positive-for-uk-covid-19-strain/>.

⁴ Interim: Implications of the Emerging SARS-CoV-2 Variant VOC 202012/01, CENTERS FOR DISEASE CONTROL AND PREVENTION, available at <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-emerging-variant.html>.

⁵ Bill Chappell, *Moderna Finds COVID-19 Vaccine Still Protects Against Variants*, NATIONAL PUBLIC RADIO (January 25, 2021), available at <https://www.npr.org/sections/coronavirus-live-updates/2021/01/25/960341384/moderna-finds-covid-19-vaccine-less-effective-against-variant-found-in-south-afr>;

already been detected in the United States.⁶ Ending widespread transmission of SARS-CoV-2 via widespread vaccination efforts is our best effort to limit the spread of variants, which are likely to become more virulent as the pandemic continues. The potential effects of these mutated strains of SARS-CoV-2⁷ only heighten the need for both strict adherence to public health guidance and urgent, effective vaccine distribution plans—plans that target high-risk settings and populations.

Congregate Residential Settings Pose Elevated Risks of COVID-19 Transmission

19. Congregate residential settings pose a very high risk of transmission both because of the physical realities of shared spaces and the inability of inhabitants to control their environments and ensure adherence to self-protective public health measures.
20. One physical reality of congregate settings is the increased likelihood of airborne transmission. The CDC has stated that high risk airborne droplet transmission of SARS-CoV-2 occurs in enclosed spaces, during prolonged exposure to respiratory particles, and in settings with inadequate ventilation or air handling.⁸ Other studies have demonstrated that SARS-CoV-2 is spread through non-contact transmission⁹ (such as droplets or airborne particles) and is particularly dangerous in indoor environments that are crowded

Michaeleen Doucleff, *Why Scientists Are Very Worried About the Variant From Brazil*, NATIONAL PUBLIC RADIO (January 27, 2021), available at <https://www.npr.org/sections/goatsandsoda/2021/01/27/961108577/why-scientists-are-very-worried-about-the-variant-from-brazil>.

⁶ *Id.*

⁷ Unless otherwise specified, “SARS-CoV-2” and “COVID-19” will be used interchangeably throughout this declaration.

⁸ CENTERS FOR DISEASE CONTROL AND PREVENTION, SCIENTIFIC BRIEF: SARS-COV-2 AND POTENTIAL AIRBORNE TRANSMISSION (OCT. 5, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html>.

⁹ Jasper Fuk-Woo Chan et al., *Surgical Mask Partition Reduces the Risk of Noncontact Transmission in a Golden Syrian Hamster Model for Coronavirus Disease 2019 (COVID-19)*, 71 CLINICAL INFECTIOUS DISEASES 16, 2139 (2020), available at <https://academic.oup.com/cid/article/71/16/2139/5848814>.

and poorly ventilated.^{10,11} The CDC brief specifies that airborne transmission of SARS-CoV-2 occurs in “enclosed spaces within which an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space.”¹² When a setting contains more people within an enclosed space, the likelihood of exposure interactions such as the ones the CDC describes increases.

21. Other physical realities are likewise drivers of transmission risk. The New York City Department of Health defines congregate settings as “an environment in which a group of usually unrelated persons reside, meet, or gather either for a limited or extended period of time in close physical proximity. Examples include homeless shelters, assisted living facilities, group homes, prisons, detention centers, schools and workplaces.”¹³ People in these settings share common spaces to eat, bathe, socialize, and even sleep. Staff enter and exit the facilities every day, carrying a risk of exposure and transmission. Research on nursing homes, a congregate residential setting, demonstrates the serious dangers of transmission of SARS-CoV-2 from infected workers—both symptomatic and asymptomatic—to the residents of the setting.¹⁴ The nature of the settings themselves necessitate close proximity to other people beyond the control of individual residents.

¹⁰ Lidia Morawska & Donald K. Milton, *It Is Time to Address Airborne Transmission of Coronavirus Disease 2019 (COVID-19)*, 71 CLINICAL INFECTIOUS DISEASES 9, 2311 (2020), available at <https://academic.oup.com/cid/article/71/9/2311/5867798>.

¹¹ Keun-Sang Kwon et al., *Evidence of Long-Distance Droplet Transmission of SARS-CoV-2 by Direct Air Flow in a Restaurant in Korea*, 35 J. KOREAN MED. SCI. 46, 415 (2020), available at <https://jkms.org/DOIx.php?id=10.3346/jkms.2020.35.e415>.

¹² CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra*.

¹³ COVID-19: Guidance for Congregate Settings, NEW YORK CITY DEPARTMENT OF HEALTH (April 4, 2020), available at <http://wnylc.com/wp-content/uploads/2020/04/guidance-for-congregate-settings-covid19.pdf>.

¹⁴ M. Keith Chen, *Nursing home staff networks and COVID-19*, PNAS (January 5, 2021) 118 (1) e2015455118, available at <https://doi.org/10.1073/pnas.2015455118>.

22. One significant reason people in coercive congregate settings cannot protect themselves against contracting COVID-19 is that usually they are powerless to control or respond with autonomy to the reckless behavior of others. The protective efficacy of masks is higher when masks are worn by the virus spreader, and there is a synergistic effect when masks are worn by all.¹⁵ While wearing one's mask provides some protection against virus particles, individuals are reliant on those around them to also wear masks to minimize virus spread. In settings where social distancing is limited or impossible, such as congregate living settings, the full effectiveness of masks relies on every person complying with masking policies.
23. A final but critical note on COVID-19 transmission in congregate residential settings: when assessing the risk level of an environment, it is essential to remember that the most robust of COVID-19 protocols cannot sufficiently prevent transmission in a congregate living space. There is evidence that even if a congregate setting follows all public health guidelines, the nature of the setting still results in a greater risk of COVID-19 transmission than non-congregate settings.¹⁶¹⁷ A recently published study of SARS-CoV-2 infections among Marine recruits demonstrates this inevitable risk. The United States Department of Defense “implemented recommended public health interventions” in a vigorous set of protocols: “recruits underwent a 2-week quarantine at home followed by a

¹⁵ Hiroshi Ueki et al., *Effectiveness of Face Masks in Preventing Airborne Transmission of SARS-CoV-2*, AM. SOCIETY FOR MICROBIOLOGY E00637 (2020), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7580955/>.

¹⁶ Andrew G. Letizia et al., *SARS-CoV-2 Transmission among Marine Recruits during Quarantine*, N ENGL J MED (2020); 383:2407-2416, available at <https://www.nejm.org/doi/full/10.1056/NEJMoa2029717>.

¹⁷ Scott Goldberg et al., *Presymptomatic Transmission of Severe Acute Respiratory Syndrome Coronavirus 2 Among Residents and Staff at a Skilled Nursing Facility: Results of Real-time Polymerase Chain Reaction and Serologic Testing*, CLINICAL INFECTIOUS DISEASES (July 15, 2020), available at <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa991/5871989>.

second, strictly supervised 2-week quarantine at a closed college campus that required mask wearing, social distancing, and daily temperature and symptom monitoring.”¹⁸

Recruits were mandated to clean and sanitize their rooms daily and bathrooms after each use; instruction and exercise took place almost completely outdoors and instructors themselves were subject to the same protocols and screening requirements, even remaining on the campus for the entire period.¹⁹ The litany of mandatory, robust protocols was not sufficient to permit transmission—by the end of the 14-day quarantine period, 2% of recruits still tested positive—and researchers pointed to the congregate nature of double-occupancy rooms, shared dining facilities, and shared bathrooms as the drivers of transmission risk.²⁰

24. This study sharpens the conclusion widely shared by the medical community: congregate living spaces are settings that pose inherent risks of COVID-19 transmission and the serious illness and death that can result.

Correctional Facilities, Such As New York City Jails, Are Exceptionally Risky Congregate Settings

25. Jails and prisons are among the congregate settings most likely to foment transmission of COVID-19. Correctional facilities share the trademark characteristics of other congregate residential settings:²¹ shared sleeping spaces, whether in a dorm or a cell, shared eating

¹⁸ Letizia, *supra*.

¹⁹ *Id.*

²⁰ *Id.*

²¹ An interview of and an article by Dr. Rachael Bedard, one of the clinicians at Correctional Health Services, the entity that provides medical services to people in New York City custody, offers descriptions of DOC facilities that comport with these congregate characteristics. See Jennifer Gonnerman, *A Rikers Island Doctor Speaks Out to Save Her Elderly Patients from the Coronavirus*, THE NEW YORKER, March 20, 2020, available at <https://www.newyorker.com/news/news-desk/a-rikers-island-doctor-speaks-out-to-save-her-elderly-patients-from-the-coronavirus>; Rachael Bedard, *I'm a doctor on Rikers Island. My patients shouldn't have to die in jail.*, THE WASHINGTON POST, April 10, 2020, available at https://www.washingtonpost.com/outlook/doctor-rikers-compassionate-release/2020/04/10/07fc863a-7a93-11ea-9bee-c5bf9d2e3288_story.html.

spaces, shared toilets, sinks, and showers. Common areas include, but are not limited to, housing unit day rooms where there are benches for communal seated gathering, shared phones, and televisions; areas where people in custody are expected to line up, such as the food or medication line; and the mess hall where they dine.

26. Correctional settings also have a daily churn of staff in and out of the facilities, posing a serious transmission risk as they travel back and forth from the community. In the California prison system, for example, the court-appointed federal receiver warned that “staff [were] the main vector for spreading COVID-19 in the state prisons.”²² This staff-based transmission is evident in other congregant living settings.²³ That risk will not be abated in the near future—correctional staff have only begun to be vaccinated under the New York State plan²⁴ or may decline or be medically ineligible for the vaccine. People who are vaccinated may also transmit the virus.²⁵ People in congregate residential settings like the city jails cannot be protected absent widespread vaccination of everyone in the setting.

27. People held in jails and prisons cannot protect themselves against contracting COVID-19 because they cannot respond with autonomy when other people in custody and staff refuse to follow public health guidance. They have no authority to require others in their housing units to wear masks, nor can they ensure that other people will maintain six feet

²² *Plata et al v. Newsom et al*, 4.01-cv-01351-JST (N.D. Cal), Joint Statement, ECF No. 3345 at 3, available at <https://rbgg.com/wp-content/uploads/3345-Plata-Joint-CMC.pdf>.

²³ Goldberg et al., *supra*.

²⁴ *Governor Cuomo Announces Additional New Yorkers, Individuals 75 and Older Can Begin Scheduling with Providers COVID-19 Vaccination Appointments*, GOVERNOR’S PRESS OFFICE, January 11, 2021, available at <https://www.governor.ny.gov/news/governor-cuomo-announces-additional-new-yorkers-individuals-75-and-older-can-begin-scheduling>.

²⁵ COVID-19 Vaccine: What You Need to Know, JOHNS HOPKINS MEDICINE, December 23, 2020, available at <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid-19-vaccine-what-you-need-to-know> (last visited January 19, 2021).

of distance or move their bed to gain more distance from others. They are constricted from leaving settings in which others are not complying with public health guidance, or where the setting itself is dangerous, such as a closed, poorly ventilated space. As described above, this inability to control the environment puts incarcerated people at inevitable risk.

28. Unlike other congregate settings, detention settings pose an additional layer of risk:

people in custody are forced to rely on the facility to provide every basic human need, and are subject to security measures as the facility provides it. They must rely on officer escorts to go to the mess hall, or a counsel visit, or to the medical clinic. Officers sometimes use physical force, and must conduct regular rounds through the unit. This reality necessitates additional contacts between people in custody and staff, increasing transmission risks. Research demonstrates the real dangers of these contacts in correctional settings, even brief exposures involving protective equipment. A CDC study published in October found that a correction officer in Vermont likely contracted COVID-19 from brief exposures to six asymptomatic people in custody during one tour—despite video showing that the officer properly donned a mask, gown, and eye protection, and never spent fifteen consecutive minutes within six feet of the people in custody.²⁶

29. Studies have shown that spread of SARS-CoV-2 is more likely in crowded, poorly ventilated indoor environments.^{27,28,29} Communal eating, which necessitates removal of a

²⁶ J.C. Pringle et al., *COVID-19 in a Correctional Facility Employee Following Multiple Brief Exposures to Persons with COVID-19*, Vermont, July-August 2020, MMWR MORB MORTAL WKLY REP 2020; 69:1569-1570, available at <http://dx.doi.org/10.15585/mmwr.mm6943e1>.

²⁷ Lidia Morawska & Donald K. Milton, *supra*.

²⁸ Keun-Sang Kwon et al., *supra*.

²⁹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra*.

mask, is a particularly perilous activity, as there is no barrier to mitigate the viral spread.³⁰³¹ This danger exists in the spectrum of meal settings found in jails and prisons, from mess halls, to shared dayrooms, and even individual cells in close proximity to one another.

30. The characteristics of other congregate living spaces in conjunction with a pronounced lack of agency in controlling the environment and managing basic necessities render correctional settings particularly susceptible to COVID-19 transmission.

Incarcerated Populations Have Greater Likelihood of Poor Health Outcomes

31. People in custody have an overrepresentation of comorbidities that increase the likelihood poor health outcomes in the course of COVID-19 disease. Compared to the broader population, incarcerated people have significantly higher rates of infection and chronic disease.³² They are more likely to present with pre-existing conditions such as obesity, cardiac disease, hypertension, and asthma.³³³⁴³⁵³⁶³⁷
32. The health vulnerabilities of the incarcerated population render them particularly susceptible to serious illness from a COVID-19 infection. The disease course of COVID-19 is varied. While most infected individuals have mild or no symptoms, hundreds of thousands of people infected with SARS-CoV-2 virus suffered a moderate to severe

³⁰ Jasper Fuk-Woo Chan et al., *supra*.

³¹ Keun-Sang Kwon et al., *supra*.

³² David H. Cloud et al., *Addressing Mass Incarceration: A Clarion Call for Public Health*, AM J PUBLIC HEALTH, 2014 March; 104(3):389-391, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3953768/>.

³³ Emily A. Wang et al., *Cardiovascular Disease in Incarcerated Populations*, J AM COLL CARDIOL (2019), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6342510/>.

³⁴ Maruschak L, Berzofsky M, Unangst J., *Medical problems of state and federal prisoners and jail inmates*, 2011-12. NCJ-248491, Bureau of Justice statistics; US Department of Justice, Washington, DC 2015.

³⁵ Paul Mathew et al., *Cancer in an incarcerated population*, CANCER (2005), available at <https://pubmed.ncbi.nlm.nih.gov/16206295/>.

³⁶ J. Baillargeon et al., *The disease profile of Texas prison inmates*, ANN EPIDEMIOL. (2000), available at <https://pubmed.ncbi.nlm.nih.gov/10691060/>.

³⁷ Joseph W. Frank et al., *Neighborhood Incarceration Rate and Asthma Prevalence in New York City: A Multilevel Approach*, AM J PUBLIC HEALTH (2013), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670652/>.

disease course that often resulted in death. Much of the damage wrought during the disease process is pulmonary, and manifests as a viral pneumonia. Patients who suffer from COVID-19 pneumonia often need supplemental oxygen in a hospital setting to assist their breathing. In severe cases of the disease, this supplemental oxygen must be supplied by some form of mechanical ventilation. Some patients progress to even more severe forms of the disease when their responding immune systems begin to ‘inadvertently’ damage their own organs. Frequently, patients, many of whom we have personally cared for, progressed to this severe form of disease. Their kidneys often fail and some have had cardiogenic shock (severe failure of the heart to pump blood), and they develop shock states requiring different forms of life support medications.

Unfortunately, despite aggressive measures with all available treatments, COVID-19 proves fatal in many patients who suffer severe consequences of disease.

33. It is now well-documented that certain pre-existing diseases predispose patients to a more severe course of COVID-19 disease.³⁸ These pre-existing conditions include, but are not limited to, obesity, diabetes, cardiac disease, hypertension, and reactive airway disease. Advanced age, while not a disease, has also been identified as a major determinant for risk of a severe form of COVID-19. All of these factors indicate that incarcerated people in correctional settings like the New York City jails are, on average, more likely to be susceptible to a serious course of COVID-19, should they contract it. The population is, on the whole, particularly vulnerable from a medical and public health standpoint.

³⁸ CENTERS FOR DISEASE CONTROL AND PREVENTION, EVIDENCE USED TO UPDATE THE LIST OF UNDERLYING MEDICAL CONDITIONS THAT INCREASE A PERSON’S RISK OF SEVERE ILLNESS FROM COVID-19 (Nov. 2, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/evidence-table.html>.

There is No Public Health or Medical Justification to Exclude Incarcerated People from Vaccine Eligibility While Prioritizing Other Congregate Settings

34. The CDC asserts that recommendations about how state and local governments should prioritize vaccine access were developed according to the following principles: decrease death and serious illness as much as possible, preserve functioning of society, and reduce the extra burden COVID-19 is having on people already facing disparities.³⁹ Further, the CDC’s Advisory Committee on Immunization Practices (ACIP) supported four fundamental principles to guide COVID-19 vaccine allocation decisions during the time of limited supply, as suggested from the vast recommendations put forth by its COVID-19 work group: “1. Maximize benefits and minimize harms 2. Promote justice 3. Mitigate health inequities and 4. Promote transparency.”⁴⁰⁴¹ New York’s vaccine distribution plan asserts additional guiding principles, including that distribution should be based “solely on clinical and equitable standards that prioritize access to persons at higher risk of exposure, illness, and/or poor outcome, regardless of other unrelated factors, such as wealth or social status, that might confer unwarranted preferential treatment.”⁴² These principles inevitably counsel offering vaccine access to congregate settings, including correctional settings.

³⁹ *When Vaccine is Limited, Who Should Get Vaccinated First?*, THE CENTERS FOR DISEASE CONTROL AND PREVENTION (January 8, 2021), available at <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations.html>.

⁴⁰ Nancy McClung, PhD, et al., *The Advisory Committee on Immunization Practices’ Ethical Principles for Allocating Initial Supply of COVID-19 Vaccine – United States, 2020*, MMWR MORB MORTAL WKLY REP 2020; 69(47);1782-1786, available at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6947e3.htm>.

⁴¹ See also Helene Gayle et al., *A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus* (2020), A Consensus Study Report of THE NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, available at <https://www.nap.edu/read/25917/chapter/1>.

⁴² *New York State’s COVID-19 Vaccination Program*, NEW YORK STATE DEPARTMENT OF HEALTH (October 2020), available at https://www.cvph.org/data/files/NYS_COVID_Vaccination_Program_Book_10_16_20_.pdf.

35. To prevent serious illness and death in New York State, public health efforts must seek to (1) curb transmission of SARS-CoV-2 by offering vaccine access targeted at hotspots of COVID-19 spread, and (2) prioritize populations vulnerable to a serious course of disease should they contract the virus. Prisons and jails offer the opportunity to do both. First, correctional settings have proven to be significant hotspots for COVID-19 outbreaks. Jails are not closed systems, with staff and people in custody cycling in and out daily—and research demonstrates that outbreaks in the jails pose significant danger to their surrounding communities.⁴³⁴⁴ Vaccinating the jail population would be likely to reduce transmission both in the jail setting itself and in the community.
36. Second, prisons and jails allow public officials to target relief to a population that is particularly susceptible to serious illness and death from COVID-19, as outlined in detail above. The incarcerated population is also significantly comprised of Black and Latinx people and other communities who “are already facing disparities” and have felt the “extra burden of COVID-19.” The people incarcerated in New York City jails are more likely to come from and return to communities like the ones we treat in the Bronx, who have also faced COVID-19 disparities during the pandemic.⁴⁵⁴⁶ The connection between the people in DOC and the communities already facing serious impact of SARS-CoV-2 is

⁴³ *How COVID in Jails and Prisons Threatens Nearby Communities*, PEW STATELINE ARTICLE (July 1, 2020), available at <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/07/01/how-covid-19-in-jails-and-prisons-threatens-nearby-communities>.

⁴⁴ Stuart A. Kinner et al., *Prisons and custodial settings are part of a comprehensive response to COVID-19*, LANCET PUBLIC HEALTH, 2020 Apr; 5(4): e188-e189, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7103922/>.

⁴⁵ Greg David, *Bronx Grapples with “Deepest Inequalities in America” and COVID Surges Again*, THE CITY, available at <https://www.thecity.nyc/bronx/2020/11/29/21725453/bronx-inequality-racism-covid-hunger-health-jobs-housing>.

⁴⁶ *Mapping disadvantage: The geography of incarceration in New York State*, PRISON POLICY INITIATIVE (February 19, 2020), available at <https://www.prisonpolicy.org/origin/ny/report.html>.

another reason that prioritizing people in custody for the vaccine is consistent with the guiding CDC principles for vaccine distribution.

37. New York has rightfully prioritized vaccine eligibility for people living and working in congregate settings like homeless shelters, substance abuse and mental health treatment centers, and facilities for people with physical and intellectual disabilities.⁴⁷ The State criteria for eligible homeless shelters is an environment “where sleeping, bathing or eating accommodations must be shared with individuals and families who are not part of the same household.”⁴⁸ That criteria squarely describes prisons and jails like New York City Department of Correction facilities. There is no meaningful difference between that description of shelters and the characteristics of jails—excepting, of course, that the City forcibly detains individuals in the latter.
38. New York has also rightfully prioritized vaccine access for the staff of jails and prisons, consistent with the evidence-based conclusion that they are workers in a setting that puts them and their potential close contacts at risk. That policy does not, however, adhere to the CDC recommendation that States should consider “vaccination of staff and incarcerated/detained persons of correctional or detention facilities at the same time because of their shared increased risk of disease.”⁴⁹
39. As practicing clinicians, we can also attest that widespread vaccination of people in jails and prisons helps to make everyone safer—including the medical staff who treat them,

⁴⁷ *Governor Cuomo Announces Additional New Yorkers, Individuals 75 and Older Can Begin Scheduling with Providers COVID-19 Vaccination Appointments*, GOVERNOR’S PRESS OFFICE, January 11, 2021, available at <https://www.governor.ny.gov/news/governor-cuomo-announces-additional-new-yorkers-individuals-75-and-older-can-begin-scheduling>.

⁴⁸ *Id.*

⁴⁹ *COVID-19 Vaccination FAQs in Correctional Facilities and Detention Centers*, THE CENTERS FOR DISEASE CONTROL AND PREVENTION (January 11, 2021), available at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/vaccine-faqs.html>.

the jail staff in the setting alongside them, and the members of the community that staff and people in custody encounter when they leave the jails. There are myriad reasons why there might be incomplete or delayed vaccination among people within correctional settings. The broader New York City community may not have widespread vaccine access for months. Public health experts across the country must also compensate for the potential of vaccine hesitancy—an implementation difficulty from which even jail medical staff are not immune, as Senior Vice President of CHS Dr. Patricia Yang acknowledged to the New York City Board of Correction in a public meeting on January 12, 2021.⁵⁰ Finally, some people who may wish to have the vaccine might not be eligible due to medical reasons. It is therefore sound public health practice to expand access to all people within a particular setting to decrease the risk to everyone therein.

40. Excluding people in custody from the current vaccine eligibility structure is irrational from a medical and public health perspective. New York State is prioritizing staff and residents of one risky setting but only prioritizing staff in another, despite a body of evidence that the latter setting is at least as dangerous as the former. The distinction is, at best, arbitrary. It certainly does not align with available COVID-19 literature and CDC guiding principles of phased vaccine distribution.

Conclusion

41. Given the increased risk of COVID-19 transmission in congregate settings, the likelihood of risk factors of serious illness and death among the incarcerated population should they contract COVID-19, and the equity and effectiveness goals of vaccine prioritization


⁵⁰ See *January 12, 2021 Public Meeting*, NEW YORK CITY BOARD OF CORRECTION, available at <https://www1.nyc.gov/site/boc/meetings/january-12-2021.page>.


strategies, correctional settings like the New York City jail system should be prioritized for vaccine access.

42. New York State has rightfully expanded vaccine eligibility to congregate settings like homeless shelters and residents of facilities housing the intellectual and developmental disability community; it is sound public health policy. By the same token, there is no justifiable public health rationale to prioritize those congregate living settings while excluding correctional settings, which have proven to be one of the most inherently risky environments during the COVID-19 pandemic. If there is an explanation for including one setting but completely excluding the other, we do not see evidence in COVID-19 literature or our clinical experience that would indicate the distinction is one driven by science. It is our medical opinion that New York State should ensure that the statewide COVID-19 vaccine prioritization schedule is consistent internally, consistent with public health guidelines, and consistent with the science: by expanding vaccine eligibility to people confined in prisons and jails, like the New York City Department of Correction.

We affirm under penalty of perjury that the foregoing is true and correct.

EXECUTED WITHIN THE UNITED STATES ON: February 1, 2021.

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