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SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams,

Petitioner.

**PETITIONER'S OPENING BRIEF IN SUPPORT OF PERSONAL
RESTRAINT PETITION**

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I. INTRODUCTION

Three staff members at Coyote Ridge Corrections Center (Coyote Ridge) have contracted COVID-19 as of May 14, 2020.¹ There are currently 2,468 people incarcerated at Coyote Ridge.² Among them is Petitioner, Robert Rufus Williams; a seventy-seven year old black man who suffers from several serious health conditions.³ Mr. Williams has diabetes, hypertension, and he suffered a major stroke in 2010 that rendered him wheelchair-bound and infirm.⁴ The stroke largely immobilized his body's right side and weakened his fine motor skills.⁵ Without his therapy aids, he is unable to leave his cell or complete basic

¹ See Wash. St. Dep't of Corrections, *COVID-19 Information* (May 14, 2020), <https://www.doc.wa.gov/news/covid-19.htm>. Staff "self report" their positive COVID-19 tests. DOC does not independently verify the actual number of staff who are or have been infected with COVID-19. There are 422 reported cases of COVID-19, resulting in 16 deaths in Franklin County, WA, where Coyote Ridge is located. John Hopkins University, *COVID-19 Status Report: Franklin County, Washington*, <https://bao.arcgis.com/covid-19/jhu/county/53021.html> (last visited May 14, 2020) (updated daily).

² See Wash. St. Dep't of Corrections, *Coyote Ridge Corrections Center (CRCC)* (last visited May 14, 2020), <https://www.doc.wa.gov/corrections/incarceration/prisons/crcc.htm>.

³ App. 1 (Declaration of Robert Williams) at 4, ¶¶ 1, 5-9.

⁴ *Id.* ¶¶ 5-11.

⁵ *Id.* ¶¶ 8-9, 11.

tasks.⁶ Due to his age and health, Mr. Williams is at risk for serious organ damage or death if he contracts COVID-19.⁷

Coyote Ridge’s confinement of Mr. Williams has not—nor can it—keep him safe from its COVID-19 outbreak. Notwithstanding his age, disabilities, and serious underlying health conditions, Mr. Williams currently lives in the general population unit where he shares a cell with three other men.⁸ His multiple requests for a face mask were denied until April 17.⁹ Twice a day he is exposed to seventy plus people at mealtimes.¹⁰

Release is the only way to ensure Mr. Williams’s safety in these circumstances. Coyote Ridge is unable to maintain a reasonably safe environment for Mr. Williams as COVID spreads throughout its facility. It is impossible for them to do so for at least two inter-related reasons: the space and sanitation constraints in a prison, and Mr. Williams’ exceedingly vulnerable health. But the fact that it is impossible for Coyote Ridge to maintain a reasonably safe environment for Mr. Williams does

⁶ *Id.* at 4 ¶¶ 10.

⁷ Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): People Who Are at Higher Risk for Severe Illness*, <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html> (last visited May 14, 2020).

⁸ App. 1 (R. Williams Decl.) at 4 ¶¶ 15.

⁹ *Id.* at 4 ¶¶ 14; App. 2 (Robert Williams Supplemental Declaration) at 9 ¶¶ 2.

¹⁰ App. 1 (R. Williams Decl.) at 4 ¶¶ 18.

not relieve it of its constitutional duty to care for those it incarcerates nor void Mr. Williams' constitutional right to be free of cruel punishment. The threat that COVID-19 poses to Mr. Williams' health in prison has increased the severity of his sentence and rendered it disproportionate under article I, section 14 of Washington's Constitution. This increase in severity is unconstitutional because it is triggered not by the nature of the crime underlying his conviction, but instead by the State's inability to accommodate Mr. Williams' disabilities. Washington's Constitution forbids this. Further, Coyote Ridge's failures to make reasonable attempts to protect Mr. Williams evidence deliberate indifference to his health in violation of the Eighth Amendment.

Accordingly, his incarceration is unlawful under RAP 16.4(c)(6). Specifically, the conditions of his confinement violate: (1) the Washington State Constitution's cruel punishment prohibition, and (2) the federal Eighth Amendment.

II. STATEMENT OF ISSUES

- A. Whether Coyote Ridge’s inability to reasonably accommodate Mr. Williams’ disabilities and health needs amid the COVID-19 outbreak constitutes disproportionate punishment in violation of article I, section 14 of the Washington Constitution.**
- B. Whether Coyote Ridge’s failure to take reasonable measures to abate the known risk of serious harm COVID-19 presents to Mr. Williams amounts to deliberate indifference in violation of the U.S. Constitution’s Eighth Amendment.**

III. JURISDICTION

Under RAP 16.4, this Court “will grant relief to a petitioner if the petitioner is under a ‘restraint’ . . . and the petitioner’s restraint is unlawful.” RAP 16.4(a). The Washington Supreme Court has original jurisdiction over personal restraint petitions. *In re Pers. Restraint of Bell*, 187 Wn.2d 558, 562, 387 P.3d 719 (2017) (“sometimes the Washington Supreme Court is ‘the proper court’ for a personal restraint petition”). This Court, given the exercise of its supervisory powers to administer justice during the novel coronavirus pandemic, is the proper court to consider Mr. Williams’ petition.

Mr. Williams’ incarceration is a “restraint” under RAP 16.4(b). His confinement’s unconstitutional conditions render his restraint “unlawful” under RAP 16.4(c)(6). When a personal restraint petitioner challenges confinement conditions, the petitioner “need not make any threshold showing of prejudice; he must show only that he is under an unlawful

restraint as defined by RAP 16.4.” *In re Pers. Restraint of Stuhr*, 186 Wn.2d 49, 52, 375 P.3d 1031 (2016).

IV. STATEMENT OF CASE

A. COVID-19.

COVID-19 now constitutes a global health crisis.¹¹ As of May 14, it has claimed more than 287,399 lives worldwide,¹² 975 in Washington State,¹³ and 16 in Franklin County where Mr. Williams is incarcerated.¹⁴ The virus is not well-understood, and its impacts vary widely between patients, ranging from relatively mild flu-like symptoms to severe respiratory distress and death.¹⁵ A large proportion of those infected require extensive medical care, including treatment in intensive care units and ventilator support.¹⁶ According to the World Health Organization

¹¹ World Health Org., *Rolling Updates on Coronavirus Disease (COVID-19)*, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen> (last visited May 14, 2020).

¹² World Health Org., *Coronavirus Disease 2019 (COVID-19): Situation Report 114* (May 13, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200513-covid-19-sitrep-114.pdf?sfvrsn=17ebbbe_4.

¹³ Wash. St. Dep’t of Health, *2019 Novel Coronavirus Outbreak (COVID-19)*, www.doh.wa.gov/emergencies/coronavirus (last updated May 13, 2020).

¹⁴ John Hopkins University, *COVID-19 Status Report: Franklin County, Washington*, *supra* note 2.

¹⁵ Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Symptoms and Testing*, <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/index.html> (last visited May 14, 2020).

¹⁶ World Health Org.: Regional Off. for Europe, *Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance*, 10, 27 (Mar. 15, 2020), http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf.

(“WHO”), “[a]round one out of every five people who are infected with COVID-19 becomes seriously ill and develops difficulty breathing.”¹⁷

Although health experts are only beginning to understand the virus, it is believed to primarily spread when respiratory droplets from an infected person are inhaled or touched through person-to-person contact.¹⁸ Alarmingly, studies now indicate that the virus is spreading between carriers who exhibit no symptoms whatsoever.¹⁹

There is no vaccine, known treatment, or cure for COVID-19.²⁰ Accordingly, the CDC advises that the best protection is to avoid exposure to the virus. Public health officials have been clear: the best way to avoid exposure is by practicing social distancing. “Social distancing” refers to maintaining a recommended minimum of six feet between people. It is particularly critical in light of emerging evidence of asymptomatic spread.²¹ Other key recommendations issued by the CDC include wearing

¹⁷ *Id.*

¹⁸ Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): How COVID-19 Spreads*, www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html (last visited May 14, 2020).

¹⁹ *Id.*

²⁰ Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Situation Summary*, <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html> (last updated Apr. 19, 2020).

²¹ CDC, *How COVID-19 Spreads*, *supra* note 19.

masks that cover the nose and mouth, thoroughly cleaning and disinfecting frequently touched surfaces, and diligent hand hygiene.²²

B. Mr. Williams’ age, race and disabilities render him particularly vulnerable to serious organ damage or death should he contract COVID-19.

Mr. Williams is a seventy-seven-year-old African American man. He suffers from diabetes, hypertension, and is wheelchair-bound.²³ Without his therapy aids, Mr. Williams is unable to leave his cell or complete basic tasks.²⁴ He has suffered many falls since his stroke.²⁵ His most recent fall in early April of 2020 left him with sustained shoulder and neck pain.²⁶ Mr. Williams’ diagnosis qualifies as a disability under the Washington Law Against Discrimination (WLAD)²⁷ and the Americans with Disabilities Act (ADA).²⁸

²² Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): How to Protect Yourself & Others*, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html> (last visited May 14, 2020).

²³ App. 1 (R. Williams Decl.) at 3, ¶¶ 6-8.

²⁴ *Id.* at 4, ¶¶ 10.

²⁵ *Id.* ¶¶ 8; 11.

²⁶ *Id.* ¶¶ 11.

²⁷ Under the WLAD, disability is defined as “the presence of a sensory, mental, or physical impairment that...[i]s medically cognizable or diagnosable.” An “impairment” can include “[a]ny physiological disorder, or condition, cosmetic disfigurement or anatomical loss” that can affect the many body systems including the cardiovascular system. RCW 49.60.040(7)(a)(i)(c)(i).

²⁸ Under the Americans with Disabilities Act, disability is defined as “a physical or mental impairment that substantially limits one or more major life activities,” “a record of such impairment,” or “being regarded as having such an impairment.” 42 U.S.C. § 12102.

For a person of Mr. William’s age and underlying health difficulties, exposure to COVID-19 poses a grave risk of severe organ damage or death.²⁹ Mr. William is 11 years over age 65, the CDC “at risk” age marker.³⁰ His diabetes and hypertension are two of the health conditions directly linked with organ damage for persons who contract COVID-19.³¹ When the virus first emerged in China, people with diabetes had much higher rates of serious complications and death than people without diabetes.³² Mr. Williams also suffers from denigrated eyesight, which medical professionals have linked to his diabetes.³³ According to the American Diabetes Association, people with underlying diabetes-related health problems, such as denigrated eyesight or limb pain, are “likely to have worse outcomes if they contract COVID-19 than people with diabetes who are otherwise healthy.”³⁴

Mr. Williams’ hypertension is another serious COVID-19 comorbidity.³⁵ Hypertension, or high blood pressure, can lead to other

²⁹ CDC, *People Who Are at Higher Risk*, *supra* note 7.

³⁰ *Id.*

³¹ *Id.*

³² American Diabetes Association, *COVID-19 FAQ*, <https://www.diabetes.org/covid-19-faq> (last visited May 14, 2020).

³³ App. 1 (R. Williams Decl.) at 4, ¶¶ 9; App. 2 (R. Williams Supp. Decl.) at 9, ¶¶ 1.

³⁴ American Diabetes Association, *COVID-19 FAQ*.

³⁵ World Health Org., *Q&A on Coronaviruses (COVID-19)*, <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses> (last visited May 14, 2020).

health problems such as heart disease.³⁶ Should Mr. Williams contract COVID-19, he would need a strong heart to fight against the virus.³⁷ Doctor Maria Carolina Delgado-Lelievre, an assistant professor of medicine at the University of Miami's Miller School of Medicine, had blunt advice for protecting individuals, like Mr. Williams, who suffer from hypertension: "grab [them] and pull [them] into the house and do not let [them] out for two months."³⁸ Dr. Delgado-Lelievre continued by emphasizing that "[t]hose with hypertension have to be very cautious about maintaining the quarantine."³⁹

As an African American man, Mr. William's race is also linked to higher rates of severe COVID-19 symptoms and death.⁴⁰ Current data reveals a devastating over-representative of blacks in patients hospitalized for COVID-19, as well as those succumbing to the virus. A recent study of 580 patients hospitalized with lab-confirmed COVID-19 found that 33

³⁶ *High Blood Pressure (Hypertension)*, Mayo Clinic <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410> (last visited May 14, 2020).

³⁷ Ryan Prior, *Those with High Blood Pressure Are at a Greater Risk for Covid-19.*, CNN <https://www.cnn.com/2020/04/17/health/blood-pressure-coronavirus-wellness/index.html> (last updated Apr. 17, 2020).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): COVID-19 in Racial and Ethnic Minority Groups*, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html> (last visited May 14, 2020).

percent of the patients were black, as compared to 18 percent representation in the surrounding community.⁴¹ Across cities and states, black people consistently account for a percentage of deaths far greater than their representative portion of the population.⁴²

The CDC has stressed that for someone with Mr. Williams' age, race, and underlying conditions, social distancing and sanitation recommendations are especially critical. Not only is Mr. Williams more likely to contract COVID-19 due to his age, but his diabetes and hypertension make him unlikely to survive the viral assault on his respiratory system.

⁴¹ *Id.*

⁴² See Linda Villarosa, 'A Terrible Price': *The Deadly Racial Disparities of COVID-19 in America*, N.Y. Times Magazine (Apr. 29, 2020), <https://www.nytimes.com/2020/04/29/magazine/racial-disparities-covid-19.html>. In Louisiana, Black/African Americans, make up 33 percent of the population and account for 70 percent of the deaths; in Michigan, black people are 14 percent of the population but 40 percent of the deaths; in Wisconsin, black people are seven percent of the population but 33 percent of the deaths; in Mississippi, black people are 38 percent of the population but 61 percent of the deaths; in Milwaukee, black people are 39 percent of the population but 71 percent of the deaths; in Chicago, black people are 30 percent of the population but 56 percent of the deaths. *Id.*

⁴² While current explanations for the increased rate of COVID deaths among African Americans largely focus on socioeconomic factors and high rates of underlying conditions such as hypertension and diabetes, the CDC is currently conducting studies on biological explanations for the death rates. See CDC, *COVID-19 in Racial and Ethnic Minority Groups*, *supra* note 39 ("The effects of COVID-19 on the health of racial and ethnic minority groups is still emerging; however, current data suggest a disproportionate burden of illness and death among racial and ethnic minority groups.").

C. Coyote Ridge has failed to implement recommended social distancing or increase sanitation amid the COVID-19 outbreak.

Despite the outbreak of COVID-19 among its staff, Coyote Ridge has done little to implement social distancing or increase sanitation within the corrections center.⁴³ Twice a day, Mr. Williams is wheeled into the cafeteria where he is exposed to over seventy people during meals.⁴⁴ He eats no more than three feet away from fellow incarcerated persons.⁴⁵ Since learning of the pandemic, Mr. Williams asked for a face mask on at least three occasions.⁴⁶ Corrections officers refused to give him one.⁴⁷ It was not until two officers reported positive for COVID-19 that prisoners were given masks.⁴⁸ There has been no increase in his cell's cleaning.⁴⁹ Coyote Ridge has not lifted its ban on hand sanitizer and incarcerated people are still required to purchase their own soap from commissary.⁵⁰

⁴³ App. 1 (R. Williams Decl.) at 4-5, ¶¶ 13-23; App. 2 (R. Williams Supp. Decl.) at 9, ¶¶ 2-6.

⁴⁴ App. 1 (R. Williams Decl.) at 4, ¶¶ 18.

⁴⁵ *Id.*

⁴⁶ App. 2 (R. Williams Supp. Decl.) at 9, ¶¶ 2.

⁴⁷ *Id.*

⁴⁸ *Id.* (stating that Coyote Ridge distributed masks on Apr. 17, 2020 to all incarcerated persons); Wash. St. Dep't of Corrections, *COVID-19 Information*, *supra* note 1 (As of Apr. 17, 2020, two staff members reported confirmed positive diagnosis for COVID-19).

⁴⁹ App. 1 (R. Williams Decl.) at 5 ¶¶ 20.

⁵⁰ App. 1 (R. Williams Decl.) at 5 ¶¶ 19; App. 2 (R. Williams Supp. Decl.) at 9, ¶¶ 5.

D. Coyote Ridge lacks the capacity to determine the extent of the COVID-19 virus within its institution.

Coyote Ridge cannot adequately protect Mr. Williams without accounting for the number of asymptomatic people in its staff and the incarcerated population. COVID-19 has hit Washington’s prisons. There are currently 66 confirmed cases among incarcerated people and DOC staff.⁵¹ The confirmed cases and deaths are rising in Franklin County, where Mr. Williams is incarcerated.⁵² There are currently 422 confirmed cases and 16 reported deaths.⁵³ However, several considerations suggest that the true number of cases is almost certain to be drastically higher. As of April 13, the DOC had only 588 test kits⁵⁴ for the more than 17,000 people in its custody.⁵⁵ While many states have begun implementing mass

⁵¹ Wash. St. Dep’t of Corrections, *COVID-19 Information*, *supra* note 1.

⁵² See Spokesman-Review, *Yakima Has Top Rate of Virus Cases on West Coast*, May 3, 2020 at 9 (reporting that Franklin County, with 326 confirmed cases, had the second highest rate of infection among counties in the state. The confirmed cases have risen since then).

⁵³ John Hopkins University, *COVID-19 Status Report: Franklin County, Washington*, *supra* note 2.

⁵⁴ Resp’t Report on the Dep’t of Corrections’ COVID-19 Response at 11, *Shyanne Colvin, et al. v. Jay Inslee, et al.*, (2020) (No. 98317-8).

⁵⁵ DOC last updated its prison population figure on Jun. 30, 2018. Its census states it had 17,845 people in its custody as of that date. Washington State Department of Corrections, *Prison Facilities*, <https://doc.wa.gov/corrections/incarceration/prisons/default.htm> (last visited May 2, 2020). In its report to this Court in the *Colvin et. al. v. Inslee et. al.*, DOC stated that its incarcerated population is “approximately 18,000.” Resp’t Report on the Dep’t of Corrections’ COVID-19 Response at 2, *Shyanne Colvin, et al. v. Jay Inslee, et al.*, (2020) (No. 98317-8). However in that same report it claimed it had reduced its incarcerated population by approximately one thousand. *Id.* at 27. In oral arguments in the *Colvin* litigation, counselor for respondent claimed that “it is [his] understanding that

testing in prisons, the DOC currently only considers testing for those exhibiting symptoms.⁵⁶ This Court questioned the DOC about the lack of testing for asymptomatic individuals in the *Colvin et. al. v. Inslee et. al.* oral arguments. Justice Montoya-Lewis asked: “my question then is that if we know that asymptomatic transmission is occurring in the community, and we know that we don’t have enough testing to identify those asymptomatic carriers, how can we conclude that what the Department of Corrections is doing is reducing that spread if they are not able to ensure that there is social distancing throughout the system?”⁵⁷ In response, the DOC did not indicate it planned to change the testing policy, but rather

as of this coming weekend the prison population will actually will drop down below 16,000.” Oral Argument Counselor for Respondent at 25:58, *Shyanne Colvin, et al. v. Jay Inslee, et al.*, (2020) (No. 98317-8), <https://www.tvw.org/watch/?eventID=2020041052>.

⁵⁶Oral Argument, Justice Worswick at 41:02, *Shyanne Colvin, et al. v. Jay Inslee, et al.*, (2020) (No. 98317-8), <https://www.tvw.org/watch/?eventID=2020041052> (Justice Worswick: “Counsel, can you explain what you mean by “circumstances change”? If you aren’t testing people, what are the changed circumstances that you foresee would create a change in the reaction from the respondents?”); Oral Argument Counselor for Respondent at 41:15, *Shyanne Colvin, et al. v. Jay Inslee, et al.*, (2020) (No. 98317-8), <https://www.tvw.org/watch/?eventID=2020041052> (“Well your honor we are, the department is testing people, they have conducted over 300 tests, and have conducted the tests in accordance with the department of health guidelines and CDC guidelines, so if somebody is either, have [sic] a fever, over a hundred, or if they answer yes to any of the screening questions, such as have you had contact with anyone who is symptomatic of COVID, they will be screened, they will be tested.”).

⁵⁷ *Id.* at 44:23.

defended the current practice as mirroring what is “occurring in the community.”⁵⁸

This policy precludes the DOC from identifying asymptomatic infected individuals. Emerging data from states that have implemented mass testing in prisons paints a frightening picture: a recent analysis of mass testing in four states found that 96 percent of the 3,277 incarcerated people who tested positive for the virus were asymptomatic.⁵⁹ One correctional health expert, responding to the findings, noted that, “prison agencies are almost certainly vastly undercounting the number of COVID cases among incarcerated persons,” and that “the only way to get ahead of this outbreak is through mass testing.”⁶⁰ Marc Stern, former medical

⁵⁸ *Id.* at 44:50 (“Again your honor, social distancing is just one, one [sic] recommendation of the CDC. And the department is trying to the best of its ability to do that. The other thing is they have supplied masks, face coverings, and made it mandatory that both the incarcerated population and staff wear those. They also, depending on the circumstances require additional PPE to be worn, either by incarcerated individuals or staff. They, they [sic], the department, isolates individuals who are suspected, as well as confirmed, so right now there are 97 individuals in isolation, just uh, with only twelve confirmed tests, but they still have an additional 85 they put in isolation. And then they quarantine individuals, they do contact mapping, figure out who that individual came in contact with, and put those individuals in quarantine. The, that is CDC recommendation, that’s what would happen if that occurs in the community. You’d be put in isolation if you’re suspected or confirmed and put into isolation if you come into contact with somebody. That’s the same thing that’s occurring in the community.”).

⁵⁹ Linda So & Grant Smith, *In Four U.S. State Prisons, Nearly 3,300 Inmates Tested Positive for Coronavirus – 96% Were Asymptomatic*, REUTERS (Apr. 25, 2020), <https://www.reuters.com/article/us-health-coronavirus-prisons-testing-in/in-four-u-s-state-prisons-nearly-3300-inmates-test-positive-for-coronavirus-96-without-symptoms-idUSKCN2270RX>.

⁶⁰ *Id.*

director for the Washington State Department of Corrections and a faculty member at the University of Washington's School of Public Health, also commented publicly on the findings, agreeing that the large number of asymptomatic cases poses a major challenge to managing the virus' spread.⁶¹

E. Coyote Ridge cannot protect Mr. Williams' from COVID-19 or treat him should he contract the virus.

Public health experts agree that prisons are an especially dangerous setting for COVID-19 to spread.⁶² Their predictions have proven true; eight of the top ten hotspots for COVID-19 outbreaks in the United States are connected to jails and prisons.⁶³ A recent report identified more than 28,300 coronavirus infections and 273 deaths in incarcerated persons and staff at state prisons, federal prisons and local jails.⁶⁴

Considering the risk of asymptomatic spread, it is critical to Mr. Williams' safety that he practice social distancing to avoid exposure. However, under current conditions, this remains impossible. The shared facilities Mr. Williams resides in and his near constant close proximity to

⁶¹ *Id.*

⁶² WHO, *Preparedness, Prevention and Control*, *supra* note 17.

⁶³ *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. Times (last updated May 14, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?action=click&module=Top%20Stories&pgtype=Homepage&action=click&module=Spotlight&pgtype=Homepage#states>.

⁶⁴ *Id.*

others are especially conducive to an infectious disease outbreak.⁶⁵ DOC Secretary Sinclair conceded that no matter how well DOC screens people coming into the prisons, nothing it can do would prevent an asymptomatic infected person from spreading COVID-19 throughout the prison.⁶⁶ Mr. Williams is elderly and suffers from multiple COVID-19 comorbidities, yet lives the general population unit. When Dr. Michael Puisis and Dr. Ronald Shansky assessed the consequences of a COVID-19 outbreak in Washington prisons, they opined, “[o]ne couldn’t devise a system more contrary to current public health recommendations . . . than a prison, especially with classification systems that house *large numbers of elderly or persons with comorbid medical conditions* in the same housing units.”⁶⁷

Not only are prisons ill-suited to prevent COVID-19 from spreading, they lack the necessary medical equipment and trained medical professionals to care for incarcerated people who contract the virus.⁶⁸ Dr. Shansky and Dr. Puisis described the lack of resources in prison infirmaries and the consequent strain on nearby hospitals, stating:

⁶⁵ *Id.*

⁶⁶ Austin Jenkins, *A Washington Inmate Fears Coronavirus Could Sweep Through His Prison Like a Fire*, KUOW/NPR (Apr. 2, 2020), <https://www.kuow.org/stories/a-washington-inmate-fears-coronavirus-could-sweep-through-his-prison-like-a-fire>.

⁶⁷ App. 4 (Declaration of Dr. Michael Puisis and Dr. Ronald Shansky) at 26, ¶¶ 10 (emphasis added).

⁶⁸ WHO, *Preparedness, Prevention and Control*, *supra* note 17, at 9.

“[p]rison health care programs are internally not set up to manage hospital level care including ventilation. Typical arrangements of transferring prisoners to a hospital, in a setting of a pandemic with large numbers would overwhelm the security staff of the [DOC] and complicate arrangements at local hospitals.”⁶⁹

Coyote Ridge is no exception. It has not disclosed how many, if any, ventilators or doctors it has ready to care for Mr. Williams should he contract COVID-19. Connell, Washington, where Coyote Ridge is located, is a town of approximately 5,500 people.⁷⁰ Franklin County, where Connell sits, has 422 confirmed COVID-19 diagnoses and 95 licensed hospital beds, only four of which are registered as ICU beds.⁷¹ If Mr. Williams were to contract the virus after a critical mass of other incarcerated persons at CRCC already had, hospitals may not be able to treat him. It is unknown whether the neighboring hospitals, Trios Health in Kennewick (44 miles from Coyote Ridge) and Kadlec Medical Center in

⁶⁹ App. 4 (Puisis and Shansky Decl.) at 29, ¶ 13.

⁷⁰ City of Connell, *About Connell*,

https://www.cityofconnell.com/index.asp?SEC=C70E9D20-22E3-44C5-AEDB-2E8BA1AA87E6&Type=B_BASIC (last visited May 14, 2020); see Driving Directions from Coyote Ridge Correction Center to Trios Health, WA., Google Maps, <http://maps.google.com> (follow “Directions” hyperlink; then search starting point field for “Coyote Ridge Corrections Center, WA” and search destination field for “Trios Medical Center” or “Kadlec Medical Center”).

⁷¹ John Hopkins University, *COVID-19 Status Report: Franklin County, Washington*, *supra* note 2.

Richland (46 miles from Coyote Ridge), could handle the medical needs for even a portion of the 2,468 men⁷² within the prison alongside the rising number of cases in Franklin County.⁷³

F. Mr. Williams' Innocence Claim.

Mr. Williams has always maintained his innocence.⁷⁴ After exhausting his appeals, he applied to Washington Innocence Project (formerly Innocence Project Northwest) to seek post-conviction representation.⁷⁵ After a thorough internal review, Washington Innocence Project accepted Mr. Williams' case.⁷⁶ For the past two years, his legal team has worked to preserve biological evidence and pursue relief through post-conviction DNA testing.⁷⁷ When the COVID-19 pandemic reached Coyote Ridge, Mr. Williams' team shifted their advocacy to keep him safe from the virus that is progressively spreading through the prison where he is incarcerated.⁷⁸

V. ARGUMENT

The conditions of Mr. Williams' confinement violate the cruel punishment provision in article I, section 14 of the Washington State

⁷² Wash. St. Dep't of Corrections, *Coyote Ridge Corrections Center*, *supra* note 2.

⁷³ *Id.* (tracking the number of cases in Franklin county daily).

⁷⁴ App. 1 (R. Williams Decl.) at 6, ¶¶ 31.

⁷⁵ App. 3 (Declaration of Jacqueline McMurtrie) at 15, ¶¶ 5.

⁷⁶ *Id.*

⁷⁷ *Id.* ¶¶ 6-7.

⁷⁸ *Id.* at 16, ¶¶ 9.

Constitution. Punishment, once valid, can become cruel and therefore unconstitutional under article I, section 14 if material circumstances change. Given Mr. Williams' age, race and health conditions, COVID-19 constitutes a material change in circumstance which arbitrarily impacts the severity of his punishment. The State has failed to reasonably mitigate that risk for Mr. Williams amid the spread of COVID-19 where he is incarcerated. Coyote Ridge's inability to take reasonable precautions to protect a man of his age, underlying health conditions, disabilities, and race increase the severity of his sentence. Washington's Constitution prohibits this.

When article I, section 14 is invoked in a new context—such as conditions of confinement amid a COVID-19 outbreak—the material inquiry is not *whether* the provision affords broader protection than the Eighth Amendment, but *how* its broader protections apply in that new context. *See, e.g., Blomstrom v. Tripp*, 189 Wn.2d 400, 399-403, 402 P.3d 831 (2017) (finding Article I, section 7 provides more robust protection than the Fourth Amendment, and utilizing the *Gunwall* factors to establish the nature of heightened protection in the new context of pretrial detainees' privacy rights). A *Gunwall* analysis illustrates how Washington's cruel punishment provision prohibits Coyote Ridge from

allowing an incarcerated person’s age, race and disabilities to increase the severity of their sentence.

Mr. Williams’ confinement also violates the Eighth Amendment because Coyote Ridge has failed to take reasonable measures to decrease a known risk of serious harm to him. While less protective than the Washington Constitution, the Eighth Amendment prohibition against “cruel and unusual” punishment imposes duties on prison officials to take reasonable measures to guarantee the safety of people incarcerated in their care. *Farmer v. Brennan*, 511 U.S. 825, 832, 114 S.Ct. 1970, 1976 128 L.Ed.2d 811 (1994). A prison official’s deliberate indifference to this standard of care is established when the official “knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.” *Id.* at 847. Such indifference violates the Eighth Amendment. *Id.*

A. Washington State’s Constitution’s “cruel punishment” clause provides greater protection to individuals disproportionately punished by the changing circumstances of COVID-19.

Washington State’s “cruel punishment” provision “affords greater protection than its federal counterpart.”⁷⁹ *State v. Gregory*, 192 Wn.2d 1, 16, 427 P.3d 621 (2018). Implicit to this broader protection is Washington

courts' continuing duty to develop article 1, section 14 jurisprudence. *See, e.g., Id.* at 14–15 (“Where feasible, we resolve constitutional questions first under our own state constitution before turning to federal law.’ If we neglect this duty, we ‘deprive the people of their “double security.”” (quoting *Alderwood Assocs. v. Wash. Envtl. Council*, 96 Wn.2d 230, 238, 635 P.2d 108 (1981) (quoting *The Federalist* nos. 51, 339 (James Madison))). This Court has noted that “the scope of article I, section 14 . . . ‘is not static,’” and that “[w]here new, objective information is presented for consideration, [the Court] must account for it.” *Gregory*, 192 Wn.2d at 18 (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion)).

A *Gunwall* analysis demonstrates that article 1, section 14 forbids the arbitrary imposition of disproportionate and cruel punishment on incarcerated persons based on their age, race or disabilities.

- a. **A *Gunwall* analysis supports reading Washington’s “cruel punishment” provision to forbid punishment that severely, disproportionately and arbitrarily harms individuals based on age, race and disabilities.**

This Court applies six nonexhaustive criteria to determine when and how the Washington State Constitution extends broader rights than its federal counterpart: (1) textual language of the state constitution; (2) differences in the texts of parallel provisions of the federal and state

constitutions; (3) state constitutional and common law history; (4) preexisting state law; (5) structural differences between the federal and state constitutions; and (6) matters of particular state interest or local concern. *State v. Gunwall*, 106 Wn.2d 54, 61-62, 720 P.2d 808 (1986).

1. Factors One and Two: Plain Language, Differences Between State and Federal Provisions

The first two *Gunwall* factors support reading article I, section 14 to bar punishments that are disproportionate and arbitrary. Washington’s Constitution provides that “[e]xcessive bail shall not be required, excessive fines imposed, nor cruel punishment inflicted.” WASH. CONST. art. I, § 14. This provision is similar to the Eighth Amendment but omits the words “and unusual.” U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”). The distinction indicates that “[a]rticle 1, section 14, on its face, may offer greater protection than the Eighth Amendment, because it prohibits conduct that is merely cruel; it does not require that the conduct be both cruel and unusual.” *See State v. Dodd*, 120 Wn.2d 1, 21, 838 P.2d 86 (1992).

The exclusion of the word unusual is significant: “The historical evidence reveals that the framers of [Wash.] Const. art. 1, § 14 were of the view that the word ‘cruel’ sufficiently expressed their intent, and refused

to adopt an amendment inserting the word ‘unusual.’” *State v. Fain*, 94 Wn.2d 387, 393, 617 P.2d 720, 723-24 (1980). This aligns with a view that even where, as here, many people may be commonly impacted by a cruel condition, the fact that such cruelty is “usual” does not render that condition immune to constitutional scrutiny.

2. Factor Three: State Constitutional and Common Law History

A sentence, once proportional to the crime committed, can become cruel under article I, section 14 if there is a material change in circumstances. This Court has relied on advances in social science data and psychology to determine whether a sentence is disproportionate. Research developments in the area of juvenile decision-making capabilities rendered a sentence of life without the possibility of parole disproportionate cruel punishment for juvenile offenders. *State v. Bassett*, 192 Wn.2d 67, 91, 428 P.3d 343 (2018); *see also State v. O'Dell*, 183 Wn.2d 680, 695, 358 P.3d 359 (2015) (“in light of “advances in the scientific literature” concerning cognitive and emotional development, while not overruling *State v. Ha'mim*, 132 Wn.2d 834, 940 P.2d 633 (1997), we concluded that youth is far more likely to diminish a defendant’s culpability for sentencing purposes than we had implied in prior cases). In *Gregory*, 192 Wn. 2d at 12, research established “black

defendants were four and a half times more likely to be sentenced to death than similarly situated white defendants.” *Gregory* held that capital punishment becomes unconstitutionally disproportionate and arbitrary when people are subjected to it because of their race rather than the nature of their crime. 192 Wn.2d at 35.

3. Factor Four: Pre-Existing State Law

When considering other bodies of law that “bear on the granting of distinctive state constitutional rights,” the Court is not limited to law that pre-dates or was enacted contemporaneously to the provision at issue. *Gunwall*, 106 Wn.2d at 61, 720 P.2d 808. The fourth *Gunwall* factor also calls on the Court to address contemporary statutes, case law, and modern trends in constitutional jurisprudence. When considering the constitutionality of juvenile life without parole sentences, the *Bassett* Court rejected arguments based on 100-year-old cases approving death sentences for children. 192 Wn.2d at 81. Instead, the Court reasoned that “it is more instructive to look at how our jurisprudence on juvenile sentencing has evolved to ensure greater protections for children,” and relied on modern case law and statutes to hold that sentencing juvenile offenders to life without parole or early release constitutes cruel punishment. *Id.* at 90.

Three bodies of contemporary statutes, case law, and modern trends support reading article 1, section 14 to prohibit the arbitrary imposition of disproportionate and cruel punishment on incarcerated persons on the basis of their age, race or disabilities.

a. The State has a duty to protect those in its custody.

For over 100 years, Washington courts have recognized that prison and jail officials have an affirmative duty to protect the health and safety of the people they incarcerate. *See Kusah v. McCorkle*, 100 Wash. 318, 323 (1918) (jails have a duty to people it incarcerates “to keep [them] in health and safety”). The reasoning behind the responsibility is simple: “when one is arrested and imprisoned for the protection of the public, he is deprived of his liberty, as well as his ability to care for himself.” *See Shea v. City of Spokane*, 17 Wn. App. 236, 241-42, 562 P.2d 264 (1977), *aff’d*, 90 Wn.2d 43, 578 P.2d 42 (1978).

To meet this duty, Coyote Ridge must recognize the *individual* health and safety needs of each person it incarcerates, including needs arising from an incarcerated person’s age and disabilities. As DOC policies recognize in other contexts, the health and safety of prisoners with disabilities requires individual assessment. All DOC facilities must develop emergency procedures “for the rapid identification and safe evacuation of all offenders with disabilities. Offenders with disabilities

will be instructed on emergency procedures *specific to their needs*.”⁸⁰

Placement of “[o]ffenders with disabilities” must be “consistent with their health, safety, and security requirements.”⁸¹

b. The Washington Law Against Discrimination prohibits unfair treatment of people based on race, age, or disabilities.

In enacting the Washington Law Against Discrimination (WLAD), the legislature expressly recognized the right of individuals to be free from discrimination based on race, age, or disability.⁸²

The WLAD was enacted in 1949 and in its original form, provided protections only from discrimination based on race or national origin.⁸³ In 1961, the statute was amended to prohibit age-based discrimination.⁸⁴ In 1973, as society increasingly came to recognize the widespread, systemic marginalization of people with disabilities, the law was amended to protect against disability-based discrimination.⁸⁵ The WLAD, for more than four decades, has served as formal declaration with the power of law that “[disability-based] discrimination against any of [Washington’s] inhabitants . . . [is] a matter of state concern” and that such discrimination

⁸⁰ See Dep’t of Corrections Policy No. 690.400 (emphasis added).

⁸¹ *Id.*

⁸² RCW 49.60.010.

⁸³ 1949 Wash. Sess. Laws 506.

⁸⁴ 1961 Wash. Sess. Laws 1586.

⁸⁵ 1973 Wash. Sess. Law 1648.

“threatens not only the rights and proper privileges of its inhabitants[,] but menaces the institutions and foundation of a free democratic state.”⁸⁶

c. The “cruel punishment” provision requires fundamental fairness in punishment.

Article 1, section 14 jurisprudence is deeply concerned with principles of “fundamental fairness,” equal outcomes for those similarly situated, and avoiding disproportionate punishment. *See, e.g., State v. Bartholomew*, 101 Wn.2d 631, 640, 683 P.2d 1079 (1984) (“[w]here the trial which results in imposition of the death penalty lacks fundamental fairness, the punishment violates article 1, section 14”); *Fain*, 94 Wn.2d at 402 (deeming a sentence disproportionate to seriousness of crimes constitutes cruel punishment in violation of article 1, section 14).

Washington courts have long observed that this fundamental principle of fairness “is not static, but rather, ‘must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.’” *See Fain*, 94 Wn.2d at 397 (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)). In *Gregory*, this Court recognized and acted upon its duty to reconsider whether the death penalty constituted cruel punishment in light of substantial evidence on the record indicating racial inequity in the death penalty’s administration. 192 Wn.2d at 18. Although Washington courts

⁸⁶ *Id.*

had, up to that point, repeatedly upheld the practice in the face of constitutional challenges, *Gregory* held that Washington’s death penalty constituted cruel punishment in violation of article 1, section 14, because of the “arbitrary and racially biased manner” in which it was applied. 192 Wn.2d at 35.

The same principles relied upon by the *Gregory* Court ring true here: Washington’s constitution requires fundamental fairness in punishment. Administering punishment in a way that lets immutable traits such as age, race, or disabilities increase a punishment’s severity violates that protection. And where the consequence of a discretionary treatment of an incarcerated person may be death, the State has a responsibility to avoid exercising that discretion in a way that arbitrarily punishes individuals based on their immutable characteristics.

4. Factor five: Structural Differences Between State and Federal Constitutions.

Unlike the Federal Constitution, the Washington Constitution grants positive rights. *Grant Cty. Fire Prot. Dist. No. 5 v. City of Moses Lake*, 150 Wn.2d 791, 811, 83 P.3d 419 (2004) (“Where the [F]ederal [C]onstitution is a grant of enumerated powers, the state constitution serves to limit the sovereign power, which directly lies with the residents and indirectly lies with the elected representatives.”). The “cruel

punishment provision” is part of article I’s “Declaration of Rights.” That article’s protections are “absolute.” *See State v. Schelin*, 147 Wn.2d 562, 579, 55 P.3d 632 (2002) (Sanders, J., dissenting) (“Although the constitutional right to bear arms is not unlimited in scope, *within* its scope that right is absolute”). The neighboring article I, section 12 Privileges and Immunities clause solidifies the positive nature of the right, stating “each citizen enjoys equal privilege to the right guaranteed by this provision.” *Id.* at 589, 646 (Sanders, J., dissenting); WA. CONST. art. I, § 12.

The right to be free from cruel punishment – and the Constitution’s promise to protect that right – prohibits the arbitrary imposition of disproportionate and cruel punishment on incarcerated persons based on their age, race or disabilities.

5. Factor Six: Matters of State and Local Concern

The Court must decide “whether the right claimed, in the context of the particular case before us, is a matter of such singular state interest or local concern that our constitution should be interpreted independently of the federal constitution.” *State v. Foster*, 135 Wn.2d 441, 461, 957 P.2d 712 (1998). The right to be free from cruel punishment imposed on those incarcerated within Washington State’s prisons is a matter of state and local concern.

Washington leaders, rather than their federal counterparts, are taking the most direct action to combat the virus in Washington State.⁸⁷ The novel virus impacting our region requires local leaders to protect incarcerated persons whose age, race and disabilities make them particularly susceptible to falling ill. Washington's constitution cannot tolerate inaction that results in disproportionately harsh conditions of confinement for some of the most vulnerable citizens of our state.

In sum, Washington's cruel punishment provision is more protective than its federal counterpart in the context of a novel virus arbitrarily and disproportionately threatening people the state incarcerates on the basis of age, race or disabilities.

b. Mr. Williams' continued incarceration during the COVID-19 pandemic violates Washington State's Constitution's "cruel punishment" prohibition because it results in disproportionate punishment.

At least two interrelated changes in circumstances render Mr. Williams' sentence constitutionally disproportionate. The first is the steady spread of COVID-19 in an institution unable to keep Mr. Williams safe from exposure or care for him if he contracts the novel virus. The

⁸⁷ See *Proclamation of the Governor No. 20-05: Reducing Prison Population*, Wash. Off. of the Governor (Apr. 15, 2020) (ordering various actions to address risk to incarcerated population in light of the "continued worldwide spread of COVID-19, its significant progression in Washington State, and the high risk it poses to our most vulnerable populations").

second is Mr. Williams' immutable characteristics. Taken together, these changes in circumstances make what was once a valid sentence disproportionate and cruel under Washington's Constitution.

Mr. Williams' age, race, and disabilities play a critical role in his sentence's cruelty under Washington's Constitution. Risk of exposure to COVID-19 became an unofficial, yet real, part of the sentence for every person incarcerated in Coyote Ridge the day the first two staff members reported positive for the virus. For Mr. Williams, this new element to his sentence is exacerbated by his age, race, and disabilities. The imminent, ongoing, and severe risk of serious bodily harm or death posed by Mr. Williams' conditions of confinement serve no penological purpose. Nor does it bear any relationship to the crime of conviction. Instead, it arises from the interplay of factors outside his control: his immutable characteristics, the COVID-19 crisis, and the State's response to that crisis.

Washington's Constitution prohibits this. Under the doctrine of proportionality, only the gravity of the crime committed can increase the gravity of the sentence. *See, Fain*, 94 Wn.2d at 392–93; *State v. Manussier*, 129 Wn.2d 652, 676, 921 P.2d 473, 484–85 (1996). When this Court confronted life without the possibility of parole sentences for juveniles, it made clear that the offender's biological traits can render a

sentence disproportionate regardless of the nature of the crime. *See Bassett*, 192 Wn.2d at 90 (acknowledging that “while aggravated murder warrants a serious punishment, youth convicted of the offense have the special protections” that required the Court to consider their diminished mental capacity in sentencing).

In *Gregory*, the Court was presented with evidence that a person’s immutable trait of race, rather than the nature of the crime, resulted in a heightened sentence. 192 Wn.2d at 35. Given that evidence, the Court found Washington’s death penalty arbitrary and disproportionate in violation of article 1, section 14. *Id. Gregory* held that Washington’s death penalty is unconstitutional “*as administered*, because it is imposed in an arbitrary and racially biased manner.” *Id.* at 35 (emphasis added). Critically, in *Gregory* the Court did not rule that the defendant had suffered from race discrimination.⁸⁸ Instead, the injury in *Gregory* was an unacceptable risk of constitutional deprivation based on race.

⁸⁸ The Court declined to rule on statutory grounds in *Gregory*, meaning that it declined to look solely at whether race impermissibly entered into the proportionality review of Gregory’s own death sentence. *Gregory*, 192 Wn.2d at 14 (“Because Gregory challenges the process by which the death penalty is imposed, the issue cannot be adequately resolved on statutory grounds. Proportionality review is a statutory task that this court must perform on the specific death sentence before us, but it is not a substitute for the protections afforded to all persons under our constitution.”)

Here, as in *Gregory*, Mr. Williams' sentence is 'unconstitutional as administered' because Coyote Ridge has not – and cannot – take reasonable precautions to protect a man of his vulnerability from the infectious disease. Coyote Ridge is thus 'administering' Mr. Williams' sentence in a way where his immutable traits – age, disabilities and race – rather than his crime of conviction, increase the severity of his sentence. Here, as in *Bassett*, Mr. Williams' sentence is disproportionate amid the COVID-19 outbreak because it fails to take into account his relevant biological traits. For Mr. Williams, these traits are his age, race, disabilities, and health conditions that would make contracting COVID-19 especially lethal.

Mr. Williams' conditions of confinement impermissibly allow his age, race, and disabilities to increase the risk of his contracting a virus, that, given his health conditions, will likely lead to serious organ damage or death. The COVID-19 outbreak where Mr. Williams is incarcerated constitutes a material change in circumstance that renders his sentence disproportionate and cruel under article I, section 14 of Washington's Constitution.

B. Mr. Williams’ confinement constitutes cruel and unusual punishment in violation of the Eighth Amendment of the U.S. Constitution.

While Washington State’s “cruel punishment” provision provides greater protection than the Eighth Amendment, Mr. Williams’ confinement also constitutes “cruel and unusual punishment” in violation of the Federal Constitution. Under the Eighth Amendment, prisons must maintain reasonably safe conditions for incarcerated individuals. *See Farmer*, 511 U.S. at 832. “Deliberate indifference” to a substantial risk of serious harm to an incarcerated individual violates the Eighth Amendment. *See Estelle v. Gamble*, 429 U.S. 97, 104-05, 97 S. Ct. 285, 50 L. Ed.2d 251 (1976). Officials act with deliberate indifference when: (1) “a substantial risk of serious harm” exists, and (2) the “prison official[s] [] have a sufficiently culpable state of mind,” which can be demonstrated by not “respond[ing] reasonably to the risk” of harm. *Farmer*, 511 U.S. at 834, 844. Deliberate indifference does not require actual intent to cause harm, but rather “it is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result.” *Id.* at 835. Moreover, deliberate indifference must be “compatible with the evolving standard of decency that mark the progress of a maturing society.” *Estelle*, 429 U.S. at 102.

1. Coyote Ridge officials have disregarded Mr. Williams’ health and well-being.

Coyote Ridge has an affirmative duty to provide *reasonable safety* to individuals who the State confines.⁸⁹ *DeShaney v. Winnebago County Dept. of Social Servs.*, 489 U.S. 189, 200, 109 S. Ct. 998, 103 L. Ed.2d 249 (1989). “[W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.” *Id.* at 199-200. Despite Coyote Ridge knowing for months about COVID-19’s severity, Mr. Williams’ confinement conditions remain unreasonably unsafe.⁹⁰

Determining whether prison officials’ responses are reasonable is fact-specific and depends on the alleged dangerous risk. *See Farmer*, 511 U.S. at 844 (“[P]rison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability if they responded reasonably to the risk.”). In *Reece v. Groose*, 60 F.3d 487, 491 (8th Cir. 1995), the court affirmed the denial of a summary judgment motion in an

⁸⁹ This affirmative duty arises from the fact that prison officials control all aspects of incarcerated people’s confinement. *DeShaney*, 489 U.S. at 199–200. For Mr. Williams, these factors include housing, his movement within the facility, the manner in which he eats, and staffing levels to serve his medical needs. App. 1 (R. Williams Decl.) ¶¶ 2, 10.

⁹⁰ Wash. Dept. of Health, *2019 Novel Coronavirus Outbreak (COVID-19)*, <https://www.doh.wa.gov/emergencies/coronavirus> (last visited May 14, 2020).

action against prison officials based on their failure to protect an incarcerated person from harm. The *Reece* Court found that a factfinder could reasonably conclude prison officials failed to act reasonably to protect an informant from the harm inflicted by a fellow inmate. *Id.* at 491; *C.f.*, *Wilkins v. Merkle*, No. 13 C 375, 2015 WL 5544312, at *6 (N.D. Ill. Sept. 18, 2015) (finding a prison official who placed work orders to have plumbing repaired responded reasonably to risk); *Bistrrian v. Levi*, 696 F.3d 352, 368 (3d Cir. 2012) (looking at prison guidelines to assess whether placing an incarcerated man in solitary confinement was a reasonable response to protect him from violence).

Coyote Ridge’s response to COVID-19 is unreasonable because prison officials are not providing—nor can they provide—reasonable safety to Mr. Williams. Specifically, Coyote Ridge’s inability to provide Mr. Williams reasonably safe confinement conditions is demonstrated threefold: (1) inability to social distance; (2) poor sanitation; and (3) failure to determine COVID-19’s actual risk through testing and contact tracing. Thus, Coyote Ridge’s confinement of Mr. Williams during the COVID-19 pandemic constitutes “cruel and unusual punishment” under the Eighth Amendment of the U.S. Constitution.

a. *Mr. Williams' inability to social distance in Coyote Ridge makes his confinement unreasonably unsafe.*

Mr. Williams cannot effectively social distance at Coyote Ridge.⁹¹

A federal court recently recognized how “without social distancing measures, reliable containment of a highly contagious disease is nearly impossible.” *See Martinez-Brooks v. Easter*, No. 3:20-cv-00569, at 49 (D. Conn. May 12, 2020) <https://assets.documentcloud.org/documents/6889529/judge-s-decision-on-Danbury-inmates-request-to.pdf>. Highly relevant to Mr. Williams’ case, the federal court stated that “transfer to home confinement [is] *the only viable measure* by which the safety of highly vulnerable inmates can be reasonably assured.” *Id.*

Mr. Williams is frequently less than six feet from fellow incarcerated individuals and staff throughout the day.⁹² This includes passing people in the narrow hallways, in the communal bathrooms and in

⁹¹ Coyote Ridge’s lack of social distancing guidelines is unsurprising; an inspection by the state prison watchdog noted that “incarcerated individuals *physically cannot social distance*.” Joanna Carns & Steve Sinclair, Off. Of the Corrections Ombuds (OCO) Monitoring Rep.at 12 (Apr. 17, 2020), <https://oco.wa.gov/sites/default/files/public/OCO%20Monitoring%20Visit%20to%20Monroe%20Correctional%20Complex.pdf> (emphasis added). The prison watchdog continued by explaining “[t]he facility is unable to effectively impose social distancing due to facility structure.” *Id.* at 2.

⁹² App. 1 (R. Williams Decl.) at 4, ¶¶ 10; 13; 15; 18.

the cafeteria.⁹³ Mr. Williams shares a two-hundred-square-foot cell with three other men.⁹⁴ In order to eat, Mr. Williams must expose himself to the prison’s cafeteria twice a day where seventy other people gather with no social distancing measures in place.⁹⁵ At most, Mr. Williams sits no further “than three feet away from fellow inmates.”⁹⁶ These living conditions are unreasonably unsafe for Mr. Williams, given his age, underlying conditions, and the pandemic.

Even if Coyote Ridge could produce a reasonably safe environment where social distancing was possible, Mr. Williams—who requires a pusher to move his wheelchair—is physically incapable of social distancing.⁹⁷ He lives with three other men in the prison’s general population,⁹⁸ and his therapy aids do not wear gloves when pushing Mr. Williams.⁹⁹ Being unable to social distance under Coyote Ridge’s custody renders his confinement unreasonably unsafe.

⁹³ *Id.*

⁹⁴ *Id.* at ¶¶ 15.

⁹⁵ *Id.* at ¶¶ 18.

⁹⁶ *Id.*

⁹⁷ *Id.* ¶¶ 10.

⁹⁸ *Id.* ¶¶ 15.

⁹⁹ App. 2 (R. Williams Supp. Decl.) at 9, ¶¶ 6.

b. Coyote Ridge has not created a safe, clean, and sanitary environment for Mr. Williams.

Coyote Ridge prison officials have acted unreasonably by not sanitizing and cleaning their prison enough to protect Mr. Williams from contracting COVID-19. Coyote Ridge has not increased cleaning or sanitizing of Mr. Williams’ two-hundred square foot cell, despite his vulnerability to the virus.¹⁰⁰ The prison still requires Mr. Williams to purchase soap, despite the COVID-19 outbreak within its walls.¹⁰¹ Mr. Williams has not been provided any hand sanitizer, despite DOC claiming that it had lifted bans on hand sanitizer in light of COVID-19.¹⁰² Coyote Ridge officials’ disregard for Mr. Williams’ health by failing to provide adequate sanitation or cleanliness is unreasonable given his medical complications and age. Just as “being violently assaulted in prison is simply ‘not part of the penalty that criminal offenders pay for their offenses against society,’” being confined in an unclean, petri-dish environment to contract a lethal virus is not part of Mr. Williams’ penalty. *Farmer*, 511 U.S. at 834 (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)).

¹⁰⁰ App. 1 (R. Williams Decl.) at 4, ¶¶ 15.

¹⁰¹ App. 2 (R. Williams Supp. Decl.) at 9, ¶¶ 5.

¹⁰² App. 1 (R. Williams Decl.) at 5, ¶¶ 19.

c. *Coyote Ridge cannot provide reasonable safety to Mr. Williams because it has failed to identify asymptomatic affected individuals.*

By not identifying asymptomatic people, Coyote Ridge has demonstrated its deliberate indifference to Mr. Williams. With every day that passes, Mr. Williams is unreasonably put at risk to contract COVID-19. No testing is available to Mr. Williams and other incarcerated people; irrespective to whether he could afford it.¹⁰³

The lack of testing of incarcerated persons is accompanied by a lack of testing of staff who work at Coyote Ridge. Staff undergo temperature checks and are asked about COVID-19 symptoms before entering the facility.¹⁰⁴ However, temperature checks cannot detect people who are asymptomatic, or who have not yet developed symptoms. Coyote Ridge is within a county with the second highest rate of infection among counties in the state.¹⁰⁵ Coyote Ridge cannot protect Mr. Williams from the novel coronavirus poised to spread throughout its facility. As of May

¹⁰³ *Id.* at 5, ¶¶ 21.

¹⁰⁴ Wash. St. Dep't of Corrections, *COVID-19 Screening, Testing, and Infection Control Guideline Version 17*, at 2 <https://www.doc.wa.gov/news/2020/docs/wa-state-doc-covid-19-screening-testing-infection-control-guideline.pdf> (last visited May 11, 2020) .

¹⁰⁵ See *Spokesman-Review, Yakima Has Top Rate of Virus Cases on West Coast*, May 3, 2020 at 9 (reporting on that Franklin County, with 326 confirmed cases, had the second highest rate of infection among counties in the state).

14, Coyote Ridge has made no announcements as to whether any incarcerated persons have come down with COVID-19 symptoms.

VI. CONCLUSION

This Court has declared that “jails themselves are no longer the pestilential death traps they were in eighteenth century England.” *State v. Valentine*, 132 Wn.2d 1, 16, 935 P.2d 1294 (1977). The COVID-19 outbreak challenges it to ensure this remains the case.

For the reasons illustrated above, this Court should find that Coyote Ridge has violated federal and Washington state constitutional law for its treatment of Mr. Williams. Its inaction urges remedial action by this Court. That remedy is to release Mr. Williams immediately, so that he can live under his sister’s care.

DATED this 14th day of May, 2020.

Respectfully Submitted,

WASHINGTON INNOCENCE PROJECT

/s/

Jacqueline McMurtrie, WSBA No. 13587
Kaylan L. Lovrovich, WSBA No. 55609
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Dayton L. Campbell-Harris, Law Student
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Attorneys for Petitioner

FILED
SUPREME COURT
STATE OF WASHINGTON
5/15/2020 8:00 AM
BY SUSAN L. CARLSON
CLERK

No. _____

SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams

Petitioner.

PETITIONER'S OPENING BRIEF APPENDIX

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APPENDIX 1

No. _____

SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams,

Petitioner.

DECLARATION OF ROBERT R. WILLIAMS

WASHINGTON INNOCENCE PROJECT
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Dayton L. Campbell-Harris, Law Student
Tierney Vial, Law Student

Attorneys for Petitioner

I, Robert Rufus Williams, declare under penalty of perjury under the laws of the State of Washington that the following statements are true and correct to my best knowledge and belief:

1. I am 77 years old and am competent to testify as to the contents of this declaration.
2. I am currently serving time at Coyote Ridge Correctional Facility in Connell Washington. My DOC Number is #722679.
3. I have been at Coyote Ride since 2009 but incarcerated since 2007.
4. I was born in Barbados but grew up largely in South Carolina. Much of my family still resides in South Carolina and in Florida. I have siblings and a son and a daughter who live in the South.

Medical Conditions

5. I have numerous medical conditions that, in combination with my age, cause me great concern about my susceptibility to COVID-19.
6. I have diabetes, for which I take a daily medication.
7. I suffer from hypertension and chronic back pain.
8. Since having a major stroke in 2010, I am wheelchair bound and the right side of my body is largely immobilized.

9. Due to my deteriorated sight and lack of fine motor control in my hands, I am no longer able read or write.
10. I am reliant on therapy aids to travel and complete basic tasks.
11. I have fallen many times in the recent past. My last fall was in early April and I injured my back, legs and neck. I am in severe pain due to the fall.
12. Before and during my incarceration, I have suffered from Post-Traumatic Stress Disorder from my military service in Vietnam.

Lack of Protective Measures at Coyote Ridge

13. I am deeply fearful that the lack of social distancing at Coyote Ridge and my vulnerable health condition will result in my contracting Covid-19.
14. I have asked for a face mask, but correctional officers have not provided me with one. *• MASK provided 17 April 2020, 2000 hours.*
15. Despite my age and disabilities, I am living in a general population block and share my cell with three other men. *cell size apx 200sq ft. Two bunk beds.*
16. None of my cell mates have been given a mask. *• MASKS issued 17 apr, 2000 hrs.*
17. Some of the staff have masks, but the general inmate population do not have masks. *-ISSUED finally, 17 apr, 2000 hrs.*
18. Each meal period I am exposed to over 70 people in the cafeteria where I sit no farther than ~~four~~^{three} feet away from fellow inmates.

19. We have no access to hand sanitizer.
20. There has not been any increase in the cleaning or sanitizing of our cell.
21. Correctional staff have not shared information about whether there is testing for COVID-19 available at our prison. *Med staff not only refuses to test offenders - but also refuses to allow us to pay for it.*
22. There have been no announcements as to whether any staff or inmates have come down with symptoms.
23. I rely on limited television access for information about the coronavirus.
24. I am aware that I am very vulnerable to the virus due to my age and health condition.
25. I have had trouble sleeping and am in a constant state of stress that the virus will spread in Coyote Ridge and that I might contract it.

Housing and Care Secured Upon Release

26. My sister, Angie Williams, has offered to take care of me if I were allowed to leave Coyote Ridge as a result of this virus.
27. I have remained close with Angie throughout my nearly thirteen years of incarceration. We speak on the phone periodically and she often gathers the rest of my family for these conversations.
28. She is aware of my health conditions and is willing to care for me upon release.

29. I know I would be safe with Angie and would be better able to social distance in her care.

Connection with Washington Innocence Project

30. I sent the Washington Innocence Project (formerly Innocence Project Northwest) Applications for Assistance in 2012 and 2014.

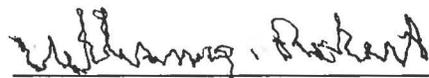
31. In 2019, attorneys and students from the Washington Innocence Project visited me at Coyote Ridge to talk about my claim of innocence and the potential for postconviction DNA testing in my case. They asked whether I wanted to pursue postconviction DNA testing. I said absolutely yes. Test everything. I am innocent.

32. The Washington Innocence Project was pursuing postconviction DNA testing on my behalf before the coronavirus pandemic broke.

33. I have served almost thirteen years of my 22.5 year (270.75 month) sentence. My current release date is April 30, 2028.

34. I give Washington Innocence Project permission to file litigation on my behalf to seek legal relief for myself and for other persons incarcerated.

DATED this 22 day of April 2020 in Connell, Washington.



Robert R. Williams

APPENDIX 2

No. _____

SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams,

Petitioner.

SUPPLEMENTAL DECLARATION OF ROBERT R. WILLIAMS

WASHINGTON INNOCENCE PROJECT
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(206) 543-5780

Dayton L. Campbell-Harris, Law Student
Tierney Vial, Law Student

Attorneys for Petitioner

I, Robert Rufus Williams, declare under penalty of perjury under the laws of the State of Washington that the following statements are true and correct to my best knowledge and belief:

Medical Conditions

1. My eyesight has worsened. My doctor tells me that this is connected to my diabetes.

Lack of Protective Measures at Coyote Ridge

2. Starting in early April, I asked for a face mask three times. Corrections staff refused to give me one each time I asked. Then, On Friday April 17, they passed masks out to everyone.
3. The mask they gave me is washable. It has not been washed however since it was given to me on April 17th.
4. There is no sink in our cell.
5. While we can purchase soap in commissary, none has been provided to us for free.
6. My therapy aids do not wear gloves when they assist me.
7. On Tuesday, April 21, cell 19 was quarantined. They took one person out of that cell when it was quarantined. I don't know where they took him.

8. I have recently been reprimanded for sleeping in the shower, but I only tried to sleep there because I haven't been able to sleep at night in my cell. I am too stressed to sleep well.

I am unable to sign this document as it was prepared in Seattle, Washington, but I have had it read to me over the telephone and authorize Jacqueline McMurtrie to sign it on my behalf.

DATED this 12th day of May, 2020 at Seattle, Washington.

/s/ Jacqueline McMurtrie

Robert Rufus Williams, by Jacqueline McMurtrie, WSBA #13587

**CERTIFICATION RE AUTHORIZATION TO SIGN ON BEHALF
OF ROBERT R. WILLIAMS**

I, Jacqueline McMurtrie, declare under penalty of perjury under the laws of the State of Washington:

1. I am counsel for Mr. Williams in this action.
2. Due to shortened time and limitations on access to Mr. Williams due to the current public health emergency, distance, shortened time, and prison procedures, I was unable to obtain a physical signature from Mr. Williams for this declaration.
3. I personally spoke with Mr. Williams on April 29, 2020 and May 6, 2020.

4. At the conclusion of the call, the contents of the supplemental declaration were read to him, and he stated to me that he believed the contents to be true and correct, and authorized me to sign the declaration on his behalf.

DATED this 12th day of May, 2020 at Seattle, Washington.

A handwritten signature in black ink, appearing to read "J. McMurtrie", written in a cursive style.

Jacqueline McMurtrie, WSBA #13587

APPENDIX 3

No. _____

SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams,

Petitioner.

DECLARATION OF JACQUELINE McMURTRIE

WASHINGTON INNOCENCE PROJECT
Jacqueline McMurtrie, WSBA No. 13587
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Dayton L. Campbell-Harris, Law Student
Tierney Vial, Law Student

Attorneys for Petitioner

I, Jacqueline McMurtrie, declare under penalty of perjury under the laws of the Washington that the following statements are true and correct to my best knowledge and belief:

Background and Qualifications

1. I am the Betts, Patterson & Mines Professor of Law at the University of Washington. I joined the faculty in 1989. I have been a Washington State Bar Association member since 1983.
2. In 1997, I founded the Washington Innocence Project (formerly Innocence Project Northwest) as the nation's third innocence organization. I started the Washington Innocence Project (WashIP) Clinic at UW Law in 2002 and continue to teach the Clinic. I have overseen WashIP's growth from a volunteer organization to a law clinic and finally to a non-profit organization.
3. WashIP has exonerated 15 people who collectively served over 100 years in prison for crimes they did not commit. I was lead, or co-counsel, in the majority of WashIP exoneration cases. Each exoneration, including the five based on exculpatory postconviction DNA evidence, involved extensive investigation and litigation efforts ranging from one to eight years.

4. WashIP receives hundreds of new requests for assistance every year. Because we are a small organization with limited staffing, it can take years, as it has in Mr. Williams' case, to move a case forward.

Robert R. Williams' Case

5. Mr. Williams sent an Application for Assistance to WashIP in 2012 and a second one in 2014. WashIP began to gather documents (crime lab reports, evidence logs) to review his innocence claim.
6. I began working on the case in 2019 with a team of WashIP Clinic students. We gathered additional case materials (trial transcripts, police reports), spoke with defense counsel and communicated with Mr. Williams by letter. A second team of Clinic students, Dayton Campbell-Harris and Tierney Vial, began working on Mr. Williams' case in the 2019-2020 academic year. We identified avenues of relief through postconviction DNA testing.
7. In December of 2019, Dayton Campbell-Harris, Tierney Vial, DNA Staff Attorney Kaylan Lovrovich and I visited Mr. Williams at the Coyote Ridge Correctional Center. We discussed the potential for postconviction DNA testing in his case and Mr.

Williams enthusiastically endorsed having the WashIP pursue postconviction DNA testing on his behalf.

8. We contacted the Office of the Pierce County Prosecuting Attorney to request their cooperation in securing a preservation order in the case. They indicated a willingness to agree to a preservation order, but we have not yet secured the preservation order.
9. WashIP's motion for postconviction DNA testing is drafted and being finalized. However, our advocacy efforts have shifted to protecting Mr. Williams from becoming a victim of the COVID-19 virus which is spreading throughout the prisons.

COVID-19 in the WA Dep.'t of Corrections

10. I am familiar the *Colvin et al. v. Jay Inslee et al.* litigation currently pending in the Washington Supreme Court and have reviewed the pleadings in the case. WashIP, along with the Korematsu Center, ACLU-WA, and the Public Defender Association, filed an amicus brief on April 16, 2020.
11. This Court received numerous declarations and reports in *Colvin et al. v. Jay Inslee et al.* documenting public health experts, correctional health care experts and other experts' opinions regarding the grave danger COVID-19 poses to incarcerated

persons. These declarations and reports also show that outbreaks are likely because the prisons are not effectively imposing social distancing or other public health measures.

12. Robert R. Williams is a 77-year-old African American male with serious underlying medical conditions. He reports he has diabetes, suffers from hypertension and became wheelchair bound after a 2010 stroke which left his right-side largely immobilized.
13. Mr. Williams' age, race and health issues make him particularly vulnerable and concerned about contracting COVID-19. The conditions Mr. Williams describes regarding his imprisonment – living in a cell with three other men, having no access to hand sanitizers or a mask, and the lack of social distancing in meal halls – exacerbate the dangers posed to him by the pandemic.

DATED this 12th day of May, 2020 in Seattle, Washington.



Jacqueline McMurtrie

APPENDIX 4

FILED
SUPREME COURT
STATE OF WASHINGTON
3/25/2020 8:00 AM
BY SUSAN L. CARLSON
CLERK

No. _____

SUPREME COURT OF THE STATE OF WASHINGTON

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

Petitioners,

v.

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

Respondents.

**DECLARATION OF DR. MICHAEL PUISIS AND DR. RONALD
SHANSKY CONCERNED ABOUT THE RISK OF THE SPREAD
OF COVID-19 IN THE WASHINGTON STATE PRISON SYSTEM**

Nicholas Allen, WSBA #42990
Nicholas B. Straley, WSBA #25963
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Attorneys for Petitioners

Michael Puisis, D.O., and Ronald Shansky, M.D. declare under penalty of perjury under the laws of the State of Washington that the contents of this declaration are true and correct.

1. Dr. Michael Puisis is an internist who has worked in correctional medicine for 35 years. He began working at the Cook County Jail as a physician in 1985 and became the Medical Director of Cook County Jail from 1991 to 1996 and Chief Operating Officer for the medical program at the Cook County Jail from 2009 to 2012. He has worked in and managed correctional medical programs in multiple state prisons including in Illinois and New Mexico. He has worked as a Monitor or Expert for Federal Courts on multiple cases and has worked as a Correctional Medical Expert for the Department of Justice on multiple cases. He has also participated in revisions of national standards for medical care for the National Commission on Correctional Health Care and for the American Public Health Association. He also participated in revision of tuberculosis standards for the Center for Disease Control. Dr. Puisis has edited the only textbook on correctional medicine, *Clinical Practice in Correctional Medicine*. A *curriculum vitae* is attached.

2. Dr. Ronald Shansky is an internist who has worked in correctional medicine for 45 years. He was the Medical Director of the Illinois Department of Corrections from 1982 to 1992 and from 1998 to

1999. He was a Court Appointed Receiver of two correctional medical programs. He has been appointed by U.S. Courts as a Medical Expert or Monitor in ten separate Court cases and has been a Court appointed Special Master in two cases. He has been a consultant to the Department of Justice involving correctional medical care. He also participated in revision of national standards for medical care for the American Public Health Association and for standards for the National Commission on Correctional Health Care. A *curriculum vitae* is attached.

3. Coronavirus disease of 2019 (COVID-19) is a viral pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.

4. **The number of cases of COVID-19 in the United States are rising rapidly.** As of March 20, 2020, the CDC reported on its website 15,219 COVID-19 cases with 201 deaths. The New York Times reported that on Sunday morning, March 22, 2020 there were 24,380 and at least 340 deaths. The United States is on the upswing of the pandemic curve. The case numbers are changing rapidly upward with a case doubling rate every three days.

5. **Washington State is in the forefront of the COVID-19 pandemic in the United States.** Washington reported the first case of COVID-19 in the United States on January 19, 2020 in a person who had

recently traveled to Wuhan, China.¹ Washington has the 2nd most COVID-19 cases next to New York. On February 29, 2020, Governor Inslee declared a state of emergency. The Governor has, on an emergency basis, permitted out-of-state health practitioners to practice in the state without obtaining a Washington license because of a lack of medical personnel to provide care to infected Washingtonians. Based on data on the State of Washington Department of Health website on March 21, 2020, Washington State had 1,793 cases (8% of total U.S. cases) but 94 deaths (approximately 30% of the U.S. deaths). Washington has the highest number of deaths in the U.S. The New York Times reported that Washington State officials are discussing plans on triaging the severely ill to determine who will get access to full medical care, including ventilator care, and who will not.² Hospital resources in Washington are so stretched that King County officials are building temporary hospitals; one was recently reported as being constructed on a soccer field.³

¹ Michelle Holshue, et.al, *First Case of 2019 Novel Coronavirus in the United States*; New England Journal of Medicine, March 5, 2020; N.Engl.J.Med 2020; 382:929-936

² “Chilling” Plans: Who Gets Care as Washington State Hospitals Fill Up? Karen Weise and Mike Baker, New York Times March 20, 2020 at <https://www.nytimes.com/2020/03/20/us/coronavirus-in-seattle-washington-state.html>

³ Workers build a field hospital as coronavirus spreads’ Washington death toll at 74; Martha Bellisle, The Columbian, March 21, 2020

6. UpToDate⁴ reports an overall case mortality rate from the disease of 2.3%. The Washington death rate is 5.2% based on the number of deaths and cases reported on the Washington State Department of Health website.

7. **COVID-19 is transmitted by droplets of infected aerosol when people with the infection cough.** Droplets of respiratory secretions infected with the virus can survive as an aerosol for up to three hours^{5 6}. Droplets can be directly transmitted by inhalation to other individuals in close proximity. Droplets can land on surfaces and be picked up by the hands of another person who can then become infected by contacting a mucous membrane (eyes, mouth, or nose) with their hand. Infected droplets can remain viable on surfaces for variable lengths of time, ranging from up to 3 hours on copper, 24 hours on cardboard, and 2-3 days on plastic and stainless steel.⁷

8. **Medical care for COVID-19 focuses on prevention, which emphasizes social distancing, handwashing, and respiratory**

⁴ UpToDate is an online medical reference widely used in hospitals, health organizations and private physicians

⁵ National Institute of Health, available at <https://www.nih.gov/news-events/news-releases/new-coronavirus-stable-hours-surfaces>

⁶ Neeltje van Doremalen and Others, Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1, Correspondence in New England Journal of Medicine, March 17, 2020 found at https://www.nejm.org/doi/full/10.1056/NEJMc2004973?cid=DM88773_&bid=17102145

⁷ *Id*

hygiene. The current CDC recommendations for social distancing and frequent handwashing measures, which are the only measures available to protect against infection, are not possible in the correctional environment. Furthermore, repeated sanitation of horizontal and touch surfaces in inmate living units and throughout the jail is not typically done and would be an overwhelming task. Prisons have worse living conditions and higher comingling of people than cruise ships and nursing homes where COVID-19 is known to have easily spread. Prevention of contact with an infected droplet is significantly more difficult in a prison than in the community.

9. **With respect to transmission of disease by droplet inhalation, correctional environments actually promote spread of respiratory contagious disease.** Jails and prisons are long known to be a breeding ground for infectious respiratory illness. Tuberculosis is a bacteria which is significantly less transmissible than COVID-19 yet has been responsible for numerous outbreaks of illness in prisons and jails over the years. Respiratory infectious disease like TB are thought to be made worse in prisons because of crowding and recirculated air. Because of transmissibility of TB in prisons the CDC still recommends screening for this condition in prisons. Proper screening for tuberculosis can control that disease in prison populations. The COVID-19 virus is a different type of respiratory illness; its spread is rapid and it is more easily transmissible.

Control through screening methods is more difficult and, in our opinion, would involve both testing all incoming inmates with COVID-19 test and with quarantine of all incoming inmates for up to 14 days. Also, there is no current guidance on screening for COVID-19 in prisons in part because the disease is so new. Furthermore, there would be insufficient supplies to screen with testing even if it were to be recommended and quarantine is impractical and logistically unrealistic even though both measures should be attempted in our opinion.

10. **Jails and prisons promote spread of respiratory illnesses because large groups of strangers are forced suddenly into crowded congregate housing arrangements. This situation is made worse by the fact that custody and other personnel who care for inmates live in the community and can carry the virus into the jail or prison and/ or leave the jail or prison with the virus and carry it back into the community.**⁸ These conditions are precisely what public health officials warn will result in spread of the pandemic. Currently the President's Task Force on COVID-19 recommends limiting gatherings to no more than 10 persons. Inmates live in large groupings with frequent (weekly or daily) introduction of newly incarcerated inmates into the

⁸ The WDOC website at <https://www.doc.wa.gov/news/covid-19.htm#testing> reports that four staff at three separate facilities have tested positive for COVID-19. O

group who are taken care of by people who live in the community who can bring infection in with them and infect the group. One couldn't devise a system more contrary to current public health recommendations and the President's Task Force recommendations than a prison, especially with classification systems that house large numbers of elderly or persons with comorbid medical conditions in the same housing units.

11. Prisons are not isolated from the surrounding community with respect to infectious or contagious disease and identification of infected persons is hampered by lack of testing supplies. There is no evidence that asymptomatic persons can transmit COVID-19. A recent study of a cruise ship⁹ demonstrated that about 17% of persons infected with COVID-19 had no symptoms. However, infected individuals become symptomatic in a range of 2.5 to 11.5 days with 97.5% of infected individuals becoming symptomatic within 11.5 days. The total incubation period is thought to extend up to 14 days but can extend beyond that period. Thus, persons coming into jails or prisons can be asymptomatic at intake screening only to become symptomatic later during incarceration. Currently, the WDOC screens employees, visitors

⁹ Kenji Mizumoto, Kayaya Katsushi, Alexander Zarebski, Gerardo Chowll; *Estimating the asymptomatic proportion of coronavirus disease 2019 (COVID-19) cases on board the Diamond Princess cruise ship, Yokohama Japan, 2020*, EURO SURVEILLANCE (Mar. 12, 2020), <https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.10.2000180>

and new inmates with symptom screening and a temperature only. While this is a reasonable one time screening, it will not identify all employees and inmates coming into the system who are infected and will not identify all employees or visitors who have the infection but will become symptomatic at a later time even possibly later in the same day that they entered the facility. Testing of all new inmates and employees with a COVID-19 test would be a reasonable screening strategy which with quarantine of new inmates might be effective. But lack of testing supplies makes this impractical and not possible at this time. Current testing procedures in WDOC are cumbersome and a barrier to testing which may be the reason that only 28 COVID-19 tests have been done in the WDOC on inmates with 22 of these tests still pending results.¹⁰ Quarantine of all new inmates is not done in WDOC based on screening guidelines on their website.¹¹ As a result, the inmate population is basically a large congregate gathering with new people intermingling on intake days

¹⁰ The WDOC website gives the procedure for testing which is very complicated. The ordering practitioner has 2 options: 1) call the State Department of Health and ask to speak to the Duty Epidemiologist and provide a brief case summary. The Duty Epidemiologist gives approval for the test. It isn't clear if the Duty Epidemiologist is available 24/7. Then a swab is taken and send Federal Express following regulations for shipping biological substances. One can only imagine attempting to contact a Duty Epidemiologist who is taking calls statewide. 2) if the Department of Health cannot be reached the test can be sent to the University of Washington virology lab which testing does not require approval but does require following testing instructions of University of Washington. Samples are to be sent Federal Express in packaging complying with shipping biological substances.

¹¹ <https://www.doc.wa.gov/news/2020/docs/2020-0319-health-services-screening.pdf>

managed by staff who daily interact in the community and then interact with inmates - a recipe for spread of the infection.

12. **An individual's immune system is the primary defense against this infection.** As a result, people over age 65 years of age and persons with impaired immunity may have a higher probability of death if they are infected. Age related risk is a result of impaired immunity with aging. The older a person is the greater the apparent risk. In the WDOC, 2% of the population is over 65 years of age but 18% are over age 50.¹² People on immunosuppressive medication, with disease causing impaired immunity, or with significant cardiac or pulmonary medical conditions also are at increased risk of death. It has recently been reported that younger patients with cardiovascular disease or hypertension may have unappreciated risk for severe disease.¹³ This has significant implications for correctional facilities with high rates of hypertension. Persons with severe mental illness in prisons are also, in our opinion, at increased risk of acquiring and transmitting infection because they are unable to understand social distancing and hand hygiene and may be unable to communicate symptoms appropriately. Also, by classification, like other

¹²Department of Corrections Washington State website found at <https://www.doc.wa.gov/corrections/incarceration/prisons/default.htm>

¹³ ACE2 is the SARS-CoV-2 Receptor Required for Cell Entry, Summary, New England Journal of Medicine, March 18, 2020 Review of article of Hoffman, M et al in Cell 2020 Mar 5

prison systems, WDOC houses inmates who are elderly, have disabilities, are mentally ill or have severe chronic illness profiles in the same housing area, making this population at great risk if one of them becomes infected. Facilities with large populations of any of these types of inmates are at very high risk. Spread of infection in these facilities would result in high rates of death.

13. **Inmates may lack access to hospital care as compared to civilians.** Currently, severe disease is treated only with supportive care including respiratory isolation, oxygen, and mechanical ventilation as a last resort. Washington is already anticipating a lack of ventilation equipment and hospital beds, placing those needing this service in a dire predicament.¹⁴ Also, prison systems have inherent structural problems that are barriers in a pandemic. Prison health care programs are internally not set up to manage hospital level care including ventilation. Typical arrangements of transferring prisoners to a hospital, in a setting of a pandemic with large numbers would overwhelm the security staff of the WDOC and complicate arrangements at local hospitals. Some WDOC facilities such as the Clallam Bay Corrections Center are remote and do not have easily accessible hospitals making care linkage more tenuous.

¹⁴ Who gets a ventilator? Hospitals facing coronavirus surge are preparing for life-or-death decisions. NBC News as found at <https://www.nbcnews.com/health/health-care/who-gets-ventilator-hospitals-facing-coronavirus-surge-are-preparing-life-n1162721>

Recommendations

1. **Steps should be taken to release any inmate who is a low risk to the community.** The additional risk to inmates by virtue of crowding in prisons and the risk of promoting spread of the infection to the inmate population, and thereby to the community, needs to be weighed against the reason for not releasing the inmate from incarceration. Release based on risk should prioritize inmates over 65 years of age, inmates with immune disorders, inmates with significant cardiac (including hypertension) or pulmonary conditions, or inmates with cognitive disorders. Keeping healthy individuals in prison for short sentences, or for parole violations or other marginal public safety reasons only promotes crowding. Crowding decreases the ability of maintaining distancing of prisoners which risks spread of the virus. Therefore, healthy prisoners with low risk sentences are best sent home as a preventive measure.

2. If and when COVID-19 testing becomes widely and readily available, all inmates coming into prison should be tested for COVID-19 prior to congregate housing. This is our expert opinion because inmates will be forced to live with one another with the uncertain risk that one of them is infected. Intake symptom screening alone will not identify all inmates who have disease because some will be asymptomatic when

intake screening is done. We understand that this is unlikely to occur due to lack of testing supplies.

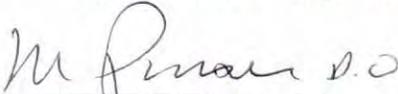
3. All inmates coming into a prison on any day should be housed in separate housing (quarantined) for 14 days and have daily symptom screening with temperature while in quarantine.

4. All persons with any symptoms consistent with COVID-19 or with fever should be placed in respiratory isolation and tested for COVID-19.

5. All persons over 65, with severe mental illness, with immune disorders, with serious cardiac or pulmonary disease, or with any cognitive disorder should have daily symptom screening and temperature screening at this time. Any positive symptom or temperature should require respiratory isolation and testing for COVID-19. Persons over 65, with immune disorders, or serious cardiac or pulmonary disease should be a high priority for release.

6. Persons in prisons should not be transferred to another prison unless they have been quarantined for 14 days prior to transfer and are known to not have COVID-19.

DATED this 23rd day of March, 2020 at Evansville, Illinois.



Michael Puisis, ~~MD~~ P.O.

DATED this 23rd day of March, 2020.

/s/Ronald Shansky, M.D.
Ronald Shansky, M.D.

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Personal Data:

Born: 6/28/50
Married, 1 child
Excellent health

Educational Experience:

Quigley North High School; graduated 1968
B.S. University of Illinois at Chicago 1978
Chicago College of Osteopathic Medicine 1982

Residency Training:

Internal Medicine, Cook County Hospital 1985

Board Certification:

Diplomate Internal Medicine, American Board of Internal Medicine 1985

Professional Activities:

National Health Service Corps Physician assigned as staff physician to Cermak Health Service (Cook County Jail) 1985-89.

Assistant Medical Director, Cermak Health Service 1989 to 1991

Medical Director, Cermak Health Services (Cook County Jail) 1991 to 1996

Voluntary Attending Cook County Hospital, 1985 to 1996

Advanced Cardiac Life Support Instructor at Cook County Hospital 1985-89

Director of Quality Assurance at Cermak Health Service 1985-91.

Regional Medical Director, State of New Mexico for Correctional Medical Services, 1996 to 1999

Corporate Medical Director, Correctional Division, Addus HealthCare, 1999 to 2004

Consultant on correctional healthcare, 1988 to present

Director of Research and Operations, Cermak Health Services, Cook County Jail 2006-2007

Medical Director, Illinois Department of Corrections 2008

Chief Operating Officer, Cermak Health Services, Cook County Jail May, 2009 to December 2012

Consultant Work:

Consultant to the U.S. Department of Justice 1989 to present on conditions at a variety of prisons and jails throughout the United States including reviews and/or monitoring of the follow programs:

- San Diego County Jail 1989
- Angola State Prison Louisiana 1992
- Simpson County Jail/ Sunflower County Jail and Jackson County Jail, Mississippi 1993
- Crittenden County Jail 1994
- Gila County Jail 1994
- Maricopa County Jail 1994
- Cape Girardeau Jail 2000
- Montana State Prison 2004
- Wicomico County Jail 2004
- Baltimore City Jail 2005
- Cleveland City Jail 2005
- Augusta State Prison, Georgia, 2007
- Lake County Jail 2011
- Orange County Jail 2013 and 2017

Consultant to the American Civil Liberties Union on the prison health system at the Indiana State Prison in Westville Indiana, 1988.

Consultant to the Legal Services Organization of Indianapolis regarding the prison health system at the Indiana State Prison in Michigan City and the Pendelton Reformatory in Indianapolis. 1988

Consultant to the Indiana Civil Liberties Union reviewing Pendleton Correctional Facility, April 2000.

Member of the National Commission on Correctional Health Care Task Force for the revision of the *Standards for Health Services in Jails*, 1995

Reviewer for the Centers for Disease Control for the *Prevention and Control of Tuberculosis in Correctional Facilities*, 1995

Member of the Advisory Board for the “Evaluation of the Centers for Disease Control Guidelines for TB Control in Jails”, 1999

Clinical Reviews, grant review committee, Centers for Disease Control, 1999

Member of the committee to revise the correctional health care standards for the American Public Health Association, 1999

National Commission on Correctional Health Care’s Physician Panel on Clinical Practice 1999.

Consultant to the United States Department of Justice to provide expert advice on the development of Standard Operating Procedures when federal inmates are confined in private prisons, September 2000.

Medical Expert for plaintiff in *Schilling v. Milwaukee County Jail* 2001

Expert witness for Southern Center for Human Rights in *Marshall, et al v. Whisante, et al* in review of conditions at the Madison County Jail in Madison County Alabama, 2002.

Expert witness for Legal Aid Society in *James Benjamin, et al.v. William Fraser, et al*. This resulted in a deposition in 2002 regarding medical complications in the utilization of shackles.

Expert consultant to the California Attorney General in *Plata v. Davis* 2002

Expert consultant to the California Attorney General on medical care provided in the California Youth Authority 2003

Committee member of the American Diabetes Association to revise the standard for diabetes care in correctional facilities 2003

Consultant to the Southern Poverty Law Center in assisting them in review of diabetes care for inmates in the Alabama Department of Corrections.

Medical Expert for Scott Ortiz plaintiff attorney in *Salvadore Lucido v CMS* 2005

Liason member representing the National Commission on Correctional Healthcare to the Advisory Committee for the Elimination of Tuberculosis (ACET) 2004 to 2007

Medical Consultant to the Administration of Corrections in Puerto Rico via MGT of America in monitoring medical contract with Court Appointed medical corporation 2005 to 2007

Program Review of San Joaquin Juvenile Detention Center for San Joaquin County related to Walter Hixson et al v. Chris Hope, July-August 2007

Medical Expert, review of Fresno County Jail 2013

Medical Expert, review of Monterey County Jail 2013

Medical Expert Consultant to Department of Homeland Security 2013 to present

Consultant to Maryland Attorney General's Office with respect to Duval et al v Hogan et al litigation 2015

Medical Consultant to the Southern Poverty Law Center with respect to Dunn et al v. Thomas et al with respect to the Alabama prison system medical program 2015

Medical Consultant to Promise of Justice Initiative, Advocacy Center of Louisiana, American Civil Liberties Union of Louisiana, and Cohen Milstein Sellers & Toll PLLC collectively with respect to the case Lewis et al v. Cain et al concerning medical care to prisoners at Louisiana State Prison. 2016

Court Appointed Monitor Assignments

Court appointed Medical Expert in Plata v. Davis, a consent decree regarding medical care in the California Department of Corrections 2003

Court appointed Medical Monitor in *Laube et al v. Campbell* involving medical care at the Tutwiler women's prison in Alabama, 2004

Court appointed Monitor of Dallas County Jail in consent agreement between Dallas County and U.S. Department of Justice, 2007

Court appointed Medical Monitor of Consent Decree Hall v. County of Fresno in regard to Fresno County Jail 2015

Court appointed Medical Monitor for medical provisions of Duval et al v. Hogan et al Settlement Agreement 2015

Medical Monitoring Assignments

Medical Monitor for California Youth Authority 2004 based on consent agreement between State of California and Prison Litigation Office

Monitor Montana State Prison 2004 based on consent agreement between US Department of Justice and State of Montana

Member of the Medical Oversight Committee, the monitoring body in a consent agreement covering the Ohio Department of Corrections and Rehabilitation, 2006

Medical Expert on monitoring team in consent agreement covering the Delaware Department of Corrections 2006

Monitor Lake County Jail 2011 based on consent agreement between US Department of Justice and Lake County, Indiana

Publications:

Radiographic Screening for Tuberculosis in a Large Urban Jail, Puiasis M, Feinglass J, Lidow E, et al: *Public Health Reports* 111:330-334,1996

Adding on Human Bites to Hepatitis B Prophylaxis; *Correct Care*, newsletter of the National Commission on Correctional Health Care, Vol.2, Issue 3, July 1988.

Editor, *Clinical Practice in Correctional Medicine*, Mosby, 1998.

Tuberculosis Screening, Overview of STDs in Correctional Facilities, & Chronic Care Management, Chapters in the textbook *Clinical Practice in Correctional Medicine*, Mosby, 1998

Editor, *Clinical Practice in Correctional Medicine 2nd Edition*, Mosby/Elsevier, 2006

Chronic Disease Management & Overview of Sexually Transmitted Disease, chapters in textbook *Clinical Practice in Correctional Medicine 2nd Edition*, Mosby/Elsevier 2006

Deaths in the Cook County Jail: 10-Year Report, 1995-2004; Seijong Kim, Andrew Ting, Michael Puiasis, et al; *Journal of Urban Health* 2006

Risk Factors for Homelessness and Sex Trade Among Incarcerated Women: A Structural Equation Model; Seijong Kim, Timothy Johnson, Samir Goswami, Michael Puiasis: *Journal of International Women's Studies*; 2011 January; 12(1):128-148

Improving Health Care after Prison: Invited Commentary on Forced Smoking Abstinence: Not Enough for Smoking Cessation; *JAMA Intern Med* 2013; 173(9) 795-796

Progress in Human Immunodeficiency Virus Care in Prisons: Still Room for Improvement? Invited Commentary, *JAMA Internal Medicine*, published online 2014 March 31, doi 10.1001/jamainternmed.2014.521 epublished ahead of print

Improved Virologic Suppression With HIV Subspecialty Care in a Large Prison System Using Telemedicine: An Observational Study With Historic Controls: Jeremy Young, Mahesh Patel,

Melissa Badowski, Mary Ellen Mackesy-Amiti, Pyrai Vaughn, Louis Shicker, Michael Puisis and Lawrence Ouellet; *Clinical Infectious Diseases*, May 7, 2014 [Epublished ahead of print]

Awards

National Commission on Correctional Health Care Outstanding Correctional Health Care Publication of the Year for Clinical Practice in Correctional Medicine, November 1998

National Commission on Correctional Health Care B. Jaye Anno Award of Excellence in Communication for Clinical Practice in Correctional Medicine, 2nd Edition, 2006

2006 Armond Start Award of Excellence, from Society of Correctional Physicians

Lectures:

Health Care: Correctional Medicine in the 90's
Illinois Correctional Association Fall Training Institute; October 22-23 1991.

Quality Improvement and Ethics, Who is the Customer, presentation at the University of Wisconsin, Madison, School of Medicine Second Annual Summer Forum, National Center for Correctional Healthcare Studies, July 1992

Chest X-ray Screening for Tuberculosis in a Large Urban Jail, 16th National Conference on Correctional Health Care, September, 1992

Overview of Tuberculosis as a Public Health Issue, National Association of Counties' public hearing of "County Government and Health Care Reform", October, 1992

Screening for Tuberculosis, lecture at the Comprehensive AIDS Center, Northwestern University Medical School, August, 1993

Management of Tuberculosis in Correctional Facilities, National Commission on Correctional Healthcare Roundtable, November, 1995

Moderator: *Health Care Delivery in a Jails Setting*, at the 8th National Workshop on Adult and Juvenile Female Offenders, September, 1999, Chicago, Illinois

Lecturer: Correctional Medical Services' Medical Director's Orientation, 1997-1999

Satellite broadcast, "TB Control in Correctional Facilities", Texas Department of Health, February, 1999

Presenter: *Chronic Care in Correctional Settings*, March, 2000, at a conference by Health and Medicine Policy Research Group, *Emerging Issues in Correctional Health*

Presenter: *STD Screening, Treatment, and Early Intervention*, American Correctional Health

Services Association's conference Public Health in Corrections co-sponsored by the Centers for Disease Control (CDC) March 2001

Presenter: *Diabetes Cases in Corrections* Fall Conference 2003, National Commission on Correctional Health Care

Presenter: *Contracting Out Medical Services* Spring Conference May, 2004, National Commission on Correctional Health Care

Lecturer: Screening for STDs and HIV in Jails, 2005 National HIV Prevention Conference, Atlanta, Georgia

Panel with Honorable Frank Easterbrook, Chief Judge, 7th Circuit and Ben Wolfe, ACLU at the John Marshall Law School American Constitution Society on inmate rights and access to health care; 2009.

Society and Organization Affiliations:

Society of Correctional Physicians

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ACADEMIC TRAINING

Bachelor of Science, University of Wisconsin, 1967
Doctor of Medicine, Medical College of Wisconsin, 1971
Master of Public Health, University of Illinois School of Public Health, 1975

PROFESSIONAL LICENSE

Licensed Physician (Illinois) No. 36-46042

INTERNSHIP AND RESIDENCY TRAINING

Internship – Cook County Hospital, July 1971-1972
Residency – Internal Medicine, Cook County Hospital, July 1972-1974

BOARD CERTIFICATION AND FELLOWSHIPS

Diplomate of the American Board of Internal Medicine – September 1978
Diplomate of the American Board of Quality Assurance and Utilization Review Physicians – 1992
Elected Fellow of the Society of Correctional Physicians – 1999

EMPLOYMENT

Medical Director, Center for Correctional Health & Policy Studies, Washington, D.C. Jail –
2004 to 2006
Consultant, Corrections Medicine and Continuous Quality Improvement – 1993 to present on a full-time
basis; and throughout career while holding other positions
Medical Director, Illinois Department of Corrections – 1982-1993, 1998-1999
Attending Physician, Department of Medicine, Cook County Hospital – 1978 to present
Surveyor (part-time), Joint Commission on Accreditation of Healthcare Organizations – 1993-1997
Staff Physician, Metropolitan Correctional Center of Chicago – 1975-1982

CONSULTATIONS

Condition of Confinement Reviews for PricewaterhouseCoopers, reviewing detention facilities housing federal detainees; 2000–2004
Essex County Jail, Newark, N.J.
Michigan Department of Corrections
Montana Department of Corrections
New Mexico Department of Corrections
Polk Correctional Center, Raleigh, N.C.
South Dakota Department of Corrections
Washington DC Department of Corrections

APPOINTMENTS

Dockery vs. Epps, Plaintiff Expert – 2015
Mutually Agreed Expert Leader of Investigation Team, *Lippert v. Quinn* – January 2014
Court Monitor, *Riker v. Gibbons*, Ely State Prison, Ely, Nevada – 2010
Plaintiff Expert, *Plata vs. State of California* – Crowding case – 2010
Surveyor, NCCHC, 2010 to present
Member, Department of Justice Compliance Monitoring Team, King County Jail, Seattle, WA – 2009 to present
Member, Monitoring Team, Ohio Department of Youth Services – 2009 to present
Member, Department of Justice Monitoring Team, Dallas County Jail – 2008 to present
Member, Department of Justice Monitoring Team, Delaware Department of Corrections – 2007 to present
NCCHC Board Appointment – 1999-2009
Member, Task Force to Revise NCCHC Standards for Jails and Prisons – 2003 and 2007-2008
Member of Medical Oversight Team reviewing the Ohio prison system – 2005 to present
Court Monitor, De Kalb County Jail, Decatur, Georgia – 2002-2005
Consultant to California Department of Corrections, negotiated for defendants, Plata Agreement-2002
Consultant, California Department of Corrections – 2000
Court Monitor, Milwaukee County Jail – 1998 to present
Court Monitor, Essex County Jail, Newark, NJ – 1995 to present
Medical Expert, State of Michigan – 1995
Consultant to Special Master, *Madrid v. Gomez*, Pelican Bay Prison, California Department of Corrections – 1995
Medical Expert, State of New Mexico – 1994
Consultant, Connecticut Department of Corrections – 1994
National Advisory Board of the National Center for Health Care Studies – 1991
Illinois AIDS Interdisciplinary Advisory Council – November 1985
Illinois AIDS Caretaker Group – November 1985
Task Force to Rewrite American Public Health Association Standards for Medical Services in Correctional Facilities – 1983
Corrections Subcommittee, Medical Care Section, APHA – 1983
Preceptor, then Clinical Associate Professor, Department of Preventive Medicine and Community Health, Abraham Lincoln School of Medicine, University of Illinois, Chicago, Illinois – 1972-1979
Clinical Associate Professor, Department of Medicine, Ravenswood Medical Center, Chicago, Illinois – 1979-1981
Director, Phase 1 and 2 Program at Cook County Hospital for the Abraham Lincoln School of Medicine – 1976-1978
Medical Director, Uptown People's Health Center – September 1978
Director, General Medicine Clinic, Department of Medicine, Cook County Hospital – 1975
Director, Clinical Services, Department of Internal Medicine, Cook County Hospital – 1975

Associate Attending Physician, Department of Internal Medicine, Cook County Hospital – 1974-1975
Instructor, Illinois College of Optometry, Chicago, Illinois – 1972-1974

COMMITTEE MEMBERSHIPS

Chairman, State of Illinois AIDS Caretakers Committee – 1985
Chairman, Corrections Subcommittee, Medical Care Section – 1983
Chairman, Medical Records Committee, Cook County Hospital – 1981
Member, Executive Medical Staff, Cook County Hospital – 1979
Member, Task Force to Rewrite the *Standards for Health Services in Correctional Institutions* – published 1986

PROFESSIONAL ORGANIZATIONS

Society of Correctional Physicians – President, 1993-1995
American Public Health Association – 1974 to present
American Correctional Health Services Association – 1988
American Correctional Association – 1982
Federation of American Scientists – 1974-1981

CIVIC

At the request of the Center for Children’s Law and Policy, Review of the Quality of the Medical Program at Long Creek Juvenile Detention Center, Portland, Maine - September 2017
Medical Monitor, Department of Justice vs. Virgin Islands – 2013 to present
Medical Monitor, Department of Justice vs. Erie County – 2011 to present
Medical Monitor, Department of Justice vs. Cook County – 2009-2013
Medical Monitor, Department of Justice vs. King County – 2008-2012
Medical Monitor, Department of Justice vs. Dallas County – 2008 to present
Contract Monitor, Essex County New Jersey – 2008 to present
Mutually agreed upon expert, Milwaukee County Jail – 2001
Mutually agreed upon expert, *Inmates v. Essex County Jail*, 1995-2007
Appointed Receiver by Judge William Bryant, Medical and Mental Health Programs, District of Columbia Jail, *Campbell v. McGruder* – 1995
Mutually agreed upon neutral expert, State of Montana, *Langford v. Racicot* – 1995
Mutually agreed upon neutral expert, State of Vermont, *Goldsmith v. Dean* – 1996
Executive Committee Overseeing Health Care, Puerto Rico Administration of Corrections – 1993
Appointed by Judge Gerald Jenks, District Court for the Central District of Utah, as Impartial Expert in the matter of *Henry v. Deland* – 1993
Appointed by Magistrate Claude Hicks Jr., U.S. District Court in Macon, Georgia as Medical Expert in the matter of *Cason v. Seckinger* – 1993
Appointed by Judge Owen M. Panner, District of Oregon, as Special Master in *Van Patten v. Pearce* involving medical services at Eastern Oregon Correctional Institution – December 1991
Appointed by Allan Breed, Special Master, *Gates* case, as Medical Consultant regarding California Medical Facility in Vacaville
Appointed by Judge M. H. Patel, Special Master, case involving San Quentin Prison – 1989 to 1995
Selected as part of delegation to inspect the medical services provided to Palestinian detainees in the Occupied Territories and Israel by Physicians for Human Rights – 1989
Appointed by U.S. District Judge Williams as member of medical panel monitoring medical services in Hawaii Prison System – 1985
Appointed by U.S. District Judge Black to evaluate medical services in the Florida Prison System – 1983

Appointed by U.S. District Judge Kanne as monitor to the Lake County, Indiana Jail in the litigation of the *Jensen* case (H74-230) – 1982
Appointed by U.S. District Judge J. Moran as Special Master of the Lake County, Illinois Jail in the litigation of *Kissane v. Brown* – 1981
Board Member, Health and Medicine Policy Research Group, Chicago, Illinois – 1980
Appointed to Advisory Committee, State of Alabama, Department of Mental Health – 1980
Appointed as consultant to the State of Alabama, Department of Mental Health – 1979
Consultant, U.S. Department of Justice Civil Rights Division, Special Litigation Section – 1977
Appointed by U.S. District Judge J. Foreman to a three-member panel of medical experts to advise on health conditions at Menard Correctional Center, Menard, Illinois – 1976

AWARDS

NCCHC Bernard Harrison Award for Distinguished Service to the Field of Correctional Medicine – 2010
Armond Start Award for Excellence in Correctional Medicine, Society of Correctional Physicians – 1999
American Correctional Health Services Association Distinguished Service Award – 1992

PUBLICATIONS

Michael Puisis, editor, Ronald Shansky, associate editor, *The Clinical Practice in Correctional Medicine, second edition*, 2006.

Schiff, G., Shansky, R., chapter: “The Challenges of Improving Quality in the Correctional Health Care Setting,” in *The Clinical Practice in Correctional Medicine, second edition*, 2006.

Schiff, G.; Shansky, R.; Kim, S., chapter: “Using Performance Improvement Measurement to Improve Chronic Disease Management in Prisons,” in *The Clinical Practice in Correctional Medicine, second edition*, 2006.

Anno, B.J., Graham, C., Lawrence, J., and Shansky, R. *Correctional Health Care – Addressing the Needs of the Elderly, Chronically Ill, and Terminally Ill Inmates*. National Institute of Corrections, 2004.

Schiff, G., Shansky, R., chapter: “Quality Improvement in the Correctional Setting,” in *The Clinical Practice in Correctional Medicine*, 1998.

How-To Manual, *Quality Improvement in a Correctional System*, State of Georgia, Department of Corrections, 1995.

Journal of Prison and Jail Health, Editorial Board; 1988 – present.

Shansky, R., “Advances in HIV Treatment: Administrative, Professional and Fiscal Challenges in a Correctional Setting,” *Journal of Prison and Jail Health*, Volume 9, Number 1.

B. Jaye Anno, Ph.D., *Prison Health Care: Guidelines for the Management of an Adequate Delivery System*, 1991; Member of Editorial Advisory Board.

Coe, J., Kwasnik, P., Shansky, R., chapter: “Health Promotion and Disease Prevention” in B. Jaye Anno, Ph.D., *Prison Health Care: Guidelines for the Management of an Adequate Delivery System*, 1991.

Hoffman, A.; Yough, W.; Bright-Asare, P.; Abcariam, H.; Shansky, R.; Fitzpatrick, J.; Lidlow, E.;

Farber, M.; Summerville, J.; Petani, C.; Orsay, C.; Zal, D., "Early Detection of Bowel Cancer at an Urban Public Hospital: Demonstration Project," *Ca – A Cancer Journal for Clinicians*, American Cancer Society, Nov/Dec 1983, Vol. 33, No. 6.
Mehta, P.; Mamdani, B.; Shansky, R.; and Dunea, G., "Double Blind Study of Minoxidil and Hydralazine." Sixth International Conference of Nephrology, Florence, Italy – June 1975.

PRISONS INSPECTED

State of Alabama Prisons at Kilby, Holman, Fountain, Tutweiller, Staton, and Draper
Parchman State Prison, Mississippi Jefferson County and Birmingham City Jails, Alabama
Arizona State Prison, Florence, Arizona
Washington County Jail, Fayetteville, Arkansas
California Medical Facility, Vacaville
California State Penitentiary, San Quentin
Colorado State Penitentiaries, Centennial, Fremont, Territorial
District of Columbia Jail at Occoquan
Florida Prison System
Florida County Jails, including Monroe County, Pasco County and Polk County
Krome Detention Facility (INS), Miami, Florida
Department of Juvenile Justice, State of Georgia
Georgia Diagnostic Center, Jackson, Georgia
Hawaii Prison System
Menard Correctional Center, Illinois
Rock Island County Jail, Rock Island, Illinois
Indiana State Penitentiary, Michigan City, Indiana
Indiana Reformatory, Pendleton, Indiana
Lake County Indiana Jail, Crown Point, Indiana
Maine State Prison, Thomaston, Maine
State Prison of Southern Michigan
New Hampshire State Penitentiary, Concord
New York City Jails
Sing Sing Penitentiary, New York
Ohio Women's Prison
State of Vermont Prison System
Walla Walla State Penitentiary, Washington
Wisconsin State Penitentiaries at Waupan, Fox Lake, Taycheedah and Dodge

SURVEYED MEDICAL PROGRAMS

Federal Bureau of Prisons, approximately 20 facilities

INTERNATIONAL INSPECTION

Israeli Prisons and Jails Housing Palestinian Detainees

APPENDIX 5

No. _____

SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams,

Petitioner.

DECLARATION OF ANGIE D. WILLIAMS

WASHINGTON INNOCENCE PROJECT
Jacqueline McMurtrie, WSBA No. 13587
Kaylan L. Lovrovich, WSBA No. 55609
4293 Memorial Way N.E.
Seattle, WA 98195-0001
(206) 543-5780

Dayton L. Campbell-Harris, Law Student
Tierney Vial, Law Student

Attorneys for Petitioner

I, Angie D. Williams, declare under penalty of perjury under the laws of the Washington that the following statements are true and correct to my best knowledge and belief:

1. I am 56 years old and am competent to testify as to the contents of this declaration.
2. I am currently residing in Jacksonville, Florida.
3. I am financially able and willing to care for my brother, Robert Rufus Williams, should he be released from Coyote Ridge Correctional Facility.
4. My sisters, one who lives nearby in Jacksonville and the other who lives in Charleston, SC, are also willing to support me and take care of Robert.

Employment

5. I am employed at the Jacksonville Transportation Authority. I serve as a Design and Construction Project Manager II.
6. I have been employed at the Jacksonville Transportation Authority for four years.
7. My educational background is a Bachelor of Science in Mechanical Engineering from the University of South Carolina.

8. I am currently pursuing a Master in Public Policy degree at Jacksonville University.
9. I have consistently stayed employed since graduating from the University of South Carolina.
10. I maintain a well structured and organized lifestyle.
11. My position at the Jacksonville Transportation Authority allows me to work from home while social distancing measures are implemented.

Community Service

12. I have been a member of good standing at Julington Baptist Church, in Jacksonville Florida.
13. I was appointed by the Mayor of Jacksonville to serve on the Construction Trade Qualifying board as the general contractor's representative for Duval County and am a State Certified General Contractor.

Housing

14. I am a single-family homeowner in Jacksonville, Florida.
15. I live in a home with five bedrooms and four bathrooms, where most of the bedrooms and major amenities are downstairs.
16. My home's entrance is a double door opening that provides ample space for a wheelchair to enter the house.

17. I have no roommates or live-in partners. I am currently engaged to the Chief Pilot and Special Agent for the Florida Department of Law Enforcement.

18. My home offers heating, air conditioning, and plumbing.

Financial Stability

19. The Jacksonville Transportation Authority pays me a salary sufficient to provide for both my brother and me, if he is released from Coyote Ridge Correctional Facility.

20. Should a situation arise where I was unable to financially support my brother, my sister has offered to support him.

21. I have a good credit score.

22. I am not nor have ever been at risk of having my home, vehicle(s), or other property being repossessed.

23. I am confident that my current financial situation allows me to take care of my brother for the duration of social distancing measures being implemented.

DATED this 16th day of April 2020 in Jacksonville, Florida.

Angie D. Williams

WASHINGTON INNOCENCE PROJECT CLINIC

May 14, 2020 - 5:57 PM

Filing Personal Restraint Petition

Transmittal Information

Filed with Court: Supreme Court
Appellate Court Case Number: Case Initiation
Trial Court Case Title: State of Washington Vs Williams, Robert Rufus
Trial Court Case Number: 07-1-03073-7
Trial Court County: Pierce County Superior Court
Signing Judge: Serko
Judgment Date: 01-30-2009

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Personal Restraint Petition
Statement of Finances
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