UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE

Favian Busby, Michael Edgington, Russell Leaks, and Joseph Nelson, *on their own behalf and on behalf of those similarly situated*; Petitioners-Plaintiffs, v. Floyd Bonner, Jr., *in his official capacity*, Shelby County Sheriff, and the Shelby County Sheriff's Office, Respondents-Defendants.	Civil Action No. 3:20-cv-2359-SHL

EXPERT REPORT OF DR. HOMER D. VENTERS, M.D. IN SUPPORT OF PLAINITFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER

I, Homer Venters, pursuant to 28 U.S.C. § 1746, declare as follows:

A. Background

1. I am a physician, internist, and epidemiologist with over a decade of experience in providing, improving, and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with U.S. Immigration and Customs Enforcement ("ICE") on numerous individual cases of medical release, the formulation of health-related policies, as well as testimony before the U.S. Congress regarding mortality inside ICE detention facilities.

2. After my fellowship training, I became the Deputy Medical Director of the Correctional Health Services of New York City. This position included both direct care to persons held in NYC's twelve (12) jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical

Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry, morbidity and mortality reviews as well as all training and oversight of physicians, nursing and pharmacy staff. In these roles, I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacts almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection and several other smaller outbreaks.

3. In March 2017, I left Correctional Health Services of New York City to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers.

4. Between December 2018 and April 2020, I served as the Senior Health Fellow and President of Community Oriented Correctional Health Services ("COCHS"), a nonprofit organization that promotes evidence-based improvements to correctional practices across the United States. I have also worked as a medical expert in cases involving correctional health since 2017, and I wrote and published a book on the health risks of jail (*Life and Death in Rikers Island*) that was published in early 2019 by Johns Hopkins University Press.

5. Since April 2020, I have worked exclusively on COVID-19 responses in detention settings. During this time, I have conducted court-ordered inspections of detention facilities to assess the adequacy of their COVID-19 responses in the following settings;

a. MDC Brooklyn (BOP), NY
b. MCC Manhattan (BOP), NY
c. FCI Danbury (BOP), CT
d. Cook County Jail, IL
e. Sullivan County Jail, NY
f. Broome County Jail, NY

6. I have also been invited to present COVID-19 guidance to several organizations including the National Academy of Sciences, the National Association of Counties and the American Medical Association.

7. A copy of my curriculum vitae is attached as **Exhibit A** to this report which includes my publications and a listing of depositions and testimony I have provided.

B. Expert Assignment

8. Plaintiffs' counsel in this matter have asked me to:

a. Conduct an inspection of the Shelby County Jail with a focus on the adequacy of the facility's response to COVID-19, specifically as it relates to the safety of those at highest risk of serious illness or death if they contract the disease (referred herein as "medically vulnerable" or "high risk"). This is my seventh such physical inspection of COVID-19 response in a detention setting. I was asked to ascertain the adequacy of COVID-19 mitigation and response efforts that are relevant to the identification, protection and care of medically vulnerable or high risk detained people;

b. Review the declarations of Dr. Joe Goldenson (Doc. No. 2-2); Dr. Nina Fefferman (Doc. No. 2-1), and Dr. Marie Griffin (Doc. No. 2-3) submitted in this case, the independent inspection report of Mr. Mike Brady;

c. Document my findings in this report; and

d. Be available to testify in the hearing scheduled in this matter on Friday, July 10, 2020.

C. Methodology

9. In order to conduct my assessment, I visited and physically inspected the Shelby County Jail on the morning of July 7, 2020, from approximately 8 a.m. to 11:45 a.m. I was able to inspect the facility freely with unfettered access to the facility, and was also empowered to speak with staff or detainees along the path of the various areas of the facility. The staff members I spoke with were helpful in answering my questions.

10. Prior to conducting my inspection of the facility, I was able to review the expert report submitted by Mr. Mike Brady, as well as several other publicly available documents relating to the COVID-19 response in Shelby County Jail.

11. My inspection included review of the entry area, administrative offices, several housing areas, the jail intake and medical unit. Specific housing areas inspected included the new admission housing area on the lower level, the various housing areas on the second floor and those on the 5th floor.

12. I was accompanied on the tour by Captain Dotson and Lieutenant Reed as well as the health services administrator for Wellpath, Mr. Sanders. Prior to the inspection, and at the conclusion, I met briefly with Chief Kirk Fields and some of his senior staff to thank them for their assistance.

D. Findings

COVID-19 and the Shelby County Jail

13. It is my opinion that the threat COVID-19 poses to medically vulnerable persons detained in the Shelby County Jail is high, and is likely to increase as infection numbers escalate in Tennessee and in Shelby County as a whole. I have reviewed the declarations of Dr. Joe Goldenson, Dr. Marie Griffin, and Dr. Nina Fefferman submitted by the plaintiffs in this case. I agree with and incorporate the principles outlined in these declarations, including but not limited to:

a. COVID-19 is a pandemic, highly contagious, and serious disease transmitted primarily via respiratory droplets, including by people who are not exhibiting symptoms, for which there is no vaccine or cure, and for which the best preventive measures are social distancing as well as other infection control measures including rigorous sanitation, hygiene and the consistent wearing of face coverings. (Goldenson Dec., Doc. No. 2-2 ¶¶ 7–8, 11–14; Griffin Dec., Doc. No. 2-3 ¶¶ 3–4, 10).

b. COVID-19 can cause severe illness, long-term physical injury including damage to the heart and lungs, and death, particularly among people with certain co-morbidities or over the age of 55 (Goldenson Dec. ¶¶ 8–10; Griffin Dec. ¶¶ 5–9).

c. Jails, as a congregate environment, are higher risk environments for the transmission of COVID-19 (Goldenson Dec. ¶¶ 15–22; Griffin Dec. ¶¶ 11–12; Fefferman Dec., Doc. No. 2-1 ¶¶ 13).

d. Cases of infection within a jail drive worse outcomes for the broader population, as the jail itself can continue to re-seed infection into the wider community. The jail and community's public health protocols are inextricably linked, and deterring all cases of COVID-19 is of the utmost importance given limited capacity of local healthcare systems. (Fefferman Dec. ¶¶ 10–12, 17, 19).

14. I am aware that Dr. Joe Goldenson did not conduct an inspection of the Shelby County Jail facility. There are some ways that my observations differed from what he described in his declaration of May 20, 2020. For example, though Dr. Goldenson noted that he understood that detainees were required to purchase soap (¶ 33), I observed that soap was largely being provided to detainees. Similarly, Dr. Goldenson indicated (¶ 34) that he understood that "many staff do not wear masks and when they do wear the masks, they do not wear them adequately so that it covers their mouths at all times." I observed staff wearing masks properly for the most part.

Chief Findings from Inspection

15. What I observed in the Jail largely aligned with the independent inspection report of Mr. Mike Brady, including in the following ways:

a. I observed a lack of consistent social distancing throughout all areas of the Jail. While there were limited ways in which Jail officials appeared to have made recent improvements, for example by putting down tape markers to encourage social distancing during pill calls, it is my opinion that social distancing is not being facilitated or practiced with the rigor required to prevent disease spread;

b. I left with the impression that the purported 21-day quarantine practice is not being consistently followed for new arrestees. Based on my conversations with people living and working in the Jail, it is not clear that individuals actually remain in quarantine on the lower level for a full 21 days. Further, the structure of the lower level units does not enable social distancing, lack a common area through which detained persons could attend to phone calls and other business with sufficient space from other people, and the cell doors are open bars that allow air and virus to spread throughout the area.

c. The Shelby County Jail relies on these medical isolation strategies in lieu of a comprehensive testing strategy to address COVID-19, but the flaws in the medical isolation strategy renders them ineffective;

16. My inspection of the Shelby County Jail revealed several areas of strength in the response by the facility. I observed the staff screening process at entry, and the process appeared to be fully compliant with CDC recommendations.[1] Most officers were wearing masks when I toured (only 4 staff were not during the time of my inspection). All of the detained people I spoke

[1] I would recommend adding a question on the staff and inmate screening forms regarding travel to states with high rates of COVID-19 (more than 10/100,000). This is particularly important for staff, many of whom are currently taking their first vacations in many months and may be returning to work after travel to high-risk settings.

with had at least one mask in their possession that I was able to observe myself. Another area of strength was the occurrence of regular meetings with the local department of health, jail security and health leadership. In addition, detained people in the intake area and medical clinic waiting rooms were sitting with space between them.

17. My inspection of the Shelby County Jail left me with several findings relating to deficiencies that should be addressed in the COVID-19 response. Below I set forth recommended courses of action designed to limit the potential risks of morbidity and mortality from COVID-19. However, it is my opinion that due to the severity of the risks, the limitations in how safe medically vulnerable people can be made in the facility, and the time it would take for the Jail to implement protocols they have not undertaken, that medically vulnerable people should be evaluated for release from the Shelby County Jail.

Lack of Social Distancing

18. As noted above, social distancing is not being consistently practiced throughout the Jail. For example, in Lower Level B unit, one of the units where newly arrived detainees are housed, I observed four people standing very close to each other waiting to use the phone, less than 2 feet apart. In unit 2A, I observed that despite many unused bunks, there were many adjacent that were occupied without an unused bunk in between. In addition, I observed detainees sitting and standing together in close quarters, 1-2 feet apart.

Lack of Testing

19. While a handful of rounds of testing have been provided to detained persons in the Shelby County Jail, the testing is not adequate to track infections in the facility. Further, given the punitive conditions in which those who test positive for COVID-19 are housed, I got the impression that detained people are disincentivized from reporting symptoms or taking a COVID-19 test. This is consistent with my experience working in other facilities.

20. As noted in Mr. Brady's report, the Jail has a concededly "non-test based" approach to managing COVID-19. Under such an approach, the containment of the disease depends on rigorous isolation of persons with potential and known exposure to the disease. Shortcomings in the Jail's isolation strategy indicate that the disease is not contained in the facility.

21. In my experience, "medical isolation" refers to the practice of taking people who have COVID-19 or have symptoms of COVID-19, separating them from other people, and providing them with additional surveillance and care. "Quarantine" refers to separating people who may have been exposed to COVID-19 from everyone else for a period of up to 14 days with daily surveillance for new symptoms.

22. Notably, the medical isolation unit on 2A, where people with confirmed cases of COVID-19 are detained, represents a serious threat to staff and detainees. There are multiple features of the medical isolation unit on 2A that represent a threat to the health of staff and detainees, particularly those with risk factors for serious illness or death from COVID-19, some of which reflect physical plant limitations and others that reflect practices by the security or health staff. These include:

a. Despite being called a medical isolation unit, 2A is open to the hallway and the mental health unit across the hall, where patients with serious mental illness and those with mental health emergencies are being held. All cells in 2A are comprised of open bar windows on the doors, meaning that there is free flow of air (and virus) from people inside 2A to anyone in the hallway and across the hall, which is approximately 10 feet across. There is no closed door anywhere to separate patients with COVID-19 from staff or other inmates on this floor.

b. The open nature of the medical isolation unit represents a deviation from CDC recommendations and basic infection control principles. While I observed that staff don PPE outside 2A before entering, there are numerous staff in the hallway outside this unit, as well as the patients immediately across the hallway in the mental health unit 2N that do not have full PPE on.

c. In addition, many of the patients in 2N were clearly in the midst of psychological decompensation, yelling and banging on their doors, without masks on. One patient was being held in an open cage, roughly the size of a phone booth, facing the hallway and medical isolation unit. He was yelling and screaming throughout the time I was on this floor. Another patient was banging on his cell floor hard enough to shake the entire door against its frame, all the time yelling undecipherable words. Many other people were yelling from their cells both while I was on the unit, before and after. I did not observe any mental health staff enter this unit at the time I was there, or during the time I was in the hallway outside or on the medical isolation unit. The combination of no masks, with increased respiratory rate and tidal volume among these agitated patients places them at much higher risk of contracting COVID-19 than other people.

d. I am extremely concerned that anyone in the hallway outside 2A is routinely exposed to COVID-19 and would recommend testing of all staff and detainees who have been in this vicinity. This would include patients and staff who have been in the mental health unit 2N. These deficiencies are even more concerning given

mounting evidence that the COVID-19 virus persists and travels in the air for longer than originally thought.[2]

e. Patients in 2A reported that they were locked in their cells all weekend, from Friday evening until Monday morning. This represents a punitive and unnecessary practice and should be discontinued.

f. Several patients in 2A reported being unsure about why they were in the unit. One person reported being unsure if he had COVID-19. Two other patients reported that they had received positive COVID-19 tests but were not sure when they could leave the unit. In addition to addressing these specific concerns, a more regular health presence on the unit would improve the general level of engagement and understanding of how people come to be on this unit and how long they will be held there. Neither these patients nor the staff reported any plans for retesting of these patients.

g. There was no PPE cart or waste receptacle outside unit 2A. Each person brought PPE with them to the unit and then utilized a garbage bag to doff their PPE into. This approach makes it more likely that staff will enter the unit without proper PPE since supplies are not present to replace broken or torn PPE and also increases the contact spread of virus because there is not any no-touch waste receptacle to doff PPE as recommended by the CDC.

Lack of Contact Tracing

23. The quarantine units I inspected on the fifth floor revealed several concerns regarding identification of new COVID-19 cases and protection from COVID-19 spread.

a. At the time of my inspection, two of three adjacent housing areas, 5b and 5c, were on quarantine because of previously identified cases. Unit 5a was not on quarantine. The front of all three units come together in a small shared hallway, with open bars that allow for free movement of air (and virus) into and out of the three units.

b. This is extremely problematic because the central purpose of a quarantine unit is to keep one group isolated from the rest of the facility to observe whether an initial case of COVID-19 results in more subsequent cases. Keeping a quarantine cohort isolated from the rest of the facility is critical both because they may have more COVID-19 patients who can spread the infection, and also because it is important to be able to attribute subsequent cases to the original one. When the quarantine patients are mixing with others, then it is not knowable whether a subsequent case actually results from the original case or simply some other transmission from staff who pass by or people detained in the other units.

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[2] *See, e.g.*, Apoorva Mandavilli, *239 Experts with One Big Claim: The Coronavirus is Airborne*, New York Times (July 4, 2020), https://www.nytimes.com/2020/07/04/health/239-experts-with-one-big-claim-the-coronavirus-is-airborne.html.

c. I observed the screening process for quarantine unit 5b, and this involved a nurse taking temperatures of patients, with results recorded on a sheet of names. Health staff did not ask detainees about symptoms. The Health Services Administrator ("HSA"), Mr. Sanders, explained that these sheets were then given to infection control staff who entered the temperatures of each patient into the Wellpath EMR, Nexgen. The CDC has made clear that the presence of symptoms of COVID-19 is a critical element of screening, and patients in quarantine, as well as any high-risk patients throughout the facility should be screened at least daily for symptoms of COVID-19 as well as temperature. This approach involves nursing staff using a paper or electronic template of symptom questions and temperature, much like is done for every staff member entering the facility. This approach is crucial because the CDC has made clear that patients may present with symptoms of COVID-19 without fever, and reliance on temperature alone results in a delay in identification of new cases. In fact, the updated CDC guidance on expended testing includes an explicit recommendation to test based on symptoms of COVID-19 in congregate settings including detention facilities. This approach cannot be utilized without actively asking about symptoms.

24. The ability of COVID-19 to move freely from one unit to another in the Shelby County Jail and the lack of social distancing renders any contact tracing of very limited value, since people are often in close quarters and able to transmit the virus in ways that are not knowable or are not detected by staff. Facility leadership acknowledged that they are responsible for conducting contact tracing when new cases of COVID-19 occur.

Inadequate Screening and Care for Medically Vulnerable

25. Special protections can and should be created for detained people who are at increased risk for serious illness or death from COVID-19. The facility HSA, Mr. Sanders, reported that approximately 300 of the 1800 detained people meet CDC criteria for being high risk. When we discussed the health services and COVID-19 response for these patients, several concerns arose.

a. There does not appear to be any plan to cohort or house together people who are medically vulnerable. This is a basic approach that allows for increased focus on screening, infection control and social distancing among the most vulnerable detained people and should be implemented.

b. After medically-vulnerable patients enter the jail, there is no daily screening of their temperature or symptoms of COVID-19. This should occur on a daily basis, from the first day in new admission housing and throughout their incarceration.

c. There did not appear to be any specific effort to create a COVID-19 plan for the care of each medically-vulnerable patient. It is imperative that the health service create a COVID-19 plan for the care of anyone who is at increased risk of serious

illness or death from COVID-19. Such a plan would involve, at a minimum, reviewing a patient's high-risk status, assessing the degree to which their health problems are under control, and evaluating the impact of their medications for their conditions on COVID (e.g., some essential medications impact the body's immune response or may otherwise create special vulnerabilities during COVID-19 infection). That level-of-control assessment would detail the patient's baseline symptoms, including the frequency of symptoms, the circumstances under which the symptoms improve or worsen, and the efficacy of any current medication. A care plan for an individual at a high-risk for COVID-19 would also provide education about COVID-19 symptoms and planning tailored to the possibility of COVID-19 infection, which would generally involve daily screening for COVID-19 symptoms. This approach is especially critical for detainees with any heart or lung problems, or other conditions that include symptoms that can appear very similar to those for COVID-19. These measures are not mere best practices — they are all standard elements of care planning that I have implemented time and time again to protect high-risk patients during outbreaks in prisons and jails. They are necessary components of care-planning for patients at a high risk of COVID-19 infection, because the CDC explicitly states that poorly controlled health problems represent additional risk for people infected by COVID-19, over and above the risk created simply by having a particular health problem.

d. Another clinical concern I have is that medically vulnerable patients who contract COVID-19 are likely to need care after they are no longer infectious, and there did not appear to be a plan to address this need. Care for COVID-19 patients extends beyond simply clearing them to return to general population housing areas because they have reached a 14-day mark after their diagnosis. The World Health Organization has reported that physical recovery from COVID-19 can extend well beyond the period of active infection, taking six weeks or longer.[3] Many of the people I have spoken with in detention settings report ongoing symptoms post-COVID-19 infection including shortness of breath, chest pain, tinnitus and daily headaches. These symptoms last weeks or longer, and the facility must create a plan of care that assesses, documents and treats these problems among detained people. Basic elements of a post COVID-19 assessment include asking patients whether they experienced any of the CDC listed symptoms during their COVID-19 infection and whether they continue to experience any of those, or any other symptoms.

e. These efforts will likely include pulmonary rehabilitation and physical therapy or exercise as part of what patients need to recover from COVID-19.[4] At a baseline, any patient who experienced shortness of breath or other pulmonary symptoms

[3] https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf

[4] https://rehabmed.weill.cornell.edu/sites/default/files/post_covid_rehab_-_patient_guide_0.pdf and https://www.healthline.com/health-news/what-to-do-after-recovering-from-covid-19#Walking

> should have their respiratory status and symptoms documented and be considered for incentive spirometry.[5] Patients with chest pain should be evaluated for cardiac complications of COVID-19, have an EKG conducted, and referred for cardiology consultation. Because COVID-19 is associated with a high rate of blood clots as well as kidney and liver damage, these recovery encounters should also contain structured questions to elicit such concerns, and when they are present, laboratory testing should be conducted for these concerns. Implementing these basic and required elements of COVID-19 care will require adequate staff as well as training.

26. Patients held in medical isolation on 2A do not receive adequate assessments of their health status. I spoke with all 8 patients in the medical isolation unit and they all reported that the daily health assessments that occur include vital signs being taken through the bars of their cell doors. Seven of the patients reported that nobody had ever listened to their lungs with a stethoscope, including one person who reported (and produced records) that he has asthma. I addition, all eight of the patients reported that health staff conduct no assessments at all from Friday evening until Monday morning. This represents a grossly inadequate approach to care for patients who have already been identified as having COVID-19, but this lack of care is especially dangerous for medically vulnerable patients who can quickly decompensate with COVID-19 infection.

27. One patient reported to me that his initial COVID-19 symptom was a headache and that nobody has asked him about his headaches while in 2A. He and two other patients in 2A also reported that sick call slips submitted while in 2A may not be responded to for several days, even when COVID-19 symptoms are reported. This lack of regular and adequate health assessments in 2A is especially dangerous for patients who have any risk factors for serious illness or death from COVID-19. These patients can deteriorate quickly and gaps in assessments, or failure to conduct a real clinical assessment, including lung and heart auscultation, increases the risk that patients will deteriorate without being appreciated.

Additional Findings

28. In all of my inspections of detention facilities, both related to COVID-19 and otherwise, I have never seen a facility rely on a housing unit to serve as an isolation or quarantine

[5] https://lunginstitute.com/blog/incentive-spirometry-benefits/

unit for the purposes of disease control that has open bars and no solid door. This was a deeply disturbing practice that in my opinion is out of touch with basic practices of infection control.

E. Recommendations and Conclusion

29. Based on these findings, I have serious concerns regarding the safety of high risk patients held in the Shelby County Jail. I am highly confident in my assessments and recommendations, having conducted numerous similar inspections and having managed a large correctional health service, including multiple communicable disease outbreaks.

Recommendations

30. There are some measures the Jail should have taken, and can still take, to improve safety for medically vulnerable detainees. These include:

a. I recommend immediate discontinuation of unit 2A as a medical isolation unit with use of a unit that has a door that closes and does not open except for entry to the unit and which has cells with solid doors that close. I do not recommend that people in medical isolation be confined to their cells but that they be in a unit that is closed to the rest of the jail, with full PPE for anyone who enters the unit.

b. In order to ensure the proper level and frequency of health assessments, Wellpath may need to add staffing for the medical isolation unit for those who have tested positive for COVID-19;

c. In order to ensure people in medical isolation are not locked down in their cells, the Jail should provide sufficient staffing to prevent the current practice of medically isolated detainees remaining in cells over the weekend;

d. Every patient in medical isolation should have a daily assessment that includes being asked about COVID-19 symptoms, vital signs and at a minimum, auscultation of lungs and heart with a stethoscope, as well as assessment for any other symptoms that have been reported to document whether they are improving or not;

e. Wellpath should institute COVID-19 recovery encounters, as described above, with every patient who was confirmed or is suspected of having COVID-19;

f. Whatever unit is used for medical isolation should have a stocked PPE cart and a no touch waste receptacle outside; and

g. Patients in quarantine should be housed in a unit with a door that closes and that does not involve free and ready passage of air and virus in between units and common areas such as the hallway area outside 5a,b,c.

h. All medically vulnerable patients should be screened on a daily basis for both symptoms of COVID-19 and temperature.

i. Medically vulnerable people should be cohorted into hosing areas where additional infection control and social distancing measures can be implemented, where steady and limited staff can work, and where they can receive the care the need for their pre-existing conditions. I have utilized this approach during outbreaks in jail settings, and even in facilities with mixed security classifications and security risk groups and numerous separation orders, I have found this to be an effective and manageable approach.

j. Given the potential open transmission of COVID-19 throughout many parts of the facility, each new case of COVID-19 should result in testing of everyone on the floor of the facility, detainees and staff, and heavy consideration should be given to periodic retesting of all detainees and staff.

31. However, it is also my opinion that there are some dynamics in the Jail that cannot be improved, which also render medically vulnerable people unsafe. These include:

a. There appear to be relatively few housing areas with solid doors on cells or on the doors for entry to the unit. The need for this type of housing area is currently prioritized for administrative segregation, punitive segregation and other non-medical reasons. Based on discussions with security staff, I am concerned that the facility will not be able to find adequate housing area space to meet the basic needs for quarantine and medical isolation and cohorting of medically vulnerable patients. As a result, medically vulnerable patients are at elevated risk of COVID-19 as long as they are in this facility.

32. For all these reasons, and because the improvements I recommend above can in all likelihood not occur fast enough to protect medically vulnerable persons from COVID-19, it is my opinion that medically vulnerable people housed in the Shelby County Jail should be evaluated for release.

33. I believe the implementation of the recommendations I have provided, along with releasing high risk detainees who are able to self-isolate and await future court dates safely in the community, will significantly decrease the risk of serious illness or death from COVID-19 among high risk detainees.

Dated this 9th day of July, 2020 */s/ Homer D. Venters*

Dr. Homer D. Venters, M.D.

Exhibit A

Dr. Homer D. Venters
Curriculum Vitae

I. Professional Experience

Medical/Forensic Expert, 3/2016-present

- Review COVID-19 policies and procedures in detention settings including

  - Sullivan County Jail, Sullivan County, NY, 6/2020
  - Federal BOP-Metropolitan Correctional Center, NY, NY, 5/2020
  - Federal BOP-Metropolitan Detention Center, Brooklyn, NY, 5/2020
  - Federal BOP-Federal Correctional Institution, Danbury , NY, 4/2020

- Conduct analysis of health services and outcomes in detention settings.
- Conduct site inspections and evaluations in detention settings.
- Produce expert reports, testimony regarding detention settings.

President, Community Oriented Correctional Health Services (COCHS), 1/1/2020-4/30/20.

- Lead COCHS efforts to provide technical assistance, policy guidance and research regarding correctional health and justice reform.
- Oversee operations and programmatic development of COCHS
- Serve as primary liaison between COCHS board, funders, staff and partners.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), 12/1/18-12/31/2018

- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Director of Programs, Physicians for Human Rights, 3/16-11/18.

- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.
- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

- Transitioned entire clinical service (1,400 staff) from a for-profit staffing company model

to a new division within NYC H + H.
- Developed new models of mental health and substance abuse care that significantly lowered morbidity and other adverse events.
- Connected patients to local health systems, DSRIP and health homes using approximately $5 million in external funding (grants available on request).
- Reduced overall mortality in the nation's second largest jail system.
- Increased operating budget from $140 million to $160 million.
- Implemented nation's first patient experience, provider engagement and racial disparities programs for correctional health.

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.

- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from $115 million to $140 million.
- Established surveillance systems for injuries, sexual assault and mental health that drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.

- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.

- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

Clinical Attending Physician, Bellevue/NYU Clinic for Survivors of Torture, 10/07-12/11.

Clinical Attending Physician, Montefiore Medical Center Bronx NY, Adult Medicine, 1/08-11/09.

II. Academic Appointments, Licensure

Clinical Associate Professor, New York University College of Global Public Health, 5/18-present.

Clinical Instructor, New York University Langone School of Medicine, 2007-2018.

M.D. New York (2007-present).

III. Teaching

Instructor**,** Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, June 2015, June 2014, April 2019.

Instructor, Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

IV. Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture, Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo Egypt, September 20-23, 2014.

Doctors of the World**,** Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/05-11/18.

United States Peace Corps, Guinea Worm Educator, Togo West Africa, June 1990- December 1991.

- *Primary Project;* Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French
- *Secondary Project;* Malaria Prevention.

V. Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009. Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.

Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University7/2004- 5/2007.

M.D., University of Illinois, Urbana, 12/2003.

M.S. Biology, University of Illinois, Urbana, 6/03.

B.A. International Relations, Tufts University, Medford, MA, 1989**.**

VI. Peer Reviewed Publications

Parmar PK, Leigh J, **Venters H**, Nelson T. Violence and mortality in the Northern Rakhine State of Myanmar, 2017: results of a quantitative survey of surviving community leaders in Bangladesh. Lancet Planet Health. 2019 Mar;3(3):e144-e153.

Venters H. Notions from Kavanaugh hearings contradict medical facts. *Lancet.* 10/5/18.

Taylor GP, Castro I, Rebergen C, Rycroft M, Nuwayhid I, Rubenstein L, Tarakji A, Modirzadeh N, **Venters H**, Jabbour S. Protecting health care in armed conflict: action towards accountability. *Lancet.* 4/14/18.

Katyal M, Leibowitz R, **Venters H**. IGRA-Based Screening for Latent Tuberculosis Infection in Persons Newly Incarcerated in New York City Jails. *J Correct Health Care.* 2018 4/18.

Harocopos A, Allen B, Glowa-Kollisch S, **Venters H**, Paone D, Macdonald R. The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated. *J Health Care Poor Underserved*. 4/28/17.

MacDonald R, Akiyama MJ, Kopolow A, Rosner Z, McGahee W, Joseph R, Jaffer M, **Venters H**. Feasibility of Treating Hepatitis C in a Transient Jail Population. *Open Forum Infect Dis*. 7/7/18.

Siegler A, Kaba F, MacDonald R, **Venters H**. Head Trauma in Jail and Implications for Chronic Traumatic Encephalopathy. *J Health Care Poor and Underserved.* In Press (May 2017).

Ford E, Kim S, **Venters H**. Sexual abuse and injury during incarceration reveal the need for re-entry trauma screening. *Lancet.* 4/8/18.

Alex B, Weiss DB, Kaba F, Rosner Z, Lee D, Lim S, **Venters H,** MacDonald R. Death After Jail Release. *J Correct Health Care*. 1/17.

Akiyama MJ, Kaba F, Rosner Z, Alper H, Kopolow A, Litwin AH, **Venters H**, MacDonald R. Correlates of Hepatitis C Virus Infection in the Targeted Testing Program of the New York City Jail System. *Public Health Rep.* 1/17.

Kalra R, Kollisch SG, MacDonald R, Dickey N, Rosner Z, **Venters H**. Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System. *J Correct Health Care.* 2016 Oct.; 22(4):383-392.

Venters H. A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration. *Am J Public Health*. April 2016.104.

Glowa-Kollisch S, Kaba F, Waters A, Leung YJ, Ford E, **Venters H**. From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails. *Int J Env Res Public Health.* 2016. 13(2),182.

Jaffer M, Ayad J, Tungol JG, MacDonald R, Dickey N, Venters H. Improving Transgender Healthcare in the New York City Correctional System. *LGBT Health.* 2016 1/8/16.

Granski M, Keller A, Venters H. Death Rates among Detained Immigrants in the United States. *Int J Env Res Public Health.* 2015. 11/10/15.

Michelle Martelle, Benjamin Farber, Richard Stazesky, Nathaniel Dickey, Amanda Parsons, **Homer Venters**. Meaningful Use of an Electronic Health Record in the NYC Jail System. *Am J Public Health*. 2015. 8/12/15.

Fatos Kaba, Angela Solimo, Jasmine Graves, Sarah Glowa-Kollisch, Allison Vise, Ross MacDonald, Anthony Waters, Zachary Rosner, Nathaniel Dickey, Sonia Angell, **Homer Venters**. Disparities in Mental Health Referral and Diagnosis in the NYC Jail Mental Health Service. *Am J Public Health.* 2015. 8/12/15.

Ross MacDonald, Fatos Kaba, Zachary Rosner, Alison Vise, Michelle Skerker, David Weiss, Michelle Brittner, Nathaniel Dickey, **Homer Venters**. The Rikers Island Hot Spotters. *Am J Public Health*. 2015. 9/17/15.

Selling Molly Skerker, Nathaniel Dickey, Dana Schonberg, Ross MacDonalad, **Homer Venters**. Improving Antenatal Care for Incarcerated Women: fulfilling the promise of the Sustainable Development Goals. *Bulletin or the World Health Organization*. 2015.

Jasmine Graves, Jessica Steele, Fatos Kaba, Cassandra Ramdath, Zachary Rosner, Ross MacDonald, Nathanial Dickey, **Homer Venters**. Traumatic Brain Injury and Structural Violence among Adolescent males in the NYC Jail System *J Health Care Poor Underserved.* 2015;26(2):345-57.

Glowa-Kollisch S, Graves J, Dickey N, MacDonald R, Rosner Z, Waters A, **Venters H.** Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail. *Health and Human Rights*. Online ahead of print, 3/12/15**.**

Teixeira PA Jordan AO, Zaller N, Shah D, **Venters H**. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. 2014. Am J Public Health. 2014 Dec 18.

Selling D, Lee D, Solimo A, **Venters H.** A Road Not Taken: Substance Abuse Programming in the New York City Jail System. *J Correct Health Care.* 2014 Nov 17.

Glowa-Kollisch S, Lim S, Summers C, Cohen L, Selling D, **Venters H**. Beyond the Bridge: Evaluating a Novel Mental Health Program in the New York City Jail System. *Am J Public Health*. 2014 Sep 11.

Glowa-Kollisch S, Andrade K, Stazesky R, Teixeira P, Kaba F, MacDonald R, Rosner Z, Selling D, Parsons A, **Venters H**. Data-Driven Human Rights: Using the Electronic Health Record to Promote Human Rights in Jail. *Health and Human Rights*. 2014. Vol 16 (1): 157-165.

MacDonald R, Rosner Z, **Venters H**. Case series of exercise-induced rhabdomyolysis in the New York City Jail System. *Am J Emerg Med*. 2014. Vol 32(5): 446-7.

Bechelli M, Caudy M, Gardner T, Huber A, Mancuso D, Samuels P, Shah T, **Venters H.** Case Studies from Three States: Breaking Down Silos Between Health Care and Criminal Justice. *Health Affairs*. 2014. Vol. 3. 33(3):474-81.

Selling D, Solimo A, Lee D, Horne K, Panove E, **Venters H**. Surveillance of suicidal and non-suicidal self-injury in the new York city jail system. *J Correct Health Care*. 2014. Apr:20(2).

Kaba F, Diamond P, Haque A, MacDonald R, **Venters H**. Traumatic Brain Injury Among Newly Admitted Adolescents in the New York City Jail System. *J Adolesc Health*. 2014. Vol 54(5): 615-7.

Monga P, Keller A, **Venters H**. Prevention and Punishment: Barriers to accessing health services for undocumented immigrants in the United States. *LAWS*. 2014. 3(1).

Kaba F, Lewsi A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, **Venters H**. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.

MacDonald R, Parsons A, **Venters H.** The Triple Aims of Correctional Health: Patient safety, Population Health and Human Rights. *Journal of Health Care for the Poor and Underserved*. 2013. 24(3).

Parvez FM, Katyal M, Alper H, Leibowitz R, **Venters H.** Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sexually Transmitted Infections*. 89:280-284. 2013.

Brittain J, Axelrod G, **Venters H**. Deaths in New York City Jails: 2001 – 2009. *Am J Public Health*. 2013 103:4.

Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, **Venters H**. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *AIDS Behav. Nov.* 2012.

Jaffer M, Kimura C, **Venters H**. Improving medical care for patients with HIV in New York City jails. *J Correct Health Care*. 2012 Jul;18(3):246-50.

Ludwig A, Parsons, A, Cohen, L, **Venters H.** Injury Surveillance in the NYC Jail System, *Am J Public Health* 2012 Jun;102(6).

Venters H, Keller, AS. *Psychiatric Services*. (2012) Diversion of Mentally Ill Patients from Court-ordered care to Immigration Detention. Epub. 4/2012.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2011) Mental Health Concerns Among African Immigrants. 13(4): 795-7.

Venters H, Foote M, Keller AS. *Journal of Immigrant and Minority Health.* (2010) Medical Advocacy on Behalf of Detained Immigrants. 13(3): 625-8.

Venters H, McNeely J, Keller AS. *Health and Human Rights.* (2010) HIV Screening and Care for Immigration Detainees. 11(2) 91-102.

Venters H, Keller AS. *Journal of Health Care for the Poor and Underserved*. (2009) The Immigration Detention Health Plan: An Acute Care Model for a Chronic Care Population. 20:951-957.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2009) African Immigrant Health. 4/4/09.

Venters H, Dasch-Goldberg D, Rasmussen A, Keller AS, *Human Rights Quarterly* (2009) Into the Abyss: Mortality and Morbidity among Detained Immigrant. 31 (2) 474-491.

Venters H, *The Lancet* (2008) Who is Jack Bauer? 372 (9653).

Venters H, Lainer-Vos J, Razvi A, Crawford J, Shaf'on Venable P, Drucker EM, *Am J Public Health* (2008) Bringing Health Care Advocacy to a Public Defender's Office. 98 (11).

Venters H, Razvi AM, Tobia MS, Drucker E. *Harm Reduct J.* (2006) The case of Scott Ortiz: a clash between criminal justice and public health. Harm Reduct J. 3:21

Cloez-Tayarani I, Petit-Bertron AF, **Venters HD**, Cavaillon JM (2003) *Internat. Immunol.* Differential effect of serotonin on cytokine production in lipopolysaccharide-stimulated human peripheral blood mononuclear cells.15,1-8.

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Venters HD, Broussard SR, Zhou JH, Bluthe RM, Freund GG, Johnson RW, Dantzer R, Kelley KW, (2001) *J. Neuroimmunol.* Tumor necrosis factor(alpha) and insulin-like growth factor-I in the brain: is the whole greater than the sum of its parts? 119, 151-65.

Venters HD, Dantzer R, Kelley KW, (2000) *Ann. N. Y. Acad. Sci.* Tumor necrosis factor-alpha induces neuronal death by silencing survival signals generated by the type I insulin-like growth factor receptor. 917, 210-20.

Venters HD, Dantzer R, Kelley KW, (2000) *Trends. Neurosci.* A new concept in neurodegeneration: TNFalpha is a silencer of survival signals. 23, 175-80.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Bonilla LE, Jensen T, Garner HP, Bordayo EZ, Najarian MM, Ala TA, Mason RP, Frey WH 2nd, (1997) Heme from Alzheimer's brain inhibits muscarinic receptor binding via thiyl radical generation. *Brain. Res.* 764, 93-100.

Kjome JR, Swenson KA, Johnson MN, Bordayo EZ, Anderson LE, Klevan LC, Fraticelli AI, Aldrich SL, Fawcett JR, **Venters HD**, Ala TA, Frey WH 2nd (1997) Inhibition of antagonist and agonist binding to the human brain muscarinic receptor by arachidonic acid. *J. Mol. Neurosci.* 10, 209-217.

VII. Books and Book Chapters

Venters H. *Life and Death in Rikers Island*. Johns Hopkins University Press. 2/19.

Venters H. Mythbusting Solitary Confinement in Jail. In Solitary Confinement Effects, Practices, and Pathways toward Reform. Oxford University Press, 2020.

MacDonald R. and **Venters H.** Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

VIII. Public Testimony

Testimony: Connecticut Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for prisoners. Hartford CT, 2/3/17.

Testimony: Venters HD, New York Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for juveniles in New York. July 10, 2014. NY NY.

Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Oped: Venters HD and Keller AS, The Health of Immigrant Detainees. Boston Globe, April 11, 2009.

Testimony: U.S. House of Representatives, House Judiciary Committee's Subcommittee on

Immigration, Citizenship, Refugees, Border Security, and International Law: Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008.

IX. Media

A. Television Appearances

i24 Crossroads re Suicide in U.S. Jails 8/13/19.

i24 Crossroads re re Life and Death in Rikers Island 6/13/19.

Amanpour & Company, NPR/PBS re Life and Death in Rikers Island 4/15/19.

CNN, Christiane Amanpour re Forensic documentation of mass crimes against Rohingya. 7/11/18.

i24 Crossroads with David Shuster re health crisis among refugees in Syria. 7/6/18.

Canadian Broadcasting Corporation TV with Sylvie Fournier (in French) re crowd control weapons. 5/10/18

i24 Crossroads with David Shuster re Cholera outbreak in Yemen. 2/15/18.

China TV re WHO guidelines on HIV medication access 9/22/17.

B. Radio/Podcast

Morning Edition, NPR re Health Risks of Criminal Justice System. 8/9/19.

Fresh Air with Terry Gross, NPR re *Life and Death in Rikers Island*, 3/6/19.

Morning Edition, NPR re *Life and Death in Rikers Island*, 2/22/19.

LeShow with Harry Sherer re forensic documentation of mass crimes in Myanmar, Syria, Iraq. 4/17/18.

C. Print Articles

Oped: Four ways to protect our jails and prisons from coronavirus. The Hill 2/29/20.

Oped: It's Time to Eliminate the Drunk Tank. The Hill 1/28/20.

Oped: With Kathy Morse. A Visit with my Incarcerated Mother. The Hill 9/24/19.

Oped: With Five Omar Muallim-Ak. The Truth about Suicide Behind Bars is Knowable. The Hill 8/13/19.

Oped: With Katherine McKenzie. Policymakers, provide adequate health care in prisons and

detention centers. CNN Opinion, 7/18/19.

Oped: Getting serious about preventable deaths and injuries behind bars. *The Hill*, 7/5/19.

Testimony: Access to Medication Assisted Treatment in Prisons and Jails, New York State Assembly Committee on Alcoholism and Drug Abuse, Assembly Committee on Health, and Assembly Committee on Correction NY, NY, 11/14/18.

Oped: Attacks in Syria and Yemen are turning disease into a weapon of war, *STAT News*, 7/7/17.

X. Honors and Presentations (past 10 years)

Invited presentation, COVID-19 in correctional settings. Briefing for U.S. Senate Staff, sponsored by The Sentencing Project, remote, May 29, 2020

Invited presentation, COVID-19 in correctional settings. Briefing for Long Island Voluntary Organizations Active in Disaster , sponsored by The Health & Welfare Council of Long Island, remote, May 29, 2020.

Invited presentation, COVID-19 in correctional settings. National Academy of Sciences Committee on Law and Justice, remote, May 12, 2020.

Invited presentation, COVID-19 in correctional settings. National Association of Counties, Justice and Public Safety Committee, remote, April 1, 2020.

Keynote Address, Academic Correctional Health Conference, April 2020, Chapel Hill, North Carolina, postponed.

TedMed Presentation, Correctional Health, Boston MA, March 15, 2020.

Finalist, Prose Award for Literature, Social Sciences category for *Life and Death in Rikers Island*, February, 2020.

Keynote Address, John Howard Association Annual Benefit, November 2019, Chicago IL.

Keynote Address, Kentucky Data Forum, Foundation for a Healthy Kentucky, November 2019, Cincinnati Ohio.

Oral Presentation, Dual loyalty and other human rights concerns for physicians in jails an prisons. Association of Correctional Physicians, Annual meeting. 10/16, Las Vegas.

Oral Presentation, Clinical Alternatives to Punitive Segregation: Reducing self-harm for incarcerated patients with mental illness. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Analysis of Deaths in ICE Custody over 10 Years . American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Medication Assisted Therapies for Opioid Dependence in the New York City Jail System. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. American Public Health Association Annual Meeting, November 2014, New Orleans, LA.

Training, International Committee of the Red Cross and Red Crescent, Medical Director meeting 10/15, Presentation on Human Rights and dual loyalty in correctional health.

Paper of the Year, American Public Health Association. 2014. (Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.)

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. *American Public Health Association* Annual Meeting, New Orleans LA, 2014.

Oral Presentation, Human rights at Rikers: Dual loyalty among jail health staff. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, *American Public Health Association,* Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award, Advocacy on behalf of detained immigrants. Legal Aid Society of New York, October 2009.

Oral Presentation, Deaths of immigrants detained by Immigration and Customs Enforcement. Venters H, Rasmussen A, Keller A, *American Public Health Association* Annual Meeting, San Diego CA, October 2008.

Poster Presentation, Death of a detained immigrant with AIDS after withholding of prophylactic Dapsone. Venters H, Rasmussen A, Keller A, *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Poster Presentation, Tuberculosis screening among immigrants in New York City reveals higher rates of positive tuberculosis tests and less health insurance among African immigrants. *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Daniel Leicht Award for Achievement in Social Medicine, Montefiore Medical Center, Department of Family and Social Medicine, 2007.

Poster Presentation, Case Findings of Recent Arestees. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Toronto Canada, April 2007.

Poster Presentation, Bringing Primary Care to Legal Aid in the Bronx. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Los Angeles, CA, April 2006.

Poster Presentation, A Missed Opportunity, Diagnosing Multiple Myeloma in the Elderly Hospital Patient. Venters H, Green E., *Society of General Internal Medicine* Annual Meeting, New Orleans LA, April 2005.

XI. Grants

San Diego County: Review of jail best practices (COCHS), 1/2020, $90,000.

Ryan White Part A - Prison Release Services (PRS). From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/17 (Renewed since 2007). Annual budget $ 2.7 million.

Ryan White Part A - Early Intervention Services- Priority Population Testing. From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/18 (Renewed since 2013). Annual budget $250,000.

Comprehensive HIV Prevention. From HHS to Correctional Health Services (NYC DOHMH), 1/1/16-12/31/16. Annual budget $500,000.

HIV/AIDS Initiative for Minority Men. From HHS Office of Minority Health to Correctional Health Services (NYC DOHMH), 9/30/14-8/31/17. Annual budget $375,000.

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget $280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget $290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget $175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget $290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to

Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget $100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget $250,000.

XII. Membership in Professional Organizations

American Public Health Association

XIII. Foreign Language Proficiency

French	Proficient
Ewe	Conversant