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IN THE CIRCUIT COURT OF THE FIRST CIRCUIT

STATE OF HAWAI‘I

MICHELLE ACOSTA-CANON; ALAN MCCABE; ISAIAH B. KAISA; MATTHEW WILLIAMS, Plaintiffs, vs. STATE OF HAWAI‘I DEPARTMENT OF PUBLIC SAFETY; and DOE DEFENDANTS 1-20 Defendants.	CIVIL NO. ______________________ (Other Civil Action) CLASS ACTION COMPLAINT FOR DAMAGES; SUMMONS

<u>CLASS ACTION COMPLAINT FOR DAMAGES</u>

Plaintiffs MICHELLE ACOSTA-CANON, ALAN MCCABE, ISAIAH B. KAISA, and MATTHEW WILLIAMS (collectively “Plaintiffs”), individually and on behalf of the proposed

class of all other persons similarly situated, by and through their undersigned attorneys, allege as follows:

INTRODUCTION

1. On January 30, 2020, the World Health Organization ("WHO") declared a global health emergency following the initial spread of the novel coronavirus SARS-CoV-2—the virus that causes the respiratory illness known as COVID-19—and on March 11, 2020, the WHO declared a global Pandemic.

2. In the months that followed, individuals, businesses and governments everywhere made tremendous sacrifices and adaptations to daily life to protect not just themselves, but their fellow co-workers, neighbors, citizens, and human beings from what had proven to be a dangerous and often deadly virus.

3. By September 11, 2020—just six months after the WHO declared the global Pandemic—there were nearly 1 million confirmed deaths resulting from COVID-19. 192,000 of those deaths were American citizens, and by one year, well over half a million Americans had lost their lives.

4. It is well known that people incarcerated in jails and prisons are uniquely vulnerable to the dangers of communicable disease and are more than four times as likely to contract COVID-19 and more than twice as likely to die from the virus.

5. Despite having months and years to prepare for and adapt to the threat of COVID-19 in its prisons and jails, Defendant State of Hawaii Department of Public Safety ("DPS" or "Defendant") categorically failed to take reasonable measures to protect the inmate population in its care, custody, and control, and, by extension, the community at large.

6. In August, 2020, the first of many devastating COVID-19 outbreaks swept through the State's largest jail, Oahu Community Correctional Center ("OCCC"). Just days after the first reported case, OCCC reported nearly 300 inmates and staff had tested positive for COVID-19. DPS failed to conduct timely or adequate testing, failed to follow quarantine and isolation protocols, and failed to enforce social distancing, wearing of personal protective equipment ("PPE"), and other basic guidelines recommended by the Centers for Disease Control and Prevention ("CDC").

7. As a result of DPS' grossly negligent response, when mass testing was eventually conducted, inmates in all nineteen modules at OCCC tested positive for COVID-19, making the separation of COVID-negative inmates virtually impossible.

8. Large-scale outbreaks occurred at nearly every DPS facility in the months that followed, and continue today. Rather than adapt and respond to the threat of infection, DPS systematically failed at every level to take necessary and reasonable actions to abate the spread of the virus. DPS promulgated its Pandemic Response Plan ("PRP") early on, but failed to meaningfully adhere to or enforce the policies and practices therein, and failed to provide its staff with adequate training and oversight.

9. DPS' negligence directly facilitated the spread of COVID-19, and DPS' actions and inaction caused thousands of inmates and staff to contract COVID-19 and to suffer from the illness and its many long-lasting effects.

10. The proposed class members in this lawsuit are inmates who are or were incarcerated under the care, custody, and control of Defendant DPS, and who contracted COVID-19 as a result of the Defendant's grossly negligent failure to prepare for, manage, and mitigate the spread of COVID-19 (the "Class").

NATURE OF ACTION

11. This class action lawsuit seeks damages on behalf of all inmates who contracted COVID-19 while under the care, custody, and control of the Defendant, State of Hawaii Department of Public Safety, for the Defendant's grossly negligent acts and omissions that caused Plaintiffs and members of the Proposed Class to contract COVID-19—a serious and potentially fatal illness.

12. Defendant and its agents—knowing full well the serious threat that COVID-19 posed to the health and safety of the inmate population—created and perpetuated inhumane conditions of confinement that contributed to the spread of the virus and failed to take reasonable measures to ensure the proposed Class members were not exposed to the risk of contracting COVID-19.

13. As a result of Defendant's negligence, a staggeringly high number of inmates have contracted COVID-19[1]. Outbreaks swept through DPS's jails and prisons unabated—in some cases a single outbreak infecting virtually the entire population in a facility—and thousands of Class Members have suffered and will continue to suffer from the illness and its long-term health consequences.

JURISDICTION AND VENUE

14. Jurisdiction and venue are proper in this Court pursuant to HRS Section 603-21.5(a)(3) and HRS Section 603-36(5) since the acts, omissions, and occurrences alleged herein took place within the State of Hawaii, and the Defendant's principal place of business is in the City and County of Honolulu.

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[1] According to DPS records, over 5,000 inmates housed in-state have tested positive for COVID-19—far exceeding the total in-state population of approximately 2,900—and hundreds of additional inmates in Defendant's custody housed at Saguaro Correctional Center have also tested positive for COVID-19.

PARTIES

15. Plaintiff MICHELLE BLANCHET ("Blanchet") is fifty-one years old. Blanchet was incarcerated at the Women's Community Correctional Facility ("WCCC") beginning July 6, 2020 for a parole violation and was to serve a term of six months. Because of the Pandemic, Blanchet's release was delayed several times, and she was exposed to and contracted COVID-19 during an outbreak at WCCC in January, 2022, before being released on March 31, 2022. Blanchet is an insulin dependent diabetic. After contracting COVID-19 she has had difficulty regulating her blood sugar and is suffering from long-term respiratory complications. Blanchet is and has been a resident of the City and County of Honolulu, State of Hawaii at all times pertinent hereto.

16. Plaintiff ALAN MCCABE ("McCabe") was incarcerated at Kauai Community Correctional Center ("KCCC") for a parole violation. McCabe is a cancer survivor. In December, 2021, McCabe was housed in a small cell with eight inmates in what is known as the pretrial fishbowl area. McCabe's 8-person cell was part of a cluster of other 8-person cells that all shared common showers, restrooms, recreation, and dining areas. McCabe, the inmates in his cell, and nearly all those in the cluster were infected when a COVID-positive inmate was moved into the cell without any prior testing while he was symptomatic. McCabe is and has been a resident of the County of Kaua'i, State of Hawai'i, at all times pertinent hereto.

17. Plaintiff ISAIAH B. KAISA ("Kaisa") was incarcerated at Halawa Correctional Facility ("Halawa"), and is currently incarcerated at OCCC. Kaisa and his cellmate were housed in a pod with approximately thirty other inmates. Kaisa's cellmate contracted COVID-19, and Defendant transferred him out without informing Kaisa of his cellmate's positive COVID-19 status. Defendant failed to quarantine or medically isolate Kaisa in an individual room despite his status as a close contact; instead, Kaisa was cohorted with the entire pod where he was permitted to interact

and socialize with the other inmates without knowing he was exposed to and had contracted COVID-19. Defendant eventually tested Kaisa but did not provide results until five days later, at which point the entire pod had either been exposed to or contracted COVID-19. Kaisa is and has been a resident of the City and County of Honolulu, State of Hawaiʻi, at all times pertinent hereto.

18. Plaintiff MATTHEW WILLIAMS ("Williams") is a Hawaii resident who was initially incarcerated at Halawa Correctional Facility ("Halawa") before Defendant transferred him to the Saguaro Correctional Center ("Saguaro") in 2016. In September, 2020, a group of inmates was transferred to the Saguaro facility while numerous transferees were infected with and symptomatic for COVID-19 and a large-scale outbreak spread through the Saguaro facility. On October 9, 2020, DPS reported the first Hawaii inmate to test positive at Saguaro. Throughout most of October, Williams and the other 120 inmates housed in the "MC" pod were not tested or monitored and were permitted to recreate and congregate as normal within their pod despite an extremely high prevalence of confirmed COVID-19 infections throughout the Saguaro facility. Williams fell ill and began suffering from symptoms of COVID-19 on October 18, 2020, but because he was not being monitored, he was not identified for testing or isolation. Williams was eventually tested as part of a scheduled group testing and he received a positive result four days later. According to public statements, DPS did not direct mass testing of the 1083 Hawaii inmates at the Saguaro facility until October 26, 2020, when there were already 52 Hawaii inmates who had tested positive and seven who were hospitalized, and testing *did not begin* until Thursday, October 29. By the time first-round results came back 317 Hawaii inmates had tested positive, and by mid-November, 531 Hawaii inmates had contracted COVID-19 and at least one had already died. Williams became severely ill. He was unable to eat any food for an entire week, his breathing was

extremely labored to the point that he believed he was dying, and his blood oxygen levels failed to register when staff attempted checks. Williams was never referred to or seen by a doctor.

19. Defendant STATE OF HAWAIʻI DEPARTMENT OF PUBLIC SAFETY ("Defendant" or "DPS") is a public entity, duly organized and existing under the laws of the State of Hawaiʻi. In the State of Hawaii, DPS operates and manages: Hawaii Community Correctional Center ("HCCC"), Oahu Community Correctional Center ("OCCC"), Kauai Community Correctional Center ("KCCC"), Maui Community Correctional Center ("MCCC"), Halawa Correctional Facility ("Halawa"), Waiawa Correctional Facility ("Waiawa"), Kulani Correctional Facility ("Kulani"), and the Women's Community Correctional Center ("WCCC"). DPS also houses inmates under its care, custody, and control at the Saguaro Correctional Facility ("Saguaro") in Eloy, Arizona.

20. DPS is required to establish and adhere to policies and procedures that ensure the health and safety of the incarcerated population under its jurisdiction and control, and to hire, supervise, and train its employees to ensure that they carry out the policies and procedures of DPS and preserve the health and safety of all inmates.

21. At all times relevant to the facts and claims herein, Defendant was and is responsible for the acts and/or omissions and the policies, procedures, and practices of its officers, managers, employees, and/or agents.

22. DOE DEFENDANTS 1-20 (hereinafter "Doe Defendants") are associates, officers, employees, agents, and/or representatives of the named Defendant, and/or the Doe Defendants may have contributed to or may be responsible for the injuries and damages alleged herein. Doe Defendants are sued herein under fictitious names for the reason that their true names and identities are presently unknown to Plaintiffs and their attorneys despite due diligence. The true names and

capacities of the Doe Defendants will be substituted as they become known. The Doe Defendants are sued herein both in their individual and official capacities.

FACTUAL ALLEGATIONS

A. Defendant DPS Has Persistently and Pervasively Failed to Take Reasonable Measures to Prevent and Contain the Spread of COVID-19

23. The incarcerated population is uniquely vulnerable to the threat of communicable diseases. The National Commission on COVID-19 and Criminal Justice found the rate of COVID-19 infection among the incarcerated population to be more than four times that of the general population in the United States and the rate of mortality to be double. Schnepel, Kevin T., *COVID-19 in U.S. State and Federal Prisons.* Washington, D.C.: Council on Criminal Justice, September 2020.

24. For years, Defendant DPS has housed its inmate population in severely outdated and decrepit facilities at numbers well over maximum capacity.

25. Inmates are housed in cramped and confined environments with crowds of people who all live, eat, and sleep in close proximity to one another twenty-four hours a day, and they are unable to adopt most, if not all, preventative measures for themselves.

26. Instead, inmates are completely subject to the dictates of correctional officials who control virtually all aspects of their lives, including: where inmates are housed and with whom; when and to where inmates can move throughout the day; schedules for eating, showering, phone use, recreation, and other activities; access to PPE and other sanitary supplies like masks, soap, and disinfectant; and access to medical care.

27. Many portions of DPS' facilities are in abysmal condition. Inmates are kept in squalor, lacking regular access to clean running water, toilets, and sanitation products and sleep in

wet, musty cells without adequate bedding or ventilation infested with cockroaches and sometimes contaminated with human feces and urine.

28. As the Pandemic accelerated and infection rates and deaths increased, DPS failed to alleviate the disgraceful conditions of confinement in its facilities that heightened the risk of infection with COVID-19.

29. Between December, 2021 and February, 2022—nearly *two years* into the Pandemic—KCCC still regularly housed between thirty and forty inmates in a single room referred to as the fishbowl. Inmates housed in the fishbowl shared only two showers that were in filthy condition, and there was little or no soap available and no cleaning or sanitation supplies. Of KCCC's total population of 138 inmates, 87 tested positive for COVID-19 during an outbreak in January and February of 2022.

30. In May of 2021—14 months after the WHO declared a Pandemic—HCCC was still housing between forty and sixty pretrial detainees in a room measuring approximately 30 feet by 30 feet, also referred to by inmates as the fishbowl. At the time, HCCC had 263 inmates—well over the maximum design capacity of 206—and during a period of two weeks in May and June of 2021, 137 pretrial detainees and 18 DPS staff at HCCC contracted COVID-19, including virtually every inmate in the fishbowl.

31. In October, 2020, Defendant failed to order timely testing and ensure that proper monitoring and quarantine efforts were being followed at the Saguaro facility, resulting in several deaths and well over 500 positive cases among the Hawaii inmate population during one outbreak.

32. On November 18, 2020, DPS reported the start of an outbreak at Waiawa Correctional Facility. By November 24, 2020—just six days later—***well over half the facility*** had

already tested positive for COVID-19, including 149 inmates and 11 staff, and the number of cases continued to grow into December.

33. Despite the active and uncontained outbreak at Waiawa, DPS failed to mitigate the risk of interfacility transmission of COVID-19 by, *inter alia*, permitting staff to work shifts at both Halawa and Waiawa and requiring inmates at Halawa to wash the soiled laundry of infected inmates from Waiawa.

34. DPS should have known that failing to restrict its staff members from moving back and forth between facilities during an active outbreak would fuel the spread of COVID-19.

35. As a result of DPS's reckless movement of staff and disregard for safety protocols, by early December COVID-19 had predictably spread to Halawa, and the virus ravaged that facility. During several weeks in December, ***544 inmates and dozens of staff were infected and at least seven inmates were killed by the virus.***

36. As the months went by, uncontrolled outbreaks continued to crop up at nearly every facility because Defendant refused to take sufficient measures to prevent transmission of and exposure to COVID-19.

37. Defendant and its staff failed to follow the policies and practices identified in the Defendant's PRP and refused to implement or enforce policies that would have prevented outbreaks from spreading at the scale and speed at which they did.

38. Defendant and its agents apparently harbored a belief that allowing everyone to contract COVID-19 and gaining so-called "herd immunity" was the most practical course of action, even if it meant compromising the health and safety of the proposed Class members.

39. The overall number of COVID-19 infections and the rate of infection once outbreaks began demonstrate a complete breakdown in response protocol.

40. Several of the individual outbreaks that occurred in Defendant's facilities are among the worst seen in any correctional facility *in the nation*. In fact, data collected over the course of the Pandemic shows that by mid-2021, the State of Hawaii boasted the largest gap between the infection rate statewide and the infection rate in state prisons. www.nytimes.com/interactive/2021/04/10/us/covid-prison-outbreak.html, *last accessed July 18, 2022* (inmate infection rate in Hawaii is **15.8x greater** than the state infection rate, with 35 in 100 inmates testing positive compared to only 2 in 100 state residents). This does not include the significant number of inmates who likely contracted COVID-19 but were not tested.

41. In January, 2022, DPS failed to contain a devastating COVID-19 outbreak at WCCC that infected 169 inmates out of a population total of only 202! Despite having nearly two years to prepare for such an outbreak, Defendant categorically failed to follow its own PRP, guidance from the Centers for Disease Control and Prevention ("CDC"), and other reasonable policies and practices in order to identify, isolate, and protect inmates from contracting COVID-19.

42. DPS' response to the outbreak at WCCC was so delayed and inept that once the presence of the virus was confirmed, the staff was unprepared and unwilling to take *any* measures to contain its spread.

43. Instead, the head nurse revealed that DPS staff simply decided to let the virus run its course, and told Plaintiff Blanchet that DPS would not move any inmates—regardless of their COVID-19 status—and that **she would prefer "that [COVID-19] just moved through" the entire facility.** The virus did exactly that, infecting virtually every inmate at WCCC who was not already segregated in some manner.

44. During the outbreak at WCCC, corrections officers and other staff regularly moved between different dorms—some housing COVID-positive inmates and others housing COVID-negative inmates—without donning appropriate PPE.

45. During the outbreak at WCCC, inmates who had tested negative for COVID-19 were forced to shower, eat, and congregate with inmates that had already tested positive and with inmates that were exhibiting symptoms and awaiting test results.

46. Defendant made no meaningful effort to quarantine or isolate sick individuals from those who were well and did little or nothing at all to contain the spread of the virus.

47. Predictably, the WCCC inmates who initially tested negative eventually were exposed to and contracted the virus and fell ill.

B. CDC Guidelines and Defendant's Pandemic Response Plan

48. The CDC is responsible for controlling the spread of infectious diseases and provides consultation and assistance on a national and global scale to assist in disease prevention and control.

49. Because of the extraordinary danger that COVID-19 poses to jails and prisons in particular, the CDC issued specific guidance for correctional facilities to help prepare for, and mitigate, the spread of COVID-19. The CDC guidance has been regularly updated since it was first published on March 23, 2020,[2] with the most recent update being on May 3, 2022.

50. The CDC acknowledges that the detention environment greatly heightens the risk for the spread of COVID-19 once introduced.

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[2] The facts of this case cover a period ranging from the first iteration of the CDC guidance up through the present.

51. As a mitigation strategy, the CDC guidance recommends exploring "strategies to prevent over-crowding of correctional and detention facilities."

52. The guidance further recommends that detention facilities:

a. Test and quarantine individuals (in single cells for 14 days[3]) preparing for release, transfer to another facility, or entrance into the general population of a correctional facility;

b. Adopt social distancing strategies to increase space between individuals, including rearranging bunking to ensure that beds are at a minimum six feet apart in all directions, increasing space in lines and waiting areas, staggering meals and rearranging seating during meals so that detainees are sitting on only one side of the table and are separated with adequate space;

c. Medical isolation of confirmed and suspected cases and quarantine of contacts;

d. Ensure that medical isolation for COVID-19 is operationally distinct from punitive solitary confinement of incarcerated/detained individuals, both in name and in practice;

e. Do not cohort those with confirmed COVID-19 with those with suspect COVID-19, with close contacts of individuals with confirmed or suspected COVID-19, or with those with undiagnosed respiratory infection who do not meet the criteria for suspected COVID-19;

f. Post signage throughout the facility communicating COVID-19 symptoms and hygiene instructions, ensure such signage is understandable for non-English

[3] On February 10, 2022, the CDC guidance was updated to reduce quarantine duration during routine operations from 14 days to 10 days.

speaking people as well as those with low literacy, and provide clear information about the presence of COVID-19 cases within a facility and the need to increase social distancing and maintain hygiene precautions;

g. Ensure sufficient stocks of hygiene and cleaning supplies, including tissues; liquid soap where possible; hand drying supplies; alcohol-based hand sanitizer; cleaning supplies effective against the coronavirus; and recommended personal protective equipment like face masks, disposable medical gloves, and N95 respirators;

h. Provide incarcerated people no-cost access to soap (providing liquid soap where possible), running water, hand drying machines or disposable paper towels for hand-washing, and tissues (providing no-touch trash receptacles for disposal) and thoroughly and frequently clean and disinfect all areas where individuals with confirmed or suspected COVID-19 spend time; and

i. Implement "intensified cleaning and disinfecting procedures" that clean and disinfect high-touch surfaces and objects "[s]everal times per day," and "ensure adequate supplies to support intensified cleaning and disinfection practices."

53. On March 17, 2020, Defendant implemented its Pandemic Response Plan ("PRP"). DPS purportedly "reviewed the plan, which was based upon current guidance from the CDC, and adapted the plan for Hawaii's correctional system."

C. Defendant Failed to Follow its Pandemic Response Plan Policies and Other Reasonable Prevention Measures

54. Correctional facilities around the country took unprecedented measures to reduce overcrowding in response to the COVID-19 Pandemic.

55. In April, 2020, the Hawaii Supreme Court ordered that DPS release certain inmates that did not present a significant threat to the community. As a result of that order, several hundred inmates were released.

56. Ultimately, Defendant failed to alleviate overcrowding in its facilities which contributed to the rapid transmission of COVID-19.

57. By July, 2020—just prior to what would be the first major outbreak inside DPS' largest jail—the inmate population had already returned to numbers well above capacity.

58. For example, Defendant housed 360 inmates at HCCC when the facility has a design capacity of only 206 and an operational capacity of 226—thus, HCCC housed ***154 additional inmates*** over its maximum design capacity, and still 134 inmates over its purported operational maximum![4]

59. Similarly, Defendant housed inmates at numbers well above the design and operational capacity at both KCCC and MCCC, and the number of inmates Defendant housed at Halawa and OCCC were far beyond each facility's maximum design capacity.

60. DPS claimed that "Saguaro does not have an overcrowding issue and, therefore, can provide adequate space for isolation and quarantine." Nevertheless, even absent overcrowding, Defendant failed to ensure that reasonable measures were taken to monitor, test, and quarantine/isolate sick or exposed individuals until it was too late. (*see*, e.g., DPS Press Release,

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[4] DPS purports to have an *operational* bed capacity at each facility that is often significantly higher than the design bed capacity—the maximum number of beds the facility was designed for. For example, the design bed capacity at OCCC is 628—that is, the facility was designed to house a ***maximum*** of 628 inmates. However, DPS contends that OCCC has an ***operational*** bed capacity of 954—a difference of more than 300.

It is difficult to imagine how Defendant could possibly house so many additional inmates beyond a facility's maximum design capacity without unreasonably compromising the inmates' health and safety.

November 2, 2020, https://dps.hawaii.gov/wp-content/uploads/2020/03/RELEASE-Saguaro-mass-testing-results-11.2.20.pdf, noting broad-based mass testing at Saguaro was not ordered by DPS until several weeks after the outbreak began, and that isolation and quarantine protocols *were only enacted upon receiving test results*).

61. Even after the issuance of clear guidance from the CDC and the implementation of Defendant's PRP, Defendant failed to follow the directives in its PRP and failed to take reasonable measures to prevent and/or minimize transmission of and exposure to COVID-19.

62. In 2021, Defendant DPS was sued in The United States District Court for the District of Hawaii by a class of inmates seeking declaratory and injunctive relief related to the Department of Public Safety's failed response to the COVID-19 pandemic. *Chatman v. Otani*, Civil No. 21-00268 JAO-KJM.

63. The *Chatman* Court "focuse[d] on whether Defendant has done or is doing enough to reasonably keep inmates healthy and safe." *Chatman v. Otani*, Civil No. 21-00268 JAO-KJM, 2021 WL 2941990 at *14 (D. Haw. July 13, 2021).

64. After extensive consideration of the evidence detailing the terrible conditions in Defendant's prisons and jails, the Court found "that Defendant has not taken reasonable available measures to abate the risks caused by the foregoing conditions, knowing full well—based on multiple prior outbreaks—that serious consequences and harm would result to the inmates. And Plaintiffs have suffered injuries as a result." *Id*. at *18.

65. As the *Chatman* Court has already determined, DPS failed to provide Plaintiffs with basic preventative measures such as the ability to sleep, eat, or exist at least six feet apart from others, adequate access to soap and cleaning products, access to regular showers and running water, and the opportunity to regularly replace or launder face masks.

66. DPS failed to provide timely or sufficient access to medical care and monitoring, did not conduct sufficient testing or contact tracing, and failed to properly identify, isolate, and monitor sick or exposed individuals or, alternatively, avoid exposing COVID-negative inmates and staff to inmates and staff who were actively sick or had tested positive.

a. Defendant failed to enforce the use of personal protective equipment

67. Defendant's PRP and CDC guidance both recognize the use of appropriate PPE as an essential tool for preventing infection and transmission of COVID-19.

68. Defendant has not followed or enforced the directives in its PRP relating to the use of PPE.

69. DPS at every facility routinely disregards policies that require the use of masks and other PPE, and Defendant did not make appropriate PPE widely or consistently available to staff or inmates.

70. During the beginning of the Pandemic, DPS prohibited staff at HCCC from wearing masks that they had purchased.

71. Despite knowledge of non-compliance and Defendant's responsibility to ensure this basic preventative measure was being followed, Defendant did not make a reasonable effort to do so.

72. Defendant ignored reports of violations from inmates and staff and failed to investigate, discipline, or correct DPS staff who did not wear appropriate PPE.

73. During active COVID-19 outbreaks DPS staff entered areas with infected or quarantined inmates without donning and doffing appropriate PPE, and moved between the quarantine modules and other modules housing COVID-negative inmates either while still wearing the same PPE equipment, or without changing clothes.

b. Defendant did not provide adequate hygiene supplies

74. DPS failed to provide inmates with the means to regularly wash their hands with soap and running water, and does not regularly clean or disinfect, or provide inmates with adequate supplies to clean and/or disinfect, their environment.

75. At HCCC, KCCC, and areas of other facilities, inmates are housed in rooms without regular access to bathrooms or running water.

76. DPS sporadically provides inmates with one individually wrapped single-use bar of soap (0.5oz)—approximately half the size of a stick of chewing gum and less than a quarter-inch thick—that was expected to last for weeks. The single-use bar of soap is grossly insufficient, and if inmates want additional soap they were required to purchase it contrary to policy.

77. Despite its own directive to implement enhanced cleaning procedures and to routinely clean and disinfect high touch surfaces like telephones and door handles, Defendant did not do so.

78. For example, Defendant rarely, if ever, cleaned and disinfected the telephones shared by large numbers of inmates.

79. Even when inmates actively sick with COVID-19 used the phones, DPS failed to do any cleaning or disinfecting before other groups of inmates were permitted to use the same phones.

80. At Halawa, after COVID-positive inmates were transferred from their cells, the cells were not cleaned or sanitized before new inmates were transferred in.

81. At several of its facilities DPS houses large numbers of inmates in a single open room and does not regularly clean or sanitize these rooms.

82. Even during outbreaks when DPS cohorts COVID-positive inmates in these single rooms, little or no effort is made to provide cleaning or sanitation, let alone regular or enhanced cleaning efforts.

83. Inmates were provided with masks when available, but DPS refused to replace or launder masks for months at a time. When masks were not available, inmates resorted to using clothing, including underwear, as a makeshift mask.

c. Defendant made no effort to maintain social distancing

84. DPS did not create any means for inmates to maintain separation of space from one another. Rather, Defendant's practices forced inmates together in large groups and facilitated the spread of COVID-19 once the virus was present.

85. For example, DPS required that inmates eat meals together by the dozens where they sat shoulder to shoulder with no means of separation.

86. Defendant required inmates from different dorms, modules, and cells to eat together rather than staggering meal schedules or eating in their cells, and did not provide the space to do so safely.

87. At several of its facilities, DPS housed inmates permanently—or at least periodically—in single open rooms where inmates had no choice but to sit, stand, or sleep less than six feet from others.

88. Inmates slept on mattresses placed on the floor with another person on either side separated by only inches.

89. When open-room sleeping was not utilized, Defendant periodically confined large groups of inmates in a single room during the daytime where inmates were forced to spend hours without any option to social distance, and without access to drinking water, toilets, or sinks.

90. Because of overcrowding, Defendant houses three or four inmates in cells designed for two.

91. Defendant took no measures to create space or barriers between inmates housed in open-style dormitory housing—areas with groups of cells separated only by open bars.

92. These inmates shared recreation spaces, restrooms, showers, telephones, and meal times with each other and other groups housed in similar dormitory-style, open-bar cells, thus allowing ample opportunity for COVID-19 to spread.

93. Even where social distancing was possible, Defendant did not encourage or require inmates to maintain social distancing.

d. Defendant did not follow proper procedures for quarantine

94. Defendant failed to implement or enforce its policies and other basic measures to contain COVID-19 by following the recommended quarantine practices.

95. With newly admitted inmates, for example, DPS facilities regularly failed to observe the standard 14-day quarantine period (now 10 days) or require a negative COVID-19 test—failures that plainly endangered the inmate population.

96. While DPS staff regularly use the term "quarantine" to describe the placement of a new or transferred inmate, the supposed "quarantine" procedures contravene the guidance from the CDC and the PRP.

97. For example, during "quarantine" inmates are often housed with groups of other inmates in the same cell or room whose COVID status is unknown—this is despite policy that inmates should be quarantined upon intake in their own cell, preferably with a toilet.

98. DPS then routinely breaks the "quarantine" by introducing new inmates—whose COVID status may also be unknown—into the same cell in the middle of the "quarantine" period.

99. Introduction of a new inmate into a "quarantine" cohort is against policy, and at the very least, doing so should start the quarantine period over; however, DPS continued to release inmates out of "quarantine" and into the general population on a rolling basis, regardless of when new inmates were introduced into a cohort.

100. Defendant's failure to properly quarantine upon intake or transfer directly facilitated the undetected transmission of COVID-19 where transmission was clearly preventable.

e. Defendant did not follow proper procedures for medical isolation

101. According to Defendant's PRP, a "critical infection control measure for COVID-19 is to **promptly** separate inmates with confirmed or suspected COVID-19 infection from other inmates who are not infected." (emphasis added) (parenthetical removed).

102. The PRP also directs that "while cohorting inmates with laboratory confirmed COVID-19 is acceptable, cohorting inmates with suspected COVID-19 is not recommended due to the high risk of transmission from infected to uninfected inmates."

103. Defendant failed to follow either of these directives, and the result was Defendant's failure to mitigate COVID-19 outbreaks once they began.

104. DPS made no effort to separate inmates with suspected COVID-19, regardless of the level of exposure or whether the inmate was symptomatic.

105. Instead, Defendant's practice was to simply leave inmates in place for up to a week or more while they waited to take a test, and then waited for the results. During that time, DPS permitted inmates to participate in recreation, meals, showers, phone usage, and other activities often unrestricted, or while restricted to interaction with only their respective module/pod/unit.

106. In other words, it was the Defendant's *practice* to routinely cohort inmates with exposure to COVID-19 or suspected COVID-19 despite the risks of transmission from infected to uninfected inmates.

107. Only after an inmate was confirmed as COVID-positive by a laboratory test would DPS then make some effort to medically isolate that inmate; however, even that effort was not consistent or in accordance with recommendations.

108. Instead of beginning with medical isolation in individual rooms and moving to cohorting only as a last resort, it was Defendant's practice to immediately place entire housing modules/pods/units (cohorts) into lockdown together regardless of their COVID status, which inevitably led to everyone eventually contracting COVID-19.

109. For example, in the pod at Halawa where Plaintiff Kaisa was housed, Kaisa and the other inmates in his pod were tested after it was suspected that they had all been exposed to COVID-19.

110. DPS removed Kaisa's cellmate, but failed to inform Kaisa that his cellmate had tested positive for COVID-19. Defendant then permitted Kaisa to freely interact with approximately 30 other inmates in his pod ***for five days*** when he should have been medically isolated.

111. In other words, DPS cohorted the entire pod of inmates with suspected COVID. Only when an inmate was confirmed positive after a laboratory test did DPS remove the inmate.

112. Kaisa's positive test result came back in three days, but DPS staff did not inform Kaisa of the positive result or remove him from the cohort for five days.

113. The cell where Kaisa was housed was then immediately occupied by new inmates whose COVID status was unknown without any cleaning or disinfecting of the pod or cell, and other inmates were removed from the pod only after receiving a positive test result.

114. Defendant permitted the same failures at Saguaro that facilitated opportunity for transmission of COVID-19 from infected to uninfected inmates.

115. For example, once COVID-19 began spreading at the Saguaro facility in October, 2020, the pod of 120 inmates where Plaintiff Williams was housed was cohorted as a group.

116. Saguaro separated inmates only once they received a positive test result, which exposed inmates to a high risk of transmissibility from COVID-positive to COVID-negative inmates and facilitated the infection of over 500 Hawaii inmates.

f. Defendant housed large groups of inmates in single rooms or small confined areas

117. Throughout the Pandemic Defendant has continued to house large numbers of inmates in single rooms on a permanent or semi-permanent basis despite knowing that this practice creates an unreasonably high risk of infection.

118. At HCCC, where the inmate count is well-beyond the maximum capacity, Defendant housed up to ***sixty*** inmates together in one single room on a permanent basis. Inmates slept on mattresses placed on the floor only inches apart, and new inmates were routinely transferred in and out of the room without undergoing proper intake and transfer quarantine or testing.

119. Because of severe overcrowding, inmates at HCCC were also placed in the "dog cages"—small, chain-link enclosures—where they slept with anywhere from four to six other individuals packed together.

120. At Waiawa, the Defendant housed a population of up to fifty inmates in a single room called the pavilion for between four to six hours a day.

121. At KCCC DPS housed eight inmates in cells designed for a maximum of four, and DPS housed between thirty and forty people in a single room who all shared the same showers and toilets.

g. Defendant failed to conduct adequate testing and monitoring for COVID-19

122. Defendant did not conduct regular and comprehensive testing in a manner sufficient to prevent entry of COVID-19 or enable its early detection, did not provide timely and sufficient testing or results once outbreaks began, and failed to properly monitor for and respond to inmates with symptoms of infection.

123. Defendant did not conduct regular or timely movement-based screening testing to prevent the transmission of COVID-19.

124. In practice, this movement-based testing was done only sporadically or not at all.

125. For example, the *Chatman* Court highlighted the Defendant's interfacility transfer of inmates from HCCC to various DPS facilities on Oahu during the middle of a COVID-19 outbreak as an exemplification of Defendant's "knowing disregard of excessive risk to inmate health and safety."

126. The Court stated the following:

> In an effort to alleviate overcrowding at HCCC during the middle of a COVID-19 outbreak, Defendant chartered private flights to transport dozens of inmates to facilities on Oahu. Notwithstanding Defendant's public statement that only inmates who were medically cleared of COVID-19 were considered for transfer, **inmates who were symptomatic and untested, or had yet to receive test results, were among those transferred. Many of these inmates informed staff that they felt ill. At least nine of these inmates tested positive for COVID-19 at Halawa.** Inmates from HCCC were grouped with inmates from other facilities while they awaited their COVID-19 test results. COVID-positive and COVID-negative inmates are housed in the same open-air modules, share common spaces and devices, and are able to shake

> hands through the bars of their cells. One of the COVID-positive transferees has requested, but not received, medical treatment for his symptoms.

Chatman v. Otani, 2021 WL 2941990 at *18. (citations and parentheticals omitted) (emphasis added).

127. The *Chatman* Court went on to explain some of the varied issues with this interfacility transfer:

> This is problematic on multiple levels. Defendant knowingly (1) transported *symptomatic* inmates from a facility *with an active COVID-19 outbreak*, (2) who told staff they were ill, (3) who were *infected*, (4) but whose infections were unconfirmed due to ***late or no testing***, (5) on an airplane, (6) to a facility with no active COVID-19 cases *that previously experienced an outbreak*, and (7) then housed those inmates *with COVID-negative inmates*. There is almost no clearer an example of complete disregard for the [Pandemic] Response Plan and abandonment of precautionary measures to prevent the spread of COVID-19 between DPS facilities and islands.

Id. at *19. (***bold emphasis added***).

128. This is but one example of Defendant's failures across the broad spectrum of testing strategies.

129. During many of the severe outbreaks that spread through DPS facilities, Defendant failed to conduct any meaningful testing until it was far too late.

130. For example, during an outbreak at OCCC in August, 2020, scores of inmates were exhibiting symptoms and complaining of illness before any meaningful testing was done at all.

131. According to DPS, a new intake who was COVID-positive entered OCCC but Defendant failed to conduct an intake test.

132. After reported COVID-19 exposure Defendant tested the inmate and received a positive result three days later.

133. According to DPS' Director, it was only ***after*** the virus was already confirmed inside OCCC that the Defendant then acted "to *implement* the Department's COVID-19 pandemic protocol for correctional facilities, in an effort to mitigate any potential spread of the virus." (emphasis added).

134. Several days later and with cases mounting, DPS' Director was still reporting that the PRP was only just being implemented, and testing had yet to begin. (August 10, 2020 press release: "DOH is organizing the testing of OCCC staff and inmates, identified through contact tracing as having possible exposure to the virus cluster at OCCC. DOH is coordinating with the National Guard to perform the testing, starting today and through this week.").

135. Within a handful of days, hundreds of inmates and staff had tested positive.

136. Testing revealed that inmates in all nineteen modules at OCCC were COVID-positive, making quarantine, medical isolation, contact tracing, and other mitigation protocols virtually impossible.

137. In some facilities DPS only conducted testing according to a schedule. Inmates feeling ill were not tested until the scheduled date, even during an active outbreak, and would then wait several additional days to receive the results.

138. According to the PRP, the moment an inmate presents with COVID-19 symptoms DPS staff should move the inmate to medical isolation in a separate room with a toilet and sink and conduct a medical evaluation and testing.

139. Inmates with COVID-19 symptoms routinely requested but were denied the option to test, and DPS kept symptomatic inmates in their existing housing units often as part of a larger cohort.

140. Defendant utilized cohorted lockdowns as a mainstay when inmates began to exhibit symptoms rather than following the PRP and placing inmates into individual medical isolation rooms.

h. Defendant failed to identify and isolate the medically vulnerable population

141. DPS makes little or no effort to identify individuals who are at a high risk for complications from COVID-19—either before or after contracting the virus—contrary to policy.

142. For example, Plaintiff Blanchet is an insulin-dependent diabetic which places her at high risk for severe complications associated with COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, last accessed July 25, 2022 (listing Diabetes as a medical condition that places individuals "at higher risk of severe illness from COVID-19").

143. Blanchet was not identified as high risk prior to contracting COVID-19, nor was Blanchet provided any additional monitoring or medical care after she contracted COVID-19.

144. Blanchet experienced significant respiratory distress and difficulty managing her diabetes as a result of her illness, but DPS staff simply told her to drink water.

145. Blanchet has since grappled with numerous long-term health impacts following her infection with COVID-19.

i. Defendant failed to communicate with and train staff

146. Even months into the Pandemic, staff at DPS facilities report receiving virtually no guidance on how to manage COVID-19.

147. DPS staff members were not always informed about the COVID status of inmates they were in close proximity to, and were not always informed when they were around inmates whose COVID-status was unknown and awaiting test results.

148. The lack of communication between DPS administrators and staff led to large numbers of staff infections during outbreaks and, subsequently, staff shortages, leaving the facilities less equipped to manage ongoing outbreaks.

D. Defendant's Failures Caused and Exacerbated the Spread of COVID-19

149. As a result of the above-described conditions and failures of DPS, serious outbreaks of COVID-19 occurred across all facilities and continued to occur months and years into the Pandemic without any signs of improvement.

150. Close to 6,000 inmates have tested positive to date, and numerous inmates have died as a direct result of complications associated with COVID-19.

151. Many inmates lived in fear that they, too, would succumb to the deadly virus with no means to protect themselves from infection.

152. Once infected, DPS provided little or no medical care except to those inmates whose condition became critical and required outside treatment or hospitalization.

153. The vast majority of those infected were only occasionally monitored by nursing staff and were provided with no meaningful medical care at all.

154. When inmates complained of painful, frightening, and worsening symptoms, DPS staff told them to simply drink water or lie down.

155. Despite the repeated outbreaks and knowledge of significant shortcomings in its efforts to prevent transmission of COVID-19, Defendant failed to take corrective action.

156. As a direct and proximate result of Defendant's negligent failures, Plaintiffs and the proposed Class members contracted COVID-19 and were exposed to often severe and potentially deadly symptoms and dangers associated with the illness including significant pain, suffering, mental anguish, emotional distress, fear, anxiety, potential long term or permanent conditions and complications, and other mental and physical injuries to be proven at trial.

CLASS REQUIREMENTS

157. Plaintiffs bring this action individually and in their representative capacities on behalf of all others similarly situated pursuant to Fed. R. Civ. P. Rule 23. This action satisfies all requirements of Rule 23(a): numerosity, commonality, typicality, and fair and adequate representation. Additionally, this action may proceed under Rule 23(b)(3) because common questions of law and fact predominate, and adjudicating the claims as a class is superior to other methods of resolving the controversy.

158. The proposed class members consist of:

> All persons who were incarcerated under the care, custody, and control of Defendant during the applicable two-year statute of limitations period preceding this lawsuit, and who contracted COVID-19 while so incarcerated and received a laboratory-confirmed positive result for infection with COVID-19.

159. The proposed Class definition may be amended by the Plaintiffs prior to certification by the Court if such amendment is deemed necessary or appropriate, including the addition of any subclasses.

FIRST CAUSE OF ACTION
(Negligence)

160. Plaintiffs hereby incorporate by reference each of the preceding paragraphs and allegations as if fully set forth herein.

161. At all times material to this lawsuit Defendant DPS owed Plaintiffs and the proposed Class members in its care, custody, and control a duty to act with reasonable care.

162. Defendant's general duties of reasonable care owed to Plaintiffs and the proposed Class members include, but are not limited to, the following obligations:

a. To provide a reasonably safe and secure environment;

b. To provide and maintain humane conditions of confinement, including clean and sanitary living conditions; adequate food, water, clothing, shelter, and medical care; and regular access to running water, toilets, and hygiene supplies;

c. To provide for the safety and serious medical needs of Plaintiffs and the proposed Class members, including by taking reasonable measures to avoid the substantial risk of serious harm from exposure to COVID-19;

d. To refrain from violating the rights of Plaintiffs and the proposed Class members guaranteed by the United States Constitution and the Constitution of the State of Hawaii, and as otherwise protected by law;

e. To refrain from abusing the authority granted to them by law; and

f. To ensure staff members are adequately trained and perform their duties in accordance with applicable laws, regulations, policies, and procedures.

163. Defendant, by and through the acts and omissions described herein, breached the aforementioned duties owed to Plaintiffs and the proposed Class members.

164. Defendant's negligent acts and omissions resulted in the foreseeable injuries and damages alleged herein and was the proximate cause of those injuries.

WHEREFORE, Plaintiffs pray for relief as follows:

1. For certification of the proposed Class and any subclasses;

2. For entry of Judgment on all counts in favor of Plaintiffs and the proposed Class and against Defendants;

3. For general, special, and punitive damages in amounts to be proven at trial;

4. For reimbursement of Plaintiffs' costs including reasonable provision for their attorneys' fees; and

5. For such other relief as the Court may deem equitable and just.

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DATED: Honolulu, Hawai‘i, July 26, 2022.

/s/ Eric A. Seitz
ERIC A. SEITZ
JONATHAN M.F. LOO
KEVIN A. YOLKEN

Attorneys for Plaintiffs

STATE OF HAWAIʻI
CIRCUIT COURT OF THE FIRST CIRCUIT

SUMMONS
TO ANSWER CIVIL COMPLAINT /

CASE NUMBER

PLAINTIFF'S NAME & ADDRESS, TEL. NO.

MICHELLE ACOSTA-CANON; ALAN MCCABE; ISAIAH B. KAISA; MATTHEW WILLIAMS
c/o Eric A. Seitz, AAL, ALC
820 Mililani Street, Suite 502, Honolulu, HI 96813
Tel: (808) 533-7434; Fax: (808) 545-3608

PLAINTIFF VS.	DEFENDANT(S)
MICHELLE ACOSTA-CANON; ALAN MCCABE; ISAIAH B. KAISA; MATTHEW WILLIAMS	STATE OF HAWAI'I DEPARTMENT OF PUBLIC SAFETY

TO THE ABOVE-NAMED DEFENDANT(S)

You are hereby summoned and required to filed with the court and serve upon:

Eric A. Seitz, AAL, ALC
820 Mililani Street, Suite 502
Honolulu, HI 96813

______________________________,

plaintiff, as indicated above/whose address is stated above, an Answer to the Complaint /
, which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the date of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

THIS SUMMONS SHALL NOT BE PERSONALLY DELIVERED BETWEEN 10:00 P.M. AND 6:00 A.M. ON PREMISES NOT OPEN TO THE GENERAL PUBLIC, UNLESS A JUDGE OF THE ABOVE-ENTITLED COURT PERMITS, IN WRITING ON THIS SUMMONS, PERSONAL DELIVERY DURING THOSE HOURS.

A FAILURE TO OBEY THIS SUMMONS MAY RESULT IN AN ENTRYOF DEFAULT AND DEFAULT JUDGMENT AGAINST THE DISOBEYING PERSON OR PARTY.

The original document is filed in the Judiciary's electronic case management system which is accessible via eCourt Kokua at: http:/www.courts.state.hi.us

Effective Date of 1-DEC-2021
Signed by: /s/ Patsy Nakamoto
Clerk, 1st Circuit, State of Hawaiʻi

If you need an accommodation for a disability when participating in a court program, service, or activity, please contact the ADA Coordinator of the XX Circuit as soon as possible to allow the court time to provide an accommodation.
Phone No. 808-539-4400, TTY 808-539-4853, FAX 808-539-4402 or Send an e-mail to: adarequest@courts.hawaii.gov.
The court will try to provide, but cannot guarantee, your requested auxiliary aid, service or accommodation.