UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

MICHAEL AMOS, *ET AL*. **PLAINTIFFS**

V. **CASE NO. 4:20-CV-007-DMB-JMV**

TOMMY TAYLOR, *ET AL*. **DEFENDANTS**

PLAINTIFFS' EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MANDATORY PRELIMINARY INJUNCTION AS TO COVID-19

COME NOW Plaintiffs, by and through counsel, pursuant to Rule 65 of the Federal Rules of Civil Procedure, and L.U. Civ. R. 7(b)(8), as this is an urgent or necessitous matter, and respectfully request that the Court issue its order directing mandatory and affirmative action to safeguard Plaintiffs at Parchman from SARS-CoV-2, also known as, COVID-19.[1] In support, Plaintiffs would show:

1. Plaintiffs are incarcerated persons at the Mississippi State Penitentiary at Parchman, Mississippi ("Parchman"). As inmates at Parchman, Plaintiffs are held in close confinement with other prisoners, in grossly unsanitary conditions, and under a healthcare system that has come under recent scrutiny for failing to provide inmates basic healthcare. Thus, Plaintiffs, along with other inmates at Parchman, are extremely susceptible to COVID-19, which has been elevated to pandemic status by the World Health Organization.

2. By incarcerating Plaintiffs, the State of Mississippi has assumed responsibility for their health and safety. In order for the State to fulfill its duties in the face of COVID-19, Defendants must be required to implement immediately the following protocols to prevent the introduction or mitigate the spread of COVID-19 within Parchman:

[1] The official Centers for Disease Control title for the virus at issue is SARS-CoV-2. The virus also has been called coronavirus disease 2019, which abbreviated is "COVID-19."

a. **Immediate Testing**. Defendants must be required immediately to implement testing protocols for the identification and containment of COVID-19. These protocols must include the immediate testing of all inmates, Parchman employees, and all other individuals entering Parchman.

b. **Immediate Screening**. Defendants must be required to screen each employee or other person entering the facility every day to detect fever over 100 degrees, cough, shortness of breath, recent travel to a high risk country, and/or exposure to someone who is symptomatic or under surveillance for COVID-19.

c. **Current Inmate Quarantine**. Defendants must be required to establish non-punitive quarantine for all individuals who test positive for COVID-19, who were directly exposed to individuals who test positive for COVID-19, or who exhibit symptoms of the virus.

d. **New Inmate Quarantine.** Defendants must be required to establish a fourteen (14) day, non-punitive quarantine for all new inmates entering Parchman to ensure they are not infected before exposing them to the general population.

e. **Institutional Hygiene**. Defendants must be required to increase the sanitation and cleaning protocol and schedule for all public spaces, highly traveled areas, and cells.

f. **Personal Hygiene**. Defendants must be required to provide hand sanitizer with alcohol, antibacterial soap, antibacterial wipes and other hygiene products to each inmate free of charge and ensure replacement products are available as needed. Necessarily, hand sanitizer with alcohol must be declassified as contraband

temporarily, as it is one of the only methods proven to prevent or slow the spread of coronavirus.

g. **Limit Contact Visitation**. Defendants must be required to limit visitation that allows inmates to come into physical contact with visitors, and Defendants must be required to implement or increase non-contact visitation methods and opportunities such as video conferencing and/or telephone calls.

h. **Waive Copays**. Defendants, including without limitation healthcare providers working under their direction, must be required to waive copays for inmate medical evaluation and care related in any way to COVID-19 and/or its symptoms.

i. **Supply Chain**. Defendants must be required to identify the supplies and other materials upon which Parchman is dependent, such as food, medical supplies, certain medicines, cleaning products, etcetera, and prepare for shortages, delays or disruptions in the supply chain.

j. **Reporting**. Defendants must be required to report to the Court weekly to apprise the Court of: the progress in implementing the foregoing; the results of testing of employees and inmates; the numbers of COVID-19 cases at Parchman, if any; and the measures in place to separate inmates who have tested positive from the general prison population.

3. In support of their Motion, Plaintiffs also submit a Memorandum Brief and attach hereto the following exhibits, which include a proposed order pursuant L.U. Civ. R. 7(b)(2)(f).

Exhibit A	World Health Organization Director-General's Brief on COVID-19 (Mar. 11, 2020).
Exhibit B	Presidential Proclamation Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) dated 03/13/2020.
Exhibit C	State of Mississippi, Office of Governor, Proclamation dated 03/14/2020.

Exhibit D	Standing Order In Re: The Novel Coronavirus (COVID-19), 3:20-MC-9, U.S. District Court for the N.D. of Miss. dated 3/16/2020.
Exhibit E	WHO Statement, COVID-19 cases surpassing 100,000 (3/7/2020).
Exhibit F	Affidavit of Marc Stern, MD MPH
Exhibit G	MDOC Press Release "MDOC Takes Preventative Steps Against Coronavirus Exposure" dated 3/12/2020.
Exhibit H	Medical Records of Inmate Larry Maxwell (showing repeated visits to medical clinic without receiving treatment).
Exhibit I	Bureau of Justice Statistics, US DOJ, Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12, NCJ 248491 (Rev. 10/4/2016).
Exhibit J	Proposed Order.

WHEREFORE, PREMISES CONSIDERED, Plaintiffs respectfully request that the Court grant this Emergency Motion for Temporary Restraining Order and Mandatory Preliminary Injunction as to COVID-19. In addition, Plaintiffs request all further relief the Court may deem appropriate.

Date: March 16, 2020

Respectfully submitted,

/s/ Marcy B. Croft

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ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 16th day of March 2020, a copy of the foregoing was filed electronically with the Clerk of the Court using the CM/ECF system. Notice of this filing will be sent to all counsel for record registered to receive electronic service by operation of the Court's electronic filing system.

/s/ Marcy B. Croft

EXHIBIT A

World Health Organization Director – General's Brief on COVID-19 (Mar. 11, 2020)

World Health Organization

WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020

11 March 2020

Good afternoon.

In the past two weeks, the number of cases of COVID-19 outside China has increased 13-fold, and the number of affected countries has tripled.

There are now more than 118,000 cases in 114 countries, and 4,291 people have lost their lives.

Thousands more are fighting for their lives in hospitals.

In the days and weeks ahead, we expect to see the number of cases, the number of deaths, and the number of affected countries climb even higher.

WHO has been assessing this outbreak around the clock and we are deeply concerned both by the alarming levels of spread and severity, and by the alarming levels of inaction.

We have therefore made the assessment that COVID-19 can be characterized as a pandemic.

Pandemic is not a word to use lightly or carelessly. It is a word that, if misused, can cause unreasonable fear, or unjustified acceptance that the fight is over, leading to unnecessary suffering and death.

Describing the situation as a pandemic does not change WHO's assessment of the threat posed by this virus. It doesn't change what WHO is doing, and it doesn't change what countries should do.

We have never before seen a pandemic sparked by a coronavirus. This is the first pandemic caused by a coronavirus.

And we have never before seen a pandemic that can be controlled, at the same time.

WHO has been in full response mode since we were notified of the first cases.

And we have called every day for countries to take urgent and aggressive action.

We have rung the alarm bell loud and clear.

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As I said on Monday, just looking at the number of cases and the number of countries affected does not tell the full story.

Of the 118,000 cases reported globally in 114 countries, more than 90 percent of cases are in just four countries, and two of those – China and the Republic of Korea - have significantly declining epidemics.

81 countries have not reported any cases, and 57 countries have reported 10 cases or less.

We cannot say this loudly enough, or clearly enough, or often enough: all countries can still change the course of this pandemic.

If countries detect, test, treat, isolate, trace, and mobilize their people in the response, those with a handful of cases can prevent those cases becoming clusters, and those clusters becoming community transmission.

Even those countries with community transmission or large clusters can turn the tide on this virus.

Several countries have demonstrated that this virus can be suppressed and controlled.

The challenge for many countries who are now dealing with large clusters or community transmission is not whether they **can** do the same – it's whether they **will**.

Some countries are struggling with a lack of capacity.

Some countries are struggling with a lack of resources.

Some countries are struggling with a lack of resolve.

We are grateful for the measures being taken in Iran, Italy and the Republic of Korea to slow the virus and control their epidemics.

We know that these measures are taking a heavy toll on societies and economies, just as they did in China.

All countries must strike a fine balance between protecting health, minimizing economic and social disruption, and respecting human rights.

WHO's mandate is public health. But we're working with many partners across all sectors to mitigate the social and economic consequences of this pandemic.

This is not just a public health crisis, it is a crisis that will touch every sector – so every sector and every individual must be involved in the fight.

I have said from the beginning that countries must take a whole-of-government, whole-of-society approach, built around a comprehensive strategy to prevent infections, save lives and minimize impact.

Let me summarize it in four key areas.

First, prepare and be ready.

Second, detect, protect and treat.

Third, reduce transmission.

Fourth, innovate and learn.

I remind all countries that we are calling on you to activate and scale up your emergency response mechanisms;

Communicate with your people about the risks and how they can protect themselves – this is everybody's business;

Find, isolate, test and treat every case and trace every contact;

Ready your hospitals;

Protect and train your health workers.

And let's all look out for each other, because we need each other.

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There's been so much attention on one word.

Let me give you some other words that matter much more, and that are much more actionable.

Prevention.

Preparedness.

Public health.

Political leadership.

And most of all, people.

We're in this together, to do the right things with calm and protect the citizens of the world. It's doable.

I thank you.

EXHIBIT B

Presidential Proclamation Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) dated 3/13/2020

PROCLAMATIONS

Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak

Issued on: **March 13, 2020**

★ ★ ★

In December 2019, a novel (new) coronavirus known as SARS-CoV-2 ("the virus") was first detected in Wuhan, Hubei Province, People's Republic of China, causing outbreaks of the coronavirus disease COVID-19 that has now spread globally. The Secretary of Health and Human Services (HHS) declared a public health emergency on January 31, 2020, under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19. I have taken sweeping action to control the spread of the virus in the United States, including by suspending entry of foreign nationals seeking entry who had been physically present within the prior 14 days in certain jurisdictions where COVID-19 outbreaks have occurred, including the People's Republic of China, the Islamic Republic of Iran, and the Schengen Area of Europe. The Federal Government, along with State and local governments, has taken preventive and proactive measures to slow the spread of the virus and treat those affected, including by instituting Federal quarantines for individuals evacuated from foreign nations, issuing a declaration pursuant to section 319F-3 of the Public Health Service Act (42 U.S.C. 247d-6d), and releasing policies to accelerate the acquisition of personal protective equipment and streamline bringing new diagnostic capabilities to laboratories. On March 11, 2020, the World Health Organization announced that the COVID-19 outbreak can be characterized as a pandemic, as the rates of infection continue to rise in many locations around the world and across the United States.

The spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems. As of March 12, 2020, 1,645 people from 47 States have been infected with the virus that causes COVID-19. It is incumbent on hospitals and medical facilities throughout the country to assess their preparedness posture and be prepared to surge capacity and capability. Additional measures, however, are needed to successfully contain and combat the virus in the United States.

NOW, THEREFORE, I, DONALD J. TRUMP, President of the United States, by the authority vested in me by the Constitution and the laws of the United States of America, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq*.) and consistent with section 1135 of the Social Security Act (SSA), as amended (42 U.S.C. 1320b-5), do hereby find and proclaim that the COVID-19 outbreak in the United States constitutes a national emergency, beginning March 1, 2020. Pursuant to this declaration, I direct as follows:

Section 1. Emergency Authority. The Secretary of HHS may exercise the authority under section 1135 of the SSA to temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak.

Sec. 2. Certification and Notice. In exercising this authority, the Secretary of HHS shall provide certification and advance written notice to the Congress as required by section 1135(d) of the SSA (42 U.S.C. 1320b-5(d)).

Sec. 3. General Provisions. (a) Nothing in this proclamation shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This proclamation shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This proclamation is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

IN WITNESS WHEREOF, I have hereunto set my hand this thirteenth day of March, in the year of our Lord two thousand twenty, and of the Independence of the United States of America the two hundred and forty-fourth.

DONALD J. TRUMP

EXHIBIT C

State of Mississippi, Office of Governor, Proclamation dated 03/14/2020

STATE OF MISSISSIPPI

Office of the Governor

PROCLAMATION

WHEREAS, the State Health Officer has reported that there is a high risk for an outbreak of the novel coronavirus, identified as COVID-19, in the State of Mississippi; and

WHEREAS, on March 11, 2020, the Mississippi State Department of Health confirmed the first presumptive case of the novel coronavirus (COVID-19) in Mississippi and the Mississippi State Department of Health has since that time worked to identify, contact, and test others in Mississippi potentially exposed to COVID-19 in coordination with the United States Centers for Disease Control and Prevention (CDC); and

WHEREAS, COVID-19, a respiratory disease that can result in serious illness or death, is caused by the SARS-CoV-2 virus, which is a new strain of coronavirus that has not been previously identified in humans and can easily spread from person to person; and

WHEREAS, the CDC identifies the potential public health threat posed by COVID-19 both globally and in the United States as "very high", and has advised that person-to-person spread of COVID-19 will continue to occur globally, including within the United States; and

WHEREAS, on January 31, 2020, the United States Department of Health and Human Services Secretary Alex Azar declared a public health emergency for COVID-19 beginning on January 27, 2020, on March 11, 2020, the World Health Organization characterized COVID-19 as a pandemic, and on March 13, 2020, the President of the United States declared a nationwide state of emergency due to the coronavirus COVID-19 pandemic; and

WHEREAS, the CDC currently indicates there are approximately 106,000 confirmed cases of COVID-19 worldwide with 1,323 of those cases in the United States, and the Mississippi State Department of Health has now confirmed localized person-to-person spread of COVID-19 in Mississippi, significantly increasing the risk of exposure and infection to Mississippi's general public and creating an extreme public health risk that may spread quickly; and

WHEREAS, on March 4, 2020, I signed Executive Order No. 1457 to create the Mississippi Coronavirus (COVID-19) Preparedness and Response Planning Steering Committee chaired by the Mississippi State Health Officer in order to coordinate and assist with efforts related to implementation and review of Mississippi's pandemic preparedness and response to hazards related to the outbreak of COVID-19; and

WHEREAS, the Mississippi State Department of Health has instituted a Public Health Incident Management Team to manage the public health aspects of this outbreak; and

WHEREAS, the Mississippi Emergency Management Agency, State Emergency Operations Center, is coordinating resources across state government to support the Mississippi State Department of Health and local officials in alleviating the impact to people, property, and infrastructure and is assessing the magnitude and long-term effects of the incident with the Mississippi State Department of Health; and

WHEREAS, the worldwide outbreak of COVID-19 and the effects of its extreme risk of person-to-person transmission throughout the United States and Mississippi significantly impact the life and health of our people, as well as the economy of Mississippi; and

WHEREAS, the risk of spread of COVID-19 within Mississippi constitutes a public emergency that may result in substantial injury or harm to life, health, and property within Mississippi.

NOW, THEREFORE, I, Tate Reeves, Governor of the State of Mississippi, pursuant to the Constitution of the State of Mississippi and Miss. Code Ann. § 33-15-11(b)(17), do hereby declare that a State of Emergency exists in the State of Mississippi, and direct that the

Mississippi Comprehensive Emergency Management Plan be implemented. Pursuant to Miss. Code Ann § 33-15-11(c), state agencies and departments are directed to utilize state resources and to do everything reasonably possible to assist communities and entities affected by the outbreak.

As a result of this event, I also hereby direct the Mississippi State Department of Health, the Mississippi Emergency Management Agency, and other agencies, boards, and commissions, to identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.

FURTHER, I direct the following:

Pursuant to Miss. Code Ann. § 33-15-11(c)(1) the provisions of state statutes, rules, regulations or orders may be temporarily suspended or modified if compliance with such provisions would prevent, hinder, or delay action necessary to cope with this outbreak.

Health care facilities that have invoked their emergency operation plans in response to this outbreak may implement the "alternative standards of care" plans provided therein, and such are declared to be the state approved standard of care in health care facilities to be executed by health care professionals and allied professions and occupations providing services in response to this outbreak.

All health care professionals and assisting personnel executing in good faith under the "alternative standards of care" are hereby declared to be "Emergency Management Workers" of the State of Mississippi for the purposes of Miss. Code Ann. Title 41.

The State Health Officer shall inform members of the public on how to protect themselves and actions being taken in response to this outbreak.

The Mississippi State Department of Health and Mississippi Emergency Management Agency seek federal assistance as may be available.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Mississippi to be affixed.

DONE in the City of Jackson, on the 14th day of March, in the year of our Lord, two thousand and twenty, and of the Independence of the United States of America, the two hundred and forty-fourth.

TATE REEVES
GOVERNOR

BY THE GOVERNOR

MICHAEL D. WATSON, JR.
SECRETARY OF STATE

EXHIBIT D

Standing Order In Re: The Novel Coronavirus (COVID-19), 3:20-MC-9, U.S. District Court for the N.D. of Miss. dated 3/16/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI

IN RE: THE NOVEL CORONAVIRUS (COVID-19) 3:20-MC-9

STANDING ORDER

The Centers for Disease Control and Prevention has determined that COVID-19 presents a serious public health threat. Consequently, the President of the United States has issued Proclamations prohibiting travel to the United States by foreign nationals who recently visited areas acutely impacted by COVID-19. The Department of State has also issued Travel Advisories for certain affected countries. Domestic and foreign health authorities have issued guidance to citizens and visitors within their respective jurisdictions, both recommending and mandating precautionary measures to defend against the spread of COVID-19.

Mindful of the Court's duty to ensure the "just, speedy, and inexpensive determination of every action and proceeding"[1] as well as its duty to protect parties, court staff, witnesses, corporate representatives, and practitioners who appear before it and the community in which it sits, it is therefore ORDERED as follows:

(1) Any attorney or party shall promptly notify the Court and opposing counsel, if such party or attorney reasonably suspects (while erring on the side of caution) that a party, attorney, witness or other case participant scheduled to appear before the Court, or that has recently appeared before the Court, has been in contact within the past 14 days with an individual who may be infected by COVID-19.

(2) If notice is given pursuant to subsection (1), the parties shall promptly confer regarding the appropriate means to conduct the hearing, trial, or deposition that is the subject thereof in a manner consistent with all applicable domestic and foreign regulations and health authority guidance. In doing so, the parties shall consider, among other things:
    (a) Whether video conferencing would be appropriate and effective;
    (b) Whether an alternative witness, representative, attorney, or source of proof is available without conflicting with subsection (1);
    (c) Whether a delay in such hearing, trial, or deposition would alleviate the relevant concern, and if so, what is the least amount of delay necessary.

(3) After any notice given pursuant to subsection (1), the parties shall file a joint notice or joint motion within a reasonable time that:
    (a) Identifies the concern that was the subject of the notice;

[1] FED. R. CIV. P. 1.

(b) Explains the steps the parties have agreed upon and implemented to alleviate such concern;
(c) Sets forth any relief requested from the Court to address such concern;
(d) Sets forth any disagreements among the parties, including alternative proposals not mutually agreed upon.

(4) Court Proceedings: All proceedings, civil and criminal, scheduled or typically undertaken in person should be continued or conducted by video or telephone conference to every extent possible. With regard to bankruptcy cases, all hearings that can be conducted telephonically, will be. Priority will be given to criminal proceedings with speedy trial implications. The United States Attorney and Federal Defender offices should cooperate and use their discretion to prioritize proceedings, and continue non-essential proceedings wherever possible.
   (a) Video or telephonic conferencing technology, should be used for any and all court proceedings if at all possible.
   (b) The Court will entertain motions to continue jury trials on a case-by-case basis, keeping in mind that juror reporting should be eliminated if at all possible until further notice.
   (c) The Grand Jury scheduled for March will be postponed until further notice.
   (d) Attorney/Client conferences in criminal matters should be conducted by video and other electronic means to the full extent possible.
   (e) Detainee and prisoner movement should be minimized and eliminated wherever possible.

(5) Petty Offense: the hearing day set to address misdemeanor citations in April and May will be continued until June and July respectively. The cases set for the March hearing date will be disposed of at the discretion of the presiding judge.

(6) Public access to the courthouses will be limited to access that is absolutely necessary and the Court Security Officers will implement protocols to limit access and screen members of the public seeking access to the courthouses.
   (a) Every Judge retains the discretion to restrict access to Chambers for all interns, temporary Court staff, and others.

In this time of overriding concerns for life and safety the Court encourages consistent practice among all stakeholders. While the Court appreciates that unusual and emergency situations may arise, the intent behind this order is to help all of us stay well and safe. I strongly encourage adherence to this order in a strict and consistent manner.

This Order is subject to modification and change *sua sponte* and without notice and will remain in effect until further order. This Order shall be posted at the entrance to every court facility in the district, and on the court's internal and public websites.

It is so ORDERED and SIGNED on this, the 13th day of March, 2020.

Sharion Aycock

CHIEF UNITED STATES DISTRICT JUDGE

EXHIBIT E

WHO Statement, COVID-19 cases surpassing 100,000 (3/7/2020)

World Health Organization

WHO statement on cases of COVID-19 surpassing 100 000

7 March 2020 | Statement

As of today's reports, the global number of confirmed cases of COVID-19 has surpassed 100 000. As we mark this sombre moment, the World Health Organization (WHO) reminds all countries and communities that the spread of this virus can be significantly slowed or even reversed through the implementation of robust containment and control activities.

China and other countries are demonstrating that spread of the virus can be slowed and impact reduced through the use of universally applicable actions, such as working across society to identify people who are sick, bringing them to care, following up on contacts, preparing hospitals and clinics to manage a surge in patients, and training health workers.

WHO calls on all countries to continue efforts that have been effective in limiting the number of cases and slowing the spread of the virus.

Every effort to contain the virus and slow the spread saves lives. These efforts give health systems and all of society much needed time to prepare, and researchers more time to identify effective treatments and develop vaccines.

Allowing uncontrolled spread should not be a choice of any government, as it will harm not only the citizens of that country but affect other countries as well.

We must stop, contain, control, delay and reduce the impact of this virus at every opportunity. Every person has the capacity to contribute, to protect themselves, to protect others, whether in the home, the community, the healthcare system, the workplace or the transport system.

Leaders at all levels and in all walks of life must step forward to bring about this commitment across society.

WHO will continue to work with all countries, our partners and expert networks to coordinate the international response, develop guidance, distribute supplies, share knowledge and provide people with the information they need to protect themselves and others.

More on COVID-19 outbreak

EXHIBIT F

Affidavit of Marc Stern, MD MPH

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

MICHAEL AMOS, PITRELL BRISTER, ANTONIO DAVIS, WILLIE FRIEND, CHARLES GAYLES, DANIEL GUTHRIE, JONATHAN J. HAM, DESMOND HARDY, BILLY JAMES, JR., JUSTIN JAMES, QUENTEN JOHNSON, DEAUNTE LEWIS, LARRY MAXWELL, TERRANCE MCKINNEY, DERRICK PAN, BRANDON ROBERTSON, KURIAKI RILEY, DERRICK ROGERS, TYREE ROSS, H.D. ALEXANDER SCOTT, DEANGELO TAYLOR, LEMARTINE TAYLOR, CONTI TILLIS, DEMARCUS TIMMONS, CARLOS VARNADO, PHILLIP DECARLOS WEBSTER, ADRIAN WILLARD, CURTIS WILSON, CALEB BUCKNER, WILLIAM GREEN, ARIC JOHNSON, IVERY MOORE, and KEVIN THOMAS, on behalf of themselves and all other similarly situated,

Plaintiffs,

v.

TOMMY TAYLOR, in his official capacity as the Interim Commissioner of the Mississippi Department of Corrections, and MARSHAL TURNER, in his official capacity as the Superintendent of the Mississippi State Penitentiary,

Defendants.

No. 4:20-cv-00007-DMB-JMV

DECLARATION OF MARC STERN, MD MPH
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MANDATORY TEMPORARY INJUNCTION AS TO COVID-19

On this 16th day of March, 2020, I hereby declare:

1. My name is Marc Stern. I am an Affiliate Assistant Professor at the University of Washington School of Public Health.

2. I received a Bachelor of Science degree from State University of New York (Albany) in 1975, a medical degree from State University of New York (Buffalo) in 1982, and a Master of Public Health from Indiana University in 1992.

3. I am a board certified internist specializing in correctional health care. I have managed health care operations and practiced health care in multiple correctional settings. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections.

4. On a regular basis I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts; the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails.

5. Through 2013, I taught on behalf of the National Commission on Correctional Health Care (NCCHC) the NCCHC's correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and served as the principal instructor for this course.

6. In the past four years alone, I have been qualified as an expert in seven different lawsuits involvement correctional health care systems and conditions of confinement, including one such case in the Southern District of Mississippi. My full *curriculum vitae* is attached hereto as Exhibit A.

7. On February 11, 2020, I personally inspected housing units in Unit 29 at the Mississippi State Penitentiary ("Parchman") located in Sunflower County, Mississippi. I also conducted the medical evaluations of 17 of the named Plaintiffs to this lawsuit from February 12-14, 2020. Further, I have inspected the medical clinics at Unit 29 and Unit 30, as well as many areas of Unit 42, Parchman's medical unit, and have studied the policies and procedures related to health care systems at Parchman produced by the Defendants and Centurion in this matter.

8. Overall, the health-related and environmental conditions I observed at Parchman are the worst conditions I have observed in any US jail, prison, or immigration detention facility in my 20 years working in this field. The conditions under which residents exist at Parchman are sub-human and deplorable; on a daily basis, residents are exposed to a significant risk of serious harm to their health.

9. Due to the recent COVID-19 pandemic affecting the nation and world, I have recently familiarized myself with the virus, its causes and conditions, its transmission – especially in crowded and unsanitary conditions – and its ability to quickly spread through correctional facilities.

10. In my opinion, to a reasonable degree of medical certainty, the potential for an outbreak of COVID-19 through Parchman prison creates a significant risk of immediate harm to both the Plaintiffs in this lawsuit and all other residents and employees of Parchman. The results of such an outbreak through Parchman would be catastrophic, and potentially fatal to many residents with already compromised immune systems and underlying chronic conditions.

11. In order to mitigate the potential for an outbreak of COVID-19 at Parchman, the following steps should immediately be mandated by the Defendants:

a. **Immediate testing**. Patients who require testing, based on public health recommendations and the opinion of a qualified medical professional, should be tested for COVID-19.

b. **Immediate Screening**. Defendants must be required to screen each employee or other person entering the facility *every day* to detect fever over 100 degrees, cough, shortness of breath, recent travel to a high risk country, and/or exposure to someone who is symptomatic or under surveillance for COVID-19 or screening as required by public health authorities. A record should be made of each screening.

c. **Quarantine.** The prison must establish non-punitive quarantine for all individuals believed to have been exposed to COVID-19, but not yet symptomatic, and non-punitive isolation for those believed to be infected with COVID-19 and potentially infectious. Any individual who must interact with those potentially or likely inflicted with COVID-19 must utilize protective equipment as directed by public health authorities. In short, every possible effort must be made to separate infected or potentially infected individuals from the rest of the incarcerated population. Finally, it must be ensured that no individual is incarcerated past their release date, even if quarantine or isolation is warranted, so individuals requiring continued quarantine, isolation, or health care should be transferred from the institution to the appropriate outside venue.

d. **Institutional Hygiene.** The prison must be required to increase the sanitation and cleaning protocol and frequency for all public spaces, highly traveled areas, and cells.

e. **Personal Hygiene.** The prison must be required to provide hand soap, disposable paper towels, and access to water to allow residents to wash their hands on a regular basis, free of charge and ensure replacement products are available as needed. Further, hand sanitizer with alcohol must be declassified temporarily as contraband. Correctional staff should be allowed to carry hand sanitizer with alcohol on their person, and residents should be allowed to use hand sanitizer with alcohol when they are in locations or activities where hand washing is not available.

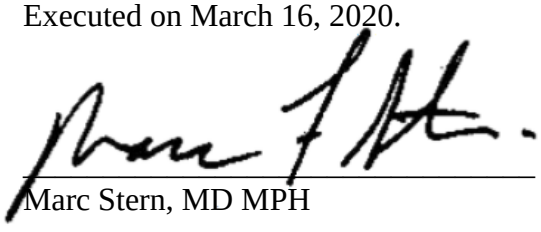
f. **Limit Contact Visitation.** I understand that the prison already has limited visitation that allows residents to come into physical contact with visitors, but officials must be required to implement or increase non-contact visitation such as video conferencing and/or telephone calls at no charge.

g. **Waive Copays.** There must be a waiving of copays for medical evaluation and care related in any way to COVID-19 and/or its symptoms. A waiver of these types of copays is necessary to avoid disincentivizing patients from requesting medical treatment. Patients with symptoms of possible COVID-19 should be seen quickly. Those with a cough should be provided masks as soon as they inform staff of this symptom or staff notice this symptom.

h. **Supply Chain.** The prison must be required to identify the supplies and other materials upon which the institution is dependent, such as food, medical supplies, certain medicines, cleaning products, etcetera and prepare for shortages, delays or disruptions in the supply chain.

12. I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 16, 2020.



Marc Stern, MD MPH

EXHIBIT G

MDOC Press Release "MDOC Takes Preventative Steps Against Coronavirus Exposure" dated 3/12/2020

FOR IMMEDIATE RELEASE

Date: **March 12, 2020**
Contact: **Office of Communications**
Phone: **(601) 359-5289, 359-5608, 359-5689**
E-mail: **MDOCOfficeofCommunications@mdoc.state.ms.us**

MDOC Takes Steps to Protect Staff, Inmates, Public against Coronavirus Exposure

JACKSON, MISS. – Effective immediately, visitation at all facilities where Mississippi Department of Corrections inmates are housed is temporarily suspended until further notice in order to establish sanitation and prevention protocols to prevent the spread of COVID-19. This is a precautionary measure to protect staff, inmates, volunteers, and visitors from potential exposure to the coronavirus.

Attorneys and essential visitors will be allowed, and the area of visits will be sanitized upon completion of each visit. Additional parameters will be determined as protocols are established.

"We acknowledge any inconveniences that inmate family members and others may experience from the temporary suspension of visitation," said Deputy Commissioner Jeworski Mallett, who manages state, private, and regional prisons in the state. "However, these actions are necessary for public safety and protecting our inmates, their loved ones, and our staff."

Also, the Corrections Department is reinforcing common health practices based on preventive measures recommended by the Mississippi Department of Health in accordance with the Centers for Disease Control and Prevention.

There are currently no confirmed cases of COVID-19 within the MDOC prison system.

EXHIBIT H

Medical Records of Inmate Larry Maxwell (showing repeated visits to medical clinic without receiving treatment)

Mississippi Department of Corrections
301 North Lamar Street Jackson, MS 39201
(601) 359-5600

[redacted]

01/30/2020 - Appointment Rescheduling: 01/30/2020 Nurse SC; to 01/31/2020 - Not transported to Medical

Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 01/31/2020
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 01/30/2020
Reason for reschedule: Not transported to Medical

[redacted]

01/29/2020 - Appointment Rescheduling: 01/29/2020 Nurse SC; to 01/30/2020 - Not transported to Medical

Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 01/30/2020
Appointment type rescheduled: Nurse SC

[redacted]

Mississippi Department of Corrections
301 North Lamar Street Jackson, MS 39201
(601) 359-5600

[redacted]

Appointment Rescheduled from 01/29/2020
Reason for reschedule: Not transported to Medical

[redacted]

01/28/2020 - Appointment Rescheduling: 01/28/2020 Nurse SC; to 01/29/2020 - Not transported to Medical
[redacted]
Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 01/29/2020
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 01/28/2020
Reason for reschedule: Not transported to Medical

[redacted]

01/26/2020 - Appointment Rescheduling: 01/26/2020 Nurse SC; to 01/27/2020 - Facility Lockdown
[redacted]
Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 01/27/2020
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 01/26/2020
Reason for reschedule: Facility Lockdown

[redacted]

01/25/2020 - Appointment Rescheduling: 01/25/2020 Nurse SC; to 01/26/2020 - Facility Lockdown
[redacted]
Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 01/26/2020
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 01/25/2020

[redacted]

Mississippi Department of Corrections
301 North Lamar Street Jackson, MS 39201
(601) 359-5600

[redacted]

09/03/2019 - Appointment Rescheduling: 09/03/2019 Nurse SC; to 09/04/2019 - Not transported to Medical

[redacted]

Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 09/04/2019
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 09/03/2019
Reason for reschedule: Not transported to Medical

[redacted]

Mississippi Department of Corrections
301 North Lamar Street Jackson, MS 39201
(601) 359-5600

[redacted]

07/28/2019 - Appointment Rescheduling: 07/28/2019 Nurse SC; to 07/29/2019 - Not transported to Medical
[redacted]
Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 07/29/2019
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 07/28/2019
Reason for reschedule: Not transported to Medical

[redacted]

07/27/2019 - Appointment Rescheduling: 07/27/2019 Nurse SC; to 07/28/2019 - Not transported to Medical
[redacted]
Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 07/28/2019
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 07/27/2019
Reason for reschedule: Not transported to Medical

[redacted]

07/26/2019 - Appointment Rescheduling: 07/26/2019 Nurse SC; to 07/27/2019 - Not transported to Medical
[redacted]
Location of Care: Mississippi State Penitentiary

Date Appt rescheduled to occur: 07/27/2019
Appointment type rescheduled: Nurse SC
Appointment Rescheduled from 07/26/2019
Reason for reschedule: Not transported to Medical

[redacted]

EXHIBIT I

Bureau of Justice Statistics, US DOJ, Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12, NCJ 248491

(Rev. 10/4/2016)

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

Revised October 4, 2016

SPECIAL REPORT

FEBRUARY 2015

NCJ 248491

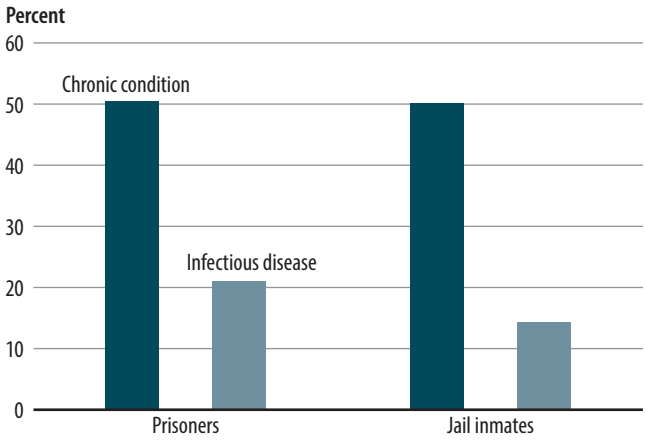
Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12

Laura M. Maruschak, *BJS Statistician*
Marcus Berzofsky, Dr.P.H., and Jennifer Unangst, *RTI International*

In 2011–12, half of state and federal prisoners and local jail inmates reported ever having a chronic condition (figure 1). Chronic conditions include cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and cirrhosis of the liver. Twenty-one percent of prisoners and 14% of jail inmates reported ever having an infectious disease, including tuberculosis, hepatitis B and C, and other sexually transmitted diseases (STDs). About 1% of prisoners and jail inmates who had been tested for HIV reported being HIV positive.

This report uses data from the 2011–12 National Inmate Survey (NIS-3) to describe the health status and the health services and treatment received by state and federal prisoners and local jail inmates. Data from the 2009–2012 National Survey on Drug Use and Health (NSDUH) were used to compare the incarcerated populations to the general population. The general population was standardized

FIGURE 1
Prevalence of ever having a chronic condition or infectious disease among state and federal prisoners and jail inmates, 2011–12



Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

HIGHLIGHTS

- In 2011–12, an estimated 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition while about half reported ever having a chronic medical condition.
- Twenty-one percent of prisoners and 14% of jail inmates reported ever having tuberculosis, hepatitis B or C, or other STDs (excluding HIV or AIDS).
- Both prisoners and jail inmates were more likely than the general population to report ever having a chronic condition or infectious disease. The same finding held true for each specific condition or infectious disease.
- Among prisoners and jail inmates, females were more likely than males to report ever having a chronic condition.
- High blood pressure was the most common chronic condition reported by prisoners (30%) and jail inmates (26%).
- The majority of prisoners (74%) and jail inmates (62%) were overweight, obese, or morbidly obese.
- While female prisoners and jail inmates were less likely than males to be overweight, they were more likely to be obese or morbidly obese.
- About 66% of prisoners and 40% of jail inmates with a current chronic condition reported taking prescription medication.
- The majority of prisoners reported having been tested for HIV (71%) and for tuberculosis (94%) since admission. Among jail inmates, 11% had been tested for HIV and 54% for tuberculosis.
- Seventeen jurisdictions reported testing all inmates for HIV during the intake process, 11 reported opt-out testing, and 10 reported opt-in testing.
- More than half of prisoners (56%) and jail inmates (51%) said that they were either very satisfied or somewhat satisfied with the health care services received since admission.

twice, once to match the prison population and once to match the jail population by sex, age, race, and Hispanic origin. Standardizing the general population to the inmate population controls for differences in the distributions of sex, age, and race, and Hispanic origin, which are important risk factors for medical problems. Standardization removes the effect of sex, age, race, and Hispanic origin when comparing the prevalence of medical conditions between the incarcerated populations and the general population. However, it does not remove the effect of other factors associated with both incarceration status and outcome. The report details the prevalence of specific chronic conditions and infectious diseases and highlights important differences in the rates of each by demographic characteristics. It examines treatment received by inmates with health problems and describes inmate satisfaction with health services received while incarcerated.

Prisoners and jail inmates were more likely than the general population to report ever having a chronic condition or an infectious disease

When compared to the general population, both prisoners and jail inmates were more likely to report ever having a chronic condition, and they were more likely to report each of the specific chronic conditions measured. When compared to the general population, the measure of ever having a chronic condition excludes cancer, kidney-related problems, and arthritis or rheumatism because data were not collected on these chronic conditions in the NSDUH. Forty-four percent of prisoners reported ever having a chronic condition, compared to 31% of persons in the general population **(table 1)**. Prisoners were about 1.5 times more likely than persons in the standardized general population to report ever having high blood pressure, diabetes, or asthma. About 45% of jail inmates reported

Difference between ever having and currently having chronic medical conditions

Estimates of chronic medical conditions among state and federal prisoners and jail inmates are based on self-reported information in the National Inmate Survey (NIS-3). Inmates were asked whether a doctor, nurse, or other health care provider *ever* told them they had select noninfectious medical conditions which were categorized as chronic conditions. Chronic medical conditions involve persistent health problems that have long-lasting effects, and include but are not limited to, the select conditions that were asked about in the NIS-3. This measure indicated a diagnosis of having the condition at least once in their lifetime, but does not mean that the inmate currently has the medical condition. As a measure of current medical conditions in the NIS-3, inmates were also asked at the time of the interview whether a doctor, nurse, or other health care provider had told them they *currently* had select noninfectious medical conditions.

The data show that an estimated 50% of prisoners and jail inmates reported ever having a chronic condition compared to 40% currently having a chronic condition. The percentage of inmates who reported currently having a chronic condition was lower than those who reported ever having a chronic condition because over time, a past condition may have been resolved, gone into remission, or no longer required treatment. The measure of ever having a chronic medical condition indicates the percentage of inmates who are potentially at risk for future medical problems while the measure of current condition indicates the percentage of inmates who may have needed health care services at the time of interview.

TABLE 1

Prevalence of ever having a chronic condition or infectious disease among state and federal prisoners and the general population (standardized), 2011–12

	State and federal prisoners		General population*[a]	
Chronic condition/infectious disease	**Percent**	**Standard error**	**Percent**	**Standard error**
Ever had a chronic condition[b]	43.9%**	1.5%	31.0%	0.3%
Cancer	3.5	0.4	/	:
High blood pressure/hypertension	30.2**	1.2	18.1	0.3
Stroke-related problems	1.8**	0.3	0.7	0.1
Diabetes/high blood sugar	9.0**	0.8	6.5	0.2
Heart-related problems[c]	9.8**	1.0	2.9	0.1
Kidney-related problems	6.1	0.7	/	:
Arthritis/rheumatism	15.0	0.9	/	:
Asthma	14.9**	0.9	10.2	0.2
Cirrhosis of the liver	1.8**	0.3	0.2	--
Ever had an infectious disease[d]	21.0%**	1.3%	4.8%	0.2%
Tuberculosis	6.0**	0.6	0.5	0.1
Hepatitis[e]	10.9**	1.0	1.1	0.1
Hepatitis B	2.7	0.4	/	:
Hepatitis C	9.8	1.0	/	:
STDs[f]	6.0**	0.5	3.4	0.1
HIV/AIDS	1.3%**	0.3%	0.4%	0.1%

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

--Less than 0.05%.

: Not calculated.

/Not collected in the NSDUH.

[a]General population estimates were standardized to match the prison population by sex, age, race, and Hispanic origin.

[b]Includes only conditions measured by both the NIS and NSDUH. In the NSDUH, persons were asked if a doctor or other medical professional had ever told them that they had high blood pressure, a stroke, diabetes, heart disease, asthma, or cirrhosis of the liver.

[c]For state and federal prisoners, heart-related problems could include angina; arrhythmia; arteriosclerosis; heart attack; coronary, congenital, or rheumatic heart disease; heart valve damage; tachycardia; or other type of heart problem.

[d]Excludes HIV or AIDS due to unknown or missing data. Only those tested reported results.

[e]Includes hepatitis B and C for the prison population and all types of hepatitis for the general population.

[f]Excludes HIV or AIDS.

Source: Bureau of Justice Statistics, National Inmate Survey (NIS), 2011–12; and the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2009–2012.

ever having a chronic condition, compared to 27% of the standardized general population (table 2). Jail inmates were nearly two times more likely than persons in the general population to report ever having high blood pressure, diabetes, or asthma.

An estimated 21% of prisoners and 14% of jail inmates reported ever having tuberculosis, hepatitis, or other STDs excluding HIV or AIDS, compared to 5% of the general population.[1] For each type of infectious disease, prisoners and jail inmates were more likely than those in the general population to report ever having that infectious disease.

[1]In the NSDUH, hepatitis includes all types. In the NIS-3, hepatitis includes hepatitis B and hepatitis C.

High blood pressure was the most commonly reported chronic condition among prisoners and jail inmates

Similar to the standardized general population, the most commonly reported chronic condition reported by both prisoners and jail inmates was high blood pressure. Nearly a third (30%) of prisoners and more than a quarter (26%) of jail inmates reported high blood pressure. Asthma (15% for prisoners and 20% for jail inmates) and arthritis (15% for prisoners and 13% for jail inmates) were the second and third most common chronic conditions.

TABLE 2

Prevalence of ever having a chronic condition or infectious disease among jail inmates and the general population (standardized), 2011–12

	Jail inmates		General population*[a]	
Chronic condition/infectious disease	Percent	Standard error	Percent	Standard error
Ever had a chronic condition[b]	44.7%**	1.2%	26.9%	0.3%
Cancer	3.6	0.4	/	:
High blood pressure/hypertension	26.3**	1.1	13.9	0.2
Stroke-related problems	2.3**	0.3	0.5	--
Diabetes/high blood sugar	7.2**	0.6	4.5	0.1
Heart-related problems[c]	10.4**	0.7	1.9	0.1
Kidney-related problems	6.7	0.5	/	:
Arthritis/rheumatism	12.9	0.7	/	:
Asthma	20.1**	1.0	11.4	0.2
Cirrhosis of the liver	1.7**	0.3	0.1	--
Ever had an infectious disease[d]	14.3%**	0.7%	4.6%	0.1%
Tuberculosis	2.5**	0.3	0.4	--
Hepatitis[e]	6.5**	0.5	0.9	--
Hepatitis B	1.7	0.2	/	:
Hepatitis C	5.6	0.5	/	:
STDs[e,f]	6.1**	0.5	3.5	0.1
HIV/AIDS	1.3%**	0.2%	0.3%	--

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

--Less than 0.05%.

: Not calculated.

/Not collected in the NSDUH.

[a]General population estimates were standardized to match the jail population by sex, age, race, and Hispanic origin.

[b]Includes only conditions measured by both the NIS and NSDUH. In the NSDUH, persons were asked if a doctor or other medical professional had ever told them that they had high blood pressure, a stroke, diabetes, heart disease, asthma, or cirrhosis of the liver.

[c]For jail inmates, heart-related problems could include angina; arrhythmia; arteriosclerosis; heart attack; coronary, congenital, or rheumatic heart disease; heart valve damage; tachycardia; or other type of heart problem.

[d]Excludes HIV or AIDS due to unknown or missing data. Only those tested reported results.

[e]Includes hepatitis B and C for the jail population and all types of hepatitis for the general population.

[f]Excludes HIV or AIDS.

Source: Bureau of Justice Statistics, National Inmate Survey (NIS), 2011–12; and the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2009–2012.

Among prisoners, hepatitis C was the most commonly reported infectious disease (10%), followed by tuberculosis and STDs (6% each). Among jail inmates, nearly 6% reported ever having hepatitis C, 6% ever had some other STD, and 2% ever had tuberculosis. About 1% of both prisoners and jail inmates who were tested reported having HIV or AIDS.

Chronic conditions were more commonly reported by female inmates both in prisons and jails

Female prisoners and jail inmates were more likely than males to report ever having a chronic condition **(table 3)**. About two-thirds of females in both prisons (63%) and jails (67%) reported ever having a chronic condition, compared to half of males in prisons (50%) and jails (48%). In prisons, 25% of females and 21% of males reported ever having an infectious disease. In jails, 20% of females reported ever having an infectious disease, compared to 13% of males.

Hispanic prisoners and jail inmates were less likely than white and black prisoners and jail inmates to report ever having an infectious disease. About 57% of white, 52% of black, and 41% of Hispanic prisoners reported ever having a chronic condition. Similarly, 54% of white, 50% of black, and 37% of Hispanic jail inmates reported ever having a chronic condition. White prisoners were almost 1.5 times more likely than black prisoners to report ever having an infectious disease. About 15% of both white and black jail inmates reported ever having an infectious disease, compared to 10% of Hispanic inmates.

Older prisoners were about 3 times more likely than younger persons to report ever having a chronic condition or infectious disease

Older prisoners and jail inmates were more likely than younger persons to report ever having a chronic condition or infectious disease. Prisoners age 50 or older were about 2.5 times more likely than those ages 18 to 24 to report ever having a chronic condition. Similarly, jail inmates age 50 or older were about 2 times more likely than those ages 18 to 24 to report ever having a chronic condition. About 1 in 10 prisoners and jail inmates ages 18 to 24 reported ever having an infectious disease. Prisoners (35%) and jail inmates (30%) age 50 or older were about 3 times more likely to report having an infectious disease than those ages 18 to 24.

TABLE 3

Prevalence of ever having a chronic condition or infectious disease among state and federal prisoners and jail inmates, by demographic characteristics, 2011–12

	Chronic condition[a]		Infectious disease[b]	
Demographic characteristic	State and federal prisoners*	Jail inmates	State and federal prisoners*	Jail inmates
All inmates	50.5%	50.2%	21.0%	14.3%**
Sex				
Male †	49.6%	47.8%	20.7%	13.4%**
Female	62.9 ††	66.6 ††	25.0	20.1 ††
Age				
18–24 †	27.5%	37.7%**	11.0%	9.5%
25–34	40.9 ††	45.6 ††	19.7 ††	13.1 ††**
35–49	55.5 ††	57.7 ††	18.8 ††	15.0 ††**
50 or older	72.6 ††	78.6 ††	35.1 ††	30.1 ††
Race/Hispanic origin[c]				
White	57.4%	54.3%	24.6% ††	14.9%**
Black/African American †	51.9	49.7	16.7	15.2
Hispanic/Latino	40.6 ††	37.1 ††	23.4	10.1 ††**
Other[d]	49.4	61.3 ††	20.0	14.9

Note: The jail population was not standardized to match the prison population. Therefore, differences observed may be due to differences in prison and jail population by sex, age, race, and Hispanic origin. See appendix table 8 for standard errors.

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

† Comparison group.

†† Difference with comparison group is significant at the 95% confidence level.

[a]Includes cancer, high blood pressure or hypertension, stroke-related problems, diabetes or high blood sugar, heart-related problems, kidney-related problems, arthritis or rheumatism, asthma, and cirrhosis of the liver.

[b]Includes tuberculosis, hepatitis B, hepatitis C, and STDs. Excludes HIV or AIDS due to unknown or missing data.

[c]Excludes persons of Hispanic or Latino origin, unless specified.

[d]Includes persons identified as American Indian or Alaska Native; Asian, Native Hawaiian, or other Pacific Islander; and two or more races.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

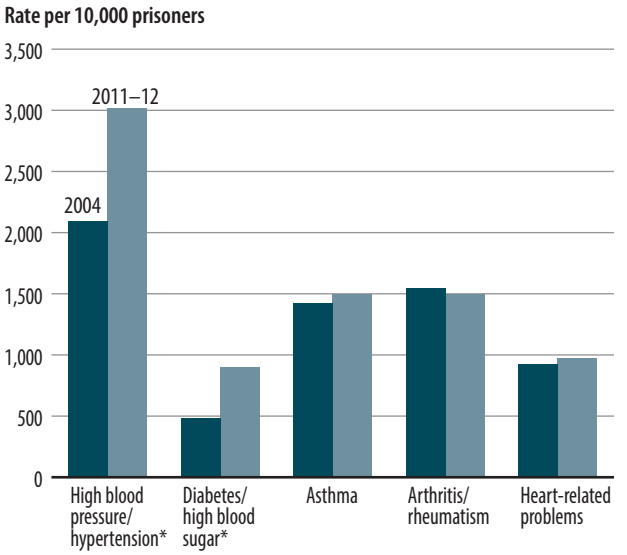
Rates of high blood pressure and diabetes increased among prisoners and jail inmates

In the Bureau of Justice Statistics' (BJS) 2002 Survey of Inmates in Local Jails and 2004 Survey of Inmates in State and Federal Correctional Facilities, inmates were asked a series of questions to determine if they ever had or currently have a chronic condition. Inmates were also asked about specific chronic conditions. The 2011–12 National Inmate Survey (NIS-3) included a more restricted measure of ever had or currently having a chronic condition. In the NIS-3, inmates were asked if a doctor, nurse, or other health care provider ever told them that they had a certain chronic condition and, if a doctor, nurse, or health care provider told them that they currently had the chronic condition. Although the NIS-3 collected a more conservative measure, prevalence estimates of some common chronic conditions were higher in 2011–12 than 2002 and 2004, indicating true increases have occurred over time.

Between 2004 and 2011–12, rates of high blood pressure and diabetes rose among prisoners **(figure 2)**. The rate of diabetes in 2011–12 (899 per 10,000 prisoners) was almost twice the rate in 2004 (483 per 10,000). The rate of high blood pressure (3,020 per 10,000 prisoners) was almost 1.5 times the rate in 2004 (2,093 per 10,000). Similar rates were observed for asthma, arthritis, and heart-related problems. Although data suggest stability in these rates, caution should be taken when interpreting data, as the methodology was updated for 2011–12.

FIGURE 2

Rate of ever having a chronic condition among state and federal prisoners, 2004 and 2011–12



Note: See appendix table 9 for standard errors.

*Differences between years are significant at the 95% confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12; and Survey of Inmates in State and Federal Correctional Facilities, 2004.

Continued on next page

Rates of high blood pressure and diabetes increased among prisoners and jail inmates (continued)

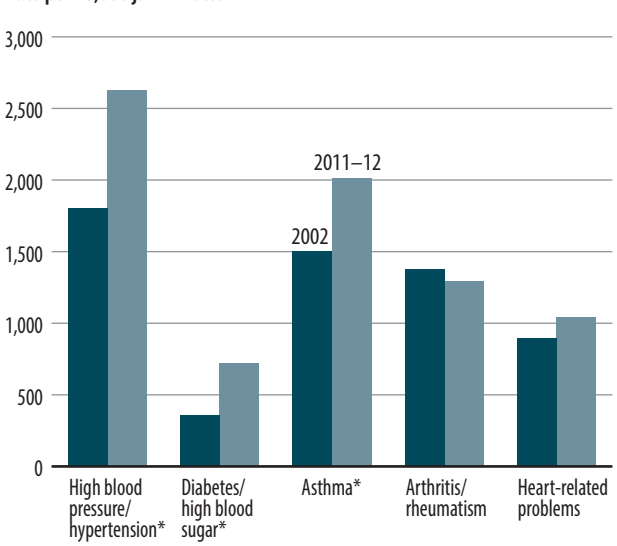
Similar trends were observed among jail inmates **(figure 3)**. The 2011–12 rate of jail inmates who reported ever having diabetes (723 per 10,000 jail inmates) was twice the 2002 rate (361 per 10,000), and the rate of high blood pressure in 2011–12 was almost 1.5 times higher than the rate in 2002. The rate of asthma also rose between 2002 and 2011–12, from 1,502 per 10,000 jail inmates to 2,012 per 10,000. Although data suggest that the rates of arthritis and heart-related problems among jail inmates were relatively stable, caution should be taken when interpreting data, as the methodology was updated for 2011–12.

Rate of HIV or AIDS in state and federal prisons continued to decline

Based on data from administrative records reported through BJS's National Prisoner Statistics (NPS-1) data collection, 18,945 state and federal prisoners were infected with HIV or had confirmed AIDS in 2012—down from 19,536 in 2011 (appendix table 1). Between 2011 and 2012, the estimated rate of HIV or AIDS declined from 145 per 10,000 prisoners to 143 per 10,000. This decline is consistent with declines observed over the previous decades **(figure 4)**.

FIGURE 3

Rate of ever having a chronic condition among jail inmates, 2002 and 2011–12



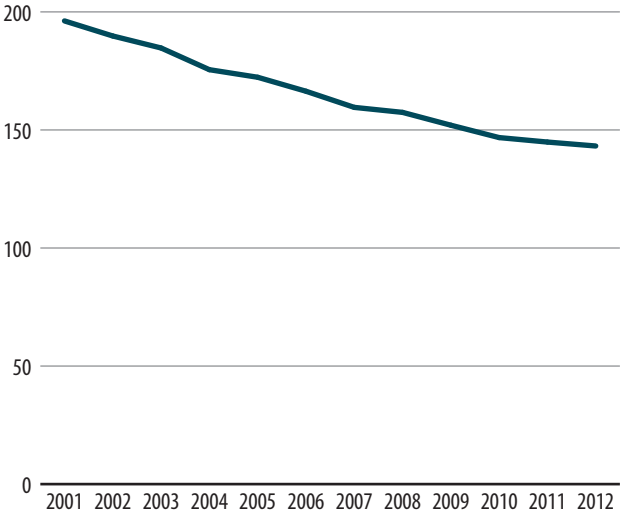
Note: See appendix table 10 for standard errors. For comparability to the 2011–12 rates, jail inmates age 17 or younger were excluded when calculating 2002 rates of ever having each specific chronic condition.

*Differences between years are significant at the 95% confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12; and Survey of Inmates in Local Jails, 2002.

FIGURE 4

Rate of HIV or AIDS cases among state and federal prisoners, 2001–2012



Source: Bureau of Justice Statistics, National Prisoner Statistics Program, 2001–2012.

24% of prisoners and jail inmates reported at least two chronic conditions

In 2012, nearly a quarter (24%) of both prisoners and jail inmates reported ever having multiple chronic conditions (table 4). About 7% of prisoners and 4% of jail inmates reported high blood pressure and diabetes—two chronic conditions that are risk factors for cardiovascular disease. About 12% of prisoners and 9% of jail inmates reported ever having a chronic condition and an infectious disease. Among prisoners and jail inmates who reported ever having hepatitis B, about 15% reported ever having cirrhosis of the liver. About 11% of those in both populations who ever had hepatitis C reported that they had cirrhosis of the liver.

TABLE 4

Prevalence of ever having multiple chronic conditions and infectious diseases among state and federal prisoners and jail inmates, 2011–12

	State and federal prisoners*		Jail inmates	
Chronic condition/ infectious disease	Percent	Standard error	Percent	Standard error
Chronic conditions				
Multiple chronic conditions	24.2%	1.3%	24.3%	1.2%
Hypertension and diabetes	6.6	0.7	4.4**	0.5
Infectious diseases[a]				
Multiple infectious diseases	4.1%	0.5%	2.2%**	0.3%
Chronic conditions and infectious diseases				
Both a chronic condition and infectious disease	12.3%	0.9%	9.1%**	0.6%
Among those who had Hepatitis B–				
Had cirrhosis of the liver	14.6	2.8	15.2	4.8
Among those who had Hepatitis C–				
Had cirrhosis of the liver	11.3	4.8	11.0	4.6

Note: The jail population was not standardized to match the prison population. Therefore, differences observed may be due to differences in prison and jail population by sex, age, race, and Hispanic origin.

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

[a]Includes tuberculosis, hepatitis B, hepatitis C, and STDs. Excludes HIV or AIDS due to unknown or missing data.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

Majority of prisoners and jail inmates were either overweight, obese, or morbidly obese[2]

In 2011–12, nearly three-quarters of prisoners were either overweight (46%), obese (26%), or morbidly obese (2%), with about a quarter of prisoners being either normal weight (26%) or underweight (1%) (table 5). Measures of overweight, obese, and morbidly obese were calculated using the body mass index (see *Methodology*). Female prisoners (35%) were less likely than males (47%) to be overweight. However, female (43%) prisoners were more likely than males (27%) to be either obese or morbidly obese (appendix table 2). Prisoners ages 18 to 24 were less likely than all other age groups to be obese. About 14% of prisoners ages 18 to 24 were obese, compared to 20% of those ages 25 to 34, 33% of those ages 35 to 49, and 25% of those age 50 or older. Black prisoners (29%) were more likely than white prisoners (23%) to be obese.

In 2011–12, more than 6 in 10 jail inmates were either overweight (39%), obese (20%), or morbidly obese (2%), while about 4 in 10 jail inmates were either normal weight (37%) or underweight (1%). Female (32%) jail inmates were less likely than males (40%) to be overweight. However, female (37%) jail inmates were more likely than males (20%) to be either obese or morbidly obese (appendix table 3). Similar to prisoners, jail inmates ages 18 to 24 were less likely than all other age groups to be obese. About 13% of jail inmates ages 18 to 24 were obese, compared to 19% of those ages 25 to 34, 27% of those ages 35 to 49, and 22% of those age 50 or older. About 44% of Hispanic jail inmates reported being overweight—the highest percentage among all racial or ethnic categories. About 1 in 5 jail inmates in each racial category was obese. Black jail inmates (3%) were more likely than white jail inmates (1%) to be morbidly obese.

TABLE 5

Body mass index of state and federal prisoners and local jail inmates, 2011–12

Body mass index	State and federal prisoners	Jail inmates
Total	100%	100%
Normal/underweight	26.4	38.4
Overweight	45.7	39.3
Obese	25.5	20.0
Morbidly obese	2.4	2.3

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

[2]This finding is consistent with the general population of adults age 20 or older (Health, United States, 2013, Centers for Disease Control and Prevention).

Most prisoners and jail inmates received medical assessments or exams since admission

Prisoners were more likely than jail inmates to report being assessed and questioned about medical issues at time of admission; to have seen a doctor, nurse, or health care professional for any medical reason; or to have been tested for infectious diseases **(table 6)**. An estimated 85% of prisoners were questioned by staff about their health or medical history, compared to 82% of jail inmates. About two-thirds of prisoners (64%) and half (50%) of jail inmates reported being assessed by staff to see if they were sick, injured, or intoxicated.

An estimated 80% of prisoners and 47% of jail inmates reported seeing a health care professional for a medical reason since admission. Prisoners (71%) were about 6.5 times more likely than jail inmates (11%) to be tested for HIV. Among prisoners, 57% were tested for hepatitis B and 54% were tested for hepatitis C, compared to 6% for both among jail inmates. Almost all prisoners (94%) reported being tested for tuberculosis since admission, compared to about half (54%) of jail inmates.

TABLE 6

Health care services and medical tests received by state and federal prisoners and jail inmates while incarcerated, 2011–12

	State and federal prisoners*		Jail inmates	
Health care services provided	Percent	Standard error	Percent	Standard error
At time of admission				
Assessed by staff for sickness, injury, or intoxication	63.6%	1.2%	49.4%**	1.6%
Questioned by staff about health or medical history	85.0	1.0	81.8**	1.1
Since admission				
Seen a doctor, nurse, or other health care professional for any reason	79.9%	1.2%	46.5%**	1.3%
Tested for—				
HIV	71.4	1.4	10.8**	0.8
Tuberculosis	93.6	0.7	53.9**	2.5
Hepatitis B	57.4	1.6	6.0**	0.6
Hepatitis C	54.4	1.7	5.7**	0.5
STDs[a]	32.6	1.2	5.4**	0.5

Note: The jail population was not standardized to match the prison population. Therefore, differences observed may be due to differences in prison and jail population by sex, age, race, and Hispanic origin.

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

[a]Excludes HIV or AIDS.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

About a third of jurisdictions reported testing all inmates on entry

In 2012, as part of the prison intake process, 17 jurisdictions reported that they test all inmates for HIV, 11 reported that they offer opt-out HIV testing (i.e., all inmates are offered the test, and the test is given unless the inmate declines the test), and 10 reported opt-in HIV testing (i.e., all inmates are offered the test, and the test is given if the inmate wants to be tested). The remaining jurisdictions either had some other practice for testing, did not test, or did not report the testing practice in their jurisdiction (appendix table 4).

Thirty-two percent of prisoners were held in the jurisdictions that reported testing all inmates for HIV, 26% were held in the jurisdictions reporting opt-out testing, and 15% were held in the jurisdictions that reported opt-in testing. The remaining quarter of prisoners were held in jurisdictions that either reported other testing circumstances or did not report their testing practices.

Among the 10 jurisdictions offering opt-in testing, consent specifically for HIV testing was obtained in 9 jurisdictions, and general consent for medical services was obtained in 1 jurisdiction. For jurisdictions with opt-out testing, type of consent for testing was not consistent. Three jurisdictions obtained consent specifically for HIV testing, six jurisdictions obtained consent for medical services, one jurisdiction did not obtain any consent, and one jurisdiction did not report type of consent.

In 2012, the majority of jurisdictions reported testing inmates in custody who requested an HIV test (42), if there was clinical indication (39), who were involved in an incident (34), and who were under court order (32) (appendix table 5). Twenty jurisdictions reported offering HIV testing during routine medical exams, and 19 offered testing to high-risk inmates.

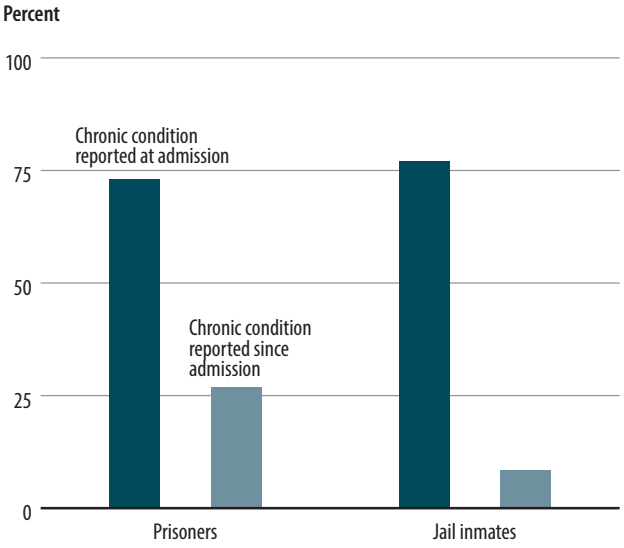
On discharge, most jurisdictions (24) provided inmates with an HIV test, if requested (appendix table 6). Seven jurisdictions offered an HIV test to all inmates being released, three offered an HIV test to some inmates, and six reported that they did not provide HIV testing on discharge.

Among prisoners and jail inmates who reported ever having a chronic condition, about three-quarters reported having a chronic condition at admission

Among those who reported ever having a chronic condition, 73% of prisoners and 77% of jail inmates reported that they had a condition at admission (figure 5). Both prisoners and jail inmates were more likely to report a chronic condition at admission than since admission. Among those who reported ever having a chronic condition, about a quarter (27%) of prisoners and a tenth (8%) of jail inmates did not report a chronic condition at admission, but were told that they had the condition since admission. Prisoners and jail inmates who had a chronic condition at admission were equally likely to report taking prescription medication or receiving some other type of treatment in the 30 days prior to admission (table 7). In both populations, about 6 in 10 reported taking prescription medication and more than 3 in 10 reported receiving some other type of treatment.

FIGURE 5

Prevalence of any chronic condition at admission and since admission among state and federal prisoners and jail inmates who reported ever having a condition, 2011–12



Note: An inmate may have reported ever having multiple conditions. As a result, one inmate may be in both categories because one condition may have been reported at admission and another condition could have been reported since admission.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

TABLE 7

Prevalence of prescription medication use and other treatment among prisoners and jail inmates with a current chronic condition or infectious disease, 2011–12

	State and federal prisoners*		Jail inmates	
Health care services provided	Percent	Standard error	Percent	Standard error
Chronic condition at admission[a]				
In 30 days prior to admission—				
Taking prescription medication	60.9%	2.5%	58.8%	2.1%
Receiving medical treatment other than prescription medication	34.4	1.9	32.6	1.6
Current chronic condition[a]				
Currently taking prescription medication	66.1%	2.3%	39.8%**	1.8%
Reasons for not taking prescription medication[b]				
Inmate had not seen a doctor	20.0	1.7	38.7**	2.2
Inmate did not like taking medication	10.9	1.2	16.0**	1.6
Doctor did not think it was necessary or facility would not provide it	36.3	2.3	36.3	1.6
Inmate did not think medication was necessary	19.4	1.8	30.5**	1.8
Other	35.0	2.4	50.9**	2.0
Currently receiving medical treatment other than prescription medication	19.9	1.7	13.8**	1.4
HIV-positive inmates				
Taking prescription medication	84.0%	8.6%	65.9%	9.6%

Note: The jail population was not standardized to match the prison population. Therefore, differences observed may be due to differences in prison and jail population by sex, age, race, and Hispanic origin.

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

[a]Includes cancer, high blood pressure or hypertension, stroke-related problems, diabetes or high blood sugar, heart-related problems, kidney-related problems, arthritis or rheumatism, asthma, and cirrhosis of the liver.

[b]Detail does not sum to 100% because inmates could select more than one reason.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

66% of prisoners and 40% of jail inmates with a current chronic condition reported taking prescription medication

In 2011–12, about 4 in 10 prisoners (41%) and jail inmates (40%) reported having a current chronic condition (appendix table 7). Among prisoners with a current chronic condition, 66% reported that they were taking prescription medication, and 20% said they were receiving some other type of medical treatment. Although inmates could report multiple reasons for not taking prescription medication, prisoners most commonly cited reasons related to lack of health services or doctor's provision of a prescription. More than a third (36%) of prisoners who were not taking prescription medication said that the doctor did not think medication was necessary or that the facility would not provide the medication, while about 20% reported that they had not seen a doctor. About 19% of prisoners reported that they did not think the medication was necessary, and about 11% reported that they did not like taking the medication. Among prisoners who were HIV positive, 84% reported taking prescription medication.

Jail inmates who reported having a current chronic condition were less likely than prisoners to report taking prescription medication or receiving some other type of medical treatment. About 40% of jail inmates with a current chronic condition reported that they were receiving prescription medication, and 14% reported receiving some other type of medical treatment. More than a third (39%) of jail inmates who were not taking prescription medication reported that they had not seen a doctor and 36% said the doctor did not think medication was necessary or the facility would not provide the medication. Nearly a third (31%) of jail inmates said that they did not think the medication was necessary, and 16% reported that they did not like taking the medication. Among jail inmates who were HIV positive, 66% reported taking prescription medication.

More than half of prisoners and jail inmates reported being somewhat or very satisfied with health care services received since admission

In 2011–12, 13% of prisoners were very satisfied with the health services received since admission and 44% were somewhat satisfied **(table 8)**. Among jail inmates, 14% were very satisfied with the health services received since admission and 37% were somewhat satisfied. Jail inmates (49%) were more likely than prisoners (44%) to report not being satisfied with the health care services received since admission.

Nearly half (48%) of prisoners and 43% of jail inmates reported that the health care received while incarcerated was better than or about the same as the care they received in the 12 months prior to admission.

TABLE 8

Satisfaction with health care services received by state and federal prisoners and jail inmates, 2011–12

	State and federal prisoners*		Jail inmates	
Health care services provided	Percent	Standard error	Percent	Standard error
Since admission				
Very satisfied	12.6%	0.9%	14.3%	0.8%
Somewhat satisfied	43.8	1.4	36.9**	1.4
Not at all satisfied	43.6	1.6	48.8**	1.5
Compared to those received 12 months prior to admission				
Better	12.4%	1.0%	11.0%	0.7%
About the same	35.8	1.6	32.0	1.1
Worse	51.8	1.8	57.0**	1.3

Note: The jail population was not standardized to match the prison population. Therefore, differences observed may be due to differences in prison and jail population by sex, age, race, and Hispanic origin.

*Comparison group.

**Difference with comparison group is significant at the 95%-confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

Methodology

National Inmate Survey

The 2011–12 National Inmate Survey (NIS-3) was conducted in 233 state and federal prisons, 358 local jails, and 15 special facilities (i.e., military facilities, Indian country jails, and Immigration and Customs Enforcement (ICE) facilities) between February 2011 and May 2012. Data were collected by RTI International under a cooperative agreement with the Bureau of Justice Statistics (BJS).

The NIS-3 administered two questionnaires to inmates—a survey about sexual victimization and a survey about mental and physical health, past drug and alcohol use, and treatment for substance abuse. Inmates were randomly assigned to receive one of two questionnaires to ensure that the content of the survey remained unknown to facility staff and the interviewers at the time of the interview.

A total of 106,532 inmates participated in the NIS-3, receiving either the sexual victimization survey or the randomly assigned companion survey. Combined, the surveys were administered to 43,721 inmates in state and federal prisons, 61,351 inmates in jails, 605 inmates in military facilities, 192 inmates in Indian country jails, and 663 inmates in ICE facilities.

The interviews, which averaged 35 minutes in length, used computer-assisted personal interviewing (CAPI) and audio computer-assisted self-interviewing (ACASI) data collection methods. For approximately the first 2 minutes, interviewers conducted a personal interview using CAPI to obtain background information and date of admission to the facility. For the remainder of the interview, inmates interacted with a computer-administered questionnaire using a touchscreen and synchronized audio instructions delivered via headphones. Respondents completed the ACASI portion of the interview in private, with the interviewer either leaving the room or moving away from the computer.

A shorter paper questionnaire was made available for inmates who were unable to come to the private interviewing room or interact with the computer. The paper form was completed by 751 state and federal prisoners (1.9% of all prisoner interviews) and 264 jail inmates (0.5% of all jail inmate interviews). Inmates who completed the paper form were not asked about their physical health, mental health, past drug and alcohol use, or treatment for substance abuse.

Additional information on the methodology for sample selection of facilities and inmates can be found in the report, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12* (NCJ 241399, BJS web, May 2013).

In this report, the analysis of the physical health module was restricted to adult inmates in prisons or jails. Therefore, this report excludes juvenile inmates ages 16 or 17 and inmates in military facilities, Indian country jails, or ICE facilities.

Administration of the physical health module

The physical health module was administered to participating inmates in the NIS-3 for one of two reasons—

1. to ensure the sexual victimization survey length was similar for all participating inmates
2. as part of the alternative survey on mental and physical health, past drug and alcohol use, and treatment for substance abuse.

Among inmates who received the sexual victimization survey (90% of inmates surveyed), a brief physical health module was randomly assigned to half of the inmates who participated. Among those inmates, respondents who completed the core sexual victimization survey in 33 minutes or less received the brief physical health module. Based on the time criteria, 11,671 state and federal prisoners (67% of the prisoners who would have been randomly assigned the brief physical health module) and 17,130 jail inmates (69% of the jail inmates who would have been randomly assigned the brief physical health module) completed the brief physical health module.

Among inmates who received the alternative survey on mental and physical health, past drug and alcohol use, and treatment for substance abuse (10% of inmates surveyed), the full physical health module was administered to those who completed the mental health and disabilities modules in 30 minutes or less. Of the 4,304 inmates randomized to the alternative survey, 3,833 (89%) inmates received and completed the full physical health module. Among the 6,704 jail inmates randomized to the alternative survey, 5,494 inmates (90%) received and completed the full physical health module.

The module on physical health, which was administered through ACASI, relied on inmates reporting their direct experiences. The brief physical health module asked the inmate about the types of medical services received at the time of admission and about any medical conditions (i.e., chronic diseases and infectious diseases) the inmate ever had, had at the time of admission, and had developed since admission. The full physical health module asked the same questions contained in the brief physical module, plus additional items on the types of services and treatments received by inmates with a medical condition and when those services and treatments were received. The entire ACASI questionnaire (listed as the National Inmate Survey-3) is available on the BJS website.

Nonresponse bias analysis to assess feasibility of using the 90% or 10% sample in the NIS-3

To produce reliable national-level statistics, a nonresponse bias analysis was needed to assess the feasibility of using data in the physical health module from the sexual victimization survey (90% sample) and the alternative survey (10% sample). Bias arises when subjects with characteristics associated with the outcome of interest are either overrepresented or underrepresented, resulting in the estimated prevalence of an outcome being different from the actual prevalence of the outcome. Because not everybody responded to the physical health module, it might be that respondents differ from nonrespondents in significant ways. Because the time to complete earlier modules in the survey was a major factor in determining whether the respondent was administered the physical health module, those who did not receive the physical health module may be different than those who did. The time requirements may have biased the physical health estimates, making them no longer nationally representative of all inmates.

To assess the potential bias in both the sexual victimization survey (90%) and alternative survey (10%) administered in the NIS-3, a nonresponse bias analysis was conducted for those who received the physical health module and those who did not. For the sexual victimization survey, differences in response status to the physical health module were assessed by whether or not an inmate had been sexually victimized, language of the interview (i.e., English or Spanish), whether or not an inmate reported a mental health problem and the interaction of victimization and mental health status. For the alternative survey, differences in response status to the physical health module were assessed by language of the interview (i.e., English or Spanish), whether an inmate reported a mental health problem, and the interaction of language of interview and mental health status.

Key findings from the nonresponse bias analysis for respondents to the sexual victimization survey include—

- For both prisons and jails, inmates who reported a sexual victimization were significantly less likely than inmates who did not report a sexual victimization to receive and complete the brief physical health module (p-value less than 0.0001 for prisoners and jail inmates).
- For both prisons and jails, inmates who responded to the survey in Spanish were significantly less likely than those who responded in English to receive and complete the brief physical health module (p-value less than 0.0001 for prisoners and jail inmates).
- For both prisons and jails, inmates who reported a mental health condition were significantly less likely than those who did not report a mental health condition to receive and complete the brief physical health module (p-value less than 0.0001 for prisoners and jail inmates).
- Among prisoners and jail inmates who reported a sexual victimization, inmates who reported a mental health condition were significantly less likely than inmates who did not report a mental health condition to receive and complete the brief physical health module (p-value less than 0.0001 for prisoners and jail inmates).
- Among prisoners, 1.5% (177 of 11,671 respondents) reported a sexual victimization, reported a mental health condition, and received and completed the brief physical health module.
- Among jail inmates, 1.1% (190 of 17,130 respondents) reported a sexual victimization, reported a mental health condition, and received and completed the brief physical health module.

Key findings from the nonresponse bias analysis for respondents to the alternative survey include—

- For both prisons and jails, inmates who reported a mental health condition were significantly less likely than inmates who did not report a mental health condition to receive and complete the full physical health module (p-value less than 0.0001 for prisoners and jail inmates). However, among those with a mental health condition, 92.0% of prisoners and 86.5% of jail inmates received and completed the physical health module.
- In prisons, 225 inmates (5.2% of respondents) responded to the alternative survey in Spanish.
- In jails, 321 inmates (5.3% of respondents) responded to the alternative survey in Spanish.
- Among prisoners and jail inmates who responded in Spanish, inmates who reported a mental health condition were not significantly less likely than inmates who did not report a mental health condition to receive and complete the full physical health module (p-values of 0.3989 and 0.0678 for prisoners and jail inmates).

For the alternative survey, based on the results of the nonresponse bias analyses, it was determined that a weight adjustment could properly correct for potential bias among respondents to the full physical health module. However, based on the results of the nonresponse bias analyses for the sexual victimization survey, it was determined that a weight adjustment might not fully compensate for the potential bias among those who responded to the brief physical health module. Therefore, the analyses of the physical health data were restricted to inmates who completed the alternative survey.

Weighting and nonresponse adjustments

Responses from interviewed inmates were weighted to produce national-level estimates. Each interviewed inmate was assigned an initial weight corresponding to the inverse of the probability of selection within each sampled facility. A series of adjustment factors was applied to the initial weight to minimize potential bias due to nonresponse and to provide national estimates. For the analysis of the physical health module, these adjustments were one of two types:

1. adjustments to account for survey nonresponse
2. adjustments to account for module nonresponse due to time constraints.

Methods to adjust for survey nonresponse are detailed in the report, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12* (NCJ 241399, BJS web, May 2013). Once adjusted weights were developed to account for survey nonresponse, an additional weighting adjustment was conducted to account for the potential bias induced by nonresponse due to time constraints. Bias could result if the module nonrespondents were different from the module respondents. The adjustment for module nonresponse included a calibration of the weights to ensure that the weight from a nonresponding inmate was assigned to a responding inmate with similar characteristics. Because both respondents and nonrespondents to the physical health module completed part of the alternative survey, the adjustment used data from modules that both groups completed. These data included demographic, criminal history, mental health, and interview debriefing characteristics. This adjustment ensured that the estimates accurately reflected the full sample, rather than only the inmates who responded to the physical health module. For each inmate, these adjustments were based on a generalized exponential model, developed by Folsom and Singh (2002), and applied to the sexual victimization survey respondents.[3]

The module nonresponse adjustment maintained the benchmark totals designed to make national-level estimates for the total number of inmates age 18 or older who were held in jails at midyear 2011 or in prisons at yearend 2011. These benchmark totals represented the estimated number of inmates by sex (from BJS's 2011 Annual Survey of Jails and 2011 National Prisoner Statistics). The national estimates for state prisons were 1,154,600 adult males and 83,400 adult females; for federal prisons, 190,600 adult males and 13,200 adult females; and for jails (with an average daily population of 6 or more inmates), 628,620 adult males and 91,551 adult females.

[3]Folsom, Jr., R.E. & Singh, A.C. (2000). The Generalized Exponential Model for Sampling Weight Calibration for Extreme Values, Nonresponse, and Poststratification. *Proceedings of the American Statistical Association, Survey Research Methods Section,* pp. 598–603.

Standard errors and tests of significance

As with any survey, the NIS-3 estimates are subject to error arising from sampling rather than using a complete enumeration of the population of adult inmates in prisons and jails. For each physical health outcome, the estimated sampling error varies by the size of the estimate, the number of completed interviews, and the intra-cluster correlation of the outcome within facilities.

A common way to express this sampling variability is to construct a 95% confidence interval around each survey estimate. Typically, multiplying the standard error by 1.96 and then adding or subtracting the result from the estimate produces the confidence interval. This interval expresses the range of values that could result among 95% of the different samples that could be drawn.

Chronic conditions and infectious disease in the general population

Prevalence rates of chronic conditions and infectious diseases in the general population included in this report come from the National Survey on Drug Use and Health (NSDUH). To be most comparable to the inmate population included in the NIS-3, the survey years from 2009 to 2012 of NSDUH were used in this analysis. Statistical tests comparing the prevalence of chronic conditions and infectious diseases measured in the NIS-3 and NSDUH are presented in tables 1 and 2. NSDUH collects information on six chronic conditions (i.e., high blood pressure, stroke-related problems, diabetes, heart disease, asthma, and cirrhosis of the liver) and four infectious diseases (i.e., HIV or AIDS, tuberculosis, hepatitis, and STDs).

Because the demographic makeup of the general population is different than that of the inmate population (i.e., the general population is older, more white, and more female), general population rates were standardized to the inmate population (i.e., the prison population for table 1 and the jail population for table 2) to assess the differences between comparable populations. Standardization calibrates the weights of one of the populations to the distribution of the other based on a set of specified characteristics. Standardized estimates were computed in SUDAAN using its standardization options in PROC DESCRIPT. For this analysis, the general population was standardized to inmate population based on sex, age, race, and Hispanic origin. The standardized general population estimates for disease can be interpreted as the estimate of disease among the general population, if the general population had the same sex, age, race, and Hispanic origin distribution as the prisoner and jail inmate populations.

Calculation of body mass index (BMI)

BMI is a measurement of body fat, based on height and weight, that applies to both men and women ages 18 to 65. BMI can be used to determine if a person is underweight (18.5 or less), normal weight (18.5 to 24.9), overweight (25.0 to 29.9), obese (30.0 to 39.9), or morbidly obese (40 or greater). In the NIS-3, BMI was based on the following formula provided by the Centers for Disease Control and Prevention:

BMI = weight (pounds) / (height (inches))^2 x 703.

APPENDIX TABLE 1

State and federal prisoners with HIV or AIDS, by jurisdiction, yearend 2010, 2011, and 2012

Jurisdiction	2010	2011	2012
U.S. total	20,093	19,536	18,945*
Federal	1,578	1,610	1,601
State	18,515	17,926	17,344*
Alabama	252	274	266
Alaska	/	/	/
Arizona	164	165	181
Arkansas	128	110	105
California	1,098	1,165	1,089
Colorado	181	198	201
Connecticut	301	301	249
Delaware	73	76	81
Florida	2,920	2,679	2,583
Georgia	912	903	891
Hawaii	18	21	13
Idaho	20	/	14
Illinois	487	457	/
Indiana	/	/	/
Iowa	36	37	37
Kansas	33	61	5
Kentucky	87	62	91
Louisiana	665	536	532
Maine	15	3	11
Maryland	722	572	485
Massachusetts	206	208	186
Michigan	233	428	370
Minnesota	47	50	70
Mississippi	254	255	287
Missouri	273	292	295
Montana	7	18	11
Nebraska	20	20	22
Nevada	133	123	115
New Hampshire	12	4	5
New Jersey	420	372	303
New Mexico	27	37	29
New York	3,080	3,010	2,950
North Carolina	720	692	718
North Dakota	9	1	2
Ohio	381	376	405
Oklahoma	155	137	131
Oregon	63	60	63
Pennsylvania	703	706	695
Rhode Island	47	32	35
South Carolina	412	387	328
South Dakota	11	12	11
Tennessee	219	213	226
Texas	2,394	2,320	2,200
Utah	35	24	24
Vermont	3	7	6
Virginia	306	307	279
Washington	75	71	75
West Virginia	25	18	29
Wisconsin	128	120	135
Wyoming	5	6	2

Note: Excludes inmates in jurisdictions that did not report data on HIV or AIDS.

*U.S. and state totals include an estimated number of prisoners with HIV or AIDS in Illinois.

/Not reported.

Source: Bureau of Justice Statistics, National Prisoner Statistics Program, 2010, 2011, and 2012.

APPENDIX TABLE 2

Body mass index of prisoners, by demographic characteristics, 2011–12

	Underweight		Normal		Overweight		Obese		Morbidly obese	
Demographic characteristic	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error
All inmates	0.8%	0.3%	25.6%	1.1%	45.7%	1.1%	25.5%	1.0%	2.4%	0.4%
Sex										
Male*	0.8%	0.3%	25.8%	1.1%	46.5%	1.2%	24.7%	1.0%	2.2%	0.5%
Female	1.0	0.7	21.6**	1.7	34.7**	2.2	37.2**	2.9	5.6**	1.1
Age										
18–24*	1.4%	0.6%	42.2%	3.1%	41.2%	2.7%	14.2%	2.1%	1.1%	0.8%
25–34	0.3	0.2	29.7**	2.6	47.3	2.5	20.3**	1.7	2.3	1.1
35–49	1.3	0.6	18.9**	1.5	43.6	1.6	33.3**	2.3	3.0**	0.5
50 or older	0.5	0.2	21.6**	2.5	50.7**	3.2	25.3**	2.2	1.9	0.7
Race/Hispanic origin[a]										
White	0.3%	0.1%	28.0%	1.8%	47.2%	1.8%	22.6%**	1.7%	1.9%	0.5%
Black/African American*	1.3	0.5	25.2	1.9	42.7	2.1	28.7	1.5	2.1	0.5
Hispanic/Latino	1.0	0.7	22.0	1.9	47.4	3.8	26.4	2.8	3.3	1.4
Other[b]	0.7	0.4	27.6	3.6	47.0	4.3	23.1	4.1	1.7	0.6

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

[a]Excludes persons of Hispanic or Latino origin, unless specified.

[b]Includes persons identified as American Indian or Alaska Native; Asian, Native Hawaiian, or other Pacific Islander; and two or more races.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

APPENDIX TABLE 3

Body mass index of jail inmates, by demographic characteristics, 2011–12

	Underweight		Normal		Overweight		Obese		Morbidly obese	
Demographic characteristic	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error
All inmates	1.2%	0.2%	37.2%	1.2%	39.3%	1.1%	20.0%	0.9%	2.3%	0.3%
Sex										
Male*	1.2%	0.2%	38.3%	1.3%	40.3%	1.1%	18.8%	1.0%	1.4%	0.2%
Female	1.8	0.7	29.7**	2.6	31.8**	2.7	28.6**	2.6	8.0**	2.3
Age										
18–24*	1.0%	0.4%	52.9%	2.0%	32.1%	2.1%	13.2%	1.4%	0.8%	0.2%
25–34	1.3	0.5	34.9**	1.6	42.3**	2.1	18.6**	1.6	3.0**	0.9
35–49	0.9	0.3	27.5**	2.1	41.7**	2.1	27.1**	1.9	2.9**	0.5
50 or older	3.1	1.1	33.5**	3.1	39.6	3.4	22.2**	3.4	1.6	0.6
Race/Hispanic origin[a]										
White	1.0%	0.3%	40.3%	2.0%	38.7%	2.0%	18.7%	1.7%	1.3%**	0.3%
Black/African American*	1.2	0.4	38.1	1.9	36.6	1.9	21.4	1.5	2.7	0.5
Hispanic/Latino	1.7	0.8	30.7**	2.0	44.2**	2.2	20.5	2.0	2.9	0.6
Other[b]	1.3	0.6	35.7	3.5	39.0	3.5	20.4	3.3	3.6	2.3

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

[a]Excludes persons of Hispanic or Latino origin, unless specified.

[b]Includes persons identified as American Indian or Alaska Native; Asian, Native Hawaiian, or other Pacific Islander; and two or more races.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

APPENDIX TABLE 4

HIV testing practices and consent received for state and federal prisoners during the intake process, by jurisdiction, 2012

	Testing practices							Consent obtained		
Jurisdiction	Mandatory	Opt-out	Opt-in	On assessment	On inmate request	Other	Do not provide	General	HIV test	None
Federal[a]						X			X	
Alabama	X									X
Arizona			X						X	
Arkansas	X									X
California		X							X	
Colorado	X									X
Connecticut							X	~	~	~
Delaware					X				X	
Florida			X						X	
Georgia	X									X
Hawaii			X						X	
Idaho	X									X
Indiana	X									X
Iowa		X						X		
Kansas[b]						X			X	
Kentucky				X					X	
Louisiana		X						X		
Maine				X					X	
Maryland			X					X		
Massachusetts			X						X	
Michigan		X						/	/	/
Minnesota		X						X		
Mississippi	X									X
Missouri	X									X
Montana				X				/	/	/
Nebraska		X						X		
Nevada	X									X
New Hampshire	X									X
New Jersey		X						X		
New Mexico			X						X	
New York[c]						X			X	
North Carolina		X						X		
North Dakota	X									X
Ohio	X									X
Oklahoma	X									X
Oregon[d]						X			X	
Pennsylvania		X							X	
Rhode Island			X						X	
South Carolina	X									X
South Dakota			X						X	
Tennessee		X								X
Texas	X									X
Utah	X									X
Vermont			X						X	
Virginia				X					X	
Washington		X							X	
West Virginia				X	X				X	
Wisconsin			X						X	
Wyoming	X									X

Note: Alaska and Illinois did not report data on testing practices during the intake process.

~Not applicable.

/Not reported.

[a]HIV testing was only offered to sentenced inmates.

[b]Inmates were only tested for HIV if blood exposure occurred with staff or inmate volunteers.

[c]All inmates were offered HIV testing.

[d]Inmates were only tested for HIV on court order.

Source: Bureau of Justice Statistics, National Prisoner Statistics Program, 2012.

APPENDIX TABLE 5

HIV testing practices for state and federal prisoners while in custody, by jurisdiction, 2012

Jurisdiction	Offered during routine exam	High-risk	Inmate request	Clinical indication	Court order	Involved in an incident
Federal	X	X	X	X	X	X
Alabama	X	X	X	X	X	
Arizona	X	X	X	X	X	X
Arkansas	X	X	X	X	X	X
California	X		X	X	X	X
Colorado	X	X	X	X	X	X
Connecticut		X	X	X	X	X
Delaware	X	X	X	X	X	
Florida[a]	X					
Georgia			X	X		X
Hawaii			X	X	X	
Idaho	X					
Indiana		X	X	X	X	X
Iowa			X	X	X	X
Kansas[b]	X		X	X	X	X
Kentucky	X	X	X	X	X	X
Louisiana		X	X	X	X	X
Maine		X	X	X		X
Maryland	X	X	X	X		X
Massachusetts	X		X			X
Michigan[c]						
Minnesota			X	X	X	X
Mississippi		X	X	X	X	X
Missouri			X	X	X	X
Montana						
Nebraska			X	X	X	X
Nevada			X	X	X	X
New Hampshire			X	X		X
New Jersey		X	X	X	X	X
New Mexico			X			
New York[d]	X	X	X	X	X	X
North Carolina	X		X	X	X	X
North Dakota			X	X		X
Ohio			X	X	X	X
Oklahoma			X	X		X
Oregon			X		X	
Pennsylvania			X			
Rhode Island	X	X	X	X	X	
South Carolina			X	X	X	X
South Dakota	X	X	X	X	X	X
Tennessee			X	X	X	
Texas	X		X	X	X	X
Utah		X		X	X	X
Vermont	X					
Virginia	X	X		X	X	X
Washington			X	X		X
West Virginia			X			
Wisconsin			X	X	X	X
Wyoming			X	X		

Note: Alaska and Illinois did not report data on testing practices while in custody.

[a]Inmates could be tested for HIV at any time during incarceration.

[b]All pregnant inmates were tested for HIV.

[c]Inmates were tested for HIV on request yearly and if blood exposure occurred.

[d]Testing for HIV was offered on a voluntary basis when transferring between facilities and participating in the Family Reunion Program.

Source: Bureau of Justice Statistics, National Prisoner Statistics Program, 2012.

APPENDIX TABLE 6

HIV testing practices for state and federal prisoners during discharge planning, by jurisdiction, 2012

Jurisdiction	All inmates offered	Some inmates offered	Only on inmate request	Other	Do not provide
Federal			X		
Alabama[a]				X	
Arizona			X		
Arkansas				X	
California		X			
Colorado			X		
Connecticut					X
Delaware		X			
Florida	X				
Georgia	X				
Hawaii			X		
Idaho					X
Indiana			X		
Iowa					X
Kansas			X		
Kentucky					X
Louisiana			X		
Maine			X		
Maryland[b]				X	
Massachusetts			X		
Michigan			X		
Minnesota					X
Mississippi			X		
Missouri[c]				X	
Nebraska	X				
Nevada[a]				X	
New Hampshire			X		
New Jersey			X		
New Mexico	X				
New York		X			
North Carolina			X		
North Dakota			X		
Ohio			X		
Oklahoma			X		
Oregon			X		
Pennsylvania	X				
Rhode Island					X
South Carolina			X		
South Dakota[d]				X	
Tennessee			X		
Texas[a]				X	
Utah[e]				X	
Vermont			X		
Virginia	X				
Washington			X		
West Virginia	X				
Wisconsin			X		
Wyoming			X		

Note: Alaska, Illinois, and Montana did not report data on testing practices during discharge planning.

[a]All inmates tested for HIV on discharge.

[b]Inmates were tested for HIV on request and offered HIV testing for upcoming releases.

[c]HIV testing was mandatory for all offenders not already HIV positive.

[d]All inmates were offered HIV testing at Mike Durfee State Prison. At South Dakota State Prison and South Dakota Women's Prison, inmates were only tested on inmate request.

[e]Utah State Health Department tested all inmates for HIV on day of parole.

Source: Bureau of Justice Statistics, National Prisoner Statistics Program, 2012.

APPENDIX TABLE 7

Prevalence of a current chronic condition among state and federal prisoners and jail inmates, 2011–12

	State and federal prisoners*		Jail inmates	
Current chronic condition	Percent	Standard error	Percent	Standard error
Total	41.0%	1.4%	39.8%	1.3%
Cancer	1.1	0.2	1.5	0.3
High blood pressure/hypertension	23.0	1.3	20.2	1.0
Stroke-related problems	0.9	0.2	1.0	0.2
Diabetes/high blood sugar	7.4	0.7	5.3**	0.5
Heart-related problems	5.1	0.7	6.0	0.5
Kidney-related problems	3.4	0.5	3.8	0.4
Arthritis/rheumatism	12.4	1.0	10.5	0.7
Asthma	11.9	0.8	15.6**	1.0
Cirrhosis of the liver	1.3	0.3	1.3	0.3

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

APPENDIX TABLE 8

Standard errors for table 3: Prevalence of ever having a chronic condition or infectious disease among state and federal prisoners and jail inmates, by demographic characteristics, 2011–12

	Chronic condition		Infectious disease	
Demographic characteristic	State and federal prisoners	Jail inmates	State and federal prisoners	Jail inmates
All inmates	1.5%	1.3%	1.3%	0.7%
Sex				
Male	1.6%	1.3%	1.4%	0.7%
Female	2.1	2.7	2.0	2.4
Age				
18–24	2.7%	2.0%	2.0%	1.0%
25–34	2.7	1.9	2.5	1.2
35–49	1.9	2.1	1.5	1.2
50 or older	4.3	2.5	3.1	4.2
Race/Hispanic origin				
White	2.1%	1.9%	1.8%	1.2%
Black/African American	2.9	1.7	1.5	1.4
Hispanic/Latino	2.8	2.3	3.4	1.2
Other	5.4	3.4	2.6	2.1

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

APPENDIX TABLE 9

Standard errors for figure 2: Rates of ever having a chronic condition among state and federal prisoners, 2004 and 2011–12

	State and federal prisoners	
Ever had a chronic condition	2004	2011–12
Chronic condition		
High blood pressure/hypertension	0.4%	1.2%
Diabetes/high blood sugar	0.2	0.8
Asthma	0.3	0.9
Arthritis/rheumatism	0.4	0.9
Heart-related problems	0.3	1.0

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12; and Survey of Inmates in State and Federal Correctional Facilities, 2004.

APPENDIX TABLE 10

Standard errors for figure 3: Rate of ever having a chronic condition among jail inmates, 2002 and 2011–12

	Jail inmates	
Ever had a chronic condition	2002	2011–12
Chronic condition		
High blood pressure/hypertension	0.5%	1.1%
Diabetes/high blood sugar	0.3	0.6
Asthma	0.5	1.0
Arthritis/rheumatism	0.5	0.7
Heart-related problems	0.4	0.7

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12; and Survey of Inmates in Local Jails, 2002.

APPENDIX TABLE 11

State and federal prisoners and jail inmates, by demographic characteristics, 2011–12

	State and federal prisoners*			Jail inmates		
Demographic characteristic	Number	Percent	Standard error	Number	Percent	Standard error
All inmates	1,441,800	100%	~	720,200	100%	~
Sex						
Male	1,345,200	93.3%	0.9%	628,600	87.3%**	0.9%
Female	96,600	6.7	0.9	91,600	12.7**	0.9
Race/Hispanic origin[a]						
White	427,100	29.9%	1.5%	261,800	36.7%**	1.6%
Black/African American	489,900	34.3	2.3	222,500	31.2	1.8
Hispanic/Latino	356,100	24.9	2.6	146,400	20.5	1.6
Other[b]	156,000	10.9	1.0	82,800	11.6	0.8
Age						
18–24	166,200	11.5%	0.9%	188,200	26.1%**	1.0%
25–34	471,700	32.7	1.4	255,100	35.4	1.1
35–49	559,500	38.8	1.5	210,400	29.2**	1.1
50 or older	244,500	17.0	1.0	66,500	9.2**	0.7

*Comparison group.

**Difference with comparison group is significant at the 95% confidence level.

~Not applicable.

[a]Excludes persons of Hispanic or Latino origin, unless specified.

[b]Includes persons identified as American Indian or Alaska Native; Asian, Native Hawaiian, or other Pacific Islander; and two or more races.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12.

The Bureau of Justice Statistics of the U.S. Department of Justice is the principal federal agency responsible for measuring crime, criminal victimization, criminal offenders, victims of crime, correlates of crime, and the operation of criminal and civil justice systems at the federal, state, tribal, and local levels. BJS collects, analyzes, and disseminates reliable and valid statistics on crime and justice systems in the United States, supports improvements to state and local criminal justice information systems, and participates with national and international organizations to develop and recommend national standards for justice statistics. William J. Sabol is acting director.

This report was written by Laura M. Maruschak, BJS Statistician, and Marcus Berzofsky, Dr.P.H., and Jennifer Unangst, RTI International. E. Ann Carson and Jennifer Bronson, Ph.D., BJS Statisticians, and Jennifer Unangst, RTI International, provided statistical verification and review.

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EXHIBIT J

Proposed Order

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

MICHAEL AMOS, *ET AL*. **PLAINTIFFS**

V. **Case No. 4:20-CV-007-DMB-JMV**

TOMMY TAYLOR, *ET AL*. **DEFENDANTS**

ORDER REQUIRING ACTION AT PARCHMAN TO PROTECT AGAINST COVID-19

HAVING COME before the Court, Plaintiffs, individually, and as putative representatives of the proposed class, pursuant to Rule 65 of the Federal Rules of Civil Procedure, requesting emergency measures to protect against COVID-19 at the Mississippi State Penitentiary at Parchman, Mississippi ("Parchman"), and the Court, having considered the Motion, its accompanying Memorandum, and the submissions and arguments of Defendants, finds that the Motion is well-taken and should be GRANTED.

IT IS THEREFORE ORDERED that:

a. **Immediate Testing**. Defendants immediately shall implement testing protocols for the identification and containment of COVID-19. These protocols must include the immediate testing of all inmates, Parchman employees, and all other individuals entering Parchman.

b. **Immediate Screening**. Defendants immediately shall implement protocols to screen each employee or other person entering the facility each and every day to detect individuals with fever over 100 degrees, cough, shortness of breath, recent travel to a high risk country, and/or exposure to someone who is symptomatic or under surveillance for COVID-19.

c. **Current Inmate Quarantine**. Defendants immediately shall establish non-punitive quarantine for all individuals who test positive for COVID-19, who were directly exposed to individuals who test positive for COVID-19, or who exhibit symptoms of the virus.

d. **New Inmate Quarantine.** Defendants immediately shall establish non-punitive quarantine for fourteen (14) days for all new inmates entering Parchman to ensure they are not infected before integrating them into the general population.

e. **Institutional Hygiene**. Defendants immediately shall institute protocols to clean and disinfect Parchman at least once daily including, without limitation, all common spaces, highly traveled areas, and cells.

f. **Personal Hygiene**. Defendants immediately shall declassify hand sanitizer as contraband and issue hand sanitizer with at least 60% alcohol, antibacterial soap, antibacterial wipes, and other applicable hygiene products to each inmate free of charge, and shall ensure that replacements are available upon reasonable request.

g. **Limit Contact Visitation**. Defendants shall continue to limit visitation that allows inmates to come into physical contact with visitors, but immediately must implement or increase non-contact visitation methods and opportunities such as video conferencing and/or telephone calls.

h. **Waive Copays**. Defendants immediately shall take steps to waive copays or other costs to inmates for inmate medical evaluations and care related in any way to COVID-19 and/or its symptoms.

i. **Supply Chain**. Defendants immediately shall identify the supplies and other goods and materials upon which Parchman is dependent, such as food, medical supplies, certain medicines, cleaning products, etcetera, and prepare a plan to accommodate shortages, delays or disruptions in the supply chain for these items.

Defendants shall report in writing to the Court within seven (7) days of the date of this Order to apprise the Court of: (1) their progress in implementing each of the foregoing measures; (2) the results of testing of employees and inmates at Parchman including the number of COVID-19 cases at Parchman, if any, in each group; and (3) the measures in place to: (a) quarantine inmates who have tested positive for COVID-19 or who potentially have been exposed and present a high risk for developing COVID-19; and (b) quarantine separately for fourteen (14) days inmates who are transferred to Parchman on or after the date of this Order. Defendants shall update the Court weekly regarding all of the foregoing efforts.

SO ORDERED AND ADJUDGED, this the ____ day of March 2020.

_____

UNITED STATES DISTRICT JUDGE

Prepared by:

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