UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

ANTHONY BAEZ, JONATHAN BERMUDEZ, JERMAINE GONSALVES, and DEDRICK LINDSEY on behalf of themselves and all others similarly situated; Plaintiffs-Petitioners, v. JOSEPH D. MCDONALD, JR., SHERIFF OF PLYMOUTH COUNTY, in his official capacity, ANTONE MONIZ, SUPERINTENDENT OF THE PLYMOUTH COUNTY CORRECTIONAL FACILITY, in his official capacity, and JOHN and JANE DOES, in their individual and official capacities, Defendants-Respondents.	CIVIL ACTION NO._____ **CLASS ACTION PETITION SEEKING WRIT OF HABEAS CORPUS UNDER 28 U.S.C. § 2241 AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

Plaintiffs-Petitioners Anthony Baez, Jonathan Bermudez, Jermaine Gonsalves, and Dedrick Lindsey (collectively, "Petitioners"), on behalf of themselves and a class of similarly situated federally-detained individuals currently in the custody of the Defendants-Respondents (collectively, "Respondents") at the Plymouth County Correctional Facility ("PCCF") in Plymouth, Massachusetts, by and through their undersigned counsel, hereby allege as follows:

PRELIMINARY STATEMENT

1. This case presents a request for immediate relief on behalf of a putative class of Petitioners—individuals currently being detained at PCCF in connection with criminal charges filed against them in the United States District Court for the District of Massachusetts and individuals. Because of the ongoing and unsafe conditions in which Petitioners are being held, Petitioners are at imminent risk of contracting COVID-19, the lethal virus that is sweeping the globe.

2. Over the course of the past month, Petitioners and the other class members have watched in panic as the COVID-19 epidemic has spread across the world, throughout the United States and in the Commonwealth of Massachusetts, wondering what, if anything, the Respondents would do to keep them safe. Now that the COVID-19 virus has begun entering correctional facilities in Massachusetts, the answer is clear: far too little.

3. Like the rest of society, Petitioners and the other class members have read and viewed news reports in which the President of the United States and the Governor of the Commonwealth of Massachusetts have devoted hours to imploring –and in some instances requiring – all Americans to engage in "social distancing," to avoid congregating in groups, to wash their hands and to use hand sanitizer frequently, to disinfect frequently touched surfaces, and to seek prompt medical attention if COVID-19 symptoms develop.

4. But unlike the rest of society – people who are able to, and often must, heed the directives and guidance promoted by the government relating to COVID-19 – Petitioners and the other class members cannot do so. Although they are fully aware of the serious risks posed by COVID-19 and the precautions that must be taken to protect themselves from the virus, Petitioners and the other class members are being systematically denied the opportunity to take the basic steps that are being urged by federal and local officials to protect their safety. That is because, despite knowledge of those directives—including specific and detailed guidance provided by the United States Centers for Disease Control and Prevention ("CDC") to correctional and detention facilities like the one operated by the Respondents—Respondents have failed to implement many of the basic procedures recommended by the CDC and other government officials, including steps as straightforward as requiring 6-foot social distancing among individuals within their facility, distributing sufficient hygienic products, engaging in

frequent and regular cleaning, and requiring the use of personal protective equipment (PPE). Most critically, Respondents have failed to take sufficient steps to reduce the populations of federal detainees at PCCF in order to ensure that the CDC guidance, including the 6-foot social distancing requirements, can be followed in order to adequately protect Petitioners' and other class members' health and safety.

5. Respondents' conduct, including but not limited to their failure to follow published CDC guidance and their ongoing deliberate indifference to the significant and serious health risks posed by the COVID-19 outbreak to the Plaintiffs has violated the Petitioners' and other class members' rights under the Fifth Amendment's Due Process Clause and the Eighth Amendment's protection against cruel and unusual punishment.

6. Respondents' ongoing failures to take reasonable precautions to prevent the spread of COVID-19 and to limit the severity of a potential COVID-19 outbreak at their facility gravely jeopardizes the safety of Petitioners and all of the other class members confined there.

7. Respondents are violating the due process rights of federal detainees when they "recklessly fail[] to act with reasonable care to mitigate the risk of a condition that Defendants "knew or should have known posed and excessive risk to health safety. *Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017).

8. Respondents are violating the Eighth Amendment rights of class members through their conduct and by acting with "deliberate indifference" to an "unreasonable risk of serious damages" to members of the class. *See Helling v. McKinney*, 509 U.S. 25, 33-35 (1993).

9. Because of Respondents' ongoing and systematic violation of Petitioners' and other class members' constitutional rights, Petitioners seek class-wide relief requiring Respondents to take immediate action to reduce the population at PCCF and to implement other basic policies

and procedures that would mitigate the significant and serious risk posed by COVID-19 to Petitioners' and other class members' health and safety.

PARTIES

10. Petitioner Anthony Baez is an individual currently facing criminal charges in the United States District Court for the District of Massachusetts. At all times relevant to this Complaint, Mr. Baez has been detained at PCCF, where he is at risk of death or serious injury if exposed to COVID-19. He is being held in pretrial custody and is presumed innocent.

11. Petitioner Jonathan Bermudez is an individual currently facing criminal charges in the United States District Court for the District of Massachusetts. At all times relevant to this Complaint, Mr. Bermudez has been detained at the Plymouth County Correctional Facility ("PCCF") in Plymouth, Massachusetts, where he is at risk of death or serious injury if exposed to COVID-19. Mr. Bermudez is being held in pretrial custody and is presumed innocent.

12. Petitioner Jermaine Gonsalves is an individual currently facing criminal charges in the United States District Court for the District of Massachusetts. At all times relevant to this Complaint, Mr. Gonsalves has been detained at PCCF, where he is at risk of death or serious injury if exposed to COVID-19. He is being held in pretrial custody and is presumed innocent.

13. Petitioner Dedrick Lindsey is an individual currently facing criminal charges in the United States District Court for the District of Massachusetts. At all times relevant to this Complaint, Mr. Lindsey has been detained at PCCF, where he is at risk of death or serious injury if exposed to COVID-19. He is being held in pretrial custody and is presumed innocent.

14. Respondent Joseph D. McDonald, Jr. ("McDonald") is the Sheriff for Plymouth County, Massachusetts. He has failed to adopt and failed to enforce health and safety standards at PCCF in response to the COVID-19 crisis, and those failures leave Petitioners and all those

similarly situated exposed to infection, severe illness, and death due to COVID-19. McDonald is the immediate physical custodian for the detention of Petitioners at PCCF. He is sued in his official capacity.

15. Respondent Antone Moniz ("Moniz") is the Superintendent of PCCF. He has failed to adopt and failed to enforce health and safety standards at PCCF in response to the COVID-19 crisis, and those failures leave Petitioners and all those similarly situated exposed to infection, severe illness, and death due to COVID-19. McDonald is also the immediate physical custodian for the detention of Petitioners at PCCF. He is sued in his official capacity.

16. Respondents John and Jane Does (the "Doe Defendants") are parties responsible for the custody and care of Petitioners and other similarly situated individuals who have failed to enforce health and safety standards at PCCF in response to the COVID-19 crisis, which has left Petitioners and all those similarly situated exposed to infection, severe illness, and death due to COVID-19. The Doe Defendants are sued in their individual and, as appropriate, official capacities. The total number and identities of the Doe Defendants is currently unknown to the Petitioners, who therefore sue these individuals using fictitious names. Petitioners will seek leave to amend the Complaint to state the true names of the Doe Defendants when they ascertain their identities. Petitioners will serve each Doe Defendant with process at that time.

JURISDICTION AND VENUE

17. Petitioners bring this action pursuant to 28 U.S.C. § 2241 for relief from Respondents' conduct in violation of the Fifth and Eighth Amendments to the U.S. Constitution.

18. The Court has subject matter jurisdiction over this Petition pursuant to Article I, § 9, cl. 2 of the U.S. Constitution (Suspension Clause); the Fifth and the Eighth Amendments to the U.S. Constitution; 28 U.S.C. § 1331 (federal question); 28 U.S.C. § 1651 (All Writs Act); and 28

U.S.C. § 2241 (habeas corpus). In addition, this Court has jurisdiction to grant declaratory and injunctive relief pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201.

19. Venue is proper in the District of Massachusetts pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events and omissions giving rise to these claims occurred and continue to occur in this District.

STATEMENT OF FACTS

The COVID-19 Crisis

Overview of COVID-19

20. As of 11:45 a.m. EDT on April 16, 2020, the new strain of coronavirus, COVID-19, has infected over 2,090,110 people worldwide, leading to more than 139,000 deaths.[1]

21. On March 11, 2020 the World Health Organization officially classified COVID-19 as a pandemic.[2] Current projections by the Centers for Disease Control and Prevention ("CDC") indicate that over 200 million people in the United States could be infected with COVID-19 over the course of the epidemic without effective public health intervention, with as many as 1.5 million deaths in the most severe projections.[3]

22. The mortality rate for COVID-19 worldwide is 3.4%.[3]

23. People of any age who suffer from certain underlying medical conditions, including lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis

[1] Center for Systems Science and Engineering at Johns Hopkins University, Coronavirus COVID-19 Global Cases Dashboard at https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6.

[2] WHO Characterizes COVID-19 as a Pandemic, World Health Organization (March 11, 2020) at https://bit.ly/2W8dwpS.

[3] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020

patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, and asthma, are at elevated risk from COVD-19.[4]

24. The WHO-China Joint Mission Report provides that the COVID-19 mortality rate for those with cardiovascular disease is 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.[5]

25. The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 infection than from influenza. According to recent estimates, the fatality rate of people infected with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems.[6]

26. As of April 16, 2020, there are 32,181 positive reported cases in Massachusetts.[7] To date, there have been 1,245 COVID-19 related deaths in Massachusetts. *Id.*

CDC and WHO recommendations regarding prevention and/or slowing the spread

27. There is no vaccine available to prevent COVID-19, and there is no cure for COVID-19.[8]

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[4] *Coronavirus disease (COVID-19) advice for the public: Myth buster*s, World Health Organization, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters ("Older people, and people with pre-existing medical conditions (such as asthma, diabetes, heart disease) appear to be more vulnerable to becoming severely ill with the virus.").

[5] *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization (Feb. 28, 2020), at 12, https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf (finding fatality rates for patients with COVID-19 and co-morbid conditions to be: "13.2% for those with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer").

[6] Betsy McKay, *Coronavirus vs. Flu Which Virus is Deadlier*, WALL ST. J. (Mar. 10, 2020, 12:49 PM) https://www.wsj.com/articles/coronavirus-vs-flu-which-virus-is-deadlier-11583856879.

[7] *See* COVID-19 Cases, Quarantine and Monitoring (April 16, 2020) https://www.mass.gov/info-details/covid-19-cases-quarantine-and-monitoring.

28. The Centers for Disease Control and Prevention ("CDC") has advised that the virus passes between people who are in close contact with one another (approximately six feet), through respiratory droplets produced when an infected person coughs, sneezes or talks, and by contact with surfaces.[9]

29. New data published in the New England Journal of Medicine found that the highly contagious "virus can remain viable and infectious in aerosols for hours and on surfaces up to days." COVID-19 is thought to survive for three hours in the air in droplet form that can be inhaled or transferred to surfaces, up to twenty-four hours on cardboard, up to two days on plastic, and up to three days on steel.[10]

30. The current available evidence indicates that the virus may remain on surfaces for up to three days. *See* Neeljte van Doremalen, et. al., *Aerosol and Surface Stability of SARS-CoV2 as Compared with SARS-COV-1*, New England Journal of Medicine (Mar. 17, 2020) ("SARS-CoV-2 was more stable on plastic and stainless steel than on copper and cardboard, and viable virus was detected up to 72 hours after application to these surfaces (Figure 1A)…").[11]

31. To combat transmission, the CDC has issued guidance discouraging gatherings of more than 10 people in one place.[12]

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[8] *See* Q&A on coronaviruses (COVID-19), World Health Organization (April 4, 2020) https://www.who.int/news-room/q-a-detail/q-a-coronaviruses

[9] *See* "How It Spreads," Center for Disease Control and Prevention, located at https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html.

[10] Neeltje van Doremalen, et. al, Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1, New England J. Med., (March 17, 2020), nejm.org/doi/10.1056/NEJMc2004973.

[11] Available at https://www.nejm.org/doi/10.1056/NEJMc2004973.

[12] Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission, Center for Disease Control and Prevention, 3 (Mar. 12, 2020) available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf.

32. The CDC also urges social distancing—every person should remain at a distance of at least six feet from every other person.[13]

33. Proper hygiene, including frequent cleaning of all surfaces and frequent, thorough hand washing is also recommended.[14]

The Government's Response to the COVID-19 Crisis

34. On March 13, 2020, President Donald Trump declared a national emergency to address the pandemic.[15]

35. Massachusetts Governor Charlie Baker declared a state of emergency in the Commonwealth of Massachusetts on March 10, 2020.[16]

36. To date, the pandemic has caused the Governor to issue more than 21 emergency orders.[17]

37. Those orders range from closing all elementary and secondary schools to prohibiting on-site consumption of food and beverages to restricting visitor access to nursing homes to prohibiting public gatherings of more than 10 people. *Id.*

38. On March 23, 2020, Governor Baker ordered all non-essential businesses to close. *Id.*

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[13] *See* supra note 7; see also Lisa Maragakis, "Coronavirus, Social Distancing, and Self-Quarantine," John Hopkins Univ. (last accessed March 21, 2020) https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-social-distancing-and-self-quarantine.

[14] https://www.cdc.gov/handwashing/when-how-handwashing.html

[15] Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Conference (March 13, 2020). https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-conference-3/.

[16] https://www.mass.gov/executive-orders/no-591-declaration-of-a-state-of-emergency-to-respond-to-covid-19

[17] https://www.mass.gov/info-details/covid-19-state-of-emergency.

39. Forty-two states have issued "stay at home" or "shelter in place" emergency orders prohibiting non-essential travel and assembly.[18] Three other states have "stay at home" and "shelter in place" orders in parts of the state. *Id.*

40. As of April 7, 2020, 95% of the American population is under instructions to stay at home. *Id.*

41. This Court has also issued a series of General Orders relative to coronavirus, including an Order continuing all jury trials that were scheduled to begin on or before May 29, 2020 (D. Mass. General Order 20-13) and an Order continuing all criminal hearings and deadlines for 60 days, unless there is a case-specific personal liberty or public safety interest at stake. (D. Mass. General Order 20-4).[19] Other measures recently taken by this Court in response to the COVID-19 crisis include postponing grand juries, civil mediation sessions and naturalization ceremonies, and restricting courthouse visitors.

42. Virtually all of this Court's recent Orders and precautionary measures are designed to keep people out of crowded places and to require "social distancing" to lessen the spread of the virus because it is highly contagious.

Locations particularly vulnerable to the spread of COVID-19

43. The recommended measures for mitigating the spread of COVID-19 are not readily available for incarcerated inmates or those who must interact with them.

44. Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. In prison, individuals are confined in close proximity to one another and

[18] *See Which States and Cities Have Told Residents to Stay at Home* (April 10, 2020) https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html?auth=login-email&login=email

[19] http://www.mad.uscourts.gov/caseinfo/court-orders.htm

to the staff. When people must share sleeping areas, dining halls, bathrooms, showers and other common areas, the opportunities for transmission are greater.

45. Because people — staff, residents, contractors, community members, and others — constantly cycle in and out of correctional facilities, there is an ever-present risk that new carriers will bring the virus into the facility.

46. In addition, there are reduced opportunities in jails and prisons to apply necessary hygiene measures, as those facilities are often under resourced and ill-equipped.

47. Compounding these problems, many people who are incarcerated also have chronic underlying health conditions, like asthma, diabetes, hypertension, or HIV, that place them at elevated risk for contracting serious COVID-19. Incarcerated people have poorer health than the general population, and even at the best of times, medical care is limited in federal pretrial detention centers.[20]

48. With respect to COVID-19, a prison is no different than a cruise ship[21] or a nursing home[22] – places where the virus has run rampant.

49. A prison is an environment in which the COVID-19 virus can easily gain a foothold and, when it does, it can spread rapidly jeopardizing the life and safety of prisoners.

> "[B]ehind bars, some of the most basic disease prevention measures are against the rules or simply impossible. Separating sick people from well people to prevent the disease from spreading can be nearly impossible in prison, since prisoners are already

[20] Laura M. Maruschak et al. (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. NCJ 248491. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, at https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.

[21] Center for Disease Control & Prevention, COVID-19 and Cruise Ship Travel (last accessed March 21, 2020) https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-cruise-ship.

[22] Los Angeles Times, Seattle-Area Nursing Home Deaths Jump to 13 with COVID-19 and 11 of Unknown Causes, https://www.latimes.com/world-nation/story/2020-03-07/nursing-home-coronavirus-deaths.

> grouped according to security and other logistical considerations. Even so-called social distancing can prove impossible. People in prisons and jails live every minute of the day in close proximity to each other."[23]

50. According to public health experts, incarcerated individuals "are at special risk of infection, given their living situations," and "may also be less able to participate in proactive measures to keep themselves safe;" "infection control is challenging in these settings."[24]

51. Medical professionals behind bars are sounding the alarm as well. Dr. Ross McDonald, the chief medical officer for Correctional Health Services at Rikers Island, has explained that "a storm is coming."[25]

52. In commenting on the limitations of an incarceration facility to protect individuals from the threat of COVID-19, Dr. McDonald stated, "we cannot change the fundamental nature of jail. We cannot socially distance dozens of elderly men living in a dorm, sharing a bathroom. Think of a cruise ship recklessly boarding more passengers each day. . . Please let as many out as you possibly can." *Id.*[26]

53. The "storm" that Dr. McDonald foresaw in American correctional institutions is already here. As of April 8, 2020, the Cook County Jail in Chicago, Illinois was the "largest

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[23] The Justice Collaborative, *Explainer: Prisons and Jails are Particularly Vulnerable to COVID-19 Outbreaks*, (emphasis removed) https://thejusticecollaborative.com/ wp-content/uploads/2020/03/TJCVulnerabilityofPrisonsandJailstoCOVID19 Explainer.pdf.

[24] "Achieving A Fair And Effective COVID-19 Response: An Open Letter to Vice-President Mike Pence, and Other Federal, State, and Local Leaders from Public Health and Legal Experts in the United States," (March 2, 2020), at https://bit.ly/2W9V6oS.

[25] *See* Craig McCarthy, *Top Rikers Doctor: Coronavirus 'Storm is Coming,'* N.Y. Post (Mar. 19, 2020)

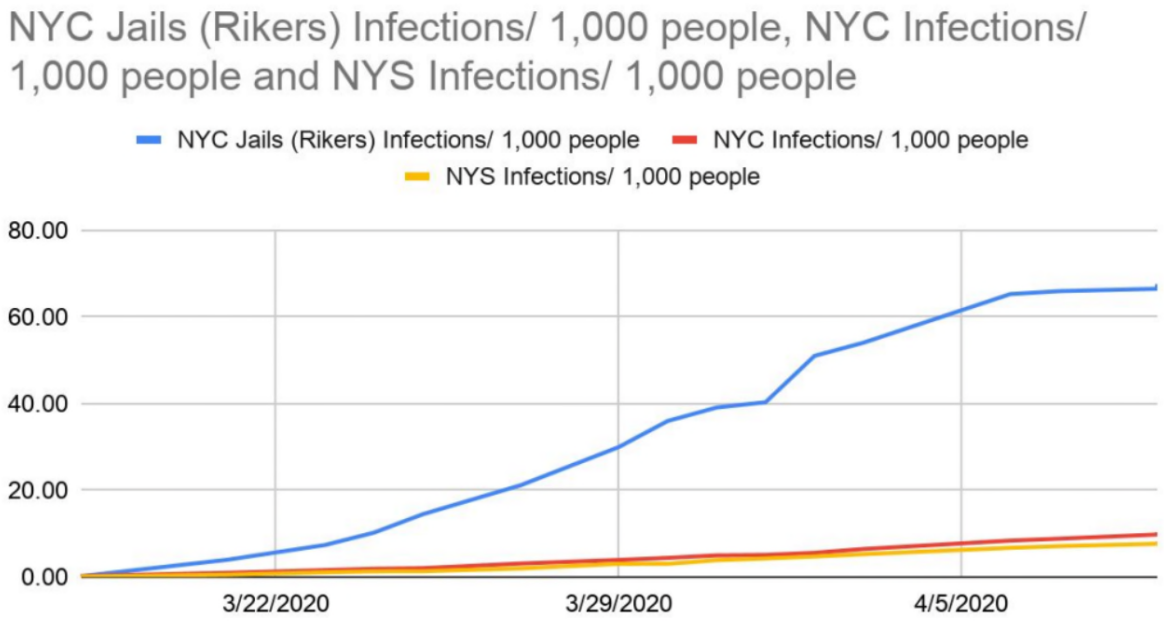
[26] *See also* Jennifer Grannerman, *A Rikers Island Doctor Speaks Out to Save Her Elderly Patients from the Cornoavirus*, The New Yorker (Mar. 20, 2020).

source" of COVID-19 infections in the United States. In that facility, 218 inmates and 115 staff members have already tested positive for COVID-19.[27]

54. In New York, statistics gathered by the Legal Aid Society demonstrate that "New York City jails have become the epicenter of COVID-19."[28] Those statistics show that the COVID-19 infection rate in New York City jails is more than *seven times greater* than in New York City in general and more than *fifty times greater* than the infection rate across the United States as a whole. *Id.*

Coronavirus Infection Rates as of April 9, 2020

Locations	Cases	Population	Infection Rate	Infections/ 1,000 people
NYC Jails (Rikers)**	288	4,263	6.76%	67.56
New York City	84,373	8,175,133	1.03%	10.32
New York State	159,937	19,440,469	0.82%	8.23
United States	462,391	331,002,651	0.14%	1.4
Hubei Province (Wuhan)	67,803	59,020,000	0.12%	1.15
China	81,865	1,439,323,776	0.01%	0.06
Lombardy, Italy	54,802	10,040,000	0.55%	5.46
Italy	143,626	60,461,826	0.24%	2.38



55. In China, officials have confirmed that the coronavirus spread at a rapid pace in Chinese prisons.[29]

56. Courts across Iran have granted 54,000 inmates furlough as part of the measures to contain coronavirus across the country.[30]

57. In the United States, steps are already being taken in some jurisdictions to facilitate the release of elderly and sick prisoners and to reduce jail populations by discouraging the admission of individuals arrested on non-violent misdemeanor charges. *See,* e.g., Zusha Elinson and Deanna Paul, *Jails Release Prisoners, Fearing Coronavirus Outbreak,* Wall Street Journal (Mar. 22, 2020). This is happening in Massachusetts as well.[31]

58. Realizing that a crisis is looming, voices in Congress have called upon the Department of Justice to "do all they can to release as many people as possible who are currently behind bars and at risk of getting sick." *See* March 19, 2020 Letter from U.S. Reps. Jerrold Nadler & Karen Bass to Attorney General William P Barr ("With large numbers of people living in close proximity to one another, many of them elderly or living with chronic diseases, DOJ must act now to save lives. Accordingly, we urge you to put in place measures to ensure that both the flow of prisoners into federal facilities is slowed significantly and that prisoners who can and should be released are released forthwith. We cannot wait any longer to take action.");[32]

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[29] Rhea Mahbubani, *Chinese Jails Have Become Hotbeds of Coronavirus As More Than 500 Cases Have Erupted, Prompting the Ouster of Several Officials*, Business Insider (Feb. 21, 2020) at https://www.businessinsider.com/500-coronavirus-cases-reported-in-jails-in-china-2020-2.

[30] *Coronavirus: Iran Temporarily frees 54,000 prisoners to combat spread,* BBC News, (Mar. 3, 2020) https://www.bbc.com/news/world-middle-east-51723398.

[31] *See Citing Risk of Coronavirus Spread, DA Rollins Seeks Release of Many Suspects From Custody*," WCVB Channel 5 (Mar. 20, 2020) available at https://www.wcvb.com/article/citing-risk-of-coronavirus-spread-da-rollins-seeks-release-of-many-suspects-from-custody/31781799#

[32] Available at https://judiciary.house.gov/uploadedfiles/2020-03-19_letter_to_ag_barr_re_covid19.pdf.

see also March 19, 2020 Letter from Senator Kamala Harris to Bureau of Prisons Director Michael Carvajal (noting that "[e]merging research has demonstrated how dangerous coronavirus is for the elderly and those with underlying conditions and compromised immune systems" and urging BOP to "tak[e] reasonable steps to reduce the incarcerated population and guard against potential exposure to coronavirus").[33]

59. Federal courts are also beginning to recognize the risk and follow suit. *See, e.g.,* United *States v. Matthaei*, ECF No. 30, Case No. 1:19-cr-243-BLW (D. Idaho Mar. 16, 2020) (extending self-surrender date by 90 days in light of COVID-19); *United States v. Barkman*, 2020 U.S. Dist. LEXIS 45628 (D. Nev. Mar. 17, 2020) (suspending intermittent confinement order because "we must take every necessary action to protect vulnerable populations and the community at large"); *In re Manrigue*, 2020 WL 1307109 (N.D. Cal. Mar. 19, 2020) ("The risk that this vulnerable person will contract COVID-19 while in jail is a special circumstance that warrants bail."); *United States v. Stephens*, 2020 WL 1295155 (S.D.N.Y. Mar. 19, 2020) (granting release based on the "unprecedented and extraordinarily dangerous nature of the COVID-19 pandemic" which places inmates, in particular, at "heightened risk"); *See also United States v. Jose Perez*, Amended Order, No. 19-cr-00297-PAE (S.D.N.Y. Mar. 19, 2020) (ECF No. 62) (ordering defendant's temporary release from custody "based on the unique confluence of

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[33] Available at https://www.harris.senate.gov/imo/media/doc/Harris%20Letter%20to%20Carvajal%20(3.19).pdf

See also March 9, 2020 letter from fifteen United States Senators to BOP Director Carvajal, available at https://www.warren.senate.gov/imo/media/doc/2020-03-09%20Senator%20Warren%20Letter%20to%20BOP%20re%20Coronavirus.pdf.

See also Mark Hallum, *Three New York Congress members tell feds to spring non-violent offenders from jail*, AMNY (Mar. 22, 2020) available at https://www.amny.com/coronavirus/three-new-york-congress-members-tell-feds-to-spring-non-violent-offenders-from-jail/.

serious health issues and other risk factors facing this defendant, including but not limited to the defendant's serious progressive lung disease and other significant health issues, which place him at a substantially heightened risk of dangerous complications should be contract COVID-19 as compared to most other individuals."); *Xochihua-James v. Barr*, No. 18-71460 (9th Cir. Mar. 23, 2020) (unpublished) (sua sponte releasing detainee from immigration detention "in light of the rapidly escalating public health crisis").

60. On March 26, 2020, Attorney General William Barr sent a memorandum to the Director of the Federal Bureau of Prisons directing the BOP to take steps to transfer inmates to home confinement where appropriate in order to decrease the risk to their health. *See* Exhibit A – Memorandum of Attorney General William Barr, dated March 26, 2020.

61. Approximately one week later, on April 3, 2020, Attorney General Barr sent a second memorandum to the Director of the BOP noting that "we are experiencing significant levels of infection at several of our facilities." The memorandum directed the BOP to "move with dispatch . . . to move vulnerable inmates out of these institutions." *See* Exhibit B – Memorandum of Attorney General William Barr, dated April 3, 2020. In that letter, Attorney General Barr issued a finding that "emergency conditions are affecting the functioning of the Bureau of Prisons." *Id.* He accordingly directed that BOP "immediately maximize appropriate transfers to home confinement of all appropriate inmates" at the affected facilities and at other similarly situated facilities. *Id.* The Attorney General explained that "[g]iven the speed with which the this disease has spread through the general public, it is clear that time is of the essence." *Id.*

62. The Attorney General's April 3, 2020, memorandum directed the immediate release of convicted defendants in response to the COVID-19 crisis. The arguments advanced by the

Attorney General in that memorandum apply with even greater force to the Petitioners, many of whom are pretrial detainees and who are entitled to the presumption of innocence.

63. On April 1, 2020, the Massachusetts Supreme Judicial Court issued a ruling recognizing the serious threat posed by COVID-19 to incarcerated individuals in the Commonwealth. *See Christie v. Commonwealth,* Case No. SJC-12927 (Mass., April 1, 2020), slip op. at 2 (holding that "the health risks to a person in custody caused by the pandemic constitute changed circumstances" that require de novo review of a lower court's earlier denial of a motion to stay the execution of a sentence). In that case, the SJC cited to the "unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff and visitors," *d.* at 5 (quoting Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (March 23, 2020), and noted that incarcerated individuals "cannot realistically maintain adequate social distancing." *Id.* at 5-6.

64. On April 3, 2020, the Massachusetts Supreme Judicial Court ("SJC") issued a broad Order addressing individuals who are detained in Massachusetts jails, houses of correction pending trial on state charges, as well as individuals who have been convicted of state offenses and are serving a sentence of incarceration in the Commonwealth.[34]

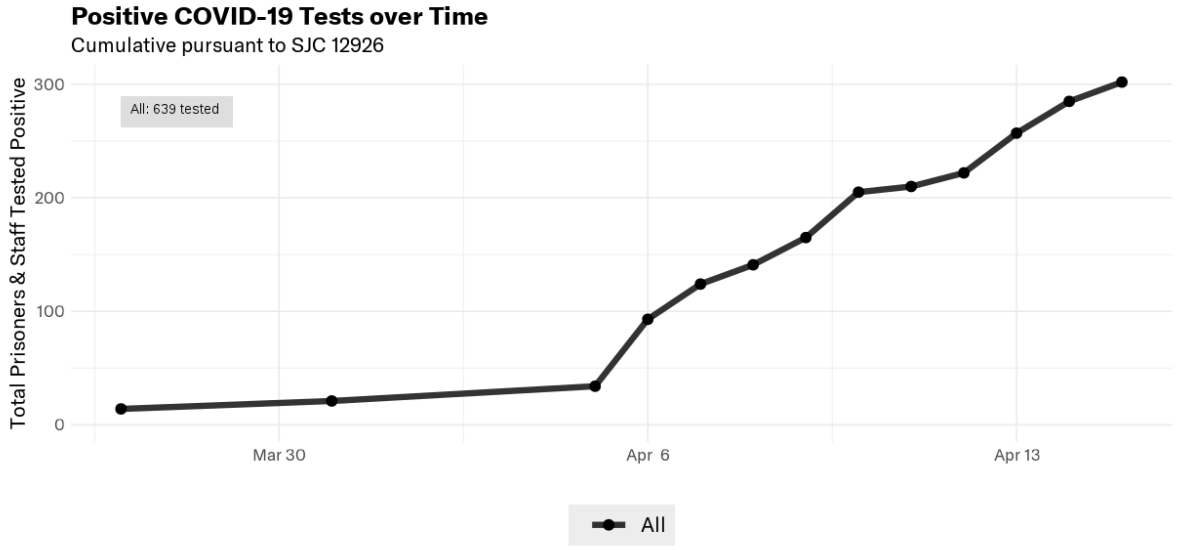
65. In its April 3, 2020, ruling, the SJC acknowledged that "correctional institutions face unique difficulties in keeping their populations safe during this pandemic." *Id.* at 9. Among many other concerns, the SJC noted that "[maintaining adequate physical distance, i.e., maintaining six feet of distance between oneself and others, may be nearly impossible in prisons and jails." *Id.* "Proper sanitation" is another problem, and SJC noted that "during recent routine

[34] *See Committee for Public Counsel Services v. Chief Justice of the Trial Court,* Massachusetts Supreme Judicial Court, Docket No. SJC-12926, Order dated April 3, 2020: https://assets.documentcloud.org/documents/6824900/12926.pdf.

inspections of Massachusetts correctional institutions (prior to the declaration of emergency), DPH inspectors discovered a concerning number of repeat environmental health violations." *Id.* at 10.

66. As of April 15, 2020, at least four incarcerated people in Massachusetts have died from COVID-19 related complications.[35]

67. At least 281 incarcerated people and staff in the Massachusetts prison and jail system have tested positive for coronavirus.[36] There has been a steady increase in confirmed positive cases in Massachusetts correctional facilities over time. *Id.*



68. As of April 14, 2020, Massachusetts has the third highest number of reported COVID-19 cases in the United States, after New York and New Jersey.[37]

[35] Coronavirus cases increase at Bridgewater prison (April 16, 2020) https://www.enterprisenews.com/news/20200413/coronavirus-cases-increase-at-bridgewater-prison

[36] *See* https://data.aclum.org/sjc-12926-tracker/

[37] *See* Tracking Covid-19 cases in the US (April 14, 2020) https://www.cnn.com/interactive/2020/health/coronavirus-us-maps-and-cases/

69. As of April 13, 2020, the Federal Bureau of Prisons ("BOP") has reported that at least 388 individuals in BOP custody have tested positive for COVID-19 and 201 BOP staff members have tested positive for COVID-19.

70. As of April 13, 2020, the BOP has reported that thirteen federal inmates have died from COVID-19.

Medical Experts Have Recommend the Immediate Reduction of Population in Detention Facilities

71. Medical experts throughout the United States and in the Commonwealth of Massachusetts have recommended that, in order to address the serious threat posed by COVID-19 to incarcerated persons, immediate steps must be taken to reduce inmate populations and to allow social distancing inside correctional institutions.

72. On April 2, 2020, Dr. Matthew J. Akiyama from the Albert Einstein College of Medicine and Montefiore Medical Center, Dr. Anne C. Spaulding from the Rollins School of Public Health at Emory University, and Dr. Josiah D. Rich from Brown University and Miriam Hospital published an article in the New England Journal of Medicine explaining that, in order to mitigate the serious impact of the COVID-19 crisis, "we need to prepare now, by 'decarcerating,' or releasing, as many people as possible."[38] They stressed the need to "consider the impact of correctional facilities in the global context" and noted that the "boundaries between communities and correctional institutions are porous, as are the borders between countries in the age of mass human travel." *Id.* They noted that "[d]espite security at nearly every nation's border, Covid-19 has appeared in practically all countries . . . [and noted that society] can't

[38] *See* Akiyama, M., Spaulding, A., Rich, J., *Flattening the Curve for Incarcerated Populations — Covid-19 in Jails and Prisons*, N Engl J Med (April 2, 2020) https://www.nejm.org/doi/full/10.1056/NEJMp2005687.

expect to find sturdier barriers between correctional institutions and their surrounding communities in any affected country." *Id.*

73. Dr. Josiah Rich, a Professor of Medicine at Brown University and the co-founder of the Center for Prisoner Health and Human Rights at The Miriam Hospital, has explained that, in light of the significant and heightened threat posed by COVID-19 to individuals in incarcerated settings, "it is imperative to scale up efforts to "decarcerate," or release, as many detainees as possible." He opines that "public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in correctional facilities during a pandemic." *See* Exhibit C – Affidavit of Josiah Rich, M.D., M.P.H.

74. Dr. Regina Celeste Larocque, an associate physician of infectious disease at Massachusetts General Hospital and an Instructor at Harvard Medical School has explained that correctional facilities like PCCF "face a very high risk of a COVID-19 outbreak." She explains that "such an outbreak would have disastrous consequences for the facility's residents and staff, and the broader community," and it therefore "is urgent that [Respondents] institute a comprehensive social distancing regimen at [PCCF] that must include elimination of shared cells if it is to be successful." *S*ee Exhibit D – Affidavit of Regina Celeste LaRocque, M.D., M.P.H.

75. Dr. Jonathan Giftos, a current professor in the Department of Medicine at Albert Einstein College of Medicine and a former Clinical Director of Substance Use Treatment for NYC Health and Hospitals, Division of Correctional Health Services at Rikers Island has recommended that "given the proximity and high numbers of inmates correctional staff and healthcare workers at pretrial detention facilities . . . it is an urgent priority to reduce the number of people in detention facilities, including PCCF, during this national public health emergency." *See* Exhibit E – Affidavit of Jonathan Giftos, M.D.

The CDC Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities

76. On March 23, 2020, the United States Centers for Disease Control and Prevention ("CDC") issued Interim Guidance on Management of Coronavirus Disease 2019 (Covid-19) in Correctional and Detention Facilities (the "Interim Guidance").[39] The Interim Guidance states that it is designed "to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff and visitors." A copy of that Interim Guidance is attached hereto as Exhibit F.

77. The Interim Guidance acknowledges that "[i]ncarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced."

78. The Interim Guidance explains that "there are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members."

79. The Interim Guidance sets forth various "Operational Preparedness" steps that it describes as "essential actions" that correctional and detention facilities should take to plan and prepare for COVID-19. Those "essential actions" include, but are not limited to:

[39] *See* Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (April 5, 2020) - https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

a. the creation and testing of "communication plans to disseminate critical information to incarcerated detained persons, staff, contractors, vendors, and visitors as the pandemic progresses:"
b. ensuring that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases;
c. for facilities without onsite health care capacity, the creation of "a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated) and provided necessary medical care;"
d. the creation of a "list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity;
e. exploring "strategies to prevent over-crowding of correctional and detention facilities during a community outbreak;" and
f. the posting of signage throughout the facility, in all appropriate languages, communicating the symptoms of COVID-19 and appropriate hand hygiene instructions.

80. With respect to "Operations and Supplies," the Interim Guidance states that all correctional and detention facilities should "ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE and medical supplies . . . are on hand and available." Such supplies include, "standard medical supplies for daily clinic needs," "tissues," "liquid soap when possible," "hand drying supplies," "[a]lcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)," "cleaning supplies," "[r]ecommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves,

and disposable gowns/one-piece coveralls)," and "sterile viral transport media and sterile swabs" for COVID-19 testing.

81. The Interim Guidance also recommends that facilities "begin implementing intensified cleaning and disinfecting procedures," including the recommendation that frequently-touched surfaces and objects (including, doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks and telephones) be cleaned several times per day.

82. With respect to "Prevention Practices for Incarcerated/Detained Persons," the Interim Guidance recommends, inter alia, that facilities "[i]mplement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms." The CDC recommends that these strategies be adopted in all common areas, during recreation and meals, during group activities, as well as in housing and medical areas.

83. With respect to sleeping areas, the CDC recommends that bunks for detainees be reassigned "to provide more space between individuals, ideally 6 feet or more in all directions."

84. With respect to hygiene, the CDC recommends that facilities "[r]einforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms)."

85. Under the current conditions at PCCF, Respondents have not and cannot reasonably implement the recommendations of the CDC Interim Guidelines without taking steps to dramatically reduce the populations at their facility. In these circumstances, release from custody

must be the primary step taken in order to protect Petitioners and the class they seek to represent from unconstitutional treatment.

Plymouth County Correctional Facility

86. Plymouth County Correctional Facility ("PCCF") is located at 26 Long Pond Road in, Plymouth, Massachusetts. PCCF is in Plymouth County where, as of April 16, 2020, there have been 2,466 confirmed positive cases of COVID-19.

87. On information and belief, there are currently more than one hundred and fifty (150) federal detainees being held at PCCF. Many of these federal detainees are awaiting trial on their charges. Other similarly situated detainees being held at PCCF have plead or have been found guilty of certain criminal charges and are awaiting sentencing.

88. There are more than eight hundred and seventy-five (875) full-time and part-time staff members who work in the Sherriff's Department in Plymouth County. On information and belief, the vast majority of these staff members work regularly on-site at PCCF. On information and belief, the hundreds of staff members working regularly at PCCF work multiple shifts per week, rotating in and out of the facility according to their assigned work schedules.

89. In response to a recent Massachusetts Supreme Judicial Court's Order, Respondent McDonald answered interrogatories related to PCCF's social distancing practices. *See* Exhibit G– McDonald's Answers to Interrogatories.

90. Approximately 49.2% of PCCF detainees sleep within six feet of one another. *Id.*

91. Approximately 56.72% of PCCF detainees eat their meals within six feet of one another. *Id.* The facility claims that detainees have multiple seating options which provide an opportunity for social distancing. *Id.*

92. Approximately 47.36% of PCCF detainees are permitted to be within six feet of one another during recreation period. The facility claims that detainees have split recreation periods, which allows for social distancing, and that officers "enforce the importance of such social distancing." *Id.*

93. Respondent McDonald has also recently disclosed information relating to certain state detainees that are in his custody at PCCF. It appears, however, that those recent disclosures do not address the conditions of confinement relating to the federal detainees at PCCF, including the Petitioners and other members of the class.

94. According to information collected in connection with the SJC litigation, as of April 16, 2020, Respondents had only conducted a total of four (4) COVID-19 tests of detainees in custody at PCCF and seventeen (17) COVID-19 tests of the hundreds of staff members who currently work at PCCF.[40]

95. Because PCCF is not regularly testing detainees or staff members for COVID-19, there is no reliable information available regarding the spread of the virus PCCF.

96. Petitioner Baez, a federal detainee being detained at PCCF, shares a cell with four other detainees. *See* Exhibit H – Affidavit of Edward P. Ryan, Jr. ¶ 4. There is one toilet in the cell that is shared by all five men. *Id.* Given the size of the cell, it is impossible for the men to maintain six feet of separation from each other during the periods when they are in the cell, including while they sleep. *Id.*

97. There are a total of approximately seventy (70) detainees in the "block" where Mr. Baez and his cellmates are being detained at Plymouth HOC. Mr. Baez and his cellmates are released from their cell for only four hours per day, during which they can go to the common

[40] *See* https://data.aclum.org/sjc-12926/tracker/ (accessed April 16, 2020).

areas of the Plymouth HOC. *Id.* ¶ 5. During those periods, approximately thirty-five (35) detainees on his "block" at the Plymouth HOC can mingle generally amongst each other. The other approximately thirty-five (35) detainees are allowed out of their cells for a different four-hour period each day. When the detainees are out of their cells, there is no effort to maintain separation of at least six feet from other detainees and staff. No "social distancing" protocols are enforced by Plymouth HOC staff in those common areas. *Id.*

98. There are two tables in the "block" that are shared by the detainees in the section of Plymouth HOC where Mr. Baez is detained. Each table has approximately eight (8) seats, and detainees regularly sit at those tables shoulder-to-shoulder. *Id.* ¶ 6.

99. Mr. Baez stated that he was recently provided with a face mask, but that he is not required to wear it at all times when he is outside of his cell. Mr. Baez has seen some Plymouth HOC staff recently wearing face masks, but the masks are not worn by all staff. Plymouth HOC staff routinely are within six feet of detainees when they interact with the detainees at the facility. *Id.* ¶ 8.

100. Petitioner Bermudez, a federal detainee being held at PCCF, is housed in the H-3 unit at PCCF. *See* Exhibit I – Affidavit of Attorney Jane Peachy, ¶ 3.

101. Petitioner Bermudez is assigned to a cell with one other person and shares a bunk bed, one toilet and one sink with his cellmate. *Id.* ¶ 4.

102. Petitioner Bermudez and other detainees in his unit are responsible for cleaning their own cells. *Id.* ¶ 5.

103. Petitioner Bermudez has had limited access to hand sanitizer; detainees are only given one bar of soap per week. *Id.* ¶¶ 6-7.

104. Petitioner Bermudez resides among 70-80 other detainees in the unit, where the detainees eat their meals at four inmates per table. *Id.* ¶ 8.

105. Petitioner Bermudez and other similarly situated PCCF detainees share nine showers among 70-80 detainees, which are cleaned a few times per week by an inmate worker. *Id.* ¶ 9.

106. Petitioner Bermudez recently suffered a medical issue that was likely the result of poor hygiene in the showers. *Id.* ¶ 10.

107. Petitioner Bermudez's cellmate recently went to the medical unit with symptoms of coronavirus. PCCF staff required Petitioner Bermudez to pack up his cellmate's property and did not give Petitioner Bermudez gloves despite the fact that his cellmate's property was likely to transmit coronavirus to Petitioner Bermudez. *Id.* ¶¶ 11-12.

108. Petitioner Bermudez and other similarly situated PCCF detainees have not been given information regarding the spread of the virus at PCCF. *Id.* ¶ 10.

109. Petitioner Gonsalves, a federal detainee being held at PCCF, is housed in a cell at PCCF with one other individual. *See* Exhibit J – Affidavit of Keith Halpern, Esq., ¶ 1-2. There is one bunk unit in the cell. The bunk has two beds, one stacked on top of the other. The beds are less than six feet apart. It is not possible for Petitioner Gonsalves and his cellmate to maintain a distance of six feet between themselves while they are in their cell together. *Id.* ¶4.

110. There has been no change in meal conditions for Petitioner Gonsalves and other similarly situated federal detainees at PCCF in response to the COVID-19 pandemic. The number of inmates eating together has not changed. Inmates eat at rectangular tables that seats six, in a room with a number of similar tables. There is no effort to maintain a distance of six feet between inmates. Rather, inmates are seated immediately next to one another at the tables, with other inmates seated across the table, all within a distance of six feet. *Id.* ¶ 5.

111. Petitioner Gonsalves has observed less than half of the correctional officers wearing masks. There has been no change in the manner in which correctional officers interact with Petitioner Gonsalves and other similarly situated federal detainees at PCCF, and no effort to maintain greater physical distance between correctional officers and inmates. Correctional officers are routinely within six feet of inmates. *Id.* ¶ 6.

112. Petitioner Gonsalves and other similarly situated federal detainees have no access to liquid soap or hand sanitizer. Inmates are provided with one small bar of soap each week. There has been no change in soap access due to the pandemic. *Id.* ¶ 7.

113. Prior to the pandemic, PCCF inmates received two rolls of toilet paper each week. Since the pandemic began, Petitioner Gonsalves and other similarly situated federal detainees at PCCF are receiving one roll of toilet paper per week. *Id.* ¶ 8.

114. Petitioner Gonsalves has observed PCCF to be a dirty environment, and there have been no visible efforts to improve cleanliness as a result of the pandemic. PCCF is as dirty as it was before the pandemic. *Id.* ¶ 9.

115. Petitioner Gonsalves has learned that a special unit, C-1, had been set up for the quarantine of inmates with symptoms suggesting COVID-19. Petitioner Gonsalves stated that inmates were reluctant to report feeling unwell because they feared being moved into the quarantine unit and being surrounded by sick inmates. *Id.* ¶ 10.

116. Petitioner Gonsalves has not observed any efforts being made at PCCF keep inmates at least 6’ apart, or to keep inmates and correctional officers at least six feet apart. *Id.* ¶ 11.

117. Petitioner Gonsalves has not observed any changes to inmates’ recreation at PCCF. Inmates have four hours of recreation per day. At recreation, inmates are able to work out, play

basketball, and engage in other activities without regard to how far apart they are from one another, and that inmates are routinely within six feet of one another. *Id.* ¶ 12.

118. Petitioner Dedrick Lindsey, who is a federal detainee being held at PCCF, currently being held in a dorm unit. *See* Exhibit K – Affidavit of Attorney Jessica Thrall. This is a setting where 6-8 individuals share a living quarters. *Id.* ¶ 4. Their beds are next to one another. *Id.* Mr. Lindsey is currently sleeping on the bottom bunk. *Id.* There is no one above him at this time, but there is someone next to him on the same level. *Id.* The beds are not 6 feet apart. *Id.*

119. Mr. Lindsey stated that the individuals living in this dorm also share meals together. *Id.* ¶ 5. There are several tables for the men to eat at, but they cannot eat at a table alone as there are not enough tables for everyone. *Id.* In order to sit at these tables and eat, they must be closer than 6 feet apart. *Id.* At any given time, additional people could be added to the dorm setting. *Id.* at ¶6.

120. Mr. Lindsey is permitted to go outdoors for recreation time. *Id.* However, this "rec time" is shared with people from other dorms or units. *Id.* Mr. Lindsey chooses not to go outdoors at "rec time" as he will then have to interact with more people than the individuals in his dorm. *Id.*

121. Mr. Lindsey reports that the detainees were recently given masks. *Id.* ¶ 8. The guards use masks and gloves with variable frequency depending on who is working that shift. *Id.*

122. Within the dorm unit, there is a spray bottle of sanitizer that the people on the dorm are allowed to utilize. *Id.* ¶ 9. As of April 16, 2020, a hand sanitizer bottle was put in the dorm unit. Previously there had been no hand sanitizer. *Id.* ¶10.

123. Mr. Lindsey is fearful for his health and is concerned because he cannot control who he shares space with. *Id.* ¶ 11.

124. Samuel Baptista, a federal detainee being held at PCCF, is currently being housed in a segregated unit at PCCF. *See* Exhibit L – Affidavit of Attorney Timothy Watkins. Mr. Baptista explained that he and other detainees were previously housed in an open-cell dormitory-style unit, where detainees sleep three feet from each other. *Id.* Mr. Baptista has not observed any changes made within that unit regarding increased social distancing or hygiene after the COVID-19 pandemic began.

125. Mr. Baptista has explained that the correctional officers at PCCF do not maintain six feet of distance from him or between themselves. *Id.* ¶ 4. He has explained that he was recently provided with a paper mask and told to wear it "when he thinks he should wear it." *Id.* ¶ 5. The correctional officers at PCCF do not consistently wear masks or gloves in the facility. *Id.* ¶ 7.

126. Mr. Baptista has explained that PCCF is "extremely dirty." *Id.* ¶ 11. He has not observed any effort to clean the facility or to enforce social distancing at the facility in response to the COVID-19 pandemic. *Id.*

127. Mr. Baptista and other PCCF detainees are not given hand sanitizer and are only given one bar of soap per week. *Id.* ¶ 8.

LEGAL ALLEGATIONS

128. Section 2241(c)(3) of Title 28 of the United States Code authorizes courts to grant habeas corpus relief where a person is "in custody in violation of the Constitution or other laws or treaties of the United States."

129. Respondents are violating Petitioners' Fifth and Eighth Amendment rights by continuing to incarcerate them in conditions where it is virtually impossible to take steps to prevent transmission of an infectious disease that will prove deadly because of the nature of the infectious disease.

130. Pretrial detainees are presumed innocent and must not be punished with likely exposure to COVID-19 due to their incarcerated status. *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979) ("Due process requires that a pretrial detainee not be punished.")

131. All federal detainees being held at the facility operated by Respondents are entitled to be protected from condition of confinement that create a serious risk to health or safety, including through release from custody when necessary. *Brown v. Plata*, 563 U.S. 493, 531-32 (2011) (upholding lower court's order releasing people from state prison even though release was based on prospect of future harm caused by prison overcrowding); *see also Farmer v. Brennan*, 511 U.S. 825, 834 (correctional official violates Eighth Amendment by consciously failing to prevent "a substantial risk of serious harm"); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) ("deliberate indifference" to serious medical needs violate the Eighth Amendment). The risk of exposure to a deadly infectious disease such as COVID-19 constitutes a serious risk to health. *Helling v. McKinney*, 509 U.S. 25, 34 (1993) (noting with approval Eighth Amendment claims based on exposure to serious contagious diseases). Under the current conditions at PCCF, Respondents have not and cannot protect Petitioners and the class from this risk of serious harm. In these circumstances, release is the only means of protecting Petitioners and the class they seek to represent from unconstitutional treatment.

132. Government officials act with deliberate indifference when they "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year," even when "the complaining inmate shows no serious current symptoms." *Helling*, 509 U.S. at 33. This Court need not "await a tragic event" to find that Respondents are maintaining unconstitutional conditions of confinement. *Id.*

133. The reach of the Fifth and Eighth Amendments includes "exposure of inmates to a serious, communicable disease." *Helling*, 509 U.S. at 33.

134. In this case, as established by the facts above, Petitioners and the other class members face a significant risk of exposure to coronavirus, with the attendant risk of death that follows given the current conditions of confinement at PCCF. Respondents are well aware of this risk, having been alerted to it by the CDC, the Attorney General, the Massachusetts Supreme Judicial Court, and advocates such as the Federal Defender Office for the District of Massachusetts.

135. Additionally, in recent weeks, courts in other jurisdictions such as the Second Circuit Court of Appeals, unprompted, acknowledged the "grave and enduring" risk posed by COVID-19 in the correctional context. *Fed. Defs. of New York, Inc. v. Fed. Bureau of Prisons*, No. 19-1778, __ F.3d __, 2020 WL 1320886, at *12 (2d Cir. Mar. 20, 2020); see also *Jovel v. Decker*, No. 20 Civ. 308, 2020 WL 1467397, at *1 (S.D.N.Y. Mar. 26, 2020) (finding "extraordinary circumstances" of COVID-19 pandemic justified release of immigration detainee from federal detention); *United States v. Little*, No. 20 Cr. 57, 2020 WL 1439979, at *4 (S.D.N.Y. Mar. 24, 2020) ("As additional people are arrested who have been out in the community as the coronavirus spreads, if they are not symptomatic, they will be brought into the MCC and MDC, and held with the existing population, potentially bringing COVID-19 into this population held in large numbers, close quarters, and low sanitary conditions.").

136. Finally, as established above, Respondents have not taken steps sufficient to protect Petitioners and the other members of the class from the grave risks that are present every moment they are in detention at PCCF. Respondents are not capable of managing the risk to Petitioners and the other members of the class in the current environments at PCCF. Whether

judged under the Fifth or Eighth Amendment, Respondents are holding Petitioners in violation of the Constitution by detaining them in the face of significant threats to their health and safety without taking sufficient steps to prevent that harm.

CLASS ACTION ALLEGATIONS

137. Petitioners bring this representative habeas action pursuant to 28 U.S.C. § 2241 and, alternatively, as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on their own behalf and on behalf of all persons similarly situated.

138. Petitioners seek to represent a class consisting of all current and future federal detainees being held at PCCF during the course of the COVID-19 pandemic, including detainees being held prior to trial and detainees who have plead or been found guilty of certain offenses, but have not yet been sentenced (the "Class").

139. The members of the Class are too numerous to be joined in one action, and their joinder is impracticable. Upon information and belief, the Class exceeds one hundred and fifty (150) individuals.

140. Common questions of law and fact exist as to all Class members and predominate over questions that affect only the individual members. These common questions of fact and law include but are not limited to: (1) whether the conditions of confinement described in this Petition amounts to Constitutional violations; (2) what measures Respondents took in response to the COVID-19 Crisis; (3) whether Respondents implemented an adequate emergency plan during the COVID-19 Crisis; (4) whether Respondents' practices during the COVID-19 Crisis exposed federal detainees in PCCF to a substantial risk of serious harm; (5) whether the Respondents knew of and disregarded a substantial risk of serious harm to the safety and health

of the Class; and (7) what relief should be awarded to redress the harms threatened to members of the Class as a result of the conditions.

141. Absent class certification, federal detainees in Respondents' custody during the COVID-19 pandemic would face a series of barriers in accessing the relief sought. Under the current circumstances, federal detainees have limited access to communication with the outside world, impeding their ability to obtain legal representation and pursue litigation. A large portion of the Class has limited educational backgrounds. And a significant percentage of the Class members suffer from physical or mental impairments.

142. Respondents' practices and the claims alleged in this Petition are common to all members of the Class.

143. The claims of Petitioners are typical of those of the Class. Petitioners are threatened with imminent inhumane conditions of confinement at the facility operated by Respondents.

144. The legal theories on which Petitioners rely are the same or similar to those on which all Class members would rely, and the harms suffered by them are typical of those suffered by all the other Class members.

145. Petitioners will fairly and adequately protect the interests of the Class. The interests of the Class representatives are consistent with those of the Class members. In addition, counsel for Petitioners are experienced in class action litigation.

146. Counsel for Petitioners know of no conflicts of interest among Class members or between the attorneys and Class members that would affect this litigation.

147. Use of the class action mechanism here is superior to other available methods for the fair and efficient adjudication of the claims and will prevent the imposition of undue financial,

administrative, and procedural burdens on the parties and on this Court, which individual litigation of these claims would impose.

148. This class action is superior to any other method for the fair and efficient adjudication of this legal dispute, as joinder of all Class members is impracticable.

149. There will be no extraordinary difficulty in the management of this class action.

CAUSES OF ACTION

FIRST CAUSE OF ACTION – VIOLATION OF FIFTH AMENDMENT
(Declaratory and Injunctive Relief)

150. Petitioners incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

151. Petitioners bring this claim on their own behalf and on behalf of the Class.

152. The Due Process Clauses guarantees pretrial detainees the right to be detained in a safe situation, free from punitive conditions of confinement. *See* U.S. Const. Amend V. The government violates that guarantee where a widespread outbreak of a contagious disease subjects detainees to inhumane conditions without adequate protection.

153. Respondents are violating Plaintiffs' and proposed class members' Fifth Amendment rights because "the challenged governmental action is not rationally related to a legitimate governmental objective or that it is excessive in relation to that purpose." *Kingsley v. Hendrickson*, 576 U.S. 389, 135 S. Ct. 2466, 2473–74 (2015).

154. Because of the conditions at PCCF, Petitioners and all others similarly situated are not able to take steps to protect themselves—such as social distancing, employing routine hygienic practices, using hand sanitizer, or washing their hands regularly—and Respondents have not provided adequate protections. If COVID-19 rapidly spreads at the PCCF, the already

deplorable conditions there will be exacerbated, and the ability to protect oneself will become even more impossible.

155. Respondents' failure to adequately protect Petitioners from these punitive conditions, or release them from the conditions altogether, constitutes an egregious violation of Petitioners' due process rights and deliberate indifference to the serious medical needs of Petitioners, and all members of the Class.

156. Respondents are aware or should have been aware of these conditions, which are open and obvious throughout the faclility.

157. Upon information and belief, Respondents have received the CDC's Interim Guidance on Management of Coronavirus Disease 2019.

158. Respondents know of and have disregarded excessive risks to the health and safety of Petitioners and the other members of the Class.

159. Respondents have failed to act with reasonable care to mitigate these risks.

160. Respondents have acted with deliberate indifference towards Petitioners and all others similarly situated by failing to safeguard their health and safety adequately.

161. Because Respondents have failed to act to remedy Petitioners' and the Class's degrading and inhuman conditions of confinement in violation of their Fifth Amendment rights, Petitioners seek relief under this Writ of Habeas Corpus.

162. Because of the unlawful conduct of Respondent, Petitioners and the Class are threatened with imminent physical injury, pain and suffering, emotional distress, humiliation, and death.

SECOND CAUSE OF ACTION – VIOLATION OF EIGHTH AMENDMENT
(Declaratory and Injunctive Relief)

163. Petitioners incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

164. Petitioners bring this claim on their own behalf and on behalf of the Class.

165. The Eighth Amendment to the United States Constitution protects Petitioners and proposed class members from cruel and unusual punishment.

166. To amount to the infliction of cruel and unusual punishment (1) jail or prison conditions must pose "an unreasonable risk of serious damage" to a prisoner's health (an objective test) and (2) prison officials must have acted with deliberate indifference to the risk posed (a subjective test). *Helling*, 509 U.S. at 33–35.

167. Petitioners and proposed class members are subject to a risk of harm that today's society does not tolerate.

168. Society does not tolerate the risk of exposure to COVID-19 to which Respondents' policies and procedures (or lack thereof) have subjected Petitioners and proposed class members.

169. Indeed, the CDC, the World Health Organization and several government officials have warned against the dangers of the very behaviors in which Petitioners and proposed class members are required daily to engage as a direct result of Respondents' policies and procedures (or lack thereof). Because of the conditions at the facility operated by Respondents, Petitioners and all others similarly situated are not able to take steps to protect themselves—such as social distancing, using hand sanitizer, or washing their hands regularly—and Respondents have not provided adequate protections. If COVID-19 rapidly spreads at the facility operated by

Respondents, as experts predict, the already deplorable conditions at that facility will be exacerbated, and the ability to protect oneself will become even more impossible.

170. Petitioners and proposed class members suffer a substantial risk of serious harm to their health and safety due to the presence of, and spread of, COVID-19.

171. Respondents' failure to adequately protect Petitioners from these punitive conditions, or release them from the conditions altogether, constitutes an egregious violation of Petitioners' due process rights and deliberate indifference to the serious medical needs of Petitioners, and all members of the Class, thereby establishing a violation of the Eighth Amendment of the United States Constitution.

172. Respondents are aware or should have been aware of these conditions, which are open and obvious throughout the entire jail.

173. Upon information and belief, Respondents have received the CDC's Interim Guidance on Management of Coronavirus Disease 2019.

174. Respondents know of and have disregarded an excessive risk to health and safety.

175. Respondents have failed to act with reasonable care to mitigate these risks.

176. Respondents have acted with deliberate indifference towards Petitioners and all others similarly situated by failing to safeguard their health and safety adequately.

177. Because Respondents have failed to act to remedy Petitioners' and the Class's degrading and inhuman conditions of confinement in violation of their Eighth Amendment rights, Petitioners seek relief under this Writ of Habeas Corpus.

178. Because of the unlawful conduct of Respondent, Petitioners and the Class are threatened with imminent physical injury, pain and suffering, emotional distress, humiliation, and death.

PRAYER FOR RELIEF

WHEREFORE, Petitioners and the Class members respectfully request that the Court enter a class-wide judgment:

A. Certify the proposed Class;

B. Enter a temporary restraining order, preliminary injunction, and permanent injunction and/or writs of habeas corpus requiring the following:

1. Require Respondents to immediately take all actions to reduce the federal detainee population at PCCF by releasing a sufficient number of federal detainees from the facility in order to ensure the health and safety of all members of the Class;

2. Appoint an expert under Federal Rule of Evidence 706 to make recommendations to the Court regarding how many and which class members to order released so as to ensure that the number of prisoners remaining at PCCF can be housed consistently with CDC guidance on best practices to prevent the spread of COVID-19, including the requirement that prisoners be able to maintain six feet of space between them and further order that such recommendations take into account CDC guidance concerning health factors that put individuals at elevated risk of death from COVID-19;

3. Allow that expert to enter PCCF unannounced in order to assess the facility's compliance with the guidance noted in Paragraph 2 and bring with them cameras, cell phones, writing implements, and any other equipment required to conduct their site visits. Once in the facility, permit the expert to inspect areas of the facility without limitation and speak with staff and residents in confidence and outside of the presence of the facility's supervisors and staff;

4. Ensure that each member of the Class receives an individual supply of hand soap, sufficient to allow frequent hand washing; paper towels; toilet paper; running water; and facial tissue;
5. Ensure that all members of the Class, when not in cells with access to hand soap and running water, have access to hand sanitizer containing at least 60% alcohol;
6. Require that all staff at PCCF wear personal protective equipment, including masks and gloves when interacting with visitors and residents and members of the Class or when touching surfaces in common areas;
7. Direct Respondents to clean and disinfect all frequently touched surfaces at PCCF with disinfectant products effective against the virus that causes COVID-19 (at the manufacturer's recommended concentration), as well as surfaces in common areas, every two hours during waking hours, and at least once during the night;
8. Order Respondents to provide a status report to this Court, twice weekly in writing, concerning the incidence of infection of COVID-19 at PCCF and the measures undertaken to mitigate the spread of COVID-19 at PCCF. The status report shall include the following information:
    A. The total number of federal detainees at PCCF that day (divided by United States Marshals Service and Immigration and Customs Enforcement detainees);
    B. The number of detainees, including federal detainees, tested for COVID-19 and the number testing positive (numbers should be cumulative);

C. The number of staff tested for COVID-19 and the number testing positive (numbers should be cumulative);

D. All efforts undertaken to mitigate the spread of COVID-19 both generally, and in response to any symptomatic inmate(s) and staff member(s) and/or positive test(s);

E. Protocols for screening and testing all detainees, staff, and others entering or leaving the facility.

9. Appoint an independent monitor with medical expertise to ensure compliance with these conditions, and provide the monitor with unfettered access to medical units, confidential communication with detained individuals in and out of quarantine, and surveillance video of public areas of the facility; and

10. Award such further relief as this Court deems appropriate.

Respectfully submitted,

ANTHONY BAEZ, JONATHAN BERMUDEZ, JERMAINE GONSALVES, and DEDRICK LINDSEY on behalf of themselves and all others similarly situated,

By their attorneys,

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Dated: April 17, 2020

EXHIBIT A

Office of the Attorney General
Washington, D. C. 20530

March 26, 2020

MEMORANDUM FOR DIRECTOR OF BUREAU PRISONS

FROM: THE ATTORNEY GENERAL

SUBJECT: Prioritization of Home Confinement As Appropriate in Response to COVID-19 Pandemic

Thank you for your tremendous service to our nation during the present crisis. The current situation is challenging for us all, but I have great confidence in the ability of the Bureau of Prisons (BOP) to perform its critical mission during these difficult times. We have some of the best-run prisons in the world and I am confident in our ability to keep inmates in our prisons as safe as possible from the pandemic currently sweeping across the globe. At the same time, there are some at-risk inmates who are non-violent and pose minimal likelihood of recidivism and who might be safer serving their sentences in home confinement rather than in BOP facilities. I am issuing this Memorandum to ensure that we utilize home confinement, where appropriate, to protect the health and safety of BOP personnel and the people in our custody.

I. TRANSFER OF INMATES TO HOME CONFINEMENT WHERE APPROPRIATE TO DECREASE THE RISKS TO THEIR HEALTH

One of BOP's tools to manage the prison population and keep inmates safe is the ability to grant certain eligible prisoners home confinement in certain circumstances. I am hereby directing you to prioritize the use of your various statutory authorities to grant home confinement for inmates seeking transfer in connection with the ongoing COVID-19 pandemic. Many inmates will be safer in BOP facilities where the population is controlled and there is ready access to doctors and medical care. But for some eligible inmates, home confinement might be more effective in protecting their health.

In assessing which inmates should be granted home confinement pursuant to this Memorandum, you are to consider the totality of circumstances for each individual inmate, the statutory requirements for home confinement, and the following non-exhaustive list of discretionary factors:

- The age and vulnerability of the inmate to COVID-19, in accordance with the Centers for Disease Control and Prevention (CDC) guidelines;

GOVERNMENT EXHIBIT 2

- The security level of the facility currently holding the inmate, with priority given to inmates residing in low and minimum security facilities;

- The inmate's conduct in prison, with inmates who have engaged in violent or gang-related activity in prison or who have incurred a BOP violation within the last year not receiving priority treatment under this Memorandum;

- The inmate's score under PATTERN, with inmates who have anything above a minimum score not receiving priority treatment under this Memorandum;

- Whether the inmate has a demonstrated and verifiable re-entry plan that will prevent recidivism and maximize public safety, including verification that the conditions under which the inmate would be confined upon release would present a lower risk of contracting COVID-19 than the inmate would face in his or her BOP facility;

- The inmate's crime of conviction, and assessment of the danger posed by the inmate to the community. Some offenses, such as sex offenses, will render an inmate ineligible for home detention. Other serious offenses should weigh more heavily against consideration for home detention.

In addition to considering these factors, before granting any inmate discretionary release, the BOP Medical Director, or someone he designates, will, based on CDC guidance, make an assessment of the inmate's risk factors for severe COVID-19 illness, risks of COVID-19 at the inmate's prison facility, as well as the risks of COVID-19 at the location in which the inmate seeks home confinement. We should not grant home confinement to inmates when doing so is likely to increase their risk of contracting COVID-19. You should grant home confinement only when BOP has determined—based on the totality of the circumstances for each individual inmate—that transfer to home confinement is likely not to increase the inmate's risk of contracting COVID-19.

II. PROTECTING THE PUBLIC

While we have an obligation to protect BOP personnel and the people in BOP custody, we also have an obligation to protect the public. That means we cannot take any risk of transferring inmates to home confinement that will contribute to the spread of COVID-19, or put the public at risk in other ways. I am therefore directing you to place any inmate to whom you grant home confinement in a mandatory 14-day quarantine period before that inmate is discharged from a BOP facility to home confinement. Inmates transferred to home confinement under this prioritized process should also be subject to location monitoring services and, where a court order is entered, be subject to supervised release.

We must do the best we can to minimize the risk of COVID-19 to those in our custody, while also minimizing the risk to the public. I thank you for your service to the country and assistance in implementing this Memorandum.

EXHIBIT B

Office of the Attorney General
Washington, D. C. 20530

April 3, 2020

MEMORANDUM FOR DIRECTOR OF BUREAU OF PRISONS

FROM: THE ATTORNEY GENERAL

SUBJECT: Increasing Use of Home Confinement at Institutions Most Affected by COVID-19

The mission of BOP is to administer the lawful punishments that our justice system imposes. Executing that mission imposes on us a profound obligation to protect the health and safety of all inmates.

Last week, I directed the Bureau of Prisons to prioritize the use of home confinement as a tool for combatting the dangers that COVID-19 poses to our vulnerable inmates, while ensuring we successfully discharge our duty to protect the public. I applaud the substantial steps you have already taken on that front with respect to the vulnerable inmates who qualified for home confinement under the pre-CARES Act standards.

As you know, we are experiencing significant levels of infection at several of our facilities, including FCI Oakdale, FCI Danbury, and FCI Elkton. We have to move with dispatch in using home confinement, where appropriate, to move vulnerable inmates out of these institutions. I would like you to give priority to these institutions, and others similarly affected, as you continue to process the remaining inmates who are eligible for home confinement under pre-CARES Act standards. In addition, the CARES Act now authorizes me to expand the cohort of inmates who can be considered for home release upon my finding that emergency conditions are materially affecting the functioning of the Bureau of Prisons. I hereby make that finding and direct that, as detailed below, you give priority in implementing these new standards to the most vulnerable inmates at the most affected facilities, consistent with the guidance below.

I. IMMEDIATELY MAXIMIZE APPROPRIATE TRANSFERS TO HOME CONFINEMENT OF ALL APPROPRIATE INMATES HELD AT FCI OAKDALE, FCI DANBURY, FCI ELKTON, AND AT OTHER SIMILARLY SITUATED BOP FACILITIES WHERE COVID-19 IS MATERIALLY AFFECTING OPERATIONS

GOVERNMENT EXHIBIT 3

While BOP has taken extensive precautions to prevent COVID-19 from entering its facilities and infecting our inmates, those precautions, like any precautions, have not been perfectly successful at all institutions. I am therefore directing you to immediately review all inmates who have COVID-19 risk factors, as established by the CDC, starting with the inmates incarcerated at FCI Oakdale, FCI Danbury, FCI Elkton, and similarly situated facilities where you determine that COVID-19 is materially affecting operations. You should begin implementing this directive immediately at the facilities I have specifically identified and any other facilities facing similarly serious problems. And now that I have exercised my authority under the CARES Act, your review should include all at-risk inmates—not only those who were previously eligible for transfer.

For all inmates whom you deem suitable candidates for home confinement, you are directed to immediately process them for transfer and then immediately transfer them following a 14-day quarantine at an appropriate BOP facility, or, in appropriate cases subject to your case-by-case discretion, in the residence to which the inmate is being transferred. It is vital that we not inadvertently contribute to the spread of COVID-19 by transferring inmates from our facilities. Your assessment of these inmates should thus be guided by the factors in my March 26 Memorandum, understanding, though, that inmates with a suitable confinement plan will generally be appropriate candidates for home confinement rather than continued detention at institutions in which COVID-19 is materially affecting their operations.

I also recognize that BOP has limited resources to monitor inmates on home confinement and that the U.S. Probation Office is unable to monitor large numbers of inmates in the community. I therefore authorize BOP to transfer inmates to home confinement even if electronic monitoring is not available, so long as BOP determines in every such instance that doing so is appropriate and consistent with our obligation to protect public safety.

Given the speed with which this disease has spread through the general public, it is clear that time is of the essence. Please implement this Memorandum as quickly as possible and keep me closely apprised of your progress.

II. PROTECTING THE PUBLIC

While we have a solemn obligation to protect the people in BOP custody, we also have an obligation to protect the public. That means we cannot simply release prison populations en masse onto the streets. Doing so would pose profound risks to the public from released prisoners engaging in additional criminal activity, potentially including violence or heinous sex offenses.

That risk is particularly acute as we combat the current pandemic. Police forces are facing the same daunting challenges in protecting the public that we face in protecting our inmates. It is impossible to engage in social distancing, hand washing, and other recommend steps in the middle of arresting a violent criminal. It is thus no surprise that many of our police officers have fallen ill with COVID-19, with some even dying in the line of duty from the disease. This pandemic has dramatically increased the already substantial risks facing the men and women who keep us safe, at the same time that it has winnowed their ranks while officers recover from getting sick, or self-quarantine to avoid possibly spreading the disease.

The last thing our massively over-burdened police forces need right now is the indiscriminate release of thousands of prisoners onto the streets without any verification that those prisoners will follow the laws when they are released, that they have a safe place to go where they will not be mingling with their old criminal associates, and that they will not return to their old ways as soon as they walk through the prison gates. Thus, while I am directing you to maximize the use of home confinement at affected institutions, it is essential that you continue making the careful, individualized determinations BOP makes in the typical case. Each inmate is unique and each requires the same individualized determinations we have always made in this context.

I believe strongly that we should do everything we can to protect the inmates in our care, but that we must do so in a careful and individualized way that remains faithful to our duty to protect the public and the law enforcement officers who protect us all.

EXHIBIT C

Affidavit of Dr. Josiah Rich, MD, MPH

1. I am a doctor duly licensed to practice medicine in the state of Rhode Island. I am currently Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital. I have been a practicing Infectious Disease Specialist since 1994. I provide clinical care at The Miriam Hospital Immunology Center, as well as at the Rhode Island Department of Corrections, where I care for prisoners with HIV infection and addiction and also work in the correctional setting doing research.

2. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I am an elected member of the National Academy of Medicine, and I have served as an expert for the National Academy of Sciences, the Institute of Medicine, and many others. I have also been appointed by Rhode Island Governor Gina Raimondo to the Overdose Prevention and Intervention Task Force Expert Team. I have published over 200 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions, and incarceration.

3. The matters that I discuss below are proceeding at a rapid pace across the country. I have published about these urgent concerns in the New England Journal of Medicine, the Washington Post, and elsewhere. I attach copies of those articles to this affidavit.

4. I submit this affidavit in support of federal detainees held at the Plymouth County Correctional Facility ("Plymouth") during the COVID-19 pandemic.

Plymouth County Correctional Facility must respond to the extreme challenges COVID-19 poses.

5. As we are quickly seeing throughout the United States and the world, highly transmissible novel respiratory pathogens such as SARS-CoV-2—the virus that causes COVID-19—create a perfect storm for correctional settings. First, correctional settings are ideal for rapid spread of viruses that are transmitted person-to-person, especially those passed by droplets through coughing and sneezing. When people must share cells, dayrooms, bathrooms, showers, and other common areas, the opportunities for transmission are great. While there is not yet conclusive evidence that SARS-CoV-2 is an airborne virus, in the context of limited information, we must assume that it is. In that case, the poor ventilation systems within correctional facilities will ensure maximal opportunities for transmission.

6. When viruses are transmitted from person to person, the best initial strategy is to practice social distancing. Yet social distancing is extremely challenging in correctional settings, especially when residents are housed in shared cells or dormitory settings. Even when facilities are locked down and use of common space is restricted, shared cells defeat the efficacy of these social distancing measures. Moreover, there is inevitably frequent contact among prisoners, and especially between prisoners and staff, during a lockdown. Even a quick cell change or shower involves multiple opportunities for contact with others. Accordingly, correctional facilities are congregate settings that are poorly designed to prevent the inevitable rapid and widespread dissemination of this virus.

7. I have reviewed the affidavits of Jane Peachy, Keith Halpern, Jessica Thrall, Timothy Watkins, and Edward Ryan. I have also reviewed Sheriff McDonald's affidavit, declaration, and answers to interrogatories and Dr. Lawrence Baker, M.D.'s declaration.

8. From my review of those materials, I understand Plymouth, like other corrections facilities, has suspended visitation and has taken other limited measures to try to prevent infection. The Sheriff's affidavit, declaration, and answers to interrogatories, Dr. Baker's declaration, and the affidavits submitted/prepared on behalf of the detainees indicate that Plymouth has not implemented effective social distancing measures at the facility. Detainees continue to eat, sleep, and recreate within six feet of each other. According to Mr. Halpern and Mr. Watkins, correctional officers still approach detainees without regard for keeping physical distance given the pandemic.

9. That is especially problematic because, irrespective of any screening that is done, infected persons—especially staff members—will inevitably continue to enter correctional settings. It is essential to understand that, despite being physically secure, jails and prisons are not isolated from the community. Rather, the boundaries between correctional institutions and the communities in which they sit are extremely porous. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, population turnover means that people cycle between facilities and communities. And people often need to be transported to and from facilities, including for disciplinary and/or quarantining purposes. All of this is problematic in the context of this pandemic: While entry temperature checks may be effective screening mechanisms for some symptomatic infections, they are ineffective with SARS-CoV-2 due to high rates of asymptomatic or pre-symptomatic infection. Therefore, Plymouth's screening procedures will not, on their own, prevent COVID-19 from entering those facilities.

10. I understand that one employee of the Plymouth County Sheriff's Department has already been diagnosed with COVID-19. The facility is fortunate that that case did not result in

widespread infection within Plymouth itself. Absent steps to ensure social distancing at Plymouth, it is likely only a matter of time before such an outbreak occurs.

11. Moreover, there are reduced opportunities for detainees and staff to practice proper hand hygiene and cleaning in prisons. During an infectious disease outbreak, free people can protect themselves by washing hands. Correctional facilities do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. These facilities are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for both people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but bleach is often unavailable, and cleaning agents used by correctional settings may not have been shown to effectively neutralize this virus, particularly in the diluted form commonly employed. There may also be a lack of people available to perform necessary cleaning procedures, which is exacerbated as people fall ill and movement is restricted. I note that Plymouth was already falling short of minimal health standards even before the COVID-19 pandemic was broadly recognized in the United States. In September 2019, the Massachusetts Department of Public Health's ("DPH") cited Plymouth for 99 *repeat* health violations that the facility had failed to rectify since the DPH's prior inspection in February 2019.

12. Having reviewed the affidavits submitted on behalf of individual detainees at Plymouth, that facility does not appear to have instituted adequate hygiene and cleaning policies or practices since that time. For example, to ensure proper hand hygiene, detainees need more than one small bar of soap. Mr. Baptista also states that he has been unable to clean his dormitory,

including his toilet and shower. Those areas must be cleaned and disinfected. Frequently touched surfaces, such as shower knobs, need to be cleaned and disinfected at least daily.

13. A containment strategy for this virus requires both widespread screening and that people who are symptomatic be immediately isolated. It also requires that correctional officers and caregivers have access to personal protective equipment, including gloves, masks, gowns, and face shields. Yet correctional settings are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility where an outbreak is occurring. Correctional settings are also unlikely to be able to perform the widespread screening and contact-tracing necessary to prevent further infection.

14. Sheriff McDonald's affidavit, declaration, and interrogatory answers and Dr. Baker's declaration do not say if Plymouth has sufficient stocks of personal protective equipment. Nor do they say if Plymouth has trained nonmedical staff or detainees how to correctly use personal protective equipment.

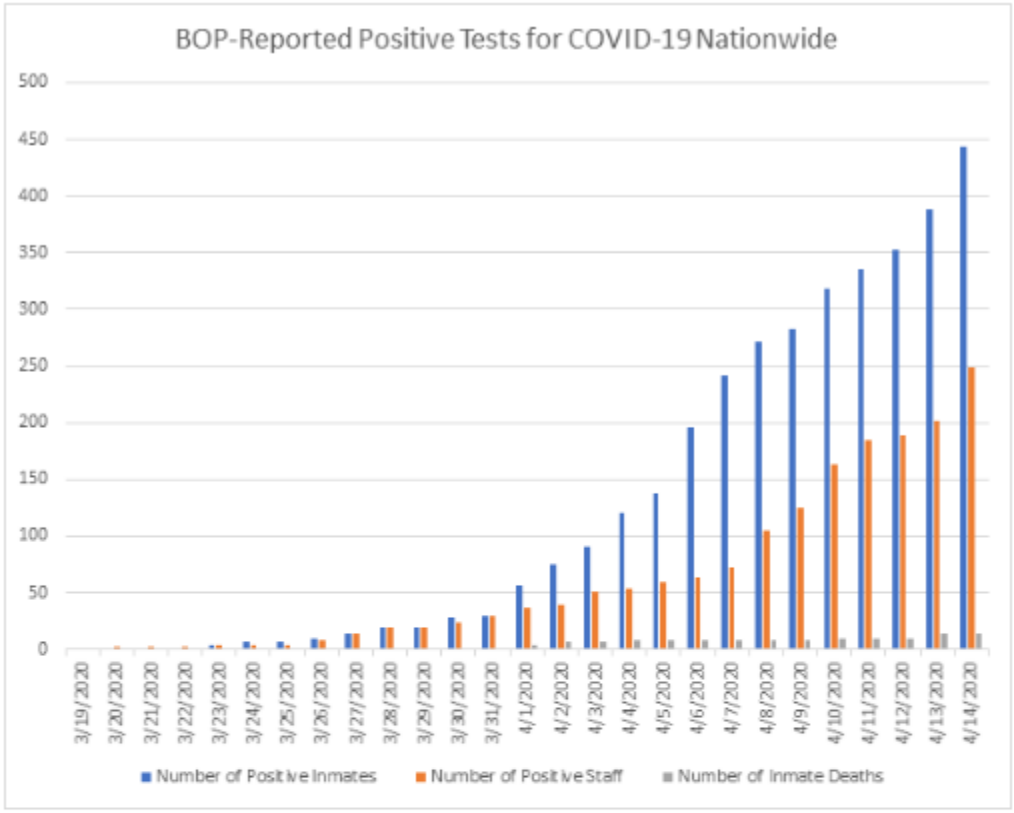
15. The risk of life-threatening infection stemming from all of the deficiencies detailed above is compounded by the fact that half of all incarcerated people in the United States have at least one chronic disease. With limited ability to protect themselves and others by self-isolating, thousands of susceptible people are at heightened risk for severe illness. Lessening the spread of COVID-19 requires urgent, scaled-up decarceration

16. The more preemptive measures taken by legal, public health, and correctional health partnerships, the lighter the burden the correctional facilities and their surrounding communities will bear. The global context offers some precedent here. Iran, for example, responded to its escalating pandemic by releasing 70,000 prisoners, something that may have helped "bend the

curve" of that country's epidemic. Conversely, failure to calm incarcerated populations in Italy led to widespread rioting in Italian prisons.

17. The Bureau of Prisons has reported positive COVID-19 tests for detainees in its custody and staff and the number of detainee deaths from COVID-19.[1] The Federal Defenders of New York have graphed the steep rise in those numbers, which confirm the extreme risk of rapid COVID-19 transmission in correctional environments. The Federal Defenders of New York have also graphed the rising rate of positive COVID-19 tests in detainees against the rate in the national population.[2] These graphs illustrate the severity of the immediate risk detention facilities such as Plymouth pose to their residents.

[1] www.bop.gov/coronavirus.
[2] https://federaldefendersny.org/ (last accessed April 14, 2020) (aggregating data from the CDC and Johns Hopkins University).


BOP-Reported Positive Tests for COVID-19 Nationwide
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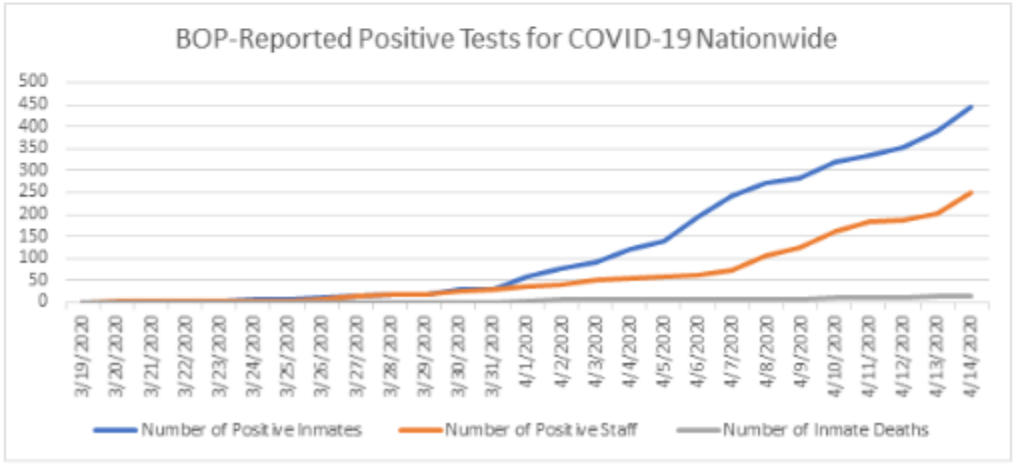
Number of Positive Inmates
Number of Positive Staff
Number of Inmate Deaths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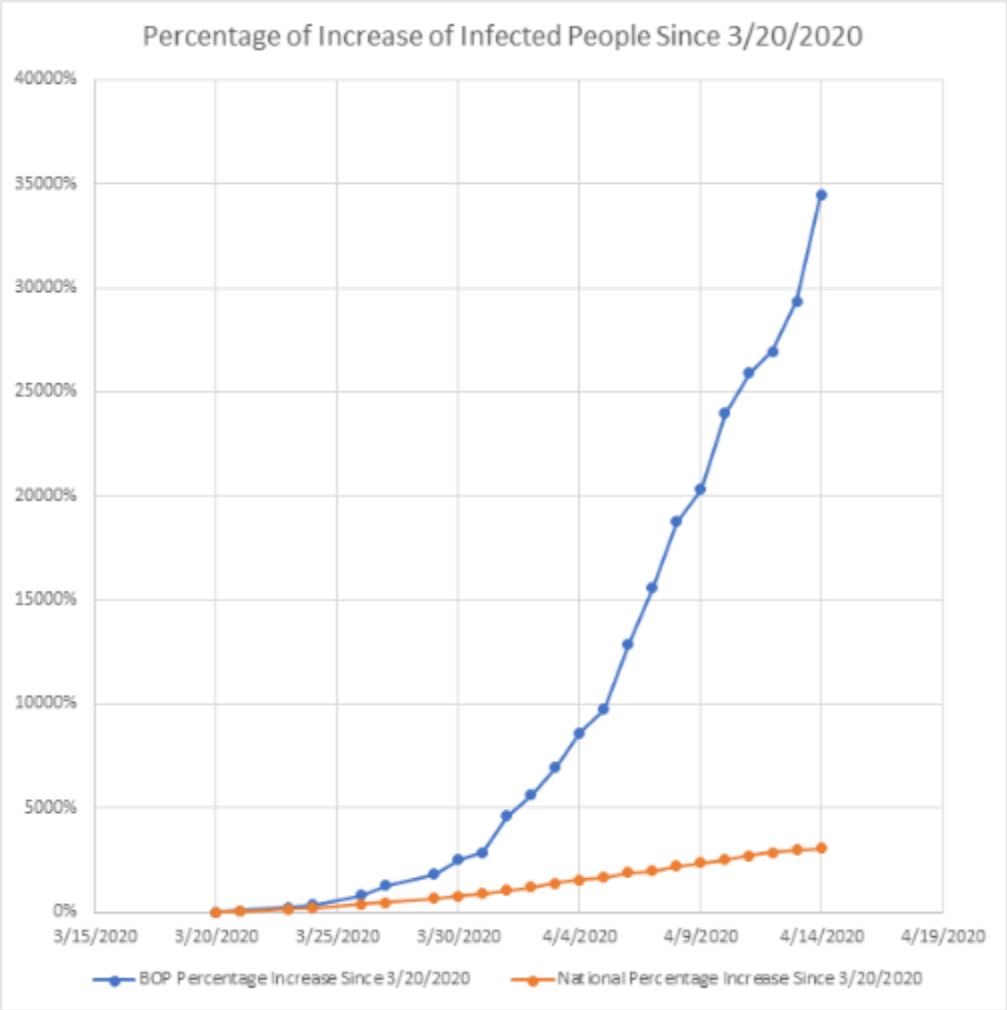
4/11/2020
4/12/2020
4/13/2020
4/14/2020
Number of Positive Inmates
Number of Positive Staff
Number of Inmate Deaths

Percentage of Increase of Infected BOP People (Inmates and Staff)

Since 3/20/2020[2]

Date	Number of BOP Cases[3]	BOP Percentage Increase Since 3/20/2020	National Percentage Increase Since 3/20/2020	Number of National Cases
3/20/2020	2	0%	0%	18,747
3/21/2020	3	50%	31%	24,583
3/23/2020	6	200%	135%	44,183
3/24/2020	9	350%	190%	54,453
3/26/2020	18	800%	355%	85,356
3/27/2020	27	1250%	451%	103,321
3/29/2020	38	1800%	651%	140,904
3/30/2020	52	2500%	772%	163,539
3/31/2020	59	2850%	892%	186,101
4/1/2020	94	4600%	1036%	213,144
4/2/2020	114	5600%	1176%	239,279
4/3/2020	141	6950%	1379%	277,205
4/4/2020	174	8600%	1526%	304,826
4/5/2020	197	9750%	1665%	330,891
4/6/2020	259	12850%	1897%	374,329
4/7/2020	313	15550%	1963%	386,800
4/8/2020	377	18750%	2140%	419,975
4/9/2020	408	20300%	2349%	459,165
4/10/2020	481	23950%	2527%	492,416
4/11/2020	520	25900%	2704%	525,704
4/12/2020	541	26950%	2860%	554,849
4/13/2020	589	29350%	2989%	579,005
4/14/2020	692	34500%	3042%	489,048

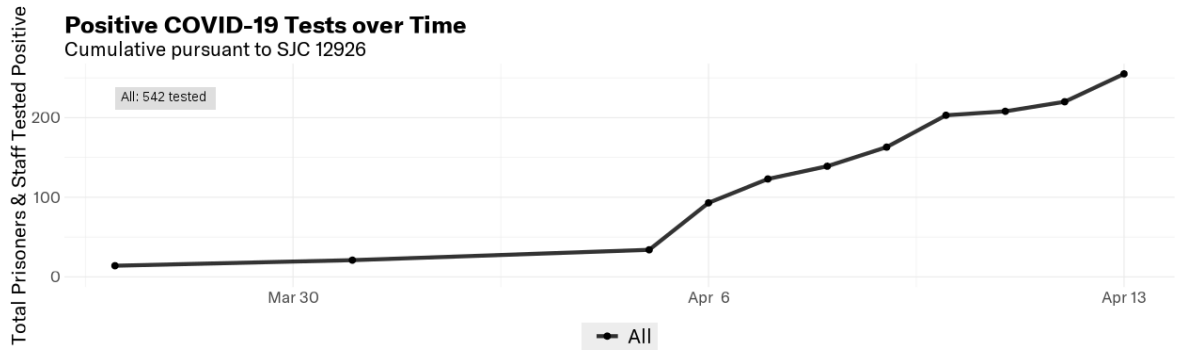


18. The Federal Defenders observe that these numbers may underreport actual positive COVID-19 tests.[3] I believe that these numbers may be underinclusive because many detainees have limited access to care and testing and may be afraid to report symptoms.

19. I have also reviewed data received by the ACLU of Massachusetts from *Committee for Public Counsel Services v. Chief Justice of the Trial Court*, SJC-12926. This data (and the graphs that the ACLU of Massachusetts created) reveal a sharp increase in positive COVID-19

[3] *Id.*

tests in the Massachusetts Department of Correction and county Houses of Correction.[4] Although Plymouth has only reported one positive test to date, the Massachusetts detention system as a whole has experienced a sharp increase in COVID-19 cases since March 2020:



20. At minimum, Plymouth must be prepared to effectively isolate and separate incarcerated persons who are infected and those who are under investigation for possible infection from the general prison population; to hospitalize those who are seriously ill; and to cope with the high burden of disease and severe staff shortages that are likely to come.

21. But this won't be enough. It is imperative to scale up efforts to "decarcerate," or release, as many detainees as possible. Each person needlessly infected in a correctional setting who develops severe illness will be one too many. And public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in correctional facilities during a pandemic.

22. It is my strong opinion that urgent decarceration is imperative to flatten the curve of COVID-19 cases among incarcerated populations and to limit the impact of transmission both inside correctional facilities and in the community. This is urgently needed at Plymouth, where

[4] *Tracking Covid-19 in Massachusetts Prison & Jails*, ACLU of Massachusetts (Apr. 14, 2020), https://data.aclum.org/sjc-12926-tracker/#tab-9488-2.

federal detainees report that beds in shared cells and dormitories in which they are housed are less than six feet apart from one another.[5] Even outside their cells, detainees reportedly contend with congested common areas. At least one detainee, Mr. Lindsey, is too afraid to leave his dorm unit, which is shared with 6-8 other people, because the recreation area is too cramped. Detainees' inability to maintain consistent social distancing undercuts the efficacy of any other mitigation efforts at the facility and exposes its population to a heightened risk of a COVID-19 outbreak.

23. The abrupt onset of severe COVID-19 infections among incarcerated individuals will require mass transfers to local hospitals. This is because most correctional facilities lack the equipment needed to treat serious COVID-19 cases, such as ventilators. But even in the absence of an outbreak, I am concerned about the healthcare available to detainees at Plymouth. Per a WBUR investigative report, 12 residents died in Plymouth between 2008 and 2018.[6] 195 died in Massachusetts houses of corrections over that period, and a third of those deaths involved "allegations or evidence of poor medical care before their deaths" according to WBUR.[7]

24. Individuals suffering from severe COVID-19 cases will likely require treatment in an intensive care unit ("ICU") and even ventilation—highly expensive interventions that are already in very short supply. Each severely ill patient coming from Plymouth who occupies an ICU bed may mean others may die for inability to obtain care. These are preventable infections, and we should act to prevent them.

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[5] *Id.* The ACLU of Massachusetts website does not display data broken out by each correctional institution that the Department of Correction oversees. *Id.*

[6] Christine Willmsen & Beth Healy, *When Inmates Die of Poor Medical Care, Jails Often Keep It Secret*, WBUR (Mar. 23, 2020), https://www.wbur.org/investigations/2020/03/23/county-jail-deaths-sheriffs-watch.

[7] *Id.*

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 16th day of April, 2020

Dr. Josiah Rich

EXHIBIT D

Affidavit of Regina Celeste LaRocque, MD, MPH

I, Regina Celeste LaRocque, certify as follows:

1. I am an associate physician in the division of infectious diseases at Massachusetts General Hospital since 2005, and an Associate Professor of Medicine at Harvard Medical School. I have taught at Harvard Medical School since 2005. I have performed laboratory and clinical research for 15 years in the fields of travel medicine and enteric infections, focusing on the prevention and management of infectious disease. I have authored over 100 peer-reviewed publications and book chapters. I am a member of the Infectious Diseases Society of America, the American Society of Tropical Medicine & Hygiene, and the International Society of Travel Medicine, among other organizations. In 2007, I received the Maxwell Finland Award for excellence in infectious disease clinical care from the Massachusetts Infection Diseases Society. I completed a fellowship in Infectious Disease at Brigham & Women's Hospital and Massachusetts General Hospital in 2003 and completed my residency in Internal Medicine at Brigham & Women's Hospital in 2001. I received a Masters' Degree in Public Health from the Harvard School of Public Health in 1997.

2. I submit this affidavit in support of federal detainees held at the Plymouth County Correctional Facility during the COVID-19 pandemic.

COVID-19 Spreads Easily and Quickly

3. COVID-19 is a highly contagious and potentially deadly disease with no known vaccine or therapeutic that has been proven safe and effective. Approximately 16% of COVID-19 cases

result in serious illness or death.[1] While the elderly and those with pre-existing medical conditions such as asthma, high blood pressure, immune system conditions, and cardiac or respiratory conditions, to name a few, are most at risk, the virus can also cause serious harm to the young and otherwise healthy. From February 12 to March 16, nearly 40% of American COVID-19 patients who were hospitalized were between the ages of 20 and 54.[2]

4. COVID-19 is deadly, even compared to other infectious diseases. As of 2:10 p.m. on April 14, 2020, 24,737 people had died from COVID-19 in the United States and 592,743 cases of COVID-19 had been confirmed at that time.[3] These data reflect a mortality rate of 4.17%.[4] To put that in perspective, the mortality rate for tuberculosis in the United States is half that of COVID-19.[5] The mortality rate of seasonal influenza is well below 0.1%.[6]

5. In many people, COVID-19 can cause fever, cough, and shortness of breath, among other symptoms. In more serious cases, COVID-19 causes acute respiratory disease syndrome ("ARDS"), which is life threatening. Fluid leaks into the lungs, impairing the body's oxygen supply and resulting in organ failure and sometimes death. Even among those who receive optimal medical care, the mortality rate is approximately 30% for those suffering from ARDS.

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[1] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.html (last accessed Apr. 14, 2020) (citing Clinical Characteristics of Coronavirus Disease 2019 in China, https://www.nejm.org/doi/full/10.1056/NEJMoa2002032).

[2] *Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19)*, Centers for Disease Control and Prevention (Mar. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w.

[3] The Massachusetts Department of Public Health ("DPH") reported that, as of April 14, 2020, Massachusetts, had 28,163 confirmed cases and 957 deaths attributed to COVID-19, a mortality rate of 3.5%.

[4] *COVID-19 Dashboard*, Johns Hopkins University (Apr. 14, 2020), https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6.

[5] Chou-Han Lin, *Tuberculosis Mortality: Patient Characteristics and Causes*, 14 BMC Infectious Diseases (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3890594/.

[6] World Health Org., Coronavirus Disease 2019 (COVID-19) Situation Report – 46, at 2 (2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200306-sitrep-46-covid-19.pdf?sfvrsn=96b04adf_4.

The virus may also affect the heart, resulting in a condition called myocarditis, or inflammation of the heart muscle. Myocarditis impacts the heart muscle and electrical system, compromising the heart's ability to pump. There is growing evidence that, in addition to respiratory failure and heart inflammation, the virus causes neurological malfunction, blood clots, intestinal damage, liver problems, and permanent injury to the kidneys.

6. Many individuals who survive COVID-19 face a protracted recovery period and may have long-lasting complications from the disease. COVID-19 can permanently damage the lungs, heart, liver, kidney, brain, and endocrine and blood systems.[7] We are learning more about the virus and its long-term consequences for infected individuals every day, including the potential for long-term complications after the immediate infection resolves.

7. The novel coronavirus that causes COVID-19 is known to spread from person to person through respiratory droplets, close personal contact, and contact with contaminated surfaces and objects. The virus, which is at its most contagious early in the course of the disease, is frequently spread by individuals who have no apparent symptoms, that is, patients who are either pre- or asymptomatic. Through the simple act of breathing or touching an object or surface, people can and do inadvertently transmit the virus to others every day. Indeed, the virus can spread swiftly throughout a population before even one positive case is reported.[8] It is estimated that, on average, every person who contracts the virus infects another 2 to 2.5 people.[9] Because the novel coronavirus can be transmitted by people who are asymptomatic, survive on surfaces

[7] Melissa Healy, *Coronavirus Infection May Cause Lasting Damage Throughout the Body, Doctors Fear*, L.A. Times (Apr. 10, 2020), https://www.latimes.com/science/story/2020-04-10/coronavirus-infection-can-do-lasting-damage-to-the-heart-liver.
[8] Kelvin Kai-Wang To et al., *Temporal Profiles of Viral Load in Posterior Oropharyngeal Saliva Samples and Serum Antibody Responses During Infection By SARS-Cov-2: An Observational Cohort Study*, Lancet (Mar. 23, 2020), https://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2820%2930196-1/fulltext.
[9] *Q&A: Similarities and Differences – COVID-19 and Influenza*, World Health Organization (Mar. 17, 2020), https://www.who.int/news-room/q-a-detail/q-a-similarities-and-differences-covid-19-and-influenza.

for several days, and remain airborne for several hours, it has a far higher secondary infection rate than seasonal influenza.

8. The virus's ability to survive for extended periods on surfaces or in the air, coupled with its transmission by those who are asymptomatic or pre-symptomatic, makes scrupulous adoption of recommended preventive measures, of which social distancing is the cornerstone, critical. Without rigorous and consistent implementation of public health experts' recommended preventive measures, especially social distancing, COVID-19 will continue to spread exponentially.[10]

Social Distancing

9. The Centers for Disease Control and Prevention ("CDC") and other public health experts have repeatedly underscored the critical importance of social distancing to combat the spread of COVID-19.[11] The CDC thus recommends that everyone consistently maintain a distance of at least six feet between themselves and anyone else who is not a member of their household, and strongly discourages even small group gatherings.[12] Pathogen-bearing droplets may even travel farther than six feet.[13] While social distancing is an essential step to mitigate the virus's spread, because the virus can remain airborne and on surfaces for an extended time, many public health

[10] *See* Sheri Fink, *Worst Case Estimates for U.S. Coronavirus Deaths*, N.Y. Times (Mar. 13, 2020) https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.
[11] *Social Distancing*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html (last accessed Apr. 13, 2020).
[12] *Id.*
[13] Lydia Bourouiba, *Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19*, JAMA Insights (Mar. 26, 2020), https://jamanetwork.com/journals/jama/fullarticle/2763852.

experts and governmental authorities have urged people not to leave their homes unless it is necessary for them to do so.[14]

Personal Protective Equipment

10. Proper and consistent use of personal protective equipment outside the home is an important adjunct to social distancing. Face masks may help limit the extent to which carriers of the coronavirus continue to spread it through airborne transmissions.[15] Paper masks must be used properly to be effective; they should be discarded as soon as they become damp. CDC recommends that correctional facilities stock PPE and train medical and non-medical staff, and incarcerated and detained people, on how to properly don, doff, and dispose of PPE.[16] But even if face masks were universally worn, social distancing would remain the paramount measure for mitigating the spread of COVID-19.[17]

Personal Hygiene

11. Hand hygiene is also vital to preventing transmission of COVID-19. Many people contract the virus by touching their faces after touching a surface that has been contaminated with the virus. Conversely, many people inadvertently spread the virus to others by touching surfaces or objects with their contaminated hands. Frequent, vigorous hand washing with soap and hot water throughout the day is therefore essential to reduce the spread of COVID-19.[18]

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[14] Press Release, *Governor Charlie Baker Orders All Non-Essential Businesses To Cease In Person Operation, Directs the Department of Public Health to Issue Stay at Home Advisory For Two Weeks*, Commonwealth of Massachusetts (Mar. 23, 2020), https://www.mass.gov/news/governor-charlie-baker-orders-all-non-essential-businesses-to-cease-in-person-operation.

[15] *Recommendations for Cloth Face Covers*, Centers for Disease Control and Prevention (Apr. 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html.

[16] *Guidance for Correctional & Detention Facilities*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#recommended-ppe (last accessed April 13, 2020).

[17] *Recommendations for Cloth Face Covers*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html (last accessed Apr. 13, 2020).

[18] *Protect Yourself*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (last accessed Apr. 13, 2020).

When soap and hot water are not readily available, hand sanitizer consisting of at least 60% alcohol should be used after (and before) touching any potentially contaminated surface or object. Even the slightest lapse in scrupulous hand hygiene can contribute to the exponential spread of the virus. Individuals should wear disposable gloves when handling objects touched by someone in quarantine to protect against infection. Glove use is recommended when cleaning and disinfecting an area or item.

Cleaning and Disinfecting

12. Environmental hygiene is another important component of the mitigation strategy for containing the COVID-19 pandemic. Because COVID-19 is frequently contracted by touching contaminated surfaces or objects, thorough cleaning and disinfecting of high-touch surfaces throughout the day can help mitigate the spread of the virus.[19]

13. Although scrubbing a contaminated surface with soap or detergent and water helps to eliminate some of the viral contamination on these surfaces, it does not kill the coronavirus. Accordingly, the only way to eliminate the risk of infection from contaminated surfaces is to disinfect them continually throughout the day with an EPA-registered disinfectant proven effective in killing the coronavirus. Rigorous adherence to this cleaning regimen will help contain the spread of COVID-19.

Screening, Testing and Quarantine

14. The CDC recommends that everybody entering a detention facility be screened for COVID-19.[20] The CDC advises detention facilities to ask visitors if they have had COVID-19 symptoms or have had contact with someone they knew to have COVID-19. The CDC also says

[19] *Detailed Disinfection Guide*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html (last accessed April 13, 2020).
[20] *Id.*

that detention facilities should perform a pre-intake screening and temperature check for all new entrants.[21] Those performing screening should wear PPE.[22]

15. It is important to note, however, that these screening measures will not identify pre- or asymptomatic visitors or visitors who had contact with pre- or asymptomatic people, or the many infected individuals whose symptoms do not include a fever. They also depend on the accuracy of residents', staff's and visitors' self-reporting of symptoms, an inherently unreliable variable. In short, adoption of these screening guidelines is no substitute for social distancing, "a cornerstone of reducing transmission for respiratory diseases such as COVID-19," hand hygiene, and cleaning and disinfecting surfaces.[23]

16. CDC guidance also calls for correctional facilities to have a plan in place to isolate confirmed COVID-19 cases and individuals exhibiting COVID-19 symptoms, and to quarantine known close contacts of positive cases.[24] The locations for medical isolation and quarantine should be separate. Because there should only be one individual within a given isolation or quarantine location, facilities should be prepared to convert multiple locations to this purpose if numerous individuals require quarantine or isolation simultaneously.

Plymouth County Correctional Facility Is Vulnerable to a Widespread Outbreak of COVID-19

17. By their very nature, congregate settings such as correctional facilities, like nursing homes and cruise ships, face an especially high risk of a COVID-19 outbreak. Wherever large multitudes of people are gathered, especially if they remain in close quarters, for prolonged periods of time, the risk of a COVID-19 outbreak increases dramatically. That risk becomes all

[21] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.
[22] *Id.*
[23] *Id.*
[24] *Id.*

the more acute in correctional facilities, where often only the most minimal standards of sanitation are found, access to personal and environmental cleaning products is limited, medical care is lacking, and many residents already suffer from chronic, often untreated illnesses. In my role triaging infection control for Massachusetts General Hospital, I have already encountered multiple patients who contracted COVID-19 while incarcerated.

18. Based on my review of the (1) affidavits of Jane Peachy, Keith Halpern, Jessica Thrall, Timothy Watkins, and Edward P. Ryan concerning conditions at the Plymouth County Correctional Facility ("Plymouth") and (2) Sheriff McDonald's affidavit, declaration and answers to interrogatories and Dr. Lawrence Baker, M.D.'s declaration regarding the policies and practices in place at Plymouth to mitigate the risk of COVID-19 infection, the conditions at Plymouth expose the detainees who reside there to a substantial risk of COVID-19 infection.

19. Based on my review of these materials, and my knowledge, experience, and expertise as an infectious disease specialist, Plymouth has failed to implement several critical measures, recommended by the CDC and public health specialists, that would materially reduce the substantial risk of a widespread outbreak of COVID-19 among detainees at the facility. These deficiencies include:

- Lack of Social Distancing. Many detainees at Plymouth are reportedly held in shared cells or open dormitories where social distancing is infeasible. They reportedly eat their meals communally, oftentimes shoulder-to-shoulder, without any ability to socially distance. Because social distancing is the cornerstone of COVID-19 mitigation, Plymouth's mitigation measures will remain fatally flawed until it stops housing its detainees in shared cells (by reducing detainee population if necessary) and implements other social distancing measures.

- Sub-standard Environmental Hygiene. Many detainees at Plymouth must share cells, toilets, showers, and common areas and high-touch surfaces with dozens of other detainees. Based on the affidavits submitted on behalf of detainees, these areas and objects are not cleaned with the requisite frequency to mitigate the spread of COVID-19, and may not be disinfected with any regularity at all. There is also an apparent shortage of cleaning and disinfection supplies available to inmates for their cells.
- Inadequate Supply of Personal Hygienic Products. Detainees at Plymouth reportedly have inadequate access to soap and hand sanitizer. Frequent hand washing is vital to preventing the spread of a highly contagious disease such as COVID-19.
- Insufficient Personal Protective Equipment for Detainees; Inconsistent Use of Personal Protective Equipment by Staff. Earlier this week, Plymouth finally reportedly provided at least some of its federal detainees with one paper mask. This modest step is clearly insufficient, as these masks should not be used over a multi-day period, and should never be used once they become damp, such as from a cough or sneeze. From an infectious disease perspective, the detainees' insufficient personal protective equipment is especially concerning given that they are unable to engage in social distancing when they must reside in shared cells and eat their meals communally. Both the CDC Massachusetts Department of Public Health ("DPH") recommend that everyone wear face masks outside the home, especially when social distancing is difficult.[25] Many staff, including both correctional officers and medical personnel, likewise reportedly do not wear face masks at the facility, even when they are interacting with detainees, or do so inconsistently. Because Plymouth's staff move in and out of the facility and interact with

[25] *Advisory Regarding Face Coverings and Cloth Masks*, Mass. Dep't of Public Health (Apr. 10, 2020), https://www.mass.gov/news/advisory-regarding-face-coverings-and-cloth-masks.

the outside community, this creates a genuine risk that they could inadvertently introduce the virus and infect detainees within the facility simply by breathing.

20. The Sheriff's affidavit, declaration, and answer to interrogatories and Dr. Baker's declaration fail to address Plymouth's ability to prevent or control a COVID-19 outbreak in several key respects, including, whether the facility's ventilation system is designed to prevent respiratory droplets from spreading throughout a closed environment; whether the facility quarantines[26] those residents potentially infected by COVID-19 separately from those with confirmed cases; and details about the facility's capacity to provide its residents with immediate medical attention if they develop emergency warning signs for COVID-19, such as trouble breathing, persistent chest pain or pressure, or turning blue in the lips or face.[27]

21. The record of the conditions at Plymouth leads me to conclude that Defendants are not taking vital steps to prevent and mitigate a COVID-19 outbreak at the facility. Such an outbreak would have disastrous consequences for the facility's residents and staff, and the broader surrounding community. Because social distancing is the cornerstone of any such mitigation strategy, it is urgent that Defendants institute a comprehensive social distancing regimen at Plymouth that must include the elimination of shared cells if it is to be successful.

[26] According to Jermaine Gonsalves, "a special unit, C-1, ha[s] been set up for the quarantine of inmates with symptoms suggesting Coronavirus. He stated that inmates were reluctant to report feeling unwell because they feared being moved into the quarantine unit and being surrounded by sick inmates." Halpern Aff. ¶ 10.
[27] *Steps to Help Prevent the Spread of COVID-19 if You Are Sick*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-ncov-fact-sheet.pdf (last accessed April 12, 2020).

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 16th day of April, 2020

Dr. Regina Celeste LaRocque

Regina Celeste LaRocque, MD, MPH

EXHIBIT E

AFFIDAVIT OF JONATHAN GIFTOS, M.D.

I, Jonathan Giftos, hereby affirm as follows:

1. I am a doctor duly licensed to practice medicine in the State of New York. I am board certified in internal medicine and addiction medicine.

2. I am currently the Medical Director, Addiction Medicine & Drug User Health at Project Renewal and a Clinical Assistant Professor in the Department of Medicine at Albert Einstein College of Medicine. I was previously the Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island. In that capacity, I was responsible for the diversion, harm reduction, treatment and reentry services for incarcerated patients with substance use disorders. I further served as the medical director of the Key Extended Entry Program (KEEP), the nation's oldest and largest jail-based opioid treatment program that provides methadone and buprenorphine to incarcerated patients with opioid use disorders. I successfully led an effort to remove non-clinical barriers to opioid treatment program enrollment in 2017, which dramatically expanded treatment access from 25% to over 80%, while also reducing post-release mortality for people with opioid use disorder.

3. I have extensive experience working with vulnerable populations such as the incarcerated and those experiencing homelessness.

4. I submit this affidavit in support of federal detainees held at Plymouth County Correctional Facility in Plymouth, Massachusetts during the COVID-19 pandemic.

I. COVID-19 Epidemic

5. On March 11, 2020, the World Health Organization declared that the rapidly spreading outbreak of COVID-19, a respiratory illness caused by a novel coronavirus, is a pandemic,

announcing that the virus is both highly contagious and deadly.[1] To date, the virus is known to spread from person-to-person through respiratory droplets, close personal contact, and from contact with contaminated surfaces and objects.[2] The CDC also warns of "community spread" where the virus spreads easily and sustainably within a community where the source of the infection is unknown.[3] Experts are still learning how it spreads.

6. As of April 16, 2020, novel coronavirus has infected over 2,090,110 people, leading to 139,000 deaths worldwide.[4] In the United States, there are at least 605,390 confirmed cases and there have been at least 24,582 deaths.[5] There are confirmed coronavirus cases in every state, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. *Id.*

7. On March 13, 2020, President Donald Trump declared a national emergency to address the pandemic.[6] Massachusetts Governor Charlie Baker declared a state of emergency in the Commonwealth of Massachusetts on March 10, 2020.[7] To date, the pandemic has caused the Governor to issue more than 21 emergency orders.[8] Those orders range from closing all

[1] World Health Organization, Media Briefing on March 11, 2020: https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[2] Centers for Disease Control and Prevention, Coronavirus Disease 2019: How it Spreads, https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html

[3] *Id.*

[4] *Novel Coronavirus Situation Dashboard*, World Health Organization https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd.

[5] *Coronavirus Map: Tracking the Spread of the Outbreak*, The New York Times (March 18, 2020), *at* https://nyti.ms/2U4kmud (updating regularly).

[6] Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Conference (March 13, 2020). https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-conference-3/.

[7] https://www.mass.gov/executive-orders/no-591-declaration-of-a-state-of-emergency-to-respond-to-covid-19

[8] https://www.mass.gov/info-details/covid-19-state-of-emergency

elementary and secondary schools to prohibiting on-site consumption of food and beverages to restricting visitor access to nursing homes to prohibiting public gatherings of more than 10 people. *Id.* On March 23, 2020, Governor Baker ordered all non-essential businesses to close. *Id.*

8. As of April 15, 2020, there are 29,918 confirmed cases of COVID-19 in Massachusetts.[9] There have been 1108 COVID-19 related deaths in Massachusetts. *Id.*

9. As of April 4, 2020, at least one incarcerated person in Massachusetts has died from COVID-19 related complications.[10]

10. At least 281 incarcerated people and staff in the Massachusetts prison and jail system have tested positive for coronavirus.[11]

11. As of April 14, 2020, Massachusetts has the third highest number of reported COVID-19 cases in the United States, after New York and New Jersey.[12]

12. As of April 13, 2020, the Federal Bureau of Prisons ("BOP") has reported that at least 388 individuals in BOP custody have tested positive for COVID-19 and 201 BOP staff members have tested positive for COVID-19.

13. As of April 13, 2020, the BOP has reported that thirteen federal inmates have died from COVID-19.

14. There is currently no vaccine or cure. The primary focus is on preventing the spread of the virus at this juncture. To prevent new infections, the Centers for Disease Control and Prevention

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[9] *See* COVID-19 Cases, Quarantine and Monitoring (April 4, 2020) https://www.mass.gov/info-details/covid-19-cases-quarantine-and-monitoring.

[10] First Massachusetts Inmate Dies From COVID-19 (April 4, 2020) https://www.wgbh.org/news/local-news/2020/04/02/coronavirus-infections-continue-to-rise-in-massachusetts-prisons

[11] *See* https://data.aclum.org/sjc-12926-tracker/

[12] *See* Tracking Covid-19 cases in the US (April 14, 2020) https://www.cnn.com/interactive/2020/health/coronavirus-us-maps-and-cases/

strongly recommend the following actions: thorough and frequent handwashing, cleaning surfaces with EPA approved disinfectants, keeping at least 6 feet of space between people, and avoiding group settings.[13] Social distancing has also been encouraged to slow the rate of COVID-19 infections so that hospitals have the resources to address infected individuals with urgent medical needs.[14] The President's *Coronavirus Guidelines for America*, to slow the spread of the coronavirus, warns that social gatherings in groups of more than 10 people should be avoided.[15] In correctional settings, such sanitation, social distancing, and self-quarantining measures are nearly impossible especially when inmates are routinely shackled and escorted with other prisoners.[16]

II. Certain Identifiable Populations Are Far More Vulnerable To COVID-19 Than The Population At Large

15. The Centers for Disease Control have identified two groups of people at higher risk of contracting and succumbing to COVID-19: adults over 60 years old and people with chronic medical conditions.[17]

16. COVID-19 is more dangerous to persons in these high-risk groups than to the general population. Older people who contract COVID-19 are more likely to die than people under the age

[13] *How to Protect Yourself*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html.

[14] *Coronavirus, Social Distancing, and Self-Quarantine*, Johns Hopkins Medicine, https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-social-distancing-and-self-quarantine.

[15] The President's Coronavirus Guidelines for America, https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20 coronavirus-guidance 8.5x11 315PM.pdf.

[16] *See We Are Not a Hospital: A Prison Braces for the Coronavirus*, New York Times, March 18, 2020, https://www.nytimes.com/2020/03/17/us/coronavirus-prisons-jails.html.

[17] *How to Protect Yourself*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html.

of 60. In a February 29th WHO-China Joint Mission Report, the preliminary mortality rate analyses showed that individuals age 60-69 had an overall 3.6% mortality rate and those 70-79 years old had an 8% mortality rate.[18] For individuals 40 years and younger, the mortality rate was as low as .2%. It has been found that older people diagnosed with COVID-19 are more likely to be very sick and require hospitalization to survive because the acute symptoms include respiratory distress, cardiac injury, arrhythmia, septic shock, liver dysfunction, kidney injury and multi-organ failure. Access to a mechanical ventilator is often required. People with chronic medical conditions (no matter their age) are also at significantly greater risk from COVID-19 because their already-weakened systems are less able to fight the virus. These chronic medical conditions include lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy. Those with pre-existing medical conditions have a higher probability of death if infected. The WHO-China Joint Mission Report provides that the mortality rate for those with cardiovascular disease was 13.2%, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.[19]

17. In a March 17th *Washington Post* article tracking the 100 United States COVID-19 deaths, it is reported that many of the fatalities had underlying medical conditions, which made it harder for their bodies to fight off COVID-19. And nearly all — about 85 percent — were older than 60; about 45 percent were older than 80.[20]

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[18] *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths* Chart, https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/ (data analysis based on WHO-China Joint Mission Report, supra).

[19] *Report of the WHO-China Joint Mission on Coronavirus Disease (COVID-19)*, https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf at 12.

[20] *U.S. Coronavirus Death Toll Reaches 100*, The Washington Post, March 17, 2020, at https://www.washingtonpost.com/national/us-coronavirus-death-toll-reaches-100/2020/03/17/f8d770c2-67a8-11ea-b313-df458622c2cc_story.html.

III. Correctional Settings Increase The Risk Of Transmission

18. Correctional settings increase the risk of contracting an infectious disease, like COVID-19, due to the high numbers of people with chronic, often untreated, illnesses housed in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and no possibility of staying at a distance from others. Correctional facilities house large groups of inmates together, and move inmates in groups to eat, do recreation, and go to court. They frequently have insufficient medical care for the population, and, in times of crisis, even those medical staff cease coming to the facility. Hot water, soap and paper towels are frequently in limited supply. Inmates, rather than professional cleaners, are responsible for cleaning the facilities and often not given appropriate supplies. This means there are more people who are susceptible to getting infected all congregated together in a context in which fighting the spread of an infection is nearly impossible.

19. Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[21]

20. In New York, statistics gathered by the Legal Aid Society demonstrate that "New York City jails have become the epicenter of COVID-19."[22] Those statistics show that the COVID-19 infection rate in New York City jails is more than *seven times greater* than in New York City in general and more than *fifty times greater* than the infection rate across the United States as a whole. *Id.*

[21] *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) at https://bit.ly/2TNcNZY.

[22] https://www.legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/

21. As of April 4, 2020, at least one incarcerated person in Massachusetts has died from COVID-19 related complications.[23] At least 56 incarcerated people and staff in the Massachusetts prison and jail system have tested positive for coronavirus.

22. As of April 8, 2020, the Federal Bureau of Prisons has reported that at least 241 individuals in BOP custody have tested positive for COVID-19 and 73 BOP staff members have tested positive for COVID-19.

23. As of April 8, 2020, the BOP has reported that eight federal inmates have died from COVID-19.

IV. Specific Conditions at Plymouth County Correctional Facility

24. Plymouth County Correctional Facility ("PCCF"), is located in Plymouth County. As of April 9, 2020, there have been 1,327 confirmed positive cases of COVID-19 in Plymouth County.

25. According to Plymouth County Sherriff Joseph D. McDonald, Jr., approximately 49.2% of PCCF detainees sleep within six feet of one another. *See* Exhibit 1 – PCCF Interrogatory Answers. Approximately 56.72% of PCCF detainees eat their meals within six feet of one another. *Id.* The facility claims that detainees have multiple seating options which provide an opportunity for social distancing. *Id.* Approximately 47.36% of PCCF detainees are permitted to be within six feet of one another during recreation period. The facility claims that detainees have split recreation periods, which allows for social distancing, and that officers "enforce the importance of such social distancing." *Id.*

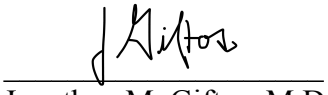
[23] First Massachusetts Inmate Dies From COVID-19 (April 4, 2020) https://www.wgbh.org/news/local-news/2020/04/02/coronavirus-infections-continue-to-rise-in-massachusetts-prisons

26. PCCF is not regularly testing detainees or staff members for COVID-19. Accordingly, there is no reliable information available regarding the spread of the virus PCCF.

V. Reducing Population Size At Specific Correctional Facilities Is A Crucial Public Health Measure

27. Every effort should be made to reduce chances of exposure to the novel coronavirus; however, given the proximity and high number of inmates, correctional staff, and healthcare workers at detention facilities, including PCCF, it will be extremely difficult to sustain such efforts. Therefore, it is an urgent priority to reduce the number of people in detention facilities, including PCCF, during this national public health emergency.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.



Jonathan M. Giftos, M.D.

Dated: April 16, 2020

EXHIBIT F

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

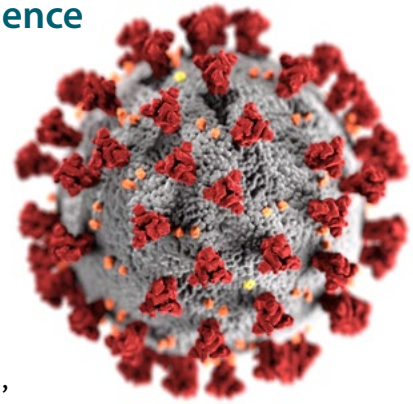
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

In this guidance

Who is the intended audience for this guidance?



This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., US Immigration and Customs Enforcement and US Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of COVID-19 in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. **The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

Why is this guidance being issued?

Correctional and detention facilities can include custody, housing, education, recreation, healthcare, food service, and workplace components in a single physical setting. The integration of these components presents unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of specific preparation, prevention, and management measures can help reduce the risk of transmission and severe disease from COVID-19.

- Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.
- In most cases, incarcerated/detained persons are not permitted to leave the facility.
- There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members. Some settings, particularly jails and detention centers, have high turnover, admitting new entrants daily who may have been exposed to COVID-19 in the surrounding community or other regions.
- Persons incarcerated/detained in a particular facility often come from a variety of locations, increasing the potential to introduce COVID-19 from different geographic areas.
- Options for medical isolation of COVID-19 cases are limited and vary depending on the type and size of facility, as well as the current level of available capacity, which is partly based on medical isolation needs for other conditions.
- Adequate levels of custody and healthcare staffing must be maintained to ensure safe operation of the facility, and options to practice social distancing through work alternatives such as working from home or reduced/alternate schedules are limited for many staff roles.
- Correctional and detention facilities can be complex, multi-employer settings that include government and private employers. Each is organizationally distinct and responsible for its own operational, personnel, and occupational health protocols and may be prohibited from issuing guidance or providing services to other employers or their staff within the same setting. Similarly, correctional and detention facilities may house individuals from multiple law enforcement agencies or jurisdictions subject to different policies and procedures.
- Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19.
- Because limited outside information is available to many incarcerated/detained persons, unease and misinformation regarding the potential for COVID-19 spread may be high, potentially creating security and morale challenges.
- The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and is determined by the supplies provided in the facility and by security considerations. Many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants.
- Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

CDC has issued separate COVID-19 guidance addressing healthcare infection control and clinical care of COVID-19 cases as well as close contacts of cases in community-based settings. Where relevant, community-focused guidance documents are referenced in this document and should be monitored regularly for updates, but they may require adaptation for correctional and detention settings.

This guidance document provides additional recommended best practices specifically for correctional and detention facilities. **At this time, different facility types (e.g., prison vs. jail) and sizes are not differentiated. Administrators and agencies should adapt these guiding principles to the specific needs of their facility.**

What topics does this guidance include?

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

- √ Operational and communications preparations for COVID-19
- √ Enhanced cleaning/disinfecting and hygiene practices
- √ Social distancing strategies to increase space between individuals in the facility
- √ How to limit transmission from visitors
- √ Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages
- √ Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors
- √ Medical isolation of confirmed and suspected cases and quarantine of contacts, including considerations for cohorting when individual spaces are limited
- √ Healthcare evaluation for suspected cases, including testing for COVID-19
- √ Clinical care for confirmed and suspected cases
- √ Considerations for persons at higher risk of severe disease from COVID-19

Definitions of Commonly Used Terms

Close contact of a COVID-19 case—In the context of COVID-19, an individual is considered a close contact if they a) have been within approximately 6 feet of a COVID-19 case for a prolonged period of time or b) have had direct contact with infectious secretions from a COVID-19 case (e.g., have been coughed on). Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

Cohorting—Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities and detention centers do not have enough individual cells to do so and must consider cohorting as an alternative. See Quarantine and Medical Isolation sections below for specific details about ways to implement cohorting to minimize the risk of disease spread and adverse health outcomes.

Community transmission of COVID-19—Community transmission of COVID-19 occurs when individuals acquire the disease through contact with someone in their local community, rather than through travel to an affected location. Once community transmission is identified in a particular area, correctional facilities and detention centers are more likely to start seeing cases inside their walls. Facilities should consult with local public health departments if assistance is needed in determining how to define "local community" in the context of COVID-19 spread. However, because all states have reported cases, all facilities should be vigilant for introduction into their populations.

Confirmed vs. Suspected COVID-19 case—A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms. A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

Incarcerated/detained persons—For the purpose of this document, "incarcerated/detained persons" refers to persons held in a prison, jail, detention center, or other custodial setting where these guidelines are generally applicable. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e, detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

Medical Isolation—Medical isolation refers to confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials (detailed in guidance below). In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion.

Quarantine—Quarantine refers to the practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms of the disease. Quarantine for COVID-19 should last for a period of 14 days. Ideally, each quarantined individual would be quarantined in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, the individual should be placed under medical isolation and evaluated for COVID-19. If symptoms do not develop, movement restrictions can be lifted, and the individual can return to their previous residency status within the facility.

Social Distancing—Social distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication.

Staff—In this document, "staff" refers to all public sector employees as well as those working for a private contractor within a correctional facility (e.g., private healthcare or food service). Except where noted, "staff" does not distinguish between healthcare, custody, and other types of staff including private facility operators.

Symptoms—Symptoms of COVID-19 include fever, cough, and shortness of breath. Like other respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the CDC website for updates on these topics.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails usually employ onsite healthcare staff and have the capacity to evaluate incarcerated/detained persons for potential illness within a dedicated healthcare space, many smaller facilities do not. Some of these facilities have access to on-call healthcare staff or providers who visit the facility every few days. Others have neither onsite healthcare capacity nor onsite medical isolation/quarantine space and must transfer ill patients to other correctional or detention facilities or local hospitals for evaluation and care.

The majority of the guidance below is designed to be applied to any correctional or detention facility, either as written or with modifications based on a facility's individual structure and resources. However, topics related to healthcare evaluation and clinical care of confirmed and suspected COVID-19 cases and their close contacts may not apply directly to facilities with limited or no onsite healthcare services. It will be especially important for these types of facilities to coordinate closely with their state, local, tribal, and/or territorial health department when they encounter confirmed or suspected cases among incarcerated/detained persons or staff, in order to ensure effective medical isolation and quarantine, necessary medical evaluation and care, and medical transfer if needed. The guidance makes note of strategies tailored to facilities without onsite healthcare where possible.

Note that all staff in any sized facility, regardless of the presence of onsite healthcare services, should observe guidance on recommended PPE in order to ensure their own safety when interacting with confirmed and suspected COVID-19 cases. Facilities should make contingency plans for the likely event of PPE shortages during the COVID-19 pandemic.

COVID-19 Guidance for Correctional Facilities

Guidance for correctional and detention facilities is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections can be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness**. This guidance is intended to help facilities prepare for potential COVID-19 transmission in the facility. Strategies focus on operational and communications planning and personnel practices.
- **Prevention.** This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility to inside. Strategies focus on reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, screening (new intakes, visitors, and staff), continued communication with incarcerated/detained persons and staff, and social distancing measures (increasing distance between individuals).
- **Management.** This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases inside the facility and prevent further transmission. Strategies include medical isolation and care of incarcerated/detained persons with symptoms (including considerations for cohorting), quarantine of cases' close contacts, restricting movement in and out of the facility, infection control practices for individuals interacting with cases and quarantined contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas visited by cases.

Operational Preparedness

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication & Coordination

√ **Develop information-sharing systems with partners.**

- Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before cases develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.
- Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.

- o Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- o Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
- o Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

√ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**

- o Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
- o Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
- o Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
- o Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.

√ **Coordinate with local law enforcement and court officials.**

- o Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
- o Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.

√ **Post signage throughout the facility communicating the following:**

- o **For all:** symptoms of COVID-19 and hand hygiene instructions
- o **For incarcerated/detained persons:** report symptoms to staff
- o **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
- o Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

√ **Review the sick leave policies of each employer that operates in the facility.**

- o Review policies to ensure that they actively encourage staff to stay home when sick.
- o If these policies do not encourage staff to stay home when sick, discuss with the contract company.
- o Determine which officials will have the authority to send symptomatic staff home.

- √ **Identify staff whose duties would allow them to work from home. Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.**
  - o Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
  - o Put systems in place to implement work from home programs (e.g., time tracking, etc.).
- √ **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.
  - o Allow staff to work from home when possible, within the scope of their duties.
  - o Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
  - o Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
  - o Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.
- √ **Consider offering revised duties to staff who are at** higher risk of severe illness with COVID-19**.** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
  - o Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.
- √ **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.
- √ **Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.**
- √ **Review** CDC's guidance for businesses and employers to identify any additional strategies the facility can use within its role as an employer.

Operations & Supplies

- √ **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**
  - o Standard medical supplies for daily clinic needs
  - o Tissues
  - o Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
  - o Hand drying supplies
  - o Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
  - o Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
- Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

√ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**

- See CDC guidance optimizing PPE supplies.

√ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.

√ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)

- Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.

√ **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**

√ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

Operations

√ **Stay in communication with partners about your facility's current situation.**

- State, local, territorial, and/or tribal health departments
- Other correctional facilities

√ **Communicate with the public about any changes to facility operations, including visitation programs.**

- √ **Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.**
  - o Strongly consider postponing non-urgent outside medical visits.
  - o If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.
- √ **Implement lawful alternatives to in-person court appearances where permissible.**
- √ **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for respiratory symptoms.**
- √ **Limit the number of operational entrances and exits to the facility.**

Cleaning and Disinfecting Practices

- √ **Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.**
- √ **Adhere to** CDC recommendations for cleaning and disinfection during the COVID-19 response. Monitor these recommendations for updates.
  - o Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).
  - o Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
  - o Use household cleaners and EPA-registered disinfectants effective against the virus that causes COVID-19 as appropriate for the surface, following label instructions. This may require lifting restrictions on undiluted disinfectants.
  - o Labels contain instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use.
- √ **Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day.**
- √ **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**

Hygiene

√ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**

√ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis.** Sample signage and other communications materials **are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

- **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
- **Practice good** hand hygiene**:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
- **Avoid sharing eating utensils, dishes, and cups.**
- **Avoid non-essential physical contact.**

√ **Provide incarcerated/detained persons and staff no-cost access to:**

- **Soap—**Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
- **Running water, and hand drying machines or disposable paper towels for hand washing**
- **Tissues** and no-touch trash receptacles for disposal

√ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.

√ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

√ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).

- **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
  - Require the individual to wear a face mask.
  - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
  - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

- **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**
  - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

√ **Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

- **Common areas:**
  - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
- **Recreation:**
  - Choose recreation spaces where individuals can spread out
  - Stagger time in recreation spaces
  - Restrict recreation space usage to a single housing unit per space (where feasible)
- **Meals:**
  - Stagger meals
  - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
  - Provide meals inside housing units or cells
- **Group activities:**
  - Limit the size of group activities
  - Increase space between individuals during group activities
  - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
  - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
- **Housing:**
  - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
  - Arrange bunks so that individuals sleep head to foot to increase the distance between them
  - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
- **Medical:**
  - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
  - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

- √ **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**
- √ **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**
- √ **Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.**
- √ **Provide** up-to-date information about COVID-19 **to incarcerated/detained persons on a regular basis, including:**
  - o Symptoms of COVID-19 and its health risks
  - o Reminders to report COVID-19 symptoms to staff at the first sign of illness
- √ **Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.**

Prevention Practices for Staff

- √ **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- √ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - o In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
  - o Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- √ **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
  - o Symptoms of COVID-19 and its health risks
  - o Employers' sick leave policy
  - o **If staff develop a fever, cough, or shortness of breath while at work:** immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
  - o **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
  - o **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- √ **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
  - o Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).

- √ **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.**
- √ **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

- √ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- √ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - o Staff performing temperature checks should wear recommended PPE.
  - o Exclude visitors and volunteers who do not clear the screening process or who decline screening.
- √ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**
- √ **Provide visitors and volunteers with information to prepare them for screening.**
  - o Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
  - o If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
  - o Display signage outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- √ **Promote non-contact visits:**
  - o Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
  - o Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
  - o Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.
- √ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**
  - o If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
  - o Inform potential visitors of changes to, or suspension of, visitation programs.
  - o Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
  - o If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons' physical health and the health of the general public. However, visitation is important to maintain mental health.

If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. See above suggestions for promoting non-contact visits.

√ **Restrict non-essential vendors, volunteers, and tours from entering the facility.**

Management

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

Operations

√ **Implement alternate work arrangements deemed feasible in the** Operational Preparedness **section.**

√ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**

- If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.

√ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.

√ **When possible, arrange lawful alternatives to in-person court appearances.**

√ **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**

- Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
  - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
  - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
  - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

√ **Coordinate with state, local, tribal, and/or territorial health departments.**

- When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below.
- When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below.
- Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See Facilities with Limited Onsite Healthcare Services section.

Hygiene

√ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)

√ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

√ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)

√ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities with Limited Onsite Healthcare Services, or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that COVID-19 cases will be appropriately isolated, evaluated, tested (if indicated), and given care.

√ **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**

√ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**

- Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
- Serve meals to cases inside the medical isolation space.
- Exclude the individual from all group activities.
- Assign the isolated individual a dedicated bathroom when possible.

√ **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.

√ **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** Cohorting should only be practiced if there are no other available options.

- If cohorting is necessary:
  - **Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
  - Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection.
  - Ensure that cohorted cases wear face masks at all times.

√ **In order of preference, individuals under medical isolation should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements
  (NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative.

√ **If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)

- Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
- Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.

√ **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.

√ **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**

√ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:

- **Cover** their mouth and nose with a tissue when they cough or sneeze
- **Dispose** of used tissues immediately in the lined trash receptacle
- **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

√ **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria.**

For individuals who will be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart

For individuals who will NOT be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- At least 7 days have passed since the first symptoms appeared

For individuals who had a confirmed positive COVID-19 test but never showed symptoms:

- At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
- The individual has had no subsequent illness

√ **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**

- If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.

- Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
- Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).

- √ **Hard (non-porous) surface cleaning and disinfection**
  - o If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
  - o For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
    - Consult a list of products that are EPA-approved for use against the virus that causes COVID-19. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
    - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
      - 5 tablespoons (1/3rd cup) bleach per gallon of water or
      - 4 teaspoons bleach per quart of water
- √ **Soft (porous) surface cleaning and disinfection**
  - o For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
    - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
    - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.
- √ **Electronics cleaning and disinfection**
  - o For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
    - Follow the manufacturer's instructions for all cleaning and disinfection products.
    - Consider use of wipeable covers for electronics.
    - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

- √ **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)
- √ **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- √ Laundry from a COVID-19 cases **can be washed with other individuals' laundry.**
  - o Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
  - o Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - o Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

√ **Consult** cleaning recommendations above **to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective quarantine, should coordinate with local public health officials to ensure that close contacts of COVID-19 cases will be effectively quarantined and medically monitored.

√ **Incarcerated/detained persons who are close contacts of a** confirmed or suspected COVID-19 case **(whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**

- If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.

√ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**

- Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
- Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

√ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**

- Provide medical evaluation and care inside or near the quarantine space when possible.
- Serve meals inside the quarantine space.
- Exclude the quarantined individual from all group activities.
- Assign the quarantined individual a dedicated bathroom when possible.

√ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.

- If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation immediately.
- If an entire housing unit is under quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
- Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.

- o If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.

√ **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.)

√ **In order of preference, multiple quarantined individuals should be housed:**

- o Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- o Separately, in single cells with solid walls but without solid doors
- o As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
- o As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door
- o As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- o As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- o As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- o Safely transfer to another facility with capacity to quarantine in one of the above arrangements

(NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

√ **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see PPE section and Table 1):

- o If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
- o If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
- o All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
- o Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.

√ **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).

- o Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.

- √ **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - o If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical Isolation section above.)
  - o See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- √ **If an individual who is part of a quarantined cohort becomes symptomatic:**
  - o **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - o **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
  - o **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- √ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- √ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- √ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- √ **Laundry from quarantined individuals can be washed with other individuals' laundry.**
  - o Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
  - o Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - o Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - o Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space for medical isolation should coordinate with local public health officials to ensure that suspected COVID-19 cases will be effectively isolated, evaluated, tested (if indicated), and given care.

- √ **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.**
- √ **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See Medical Isolation section above.**

√ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.

√ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**

- o If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
- o If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms

√ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**

- o Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
- o Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

√ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See Screening section for a procedure to safely perform a temperature check.

√ **Consider additional options to intensify** social distancing within the facility.

Management Strategies for Staff

√ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**

- o Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.

√ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**

- o See above for definition of a close contact.
- o Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

Infection control guidance below is applicable to all types of correctional facilities. Individual facilities should assess their unique needs based on the types of exposure staff and incarcerated/detained persons may have with confirmed or suspected COVID-19 cases.

√ **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates.**

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).

√ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).

√ **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

√ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**

- If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
- The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.

√ **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**

√ **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask.**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.

√ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**

√ **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**

√ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons

√ **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases.**

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program.
- For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.

√ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**

√ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (**see Table 1). **Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**

√ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**

√ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**

See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.

- **Face mask**
- **Eye protection—**goggles or disposable face shield that fully covers the front and sides of the face
- **A single pair of disposable patient examination gloves**

Gloves should be changed if they become torn or heavily contaminated.

- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
  - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.

√ **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**

- **Guidance in the event of a shortage of N95 respirators**
  - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
- **Guidance in the event of a shortage of face masks**
- **Guidance in the event of a shortage of eye protection**
- **Guidance in the event of a shortage of gowns/coveralls**

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	–	✓	–	–	–
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)	–	Face mask, eye protection, and gloves as local supply and scope of duties allow.			–
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons	–	✓	✓	✓	✓
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	✓**		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	✓	–	✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, and visitors who enter correctional and detention facilities, as well as incarcerated/detained persons who are transferred to another facility or released from custody. Below, verbal screening questions for COVID-19 symptoms and contact with known cases, and a safe temperature check procedure are detailed.

- √ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**
  - *Today or in the past 24 hours, have you had any of the following symptoms?*
    - *Fever, felt feverish, or had chills?*
    - *Cough?*
    - *Difficulty breathing?*
  - *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*
- √ **The following is a protocol to safely check an individual's temperature:**
  - Perform hand hygiene
  - Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
  - Check individual's temperature
  - **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
  - Remove and discard PPE
  - Perform hand hygiene

EXHIBIT G

The Commonwealth of Massachusetts
County of Plymouth
Sheriff's Department

24 Long Pond Road
Plymouth, MA 02360
Telephone: (508) 830-6200
Fax: (508) 830-6201
www.pcsdma.org

Joseph D. McDonald, Jr.
Sheriff

Gerald C. Puldosky
Special Sheriff

Accredited by:
ACA
American Correctional Association

April 2, 2020

Francis V. Kenneally, Clerk
Supreme Judicial Court
John Adams Courthouse
One Pemberton Square, Suite 2500
Boston, MA 02108

Re: Committee for Public Counsel Service, et al. v. Chief Justice of the Trial Court, et.al.
SJC Docket No. SJC-12926

Dear Sir:

In response to the Court's questions, the Plymouth County Sheriff provides the following information:

1. Approximately 49.2% of inmates or detainees sleep within six feet of one another. This is based on a housing analysis of all inmates and detainees in the Facility, excluding disciplinary detention inmates as instructed. Inmate bunks are constructed of 3/16 inch thick steel.

2. Approximately 56.72% of inmates eat their meals within six feet of one another. This estimate is based on observation of inmates in typical units on the date of the Order. The inmates in most housing units come out in two separated groups to eat and have multiple seating options which provide significant opportunity for social distancing.

3. Approximately 47.36% of inmates are permitted to be within six feet of one another during recreation periods. This is based on observation of inmates in typical units on the date of the Order. The inmates in most units have split recreation periods which offer significant opportunity for social distancing, and the officers and supervisors routinely reinforce the importance of such social distancing.

Respectfully submitted,

Patrick C. Lee
General Counsel

EXHIBIT H

AFFIDAVIT OF EDWARD P. RYAN , JR.

I, Edward P. Ryan, Jr., hereby state and declare as follows:

1. I am an attorney licensed to practice law in the Commonwealth of Massachusetts. I represent Anthony Baez, a defendant in the criminal matter captioned as *United States v. Anthony Baez*, Crim. No. 19-CR-40049-TSH pending in the United States District Court for the District of Massachusetts.

2. Mr. Baez is currently being detained at the Plymouth County House of Correction ("Plymouth HOC") pending his trial in the above-referenced criminal action.

3. On April 15, 2020, I spoke with Mr. Baez regarding the conditions of his confinement at Plymouth HOC in light of the ongoing COVID-19 epidemic. The following paragraphs contain a true and accurate summary of the information provided to me by Mr. Baez relating to those conditions of confinement.

4. Mr. Baez explained that he is currently confined in a cell that he shares with four other detainees. There is one toilet in the cell that is shared by all five men. Given the size of the cell, it is impossible for Mr. Baez to maintain six feet of separation from his other cellmates during the periods when they are in the cell, including while they sleep.

5. There is a total of approximately seventy (70) detainees in the "block" where Mr. Baez and his cellmates are being detained at Plymouth HOC. Mr. Baez and his cellmates are released from their cell for only four hours per day, during which they can go to the common areas of the Plymouth HOC. During those periods, approximately thirty-five (35) detainees on his "block" at the Plymouth HOC can

mingle generally amongst each other. The other approximately thirty-five (35) detainees are allowed out of there cells for a different four-hour period each day. When the detainees are out of their cells, there is no effort to maintain separation of at least six feet from other detainees and staff. No "social distancing" protocols are enforced by Plymouth HOC staff in those common areas.

6. There are eight picnic tables with benches, and no individual seats in the "block" that are shared by the detainees in the section of Plymouth HOC where Mr. Baez is detained. The detainees regularly sit at those tables shoulder-to-shoulder. There are also cushion chairs that are side by side that detainees use to watch television or just sit. There are approximately twelve on one side and eight on the other in an area where the corrections officer sits in his cubicle.

7. Mr. Baez stated that he was recently provided with a face mask, but that he is not required to wear it at all times when he is outside of his cell. He is only required to wear it, if for any reason he leaves the block. Some correction officers wear a mask and others do not. Mr. Baez has seen some Plymouth HOC staff recently wearing face masks, but the masks are not worn by all staff. Plymouth HOC staff routinely are within six feet of detainees when they interact with the detainees at the facility.

8. Mr. Baez has not been provided with hand sanitizer. Mr. Baez thinks that guards have hand sanitizer, but they are no allowed to use it. Mr. Baez stated that each man in the cell receives one roll of toilet paper and one bar of soap each week.

9. Mr. Baez does not believe that the cell block is cleaned properly.

There are no bars of soap, bacterial soap available at the canteen.

Signed this 16th day of April, 2020, under the pains and penalties of perjury.

Edward P. Ryan, Jr.

EXHIBIT I

AFFIDAVIT OF ATTORNEY JANE PEACHY

1. My name is Jane Peachy. I am an attorney at the Federal Public Defender Office. I represent Jonathan Bermudez in a pending criminal case in the District of Massachusetts, Docket No. 19-CR-10180-LTS.

2. I have filed a motion on behalf of Mr. Bermudez seeking his release from custody based on the COVID-19 pandemic. In preparation for that motion, I spoke to Mr. Bermudez on April 2, 2020, April 10, 2020, and April 16, 2020 about the conditions at the jail where he is detained. The following is the information he relayed to me about the conditions at the jail.

3. Mr. Bermudez is detained pre-trial at the Plymouth County Correctional Facility. He is housed in unit H-3 with other pretrial inmates.

4. As of last week, Mr. Bermudez was assigned to a cell with one other person. The cell is small. There is one set of bunk beds. There is one toilet and one sink in the room, which he shared with his cellmate.

5. Inmates are responsible for cleaning their own cells. They have to ask the guards for cleaning supplies to clean their cells. The guards will give them cleaning spray for this purpose.

6. Up until today, inmates were not allowed to hand sanitizer. Only guards were allowed to have hand sanitizer. Today, some hand sanitizer was made available to inmates.

7. Inmates are given only one bar of soap per week.

8. There are approximately 70-80 other inmates on Mr. Bermudez's unit. The inmates eat meals on the unit. There are tables on the unit where they eat their meals. Up to four people sit at each table.

9. The inmates on the unit share showers. There are nine showers on the unit. An inmate worker assigned to clean the showers cleans them every few days.

10. Mr. Bermudez recently had an ingrown toenail that became infected. He believes the infection was from the showers. He submitted two medical requests to be seen about the infection with no response. It was only after I contacted the jail on behalf of Mr. Bermudez that he was seen by a nurse and prescribed an antibiotic.

11. On April 2, 2020, Mr. Bermudez's cellmate went to medical with symptoms of coronavirus. He had been telling Mr. Bermudez for a couple days before that that he had been feeling sick. His cellmate told him previously that he had intestine problems and was taking antibiotics.

12. After Mr. Bermudez's cellmate was taken to medical, staff told him to pack up his cellmate's property, which he did, and they removed his property from their cell. Staff did not give Mr. Bermudez gloves to do this. Inmates are not allowed to have gloves at all unless you are a worker.

13. Mr. Bermudez heard rumors that two staff members have tested positive for the virus. When Mr. Bermudez went to medical for his toe, he heard another staff member was sent home with symptoms. Inmates are not being given any information about the spread of the virus in the jail. The only information they get is from word-of-mouth or in the news.

14. One other inmate from Mr. Bermudez's unit went to medical and has not returned. Staff removed his property from the unit.

15. Since the coronavirus outbreak, Mr. Bermudez and the other inmates on his unit have been locked in their cells for up to 26 hours in a row at a time. They are only given four hours out of their cells a day. Staff continue to come in and out of the jail.

16. Mr. Bermudez has expressed great fear and concern for health and safety due to the conditions at the Plymouth County jail and the coronavirus pandemic.

Signed under the penalties of perjury this 16th day of April 2020:

/s/Jane Peachy
Jane Peachy

EXHIBIT J

AFFIDAVIT OF ATTORNEY KEITH HALPERN

I, Keith Halpern, attest:

1. I am an attorney. I represent Jermaine Gonsalves (hereafter "Mr. Gonsalves") in a pending federal criminal case, *United States v. Djuna Goncalves, et al.*, Crim. No. 18-10468-NMG.

2. Mr. Gonsalves is a pretrial detainee at the Plymouth County House of Correction (hereafter "Plymouth"). He has been held at Plymouth since early January 2019.

3. On April 8, 2020, I spoke to Mr. Gonsalves on the phone concerning conditions at Plymouth. I affirm that the following paragraphs of this Affidavit accurately state what Mr. Gonsalves told me during this conversation.

4. Mr. Gonsalves stated that he is housed in a cell with one other inmate. There is one bunk unit in the cell. The bunk has two beds, one stacked on top of the other. The beds are less than 6' apart. It is not possible for Mr. Gonsalves and his cellmate to maintain a distance of 6' between themselves while in their cell together.

5. Mr. Gonsalves stated that there has been no change in meal conditions due to the pandemic. The number of inmates eating together has not changed. Inmates eat at rectangular tables that seats six, in a room with a number of similar tables. There is no effort to maintain a distance of 6' between inmates. Rather, inmates are seated immediately next to one another at the tables, with other inmates seated across the table, all within a distance of 6'.

6. According to Mr. Gonsalves, less than half of the correctional officers are wearing masks. There has been no change in the manner in which correctional officers interact with inmates, and no effort to maintain greater physical distance between correctional officers and inmates. Correctional officers are routinely within 6' of inmates.

7. Mr. Gonsalves stated that inmates have no access to liquid soap or hand sanitizer. Inmates

are provided with one small bar of soap each week. There has been no change in soap access due to the pandemic.

8. Mr. Gonsalves told me that, prior to the pandemic, inmates received two rolls of toilet paper each week. Since the pandemic began, inmates are receiving one roll of toilet paper per week.

9. Mr. Gonsalves stated that Plymouth is a dirty environment, and there have been no visible efforts to improve cleanliness as a result of the pandemic. Plymouth is as dirty as it was before the pandemic.

10. Mr. Gonsalves stated that a special unit, C-1, had been set up for the quarantine of inmates with symptoms suggesting Coronavirus. He stated that inmates were reluctant to report feeling unwell because they feared being moved into the quarantine unit and being surrounded by sick inmates.

11. Mr. Gonsalves stated that there were no efforts being made to keep inmates at least 6' apart, or to keep inmates and correctional officers at least 6' apart.

12. Mr. Gonsalves stated that no changes to inmates' recreation had been made. Inmates have four hours of recreation per day. At recreation, inmates can work out, play basketball, and engage in other activities without regard to how far apart they are from one another, and that inmates are routinely within 6' of one another.

Signed under the penalties of perjury this 14th day of April 2020.

Keith Halpern

EXHIBIT K

AFFIDAVIT OF JESSICA THRALL

I, Jessica Thrall, do hereby aver that the following is true, under the penalties of perjury:

1. My name is Jessica Thrall. I am employed at the Federal Public Defender Office as a trial attorney.
2. On March 20, 2019, I was appointed to represent Mr. Dedrick Lindsey in criminal matter 19-CR-10091-MLW. Mr. Lindsey has at all times during the pendency of this matter been detained that the Plymouth County Correctional Facility. I have visited him there and receive regular calls and mailings from him there.
3. Since the recent COVID-19 outbreak in the United States, I have spoken with Mr. Lindsey regularly concerning his conditions of confinement.
4. Mr. Lindsey is currently in a dorm unit. This is a setting where 6-8 individuals share a living quarters. Their beds are next to one another. Mr. Lindsey is currently sleeping on the bottom bunk. There is no one above him at this time, but there is someone next to him on the same level. The beds are not 6 feet apart.
5. The individuals living in this dorm also share meals together. There are several tables for the men to eat at, but they cannot eat at a table alone as there are not enough tables for everyone. In order to sit at these tables and eat, they must be closer than 6 feet apart.
6. At any given time, additional people could be added to the dorm setting.
7. Mr. Lindsey is permitted to go outdoors for recreation time. However, this “rec time” is shared with people from other dorms or units. Mr. Lindsey chooses not to go outdoors at “rec time” as he will then have to be in proximity with more people than the individuals in his dorm.

8. Mr. Lindsey reports that the detainees were recently given masks. The guards use masks and gloves with variable frequency depending on who is working that shift.
9. Within the dorm unit, there is a spray bottle of sanitizer that the people on the dorm are allowed to utilize.
10. As of this morning, April 16, 2020, a hand sanitizer bottle was put in the dorm unit. Previously there had been no hand sanitizer.
11. Mr. Lindsey is fearful for his health and is concerned because he cannot control who he shares space with.

Date: April 16, 2020 *Jessica P. Thrall*

Jessica P. Thrall

EXHIBIT L

AFFIDAVIT OF ATTORNEY TIMOTHY WATKINS

I, Timothy Watkins, attest:

1. I am an attorney. I represent Samuel Baptista (hereafter "Mr. Baptista") in a pending federal criminal case, *United States v. Samuel Jose Baptista*, Crim. No. 19-40057-TSH.

2. Mr. Baptista is a pretrial detainee at the Plymouth County House of Correction (hereafter "PCCF"). He has been held at Plymouth since December 2019.

3. On April 10, 2020, I spoke to Mr. Baptista on the phone concerning conditions at PCCF. I affirm that the following paragraphs of this Affidavit accurately state what Mr. Baptista told me during this conversation.

4. Mr. Baptista stated that he is housed in a segregated unit at PCCF. He stated that correctional officers do not maintain six feet of distance between Mr. Baptista and the officers, nor do they maintain six feet of distance between themselves.

5. Mr. Baptista and others in his unit were given one paper mask four days ago. Mr. Baptista was told by PCCF staff to wear the mask when he thinks he should wear it, but that each mask could only be used five times.

6. Mr. Baptista has observed approximately half of correctional officers wearing masks. He has observed the masks worn by the correctional officers to be far more durable and thicker than the one he was given.

7. Mr. Baptista has observed correctional officers to be wearing gloves occasionally. Mr. Baptista was not provided with gloves.

8. Mr. Baptista receives one bar of soap each time he asks for soap. He has not received hand sanitizer. He has asked for hand sanitizer and his request was denied. He has not been given cleaning supplies to clean his unit, his toilet and/or the shower area.

9. Mr. Baptista was housed in the protective custody unit when the COVID-19 pandemic began. The protective custody unit at PCCF is an open cell, dormitory-style format, with no doors, in which detainees sleep within three feet of each other. Mr. Baptista did not observe any changes made within the unit regarding increased hygiene or social distancing after the COVID-19 pandemic began, other than a sign which instructed to report someone with COVID-19 symptoms to a correctional officer so that the correctional officer could hand out masks.

10. Mr. Baptista was taken to the medical unit on April 10, 2020 for a heart-related issue. Mr. Baptista observed correctional officers talking to each other within two feet of each other in the medical unit. He observed other detainees cleaning the medical unit without masks or gloves. He was in close proximity and less than six feet from other detainees in the unit. The doctor who treated him had a mask on, but the nurse who treated him did not have a mask.

11. Mr. Baptista stated that PCCF is extremely dirty and he has not observed any effort to clean the facility in response to the COVID-19 pandemic. He stated he fears for his health, particularly due to certain preexisting medical issues, and believes that if he contracts COVID-19, he will die.

Signed under the penalties of perjury this 16th day of April 2020.

Timothy Watkins, Esq.