IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

OSCAR SANCHEZ, *et al*.,	)	
	)	
Plaintiffs,	)	Civil Action
	)	Case No. 3:20-cv-00832
v.	)	
	)	
SHERIFF MARIAN BROWN, *et al*.,	)	
	)	
Defendants.	)	
	)	

DEFENDANTS' RESPONSE TO MOTION FOR TEMPORARY RESTRAINING ORDER, PRELIMINARY INJUNCTION, AND WRIT OF HABEAS CORPUS

COMES NOW Defendants Dallas County, Texas and Sheriff Marian Brown (collectively "Defendants") and file their Response in Opposition to Plaintiffs' Motion for a Temporary Restraining Order, Preliminary Injunction and Writ of Habeas Corpus. Defendants make this response subject to their contemporaneously filed motions to dismiss under Federal Rule of Civil Procedure 12(b)(6).

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INTRODUCTION

The public health crisis posed by COVID-19—unprecedented in our lifetimes—is an ongoing concern for law enforcement and government at all levels. Far from being deliberately indifferent to this crisis, Sheriff Brown (along with stakeholders throughout the pretrial criminal justice system) has taken prompt action over the past weeks to address and mitigate the threat COVID-19 poses to all in the Dallas County Jail. As a result of these efforts, the jail population is already down almost one thousand people—about twenty percent—in the past three weeks.

An unprecedented crisis of this magnitude demands a coordinated, flexible, and measured response within the bounds of state law. The requested emergency relief is none of these things, and Plaintiffs fail to carry their burden of showing they are entitled to any relief at all. First, Plaintiffs are unlikely to succeed on the merits because they will be unable to show that Sheriff Brown has acted with deliberate indifference to the threat of COVID-19. To the contrary, Sheriff Brown has taken prompt and effective action to implement procedures compliant with CDC guidelines—and more—over recent weeks. As the public health understanding of COVID-19 has evolved, applicable guidelines and the Sheriff's procedures have evolved as well. But at the very least, Sheriff Brown has responded objectively reasonably to this threat. Second, Plaintiffs have an adequate remedy at law—seeking release through state court proceedings. Numerous inmates (medically vulnerable and otherwise) have successfully petitioned the courts for release in recent weeks, and the Sheriff has facilitated that review by providing the courts with information on medically vulnerable inmates. Plaintiffs did not pursue these remedies. Finally, the remedy of wholesale release will not serve the public interest either by limiting the spread of COVID-19 or by preserving community safety. It is likely to achieve the opposite.

Plaintiffs are not entitled to a temporary restraining order, preliminary injunction, or writ of habeas corpus. But saying Plaintiffs do not meet the stringent requirements for emergency relief is different from saying that the Sheriff is not taking the once-in-a-lifetime threat of COVID-19 seriously. The Sheriff, like thousands of law enforcement officials around the country, is dealing with a fluid and evolving situation. Plaintiffs' requested relief would not just hinder, but would defeat, the good work already underway. Their lawsuit is meritless and their motion for a temporary restraining order must be denied.

BACKGROUND

I. Timeline of COVID-19 Government Response.

On March 12, Dallas County Judge Clay Jenkins issued a Declaration of Local Disaster for Public Health Emergency. The County Judge also banned public or private community gatherings of a certain size, and strongly recommended that organizations serving high-risk populations cancel gatherings of more than 10 people, based on the CDC's "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission."[1] Dallas County had reported its first presumptive positive COVID-19 case three days earlier, on May 10.[2]

On March 13, the President of the United States declared a national state of emergency and the Governor of Texas declared a state of disaster. *See In re Abbott*, No. 20-50264, 2020 WL 1685929, at *2 (5th Cir. Apr. 7, 2020) (discussing timeline of government orders during early stages of COVID-19).

On March 15, Dallas County courts cancelled all jury trials through May 8.[3]

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[1] *Available at* https://www.dallascounty.org/Assets/uploads/docs/judge-jenkins/covid-19/031220-CommunityGatheringsOrder.pdf.

[2] DALLAS MORNING NEWS, Out-of-state man, 77, and a close local contact, are DallaS County's first presumptive positive cases of coronavirus (Mar. 10, 2020), *available at* https://www.dallasnews.com/news/public-health/2020/03/10/dallas-county-reports-first-presumptive-case-of-coronavirus/.

[3] *Available at* https://www.dallascounty.org/Assets/uploads/docs/judge-jenkins/covid-19/3.15.2020-Press-Release-Dallas-County-Cancels-All-Jury-Trials-through-May8-2020.pdf.

On March 19, the Texas Health and Human Services Executive Commissioner declared a public health disaster. *Id.* On that same day, the Dallas County Commissioners Court issued an Order of Continuance of Declaration of Local Disaster for Public Health Emergency, extending the declaration of local disaster of March 12 to April 3, 2020.

On March 24, the County Judge issued a stay-at-home order. On April 3, Commissioners Court voted to extend the disaster declaration until May 20, and the County Judge then extended the stay-at-home order until April 30.[4] At the time, these extensions were enacted in light of models which suggested that these measures were important in order to prevent the local and state health care system from being overrun.[5]

As of April 14, 2020, Dallas County Health and Human Services reported a total of 1,877 cases in Dallas County, including 42 deaths.[6] 36 of those cases were reported as originating in the Dallas County Jail.[7]

Table 4. Transmission Risk Factors for Cumulative COVID-19 Cases, Dallas County

Exposure Risk Factor	**Cases** (N= 1,877)	**% of Total Cases**
International Travel	54	2.9%
Domestic Travel (Out-of-state)	111	5.9%
Cruise Ship Travel	8	0.4%
Long-Term Care Facility (Residency)	120	6.4%
Jail (Inmate)	36	1.9%
Close contact or Presumed Community Transmission*	1,546	82.4%

**Includes: household transmission, and cases with no other exposure risk factors identified*

[4] *Available at* https://www.dallascounty.org/Assets/uploads/docs/covid-19/orders-media/040820-DallasCountyOrder.pdf

[5] DALLAS MORNING NEWS, Dallas County residents ordered to stay home as new shelter-in-place rules are put in place, (Mar. 22, 2020), *available at* https://www.dallasnews.com/news/public-health/2020/03/22/dallas-county-residents-ordered-to-stay-home-as-new-shelter-in-place-rules-are-put-in-place/

[6] *Available at* https://www.dallascounty.org/Assets/uploads/docs/hhs/2019-nCoV/COVID-19%20DCHHS%20Summary_041420.pdf

[7] *Available at* https://www.dallascounty.org/Assets/uploads/docs/hhs/2019-nCoV/COVID-19%20DCHHS%20Summary_041420.pdf

II. Sheriff's Efforts to Comply with CDC Guidance and Mitigate COVID-19.

The facts outlined in this section and supported by the Declaration of Chief Deputy Fredrick Robinson, attached as Exhibit A to this response ("Robinson"), have likely not anticipated and addressed all the questions which the Court and Plaintiffs will have about jail operations. Defendants will respond to those questions as they are able, including by supplementing Chief Robinson's declaration if necessary. However, the facts set forth in this response do show the efforts taken by the Sheriff and the Dallas County Sheriff's Office (DCSO) to date to implement social distancing, personal hygiene, and other reasonable steps to mitigate the spread of COVID-19 within the jail, consistent with the CDC's Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities (the "Interim Guidance").[8] Defendants also submit the Declaration of Patrick Jones, Vice President of Correctional Health Services for the Dallas County Hospital District d/b/a Parkland Health and Hospital System ("Parkland"), attached as Exhibit B ("Jones"). Mr. Jones explains Parkland's procedures at inmate intake, as well as Parkland's procedures for isolation and quarantine of inmates where necessary. Defendants also submit the declaration of Jeff Segura, Dallas County Pretrial Services Manager, as Exhibit C ("Segura"). Mr. Segura addresses the Court's questions regarding the cost of alternatives to pretrial detention, like electronic leg monitoring.

These facts are sufficient to establish that the Sheriff has not acted with deliberate indifference to conditions of confinement in the jail in light of the ongoing COVID-19 crisis.

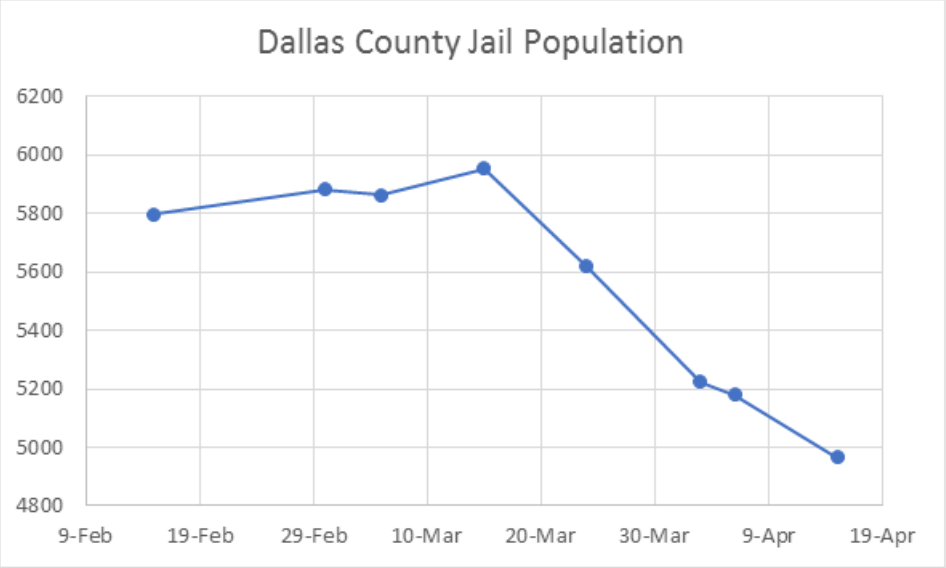
A. The Sheriff is already facilitating the court-ordered release of inmates.

The CDC Interim Guidance does not require or even suggest releasing inmates from jail. The Interim Guidance acknowledges that social distancing is a challenge within the confines of a

[8] *Available at* https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

jail, but includes several practical strategies to accomplish social distancing on an individual group, and operational level. *See* Interim Guidance, p. 11.

Nevertheless, the Sheriff has already taken voluntary steps to reduce the jail population in two significant ways: first, by requesting that local arresting agencies exercise their discretion to bring fewer people to jail in the first place; and second, by working with the felony and misdemeanor judiciary to identify medically vulnerable inmates and fast-track their release, if the court determines release to be appropriate. Due to the coordinated efforts of these stakeholders, the jail population has decreased by about one thousand people since March 17.



On any given day, most inmates in the Dallas County Jail are arrested and brought to jail by a local law enforcement agency (LEA) other than the Dallas County Sheriff, like the City of Dallas or other local jurisdictions. Robinson, ¶ 29. On March 17, Sheriff Brown sent a letter to the heads of 32 local LEAs, acknowledging the need to reduce jail population in light of COVID-19 and requesting that officers for the respective LEAs use their best judgment in determining whether persons should be cited and released, or arrested and brought to jail. *Id.*

Book-ins into the Dallas County Jail have decreased from a high of 227 on March 10, to 99 book-ins yesterday.

The Sheriff has also helped facilitate inmate release by assisting the judiciary, who under Texas law are the only ones who may order the release of an inmate from jail.[9] Starting on April 1, Parkland compiled a list of inmates who are, per CDC guidelines, at a high-risk for contracting COVID-19. Robinson, ¶ 31. Parkland provides that list to the Sheriff, who in turn provides that list to the presiding judges of the felony and misdemeanor courts. *Id.* The presiding judges distribute that list to the District Court judges and the County Criminal Court-at-Law judges assigned to the listed inmates' cases, and the assigned judge then reviews the cases and bonds for those inmates. *Id.* If the assigned judge determines that an inmate is eligible for a bond reduction or a personal bond, the judge will so order. *Id.* Upon receiving an order that results in a person's eligibility for release, the Sheriff promptly complies with that order. *Id.*, ¶ 33.

This process is conducted in coordination with efforts by the District Attorney to move to dismiss certain non-violent cases, as well as the ongoing bail review hearings held by felony and misdemeanor judges multiple times a day pursuant to the injunction entered by Judge Godbey in *Daves.* Robinson, ¶ 32. Defense attorneys can, and frequently do, request hearings to seek bond reductions or personal bonds for their clients. These joint efforts appear to have been productive, as the jail population has decreased significantly in past weeks. As of March 17, the jail population was 5,929. As of April 10, the jail population was 4,972—a reduction of approximately 1,000 inmates. *Id.*, ¶ 6. In fact, at least one of the Plaintiffs who is not currently in detention appears to have personally benefitted from stakeholder voluntary release efforts—Mr.

[9] Plaintiffs have argued in another pending suit—unsuccessfully—that the Dallas County Sheriff can go over a judge's head to release inmates from jail who are unable to pay a bond amount set by a judge. *See Daves v. Dallas County, et al.*, No. 3:18-cv-00154-N; *see also infra* Argument Section I.A.2.

Hinojosa testified that he was released due to the District Attorney seeking a court order voluntarily dismissing his case. *See* Hinojosa Dec., ECF No. 3-3.

B. Social distancing.

Fortunately (and due partly to the efforts described above) the Dallas County Jail is not at or near capacity, which is approximately 7,414 individuals. Robinson, ¶ 6. The current jail population makes it more feasible to enforce social distancing guidelines, which the Sheriff has worked diligently to do. *See* Interim Guidance, p. 11.

Part of the Sheriff's efforts include inmate education on why social distancing and personal hygiene measures are important. The Sheriff has posted a CDC one-pager, which explains why social distancing is necessary, encourages frequent hand-washing, and educates about the symptoms of the virus, throughout the jail. Robinson, ¶ 10. Additionally, the TVs located throughout the jail (in each pod and in the jail's common areas) air messages on the inmate channel explaining COVID-19 and the importance of the CDC guidelines on social distancing and personal hygiene. *Id.*, ¶ 11.

The Sheriff's officers enforce social distancing throughout the jail by repeatedly impressing upon inmates the need to practice social distancing, and by ordering increased space between inmates in common areas when officers observe that social distancing is not in effect. *Id.*, ¶ 12. Inmate movement throughout the jail has been reduced only to absolutely necessary moves. *Id.*

In-person inmate visitations have been suspended for everyone but attorneys of record. *Id.*, ¶ 13. Video visitations have instead been made available free of charge to anyone (including attorneys) who requests it. *Id.*

C. Sanitation and use of personal protective equipment.

As CDC guidelines on sanitation, personal hygiene, and the use of personal protective equipment (PPE) have evolved in response to COVID-19, the Sheriff has adapted jail standard operating procedures to accommodate those guidelines. Currently, all jail staff are required to wear face masks. Robinson, ¶ 19. Inmates are provided with masks, whether symptomatic or asymptomatic (current CDC guidelines do not require that asymptomatic inmates should wear masks, but the Sheriff has provided masks to asymptomatic inmates regardless). *Id.*, ¶¶ 19-20. Inmates receive masks immediately upon being brought to the jail. *Id.*, ¶ 15.

Cleaning supplies are widely available, and provided to inmates at all times. *Id.*, ¶ 23. Inmates are responsible for cleaning their cells, and are provided with cleaning supplies in order to do so. *Id.*, ¶¶ 21, 23. Trustees (inmates who have been entrusted with certain responsibilities by the Sheriff) are responsible for cleaning the jail's common areas. *Id.*, ¶ 21. The Sheriff's staff clean officer-only areas of the jail, and Parkland cleans the infirmary. *Id.* If an inmate tests positive while in the jail, or an inmate is suspected to have had exposure to the virus while in the jail, a third-party vendor sanitizes each part of the jail in which the positive or suspected inmate may have had contact. *Id.*, ¶ 22. Per CDC guidelines, hand soap is also made available to inmates at all times. *Id.*, ¶ 24. Hand sanitizer is not currently provided to inmates because of its alcohol content, but the Sheriff is examining ways to make hand sanitizer available to inmates (it is available to, and is used by, staff). *Id.*

D. Intake, Isolation, and Quarantine

The Sheriff, in conjunction with Parkland, also implemented new screening procedures. Robinson, ¶ 34; Jones, ¶¶ 5-9. Initial shakedown procedures are relocated outside of the intake area to a separate area, where inmates who have a fever at or above 100.4 degrees or who answer

"yes" to any of a set of questions about travel behavior and symptoms are evaluated by a nurse. Robinson, ¶ 34.b; Jones, ¶ 6. Masks are provided to each inmate immediately upon intake. Robinson, ¶ 15.

Parkland screens and classifies inmates consistently with CDC guidelines as Persons Confirmed COVID (PCC), Persons Under Investigation (PUI), and Persons Under Monitoring (PUM). Jones, ¶¶ 5-10. Parkland is responsible for the medical treatment and monitoring of these inmates. Parkland's procedures are described in more detail in the Declaration of Patrick Jones. *Id*.

III. COVID-19 Litigation Nationwide.

This is not the first case in which inmates have sought release based on the potential or actual presence of COVID-19 in their place of detention. Courts have taken different approaches to dealing with this cases, but to date, no court has ordered the kind of class-wide mass release of state court prisoners which Plaintiffs seek here.

One set of COVID-19 cases deal with federal-court challenges to a federal jail or prison facility, based either on the conditions of confinement or on the duration of confinement and conditions of pretrial release. Plaintiffs rely on each of these cases as precedent for their habeas relief, but these cases are distinguishable—they concern individual federal prisoners (or small groups of prisoners) seeking release from immigration custody based on their unique circumstances. *See, e.g.*, *Coronel v. Decker*, No. 20-cv-2472 (AJN), 2020 WL 1487274 (S.D.N.Y. Mar. 27, 2020) (granting a temporary restraining order requiring four detainees' release under 28 U.S.C. § 2241 in part because "[an immigration-court bond] hearing weeks from now may be no relief at all, because Petitioners may contract COVID- 19 in the interim and face serious health consequences—including death"); *Zhang v. Barr*, No. 20- cv-331 (C.D. Cal.

Mar. 27, 2020) (granting a habeas petitioner in immigration detention an expedited bond hearing, noting that "delay in determining Petitioner's release exposes him to unnecessary risk [in light of the pandemic]"); *Calderon Jimenez v. Wolf*, No. 18-cv-10225, Docket Entry No. 507-1 (D. Mass. Mar. 26, 2020) (ordering a single habeas petitioner's release from immigration detention on bail in light of the pandemic); *Basank v. Decker*, No. 20-cv-2518 (AT), 2020 WL 1481503 (S.D.N.Y. Mar. 26, 2020) (granting a temporary restraining order under § 2241 requiring the release of one detainee from immigration custody); *Castillo v. Barr*, No. 20-cv-605, Docket Entry No. 32 (C.D. Cal. Mar. 27, 2020) (ordering two habeas petitioners to be released from immigration detention under a temporary restraining order because of COVID-19); *Arana v. Barr*, No. 19-cv-7924 (PGG) (DCF) (S.D.N.Y. Mar. 27, 2020) (magistrate judge's report and recommendation recommending "that, due to extraordinary circumstances brought about by the COVID-19 outbreak, which has apparently reached the jail where [the habeas] Petitioner is being detained, and by which he may be particularly seriously impacted as a result of underlying medical conditions, [the] Petitioner be ordered released from [immigration] custody pending his bond hearing").

A second set of cases involves challenges to conditions of confinement in state or local jails, including allegations (like those here) that the local jailer has failed to take reasonable steps to reduce and address the risk of infection and illness from COVID-19. Plaintiffs have understandably not cited to these cases, since (to the extent those cases granted any relief at all) the relief granted has been narrowly tailored to specific, identifiable instances where the jailer was deficient in complying with CDC guidelines for social distancing, hygiene, and personal protective equipment (PPE)—not wide-ranging release of classes and subclasses of the entire jail population. *See, e.g.*, *Mays v. Dart*, No. 20-cv-2134 (N.D. Ill. Apr. 9, 2020) (granting a limited

temporary restraining order requiring certain coronavirus-related safety measures at the Cook County Jail in Chicago, but denying most requests for relief, including a putative subclass's request to be transferred to a safer facility or other form of custody); *Swain v. Junior*, No. 20-cv-21457-KMW (S.D. Fla. Apr. 7, 2020) (granting in part a temporary restraining order requiring increased coronavirus protections at Metro West Detention Center in Miami-Dade County); *Plata v. Newsom*, No. 4:01-cv-01351-JST (N.D. Cal. Apr. 4, 2020) (denying California prisoners' motion before a three-judge Prison Litigation Reform Act panel to require COVID-19-related releases, but suggesting that relief may be available at single-judge courts).

Finally, in a case pending before Judge Rosenthal in the Southern District of Texas, a class of felony arrestees represented by many of the same counsel who represent Plaintiffs in this suit recently sought a TRO staying Governor Abbott's Executive Order GA-13 (limiting the discretion of state court judges to grant personal bonds during the COVID-19 crisis) and ordering the Harris County Sheriff to release felony arrestees who had not received individualized assessments. *See Russell v. Harris County*, No. H-19-226, ECF No. 122 at p. 2. Judge Rosenthal declined to do so. Key to her decision was the record before her, which reflected voluntary and ongoing efforts by criminal justice stakeholders to accomplish the release of qualified, medically vulnerable Harris County jail inmates. *Id.* at p. 3 (citing ongoing efforts to "achieve a workable, voluntary process for the safe release of appropriate pretrial, not convicted, arrestees within the present pandemic restraints" as "a powerful reason for a federal court to decline to intervene through the blunt instrument of a temporary restraining order."). In *Russell*, Plaintiffs asked for less drastic relief than they are seeking in this case. Caution in fashioning a remedy, should the Court find a remedy is justified (which it is not) is even more appropriate here.

IV. The *Daves* Litigation.

Finally, the Court may find a short summary of the ongoing *Daves* litigation helpful in understanding some of the relief Plaintiffs seek, and why that relief is unwarranted. *See* Court's Mem. Op. and Order in *Daves v. Dallas Cnty., Tex.*, 341 F. Supp. 3d 688 (N.D. Tex. 2018).

In the *Daves* litigation, a class of misdemeanor and felony plaintiffs (represented by some of the same counsel as represent Plaintiffs in this suit) sued Dallas County, the Sheriff, the Dallas County Criminal District Court Magistrates, and the District Court and County Criminal Court-at-Law judges under 42 U.S.C. § 1983, challenging how judicial officers set bail.[10] The issues in *Daves* were virtually identical to the *ODonnell* case filed by the same counsel two years prior in Harris County. *See ODonnell v. Harris County*, 892 F.3d 147 (5th Cir. 2018) (op. on reh'g).

Judge Godbey entered an order of preliminary injunction based closely on the Fifth Circuit's model injunction from *ODonnell*. Under that injunction, each arrestee receives an individualized hearing and assessment at magistration within 48 hours of being brought to the Dallas County jail. The misdemeanor judges also conduct bail review hearings on a daily basis for any arrestee who seeks a reduction of the bail amount set by the magistrate.

Plaintiffs and Dallas County appealed parts of the preliminary injunction. Dallas County appealed Judge Godbey's finding that the judges were county policymakers for purposes of Section 1983 liability. Plaintiffs appealed Judge Godbey's rejection of their argument that substantive due process requires more than the procedural due process remedy of *ODonnell*, including a finding by clear and convincing evidence that detention is necessary, and that no

[10] *Daves* is one of about a dozen cases filed by counsel throughout the country challenging local bail systems. *See Walker v. City of Calhoun*, 4:15-cv-170 (N.D. Ga.); *Cooper v. City of Dothan*, No. 1:15-cv-425 (M.D. Ala.); *Snow v. Lambert*, No. 3:15-cv-567 (M.D. La.); *Varden v. The City of Clanton*, No. 2:15-cv-34 (M.D. Ala.); *Thompson v. City of Moss Point*, 1:15-cv-182 (S.D. Miss.); *Rodriguez v. Providence Cmty. Corrs., Inc.*, 3:15-cv-1048 (M.D. Tenn.); *Pierce v. City of Velda City*, 4:15-cv-570 (E.D. Mo.); *Buffin v. City and Cnty. of San Francisco*, 4:15-cv-4959 (N.D. Cal.); *Caliste v. Cantrell*, 2:17-cv-6197 (E.D. La.); *ODonnell v. Harris Cnty., Tex.*, 4:16-cv-1414 (S.D. Tex.); *Booth v. Galveston Cnty., Tex.*, 3:18-cv-104 (S.D. Tex.); *Edwards v. Cofield*, 3:17-cv-321 (S.D. Ala.).

other conditions of release will satisfy the government's interest. The Fifth Circuit heard oral argument on November 4, 2019, and the appeal remains pending today.

Daves has relevance to this case because Plaintiffs are attempting to smuggle in the "clear and convincing" evidentiary standard—which Judge Godbey has already rejected for setting bail—in their proposed relief here. *See* ECF No. 3, p. 34 (seeking relief that inmates must be released "absent proof of judicially-recorded findings by clear and convincing evidence that the individual poses such a serious risk of flight or danger to others that no other conditions can mitigate."). The Fifth Circuit is likely to affirm Judge Godbey's finding that what the Constitution requires is individualized consideration of each arrestee's unique facts and circumstances before setting bail according to state law factors—not the "clear and convincing" standard applicable under the federal Bail Reform Act. *See ODonnell*, 892 F.3d at 163 (holding that the remedy for constitutional deficiencies in the bail-setting process was consideration of "the various factors required by Texas state law….notice, an opportunity to be heard and submit evidence within 48 hours of arrest, and a reasoned decision by an impartial decisionmaker.").

ARGUMENT

I. Plaintiffs have not satisfied the factors necessary for injunctive relief.

A. Standard

A preliminary injunction is an "extraordinary remedy," and the "decision to grant a preliminary injunction is to be treated as the exception rather than the rule." *Mississippi Power & Light Co. v. United Gas Pipe Line Co.*, 760 F.2d 618, 621 (5th Cir. 1985). Such a remedy should not be granted unless the movant, "*by a clear showing*, carries the burden of persuasion." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (emphasis added). To carry this burden, Plaintiffs must establish "(1) a substantial likelihood of success on the merits, (2) a substantial

threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that the grant of an injunction will not disserve the public interest." *Jones v. Tex. Dep't of Criminal Justice*, 880 F.3d 756, 759 (5th Cir. 2018) (per curiam) (quoting *Byrum v. Landreth*, 566 F.3d 442, 445 (5th Cir. 2009)). The party seeking injunctive relief must meet all four requirements. *Jordan v. Fisher*, 823 F.3d 805, 809 (5th Cir. 2016).

Plaintiffs cannot sustain their substantial burden to justify the unprecedented remedy they seek, and their request for injunctive relief must be denied.

B. Plaintiffs are not likely to succeed on the merits of their underlying claims.

Plaintiffs brought this emergency request for relief against Sheriff Brown and Dallas County, alleging that conditions at the Dallas County Jail pose a substantial risk of harm to their safety—a risk that cannot be mitigated by anything less than the release of a subclass of detainees who are particularly susceptible to the virus (and a future broader class of *all* detainees to be released as necessary to allow the jail to impose social distancing throughout). ECF No. 3, p. 26. Plaintiffs' condition of confinement claim fails.

Plaintiffs' conditions of confinement claim requires Plaintiffs to demonstrate the existence of an identifiable *intended* condition or practice, not reasonably related to a legitimate governmental objective—an inquiry "functionally equivalent" to a deliberate indifference inquiry. *See Hare v. City of Corinth, Miss.*, 74 F.3d 633, 643 (5th Cir. 1996). *Hare* incorporated the Supreme Court's deliberate indifference test: "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if [she] knows that inmates face a substantial risk of serious harm and *disregards* that risk by failing to take *reasonable measures* to abate it." *See Farmer v. Brennan*, 511 U.S. 825, 847 (1994) (emphasis

added). And the mere incidence of COVID-19 in the jail is not by itself sufficient to justify a finding that confinement conditions are unconstitutional. Plaintiffs must show a "pervasive pattern of serious deficiencies." *See Duvall v. Dallas County*, 631 F.3d 203, 208 (5th Cir. 2011).

1. The Sheriff has acted reasonably, not with deliberate indifference, in responding to an unprecedented crisis.

The Sheriff's voluntary efforts to date, in conjunction with other criminal justice stakeholders, have implemented the CDC Interim Guidance and effectively reduced jail population. Judges continue to work to effectuate the safe release of appropriate pretrial arrestees, and the Sheriff has also assisted in those efforts.

The Interim Guidance suggests, among other things, that pre-intake screening and temperature checks for all new entrants should be performed. Interim Guidance, p. 10. This is happening. Robinson, ¶ 34; Jones, ¶¶ 5-10. The Interim Guidance suggests symptomatic individuals should be required to wear masks. Interim Guidance, p. 10. This is happening. Robinson, ¶¶ 19-20. Parkland has likewise implemented procedures consistent with the CDC Interim Guidance and classifications to isolate and quarantine symptomatic or confirmed inmates. *See* Jones generally.

The Interim Guidance's social distancing suggestions acknowledge that not all strategies will be feasible in all facilities, *see* Interim Guidance, p. 11, but the Sheriff is nevertheless implementing many of the suggested CDC strategies as appropriate for the Dallas County Jail. DCSO officers enforce increased space between individuals when they observe violations. Robinson, ¶ 12. Meals are provided inside cells for inmates held in single cells. *Id.*, ¶ 18. Symptomatic and confirmed inmates are assessed by medical and relocated if appropriate based on their reclassification by medical. Robinson, ¶ 34; Jones, ¶¶ 5-10. The Sheriff has posted information about COVID-19 and instructions about the importance of social distancing

throughout the jail, and on inmate television. Robinson, ¶¶ 10-11. In-person visitations (other than with attorneys) have been suspended (and, to compensate for this suspension, video visitations have been made available to whoever requests them free of charge). *Id.*, ¶ 13.

The Interim Guidance on cleaning and disinfection practices recommends ensuring adequate supplies to support intensified cleaning and disinfection practices. Interim Guidance, p. 9. This has happened. Robinson, ¶¶ 21-23. If a case is confirmed or suspected, a third-party vendor sanitizes the areas in which the confirmed or suspected inmate had contact. *Id.*, ¶ 22. On personal hygiene, the Interim Guidance recommends soap be made available, and soap is made plentifully available at no cost to inmates. *Id.*, ¶ 24.

The declarations submitted by the Plaintiffs, in several instances, confirm the Sheriff's practices described above.[11] Although the declarations are in many cases dated around March 23rd, about the same time that the stay-at-home order in Dallas County went into effect, Plaintiffs' evidence confirms that even at that early stage, COVID-19 mitigation efforts were in effect. As just one example, Mr. Hinojosa confirms that he began receiving instructions about social distancing and washing hands frequently in February. *See* ECF No. 3-3, ¶ 4. Mr. Hinojosa confirms that access to soap was available and that jail staff were wearing PPE. *Id.*, ¶¶ 6-7. Mr. Hinojosa also confirms that sick inmates around him were removed from his area and relocated. *Id.*, ¶ 1.

2. Plaintiffs are not likely to succeed on their claim for mass release of detainees.

[11] Plaintiffs' declarations often constitute hearsay, or hearsay within hearsay. Some of the Plaintiffs appear to have been interviewed over the phone and their comments transcribed by Plaintiffs' counsel. Of course, the Court is not obliged to refuse to consider hearsay at this preliminary stage. But in weighing the evidence and considering the totality of the record at this very early stage, the Court should consider that the declarations of persons seeking release from jail under these unusual circumstances are likely to be uniquely self-serving.

There is no likelihood that Plaintiffs will prevail on their claim that Sheriff Brown violated the rights of medically vulnerable detainees by refusing to release them based on nothing more than their age or potential susceptibility to infection.

First, the Sheriff has not acted unreasonably by not unilaterally releasing inmates from jail who are detained pursuant to a facially valid court order. The Sheriff has a legal obligation to follow all lawful "process and precepts," including the bond or probation orders that led to the detention of the proposed sub-classes. *See* Tex. Local Gov't Code § 85.021-22 (stating that the county sheriff "shall execute all process and precepts directed to the sheriff by legal authority"). Were Sheriff Brown to do otherwise, she could be held in contempt for "willfully refus[ing] or fail[ing] from neglect to execute any summons, subpoena or attachment for a witness, *or any other legal process* which it is made [her] duty by law to execute." Tex. Code Crim. Proc art. 2.16 (emphasis added); *see also* Tex. Local Gov't Code § 85.021-22; Tex. Code Crim. Proc art. 2.18; *Scott v. O'Grady*, 975 F.2d 366, 371 (7th Cir. 1992) (construing a similar statute and noting that the sheriff has a statutory duty to follow court orders). The Sheriff must follow state law—she cannot instead "choose" to release inmates. Because the Sheriff has no legal authority to release any jail inmate in violation of the court order setting the terms of that inmate's confinement, her inability to release the proposed classes of detainees to this point in time is objectively reasonable and not a deliberately indifferent violation of their rights.

Second, the subclasses of medically vulnerable detainees are not entitled to release by mass-writ of habeas corpus under 28 U.S.C. § 2241. *See* ECF No. 3, p. 34 (seeking a writ of habeas corpus requiring release of designated subclasses).[12] In the Fifth Circuit, the exhaustion requirement is not prudential, as Plaintiffs suggest, but mandatory absent "special

[12] For this reason, the Sheriff is also not a proper party to this suit for purposes of habeas relief. Sheriff Brown and Dallas County incorporate by reference their briefing from their concurrently filed motion to dismiss.

circumstances." *See Dickerson v. Louisiana*, 816 F.2d 220, 225 (5th Cir. 1987). This requirement serves important comity purposes—"protecting the state courts' opportunity to confront and resolve initially any constitutional issues arising within their jurisdictions as well as to limit federal interference in the state adjudicatory process." *Id.* (citations omitted).

While "inordinate and unjustified" delay may justify excusing the exhaustion requirement, *see Hopes v. Davis,* 761 Fed. Appx. 307, 310 (5th Cir. 2019) (citations omitted), Plaintiffs do not allege that any such delay has happened for any individual petitioner, or that any petitioner has even attempted to commence, let alone exhaust, state remedies. And Plaintiffs cite no relevant authority to support their conclusion that no exhaustion requirement could "conceivably" apply to state court prisoners seeking "COVID-based discharge." ECF No. 1, p. 38. Although Plaintiffs claim that courts "across the country have granted emergency habeas petitions ordering the release of medically vulnerable people from confinement," *(see* ECF No. 3, p. 31), each of the cases Plaintiff cites deal with individual *federal* prisoners (or small groups of prisoners, not the class of thousands proposed here) detained by ICE, who successfully proved that their individual circumstances and unique susceptibility to COVID-19 justified release.

Moreover, had Plaintiffs attempted a state court remedy before coming to this Court, they would likely have been successful. With the full cooperation of Sheriff Brown, the courts in Dallas County are already conducting individualized determinations of the eligibility of medically vulnerable inmates for release. And any detainee currently in the Dallas County jail—medically vulnerable or otherwise—may seek to have his or her bail reduced or eliminated altogether, under Texas law and under the injunction currently in place in Dallas County resulting from the *Daves v. Dallas County* litigation, requiring that judges hold bail review hearings for misdemeanor and felony arrestees within hours of arrest. *See Daves v. Dallas Cnty.*,

Tex., 341 F. Supp. 3d 688, 695–96 (N.D. Tex. 2018). Plaintiffs offer no evidence that these hearings are not occurring, nor do Plaintiffs offer any non-speculative evidence that the hearings do not result in the release of qualified inmates—Plaintiffs' own evidence confirms the opposite. *See* ECF No. 1-11 at 4. Plaintiffs instead invite this Court to take an end-run around this process and substitute its judgment for the judgment of state court judges, who are required by law to give individualized consideration to the facts and circumstances of each person appearing before them. The Court should decline to do so.

In the meantime, as described throughout this brief, the Sheriff has worked to implement the CDC Guidance for Correctional and Detention Facilities. Those non-binding guidelines explicitly acknowledge the unique challenges faced by jails, and allow for significant flexibility for administrators like Sheriff Brown to adapt the guidelines to the physical space, staffing, population, operations, and other conditions and limitations at the Dallas County Jail. The CDC guidelines do not require, recommend, or even hint at the possibility of mass inmate release—regardless of how susceptible those inmates are to infection. The Sheriff's decision to work with judges in lieu of categorically releasing detainees—which she may not legally do herself—is objectively reasonable. And the Sheriff's implementation of policies and procedures consistent with CDC guidelines shows that she has not been deliberately indifferent to this unprecedented threat. Plaintiff is unlikely to succeed on the merits.

C. Plaintiffs cannot establish irreparable harm.

Plaintiffs also cannot establish that the extraordinary injunctive relief they seek is necessary. Other legal processes govern Plaintiffs' ability to obtain release. Other remedies less irrevocable and drastic than mass release from the Dallas County Jail would suffice to provide for medically vulnerable detainees, if any such remedies were warranted (which they are not).

Every detainee in the Dallas County Jail is confined pursuant to a court order setting out conditions of bond or court findings justifying detention. The Sheriff may not alter those conditions. Only a judge can do that. The judges in Dallas County, with the assistance of the Sheriff, are reviewing inmates on a daily basis (specifically but not exclusively medically vulnerable arrestees) to determine their eligibility for release to address jail crowding. No one—not the Sheriff, not the judges, not anyone else in Dallas County—is simply ignoring this pervasive issue. Only Plaintiffs have elected to forego their state court remedies entirely in order to seek an emergency injunction from federal court. Because Plaintiffs have available remedies, they will not suffer irreparable harm in the absence of an injunction.

Additionally, Plaintiffs are not entitled to an injunction requiring the Sheriff to adopt procedures consistent with "public health guidance." The public health consensus regarding COVID-19 is evolving on a daily basis.[13] The Sheriff is already guided and assisted by public health experts, including the Dallas County Department of Health and Human Services and Parkland. Jones, ¶ 11. And as discussed above, the Sheriff has already taken steps to implement the CDC Interim Guidance in the Dallas County Jail. Plaintiffs have made no showing of why the CDC Interim Guidance is insufficient. (These proactive measures by the Sheriff also demonstrate why the appointment of a public health expert is unwarranted.)

Plaintiffs also fail to demonstrate why no remedy will suffice short of releasing people from the jail. No local, state, or federal guidance requires this. To the best of Defendants' knowledge, no jurisdiction in this country—not even the jurisdictions most ravaged by COVID-19—has yet determined that a blanket release of all medically vulnerable inmates, followed by the release of any other inmates necessary to guarantee social distancing, is advisable or even

[13] *See, e.g.*, DALLAS MORNING NEWS, Dallas Hospital Group: We'll be able to handle North Texas coronavirus surge (Apr. 14, 2020), *available at* https://www.dallasnews.com/news/public-health/2020/04/14/dallas-hospital-group-well-be-able-to-handle-north-texas-coronavirus-surge/.

possible. For example, Dr. Robert Cohen, one of Plaintiff's medical experts (*see* ECF No. 3-2), serves on the New York Board of Correction. Dr. Cohen testifies in support of Plaintiff's proposed mass release of inmates. But jails in New York State have thus far refrained from adopting the wholesale release of inmates. Where courts have ordered inmates to be released, those courts have been state courts, not federal courts, and the classes of inmates released have been narrow—for example, parole violations.

D. The proposed relief would be detrimental to the public interest.

Plaintiffs' proposal to remedy an unprecedented threat with unprecedented court-ordered emergency relief would be extremely detrimental to the public interest.

Ordering categorical release of the proposed subclass detainees, with no regard for their risk to society upon release, would be detrimental to the public interest. Dallas County is currently under an injunction requiring Dallas County to provide a judicial individualized assessment of all relevant state law factors when setting bail. *See* Order of Preliminary Injunction, ECF No. 166, *Daves v. Dallas County*, No. 3:18-cv-00154-N. This injunction applies to all detainees booked into the Dallas County Jail, providing for an individualized assessment at magistration (within forty-eight hours after booking) and a subsequent bail review hearing before the assigned court. In making the individualized assessment, judges consider the detainee's sworn personal and financial information, as well as the results of a validated risk assessment tool. Judges then make a determination on what conditions of release would be appropriate on a case by case basis, after examining all relevant factors and information available. The proposed class is made up, in large part, of inmates who have already been individually assessed by a magistrate (and in some cases, likely by the assigned court as well), and determined not to be eligible for a reduced bond or a personal bond. Most jail inmates are currently detained pursuant

to new felony charges—4,105 of today's jail population of jail population of 4,967. Robinson, ¶ 6. In all, less than 200 current inmates are detained pursuant to new misdemeanor charges, with about half of those inmates subject to pending holds. *Id*. This Court should presume that they are detained for a good reason—state judicial officers have conducted an individual assessment of the arrestee, applying state law factors, and set a bond accordingly.

CONCLUSION AND PRAYER

As Judge Rosenthal acknowledged yesterday, in emergency circumstances like those before this Court, "it is best to leave sensitive policy and political decisions on crafting procedures to accomplish the shared goal of safely reducing the Jail population to elected and appointed officials." *See Russell v. Harris County*, No. H-19-226, ECF No. 122 at p. 28. Defendants look forward to educating Plaintiffs and the Court further on their efforts to safeguard the jail population and the community at large. But at this time, on the record before the Court, emergency relief is not warranted and runs the risk of imposing imprecise and disruptive remedies on the day-to-day operations of the Jail.

Defendants Sheriff Marian Brown and Dallas County, Texas respectfully request that the Court enter an order denying Plaintiffs' Emergency Motion for Temporary Restraining Order or Preliminary Injunction, and all other and further relief to which they are justly entitled.

[*signatures on following page*]

Respectfully Submitted,

HUSCH BLACKWELL LLP

/s/ Kate David
Katharine D. David
Texas Bar No. 24045749
kate.david@huschblackwell.com
Nick Stepp
Texas Bar No. 24077701
nick.stepp@huschblackwell.com
Ben Stephens
Texas Bar No. 24098472
ben.stephens@huschblackwell.com
600 Travis, Suite 2350
Houston, Texas 77002
Tel: 713.525.6200
Fax: 713.647.6884

/s/ Russell H. Roden
Russell H. Roden
Texas Bar No. 17132070
russell.roden@dallascounty.org
John Butrus
Texas Bar No. 03537330
john.butrus@dallascounty.org
133 N. Riverfront Blvd., LB 19
Dallas, Texas 75207
Tel: 214.653.3600
Fax: 214.653.5774
COUNSEL FOR DALLAS COUNTY, TEXAS AND SHERIFF MARIAN BROWN

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing was served on all counsel of record via the ECF system of the Court on April 15, 2020.

/s/ Ben Stephens
Ben Stephens

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

OSCAR SANCHEZ, *et al.*,	)	
	)	
Plaintiffs,	)	Civil Action
	)	Case No. 3:20-cv-00832
v.	)	
	)	
SHERIFF MARIAN BROWN, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF FREDRICK ROBINSON

My name is Fredrick Robinson. I have never been convicted of a felony or a crime of moral turpitude. I am in all ways competent to make this declaration. Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. I am currently employed by the Dallas County Sheriff's Office ("DCSO") as the Chief Deputy. I have been employed in this role since 2019.

2. Prior to my appointment as Chief Deputy, I was a deputy sheriff from 1996 to 2006, Senior Sergeant from 2006 to 2013, Lieutenant from 2013 to 2017, Captain from 2017 to 2018, and Assistant Chief Deputy from 2018 to 2019. In all, I have over twenty-seven years of experience in the Dallas County Sheriff's Department.

3. As the Chief Deputy of Detention Services, I am responsible for overseeing Dallas County Jail operations. I am familiar with the DCSO's efforts to combat and prevent the spread of the Novel Coronavirus ("COVID-19").

4. The facts set forth in this declaration are drawn from information I have received in my work with the DCSO as part of my responsibilities and in response to the COVID-19 pandemic.

5. On March 12, 2020, Dallas County Judge Clay Jenkins issued a Declaration of Local Disaster for Public Health Emergency due to COVID-19. On March 13, 2020, Governor Abbott declared a state of disaster in Texas due to COVID-19. As of March 13, there were approximately 5,945 detainees in custody in the Dallas County Jail.

6. As of the date this suit was filed, the jail population was 4,972. The total capacity of the jail is approximately 7,414. As of the date of this declaration, the jail population is 4,967. 42 inmates have tested positive for COVID-19, with 10 inmates pending test results. 211

inmates are quarantined or isolated. To date, the Jail has confirmed zero deaths related to COVID-19. Most jail inmates detained as of today are detained pursuant to new felony charges—4,105 of today's population of 4,967. Fewer than 200 of the current 4,967 inmates are detained pursuant to new misdemeanor charges, and some of those are detained pursuant to pending holds.

7. Dallas County contracts with the Parkland Health & Hospital System (Parkland) to provide on-site physical and behavioral healthcare services for inmates at the Dallas County Jail. Parkland and its personnel are not part of the DCSO and do not work for anyone in the DCSO.

Efforts to Comply With CDC COVID-19 Guidelines

8. I am familiar with the DCSO's long-standing standard operating procedures for the management of infectious disease. *See* Exhibit A. I am also familiar with the CDC's Interim Guidance on management of COVID-19 in correctional facilities. *See* Exhibit B. Beginning in February 2020, the DCSO began implementing processes and procedures in addition to its standard operating procedures to comply with the evolving CDC Interim Guidance. The DCSO has implemented the following preventative measures, which have been refined and improved on an ongoing basis since that time:

Social Distancing

9. Although it is difficult to enforce social distancing as recommended by the CDC throughout all areas of the jail, the DCSO has worked to enforce social distancing guidelines to the extent reasonably possible.

10. Throughout the jail, DCSO staff posted a single-page flyer with CDC guidance on social distancing, use of Personal Protective Equipment (PPE), and best practices to mitigate the spread of COVID-19. A true and correct copy of the posted guidelines is attached to this declaration. *See* Exhibit C. The poster advises inmates to, if possible, maintain a distance of at least 6 feet and practice proper hand hygiene, among other practical recommendations for protecting themselves from exposure. The DCSO began posting this information, and other information about social distancing and hygiene, throughout the jail on March 25.

11. All TVs throughout the jail also air messages and run banners on the inmate channel regarding COVID-19 prevention, precautions, and procedures. TVs are located in each pod and in the common areas of the jail.

12. Consistent with CDC guidelines, DCSO deputies and staff consistently impress upon inmates the need to practice social distancing. DCSO deputies enforce social distancing in common areas when deputies observe social distancing practices not being followed. When it is necessary for the DCSO to move groups of inmates through the jail, inmates are moved in smaller groups and social distancing is practiced. In general, inmate

movement has been reduced to only absolutely necessary moves. DCSO deputies also attempt to enforce social distancing when moving inmates to court.

13. Starting on March 12, 2020, the jail suspended in-person visitations, with the exception of attorney visitations. In-person attorney visitations are conducted behind visitor glass. Videoconference and phone calls are still available for inmates to communicate with loved ones or others outside the jail. Video visitations are free of charge and are available to anyone who requests it. Attorneys often visit with inmates by video as well.

14. Attorneys who come to the jail for in-person visitations have their temperature taken before entering the jail. Persons who register a high temperature are not permitted to enter the jail. Attorneys conduct in-person visitations through visitor glass, separated from the inmate. Attorneys are not required to bring masks, but many often do.

15. At intake, deputies enforce social distancing to the extent possible. Every inmate is given a mask immediately upon intake.

16. To minimize personal contact, the Sheriff worked with the judiciary to implement virtual signatures for judges on Personal Recognizance bonds. The Sheriff also assisted in establishing an electronic box where bonds already signed by the judge would be placed and then distributed to the inmate so that the inmate would not need to travel to court. The Sheriff has also met with the judiciary and court clerks regarding electronic criminal court, as part of the overall effort to move towards virtual court appearances.

17. All persons entering the jail for any reason have their temperature taken by a Detention Service Officer.

18. Inmates in single cells who have demonstrated symptoms or have been classified for monitoring or investigation by Parkland are provided meals inside their cells. Inmates who are asymptomatic and are not under monitoring or investigation are provided meals in their pods or tanks

PPE and Sanitation

19. All jail staff are required to wear face masks. Staff in high risk areas are required to wear additional PPE, including N95 masks.

20. All inmates, whether symptomatic or asymptomatic, are provided with a facemask free of charge. Inmates are told to wear the facemask at all times. Currently, the DCSO considers its supplies of facemasks to be adequate.

21. Inmates are responsible for cleaning their cells. Trustees (inmates who have been entrusted with certain responsibilities by the DCSO) are responsible for cleaning common areas of the jail. DCSO staff is responsible for cleaning officer areas. Parkland is responsible for cleaning the infirmary areas. Cleaning has increased significantly in recent weeks.

22. If at any point an exposure to COVID-19 is suspected or confirmed at any part of the jail, inmates are removed from the pod or tank. A third-party vendor is immediately brought in to sanitize each part of the jail in which the suspected or confirmed inmate was kept or had contact.

23. Cleaning supplies for cells are made available to inmates at all times. Additional cleaning supplies are provided whenever an inmate requests more. Cleaning supplies are also available in common areas at all times.

24. Hand soap is available to all inmates at all times. If an inmate asks for more soap at any point, the DCSO provides it. While hand sanitizer is not currently provided to inmates because of its alcohol content, the DCSO is examining ways to make hand sanitizer available to inmates within the jail safely. Hand sanitizer is available to staff. Inmates are encouraged to wash their hands with soap frequently by DCSO staff, and by the posted CDC guidelines and TV banners throughout the jail.

25. Inmates may submit grievances both in writing and electronically. Terminals to submit grievances electronically are available throughout the jail. The Sheriff certainly does not have a policy of refusing to accept grievances relating to COVID-19 or any other issue, and instructions on how to submit a grievance are posted and available throughout the jail. The Inmate Handbook also gives instructions on how to file a grievance.

26. The DCSO is in constant, daily communication with Parkland Memorial Hospital, the contractual healthcare provider for the Dallas County Jail, regarding medical treatment for detainees and implementation of CDC public health guidelines.

Reducing Jail Population

27. The DCSO detains criminal defendants who are remanded to custody by the Dallas County District Court felony judges and Dallas County Criminal Court-at-Law misdemeanor judges. As a result,, the Dallas County Sheriff cannot control the number of detainees who are housed in the Jail.

28. Nevertheless, the Sheriff began working with the appropriate criminal justice stakeholders weeks ago to lower the jail population.

29. On or about March 17, Sheriff Brown sent a letter to the heads of 32 local law enforcement agencies ("LEAs"). *See* Exhibit D. At any given time, these agencies are responsible for most of the arrests leading to bookings in the Dallas County Jail. Sheriff Brown's letter acknowledged the need to reduce jail population in an effort to combat the spread of COVID-19, and requested that officers for the respective LEAs use their best judgment in determining whether to issue a cite-and-release for permissible offenses under Texas law, rather than arresting and booking a person into the Dallas County Jail.

30. As of March 17, the jail population was 5,929. As of April 10, the jail population was 4,972. As of today, the jail population is 4,967.

31. Sheriff Brown has also worked with the presiding judges for both the Dallas County Criminal District Courts and the Dallas County Criminal Courts-at-Law to identify and release eligible, medically vulnerable detainees. Starting on April 1, the Sheriff received a list prepared by Parkland Memorial Hospital, with the names of detainees whom Parkland has determined are at a high risk of contracting COVID-19. The Sheriff provides that list to the presiding judges of the felony and misdemeanor courts to review cases and bonds for those arrestees. If the assigned judge determines release is appropriate after an individualized consideration of a specific detainee's facts and circumstances, that judge orders release, and the Sheriff promptly complies with that court order.

32. The Sheriff also understands that the District Attorney is dismissing a wider variety of certain cases, including drug cases, in an effort to have more people released from jail.

33. The Sheriff will continue to follow court orders committing arrestees to custody, as well as release orders.

Intake, Isolation, and Quarantine Procedures

34. To reduce the potential spread of the virus, the DCSO has implemented changes to the manner in which detainees are booked into jail and housed within the jail to prevent the spread of COVID-19.

    a. Upon arrest, an arrestee is brought to the Dallas County Jail and booked. During booking, the arrestee's temperature is taken and the arrestee is asked a set of preliminary screening questions recommended by the DCSO's healthcare partners. Intake and these screening questions take place in an isolated sally port, rather than the regular intake area.
    b. If an arrestee has a fever of 100.4 or greater or answers "yes" to one or more preliminary screening questions during the intake process, the arrestee will be admitted to one of three levels of quarantine. A Central Intake Nurse conducts an immediate evaluation to determine which level of quarantine is appropriate—Level 1, Level 2, or Level 3. The "wand officer" (the officer responsible for moving the arrestee throughout the jail) notifies their immediate supervisor of the level determined by medical personnel.
    c. Level 1 arrestees are asymptomatic. Level 2 arrestees display some non-severe symptoms of COVID-19. Upon identification by the medical provider, a Level 1 or Level 2 arrestee is given an N95 Particulate Respirator mask and is transported to a single cell in the Jail's 3rd Floor Infirmary. The Intake Supervisor immediately notifies the Release Division Supervisors of the arrestee being transported to the 3rd Floor Infirmary, and the Release Division Supervisor ensures that officers are assigned to the floor in accordance with the Texas Commission on Jail Standards guidelines.

d. At the 3rd Floor Infirmary, the arrestee is interviewed by Dallas County Pretrial Services in order to complete the intake process. At no time is the arrestee moved out of the single cell until the arrestee is ready to be escorted to their housing unit.
e. Level 1 asymptomatic arrestees are housed in the Jail's West Tower on a designated floor. Arrestees in the West tower are in individual cells, rather than in pods or tanks as is typical of the Jail's other floors. Level 2 symptomatic arrestees are housed in single cells at Gill-Hernandez, a medical facility inside the Jail and in the West Tower in 8 man tanks with a common area, but also with individual single cells within the tank.
f. Level 3 arrestees display severe symptoms of COVID-19 at the preliminary screening stage. Level 3 arrestees are immediately released back to the arresting officer and transported to Parkland Memorial Hospital via ambulance.

35. Inmates that test positive for COVID-19 while in the Dallas County Jail are quarantined in negative-pressure designated cells or in the West Tower in the 8 man tanks with individual single cells, consistent with CDC guidelines and Dallas County Health and Human Services guidelines. These cells in the West Tower are equipped with air filter systems instead of the negative pressure cells.

36. COVID-19 tests are administered by health care professionals whom the DCSO does not control or employ. It is the DCSO's understanding that COVID-19 tests are administered for current inmates under criteria published by the Dallas County Department of Health and Human Services. Information about the results of any particular inmate's test cannot be provided to outside parties.

37. In the midst of an unprecedented pandemic, the DCSO, led by Sheriff Brown, has worked around the clock to maximize the safety and security of Jail detainees, the DCSO's staff, and the public.

I, Fredrick Robinson, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the foregoing is true and correct.

Dated this 15th day of April, 2020.

Fredrick Robinson

Exhibit A
Declaration of Fredrick Robinson

COMMUNICABLE DISEASES AND INFESTATIONS

A. Definition

1. A communicable disease is any disease that may be transmitted directly from one individual to another.

2. For practical purposes, transmission is through the air (aerosol or droplet exposure) or through blood to blood contact (cutaneous exposure).

B. Policy

It is the policy of the Inmate Housing Bureau:

1. To familiarize all employees with the term "communicable disease".

2. To identify and explain the particular communicable diseases of concern to Detention personnel.

3. To practice accepted occupational precautions when handling inmates with communicable diseases, including infection control, medical service, food service, laundry service, access to programs, and housing assignments.

4. To provide a course of action to an employee who reasonably believes they have been exposed to a communicable disease while on duty.

C. Known Communicable Diseases and Infestations

1. Disease transmitted by aerosol or droplet exposure:

a. When transmitted by this method, the disease leaves the infected person through his mouth or nose.

b. It enters the uninfected person through his mouth or nose.

c. It may be transmitted from people who cough or sneeze on their hands and fail to wash their hands before shaking hands or touching others.

d. The following diseases are transmitted by aerosol or droplet exposure:

i. Tuberculosis.

ii. Meningitis.

iii. Measles/Rubella.

iv. Chicken Pox.

2. Disease transmitted by cutaneous exposure:

a. Transmission of disease is through contact with blood or blood products of the infected person or by contact with objects contaminated with infectious blood or blood products.

b. Disease is also spread by contact with other body fluids such as saliva, semen, or vaginal secretions.

c. The following diseases are transmitted by per cutaneous exposure:

i. Hepatitis B (serum).

ii. Syphilis.

iii. AIDS/HIVS (discussed above).

3. Infestations (lice):

a. The following infestations (lice) are transmitted through close personal contact with an infected person or through sharing of personal articles such as combs and hats:

i. Head lice.

ii. Crab lice.

b. Head lice live on the head. Crab lice live in the pubic hair area (crotch, underarms).

c. Lice are dependent upon human blood for sustenance and cannot survive away from the human body for more than 24 hours.

d. Lice must crawl and cannot jump from one person to another.

D. Infection Control

1. Treat all inmates as if they were infected.

2. Wash hands frequently using a disinfectant soap.

3. Wear gloves when in physical contact with inmates or their possessions.

4. Infection control supplies and equipment, including bleach/disinfectant solution, plastic gloves, face masks, and airways for use during CPR, are available in the Supervisor's

Office.

E. Medical Treatment

Medical treatment is in accordance with PMH procedures and Dallas County Health Department guidelines for treatment and control of communicable diseases and infestations.

F. Access to Programs

1. Inmates are denied access to certain programs upon written order of a physician if the inmate's condition exposes others to the disease.

2. In other instances, inmates are allowed access to programs but are separated from the general jail population.

G. Housing Assignments

1. Inmates with these diseases or infestations may be separated from the general jail population while contagious.

2. The decision to isolate an inmate is made by the medical staff on a case-by-case basis.

K. Employee Exposure

1. If an employee reasonably believes he has been infected with a communicable disease in the course and scope of this employment, he should contact his Supervisor.

2. The Employer's First Report of Injury or Illness is completed and submitted within 24 hours.

3. A sworn affidavit detailing the date and circumstances of the exposure accompany this report.

L. Body Lice (Crabs)

1. When an inmate states they have "crabs", the Floor Officer notifies the Nurse.

2. If the Nurse determines the inmate is infected, the inmate is treated.

3. The officer goes to the laundry storage location at the housing facility and obtains clothing for the inmate to put on after his shower.

4. The inmate removes all clothing, and places it in a yellow plastic bag.

5. The inmate uses the medication provided by the Nurse, in accordance with the instructions as listed on the container. The container is removed from the tank immediately after use.

6. The plastic bag with the inmate's clothing, along with the inmate's mattress is placed in the dirty laundry storage area.

HIGH SECURITY RISK INMATES REQUIRING MEDICAL CARE AT THE HOSPITAL

A. An inmate is defined as a high security risk if his charges are

1. First degree felonies involving violence (Murder, Capital Murder, etc)

2. High Profile: notoriety (highly publicized crime, to be determined by Classification)

3. Escape (dressed in orange jail clothing)

4. Bond amounts in excess of $1,000,000.00

5. TDCJ Sentence of over 25 years, life sentence, or death sentence.

B. An inmate is defined as a high security risk if the inmate’s life has been threatened.

C. An inmate defined as a high security risk is transported to the emergency room with two deputies and if admitted, the inmate is guarded by two deputies.

D. Requests are not made to the SHOT officers to provide a guard; however, the SHOT supervisors are notified that the inmate has been admitted into the hospital and his hospital room assignment.

E. Relief of deputies assigned to guard a high security risk inmate is

provided by a sworn Release Division Supervisor and a deputy.

Exhibit B
Declaration of Fredrick Robinson

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

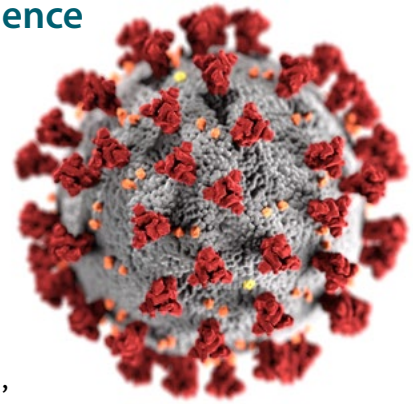
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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.

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- 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.
- 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.**

- 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.
- 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.
- Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
- 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.**

- 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.
- Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.

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

- **For all:** symptoms of COVID-19 and hand hygiene instructions
- **For incarcerated/detained persons:** report symptoms to staff
- **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.
- 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.**

- Review policies to ensure that they actively encourage staff to stay home when sick.
- If these policies do not encourage staff to stay home when sick, discuss with the contract company.
- 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.

- Staff performing temperature checks should wear recommended PPE.
- 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.**

- Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
- 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.
- 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:**

- Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
- Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
- 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.**

- If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
- Inform potential visitors of changes to, or suspension of, visitation programs.
- 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).
- 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.

- 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:**

- 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, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
- 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
- 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.)
- 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.
- 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.
- 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):

- If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
- If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
- All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
- 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).

- 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.**

- If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
- 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.**

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

- 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.**

- See above for definition of a close contact.
- 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.

Exhibit C
Declaration of Fredrick Robinson

What law enforcement personnel need to know about coronavirus disease 2019 (COVID-19)

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The outbreak first started in China, but cases have been identified in a growing number of other areas, including the United States.

Patients with COVID-19 have had mild to severe respiratory illness.

- Data suggests that symptoms may appear in as few as 2 days or as long as 14 days after exposure to the virus that causes COVID-19.
- Symptoms can include fever, cough, difficulty breathing, and shortness of breath.
- The virus causing COVID-19 is called SARS-CoV-2. It is thought to spread mainly from person-to-person via respiratory droplets among close contacts. Respiratory droplets are produced when an infected person coughs or sneezes and can land in the mouths or noses, or possibly be inhaled into the lungs, of people who are nearby.
  - Close contact increases your risk for COVID-19, including:
    - » Being within approximately 6 feet of an individual with COVID-19 for a prolonged period of time.
    - » Having direct contact with body fluids (such as blood, phlegm, and respiratory droplets) from an individual with COVID-19.

To protect yourself from exposure

- **If possible, maintain a distance of at least 6 feet**.
- **Practice proper hand hygiene**. Wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available and illicit drugs are NOT suspected to be present, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Do not touch your face with unwashed hands.
- Have a trained Emergency Medical Service/Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
- Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.

Recommended Personal Protective Equipment (PPE)

Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html.

Different styles of PPE may be necessary to perform operational duties. These alternative styles (i.e., coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.

The minimum PPE recommended is:

- A single pair of disposable examination gloves,
- Disposable isolation gown or single-use/disposable coveralls*,
- Any NIOSH-approved particulate respirator (i.e., N-95 or higher-level respirator), and
- Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face).

*If unable to wear a disposable gown or coveralls because it limits access to duty belt and gear, ensure duty belt and gear are disinfected after contact with individual.

If close contact occurred during apprehension

- Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
- Follow standard operating procedures for the containment and disposal of used PPE.
- Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

For law enforcement personnel performing daily routine activities, the immediate health risk is considered low. Law enforcement leadership and personnel should follow CDC's Interim General Business Guidance. Search "Interim Guidance for Businesses" on www.cdc.gov.

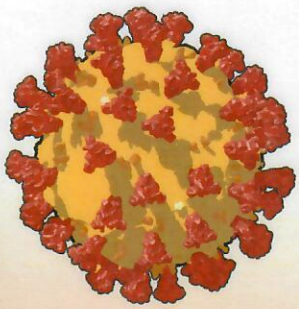


Exhibit D
Declaration of Fredrick Robinson

DALLAS COUNTY SHERIFF'S OFFICE

133 N. RIVERFRONT BLVD • DALLAS, TEXAS 75207- 4313
P: 214-653-3450 F: 214-653-3420
www.dallascounty.org

MARIAN BROWN
SHERIFF

COMMISSIONERS
CLAY JENKINS, JUDGE
DR. THERESA DANIEL
JJ KOCH
JOHN WILEY PRICE
DR. ELBA GARCIA

March 17, 2020

RE: Coronavirus (COVID-19)

Dear Law Enforcement Department Head:

In light of the current situation with COVID-19, The Dallas County Sheriff's Office is working hard to protect the health and wellbeing of the employees and the inmates charged to our custody. COVID-19 poses a real danger and health hazard to both inmates and employees. The COVID-19 crisis has affected the criminal justice system to the degree that criminal jury trials have been suspended. In addition, many other courts and services are being affected as well.

In an effort to combat the spread of COVID-19, officials encourage the reduction of population, regardless of the setting. This holds true for the corrections setting as well, and with some 32 agencies transporting inmates to the Dallas County Jail, the average daily bookin is 182.

This creates stress on an already burdened system, in that inmates are continually being booked in, but a proportionate number of inmates is not being released. Thus, the jail population continues to grow. With this in mind, I am asking for your consideration at this dire time.

As you know, Texas Criminal Code of Procedure, Article 14.06(c) allows for an alternative to arrest on class A and B misdemeanors:

If the person resides in the county where the offense occurred, a peace officer who is charging a person with committing an offense that is a Class A or B misdemeanor may, instead of taking the person before a magistrate, issue a citation to the person that contains written notice of the time and place the person must appear before a magistrate of this state.

This includes such offenses as:

- Criminal Mischief

- Possession of substance in penalty group 2A
- Possession of marijuana
- Theft
- Theft of Service
- Graffiti
- Burglary of coin operated machine
- Burglary of a vehicle
- Promoting gambling

With all these factors, I am asking for your assistance. Specifically, I am asking officers to use their best judgement on arrests and subsequent transports to the Dallas County Jail. Please consider such factors as:

- Is officer discretion appropriate;
- Can a subject be filed on at large;
- Is a warrant outside of the local jurisdiction;
- Are there extradition issues;
- Is the immediate arrest serving to protect the safety of the community?

As someone who worked the streets for 17 years, I understand that in some cases an individual's imposition on public safety REQUIRES the arrest and transport of that individual. Still, I am asking for your consideration in our efforts to help control the jail population, while we, as a community, work through this current challenging environment.

It is when we work together to fight, that we overcome.

Thank you in advance for your consideration; we appreciate your assistance.

Respectfully,

Marian Brown, Sheriff
Dallas County

Cc: Chief Paul Spencer, Addision Police Dept.
Chief Jonathan Haber, Balch Springs Police Dept.
Chief Derick Miller, Carrollton Police Dept.

Chief Marshal Rodriguez, Carrollton Marshal's Office
Chief Ely Reyes, Cedar Hill Police Dept.
Chief Danny Barton, Coppell Police Dept.
Chief Stephen Barlag, Cockrell Hill Police Dept.
Chief Ulisha R. Hall, Dallas Police Dept.
Chief James D. Spiller, DART Police Dept.
Chief Lauretta Hill, DCCD Police Dept.
Chief John Lawton, Dallas ISD Police Dept.
Chief Marlin R. Suell, Parkland Police Dept.
Chief Charles Cinquemani, DFW Airport Police
Chief Gary Lindsey, Dallas City Marshal's Office
Chief Joseph Acosta, Desoto Police Dept.
Chief Robert D. Brown, Duncanville Police Dept.
Chief David Hale, Farmers Branch Police Dept.
Chief Jeff Bryan, Garland Police Police Dept.
Chief Steve Perry, Hutchins Police Dept.
Chief Nicholas Nanez, Grand Prairie Marshal's Office
Chief Daniel Scesney, Grand Prairie Police Dept.
Chief Vernell E. Dooley, Glenn Heights Police Dept.
Chief Jeff Spivey, Irving Police Dept.
Chief Sam Urbanski, Lancaster Police Dept.
Chief Charles Cato, Mesquite Police Dept.
Chief Dustin Munn, Methodist Health System Police Dept.
Chief Michael Godfrey, Rowlett Police Dept.
Chief Ray Calverley, Seagoville Police Dept.
Chief Bryan Sylvester, Sachse Police Dept.
Chief Rick Shafer, SMU Police Dept.
Chief Larry Zacharias, UT Dallas Police Dept.
Chief Victor Kemp, Wilmer Police Dept.
Constable Tracey Gulley, Precinct 1
Constable Bill Gipson, Precinct 2
Constable Ben Adamcik, Precinct 3
Constable Edward Wright, Precinct 4
Constable Michael Orozco, Precinct 5

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

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

OSCAR SANCHEZ, *et al.*,	)	
	)	
Plaintiffs,	)	Civil Action
	)	Case No. 3:20-cv-00832
v.	)	
	)	
SHERIFF MARIAN BROWN, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF PATRICK JONES

My name is Patrick Jones. I have never been convicted of a felony or a crime of moral turpitude. I am in all ways competent to make this declaration. Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. I am currently employed by the Dallas County Hospital District d/b/a Parkland Health and Hospital System ("Parkland") as Vice President, Correctional Health Services. I have been employed in that capacity since August 2012.

2. As the vice president, I am familiar with Parkland's work with the Dallas County Sheriff's Office (DCSO) to combat the spread of the Novel Coronavirus (COVID-19) in the Dallas County Jail.

3. The facts set forth in this declaration are drawn from my personal knowledge and from information I have received in my work with Parkland and the DCSO in response to the COVID-19 pandemic.

4. Since March 2006, Parkland has been designated by Dallas County to provide on-site physical and behavioral healthcare services for inmates at the Dallas County Jail.

5. A Parkland nurse is present at intake when inmates are booked into the Dallas County Jail and performs COVID-19 screening procedures when summoned to do so.

6. Pursuant to these guidelines, the sheriff's officer located in the Sally Port scans the inmate's temperature and asks screening questions regarding COVID-19. If the arrestee's answers are positive for possible exposure or actually having the disease, the arrestee is placed in a holdover cell immediately adjacent to the screening area. The nurse is then summoned to perform an additional screening. If the nurse screen is still positive, the patient will undergo an addition step in the screening process by a

prescribing provider either in the same area or in the 3rd floor area set aside for possible COVID-19 positive arrestees. If the individual is still suspected of being positive for the virus, testing for COVID-19 will be initiated.

7. If the COVID-19 test is returned positive, the inmate is reclassified as a PCC (Patient Confirmed COVID) and is moved to either the medical infirmary or the 7th or 9th floor of the West Tower, where the inmate is isolated and quarantined in a tank with other known positive patients. If the inmate is too sick to remain at the Dallas County Jail, then he or she will be transferred to Parkland Memorial Hospital. If the COVID-19 test is returned negative, the inmate may still be kept separate from the rest of the general population depending on the situation.

8. Inmates may also be classified as PUM (Patient Under Monitoring). PUMs are inmates whom the nurse at the initial screening believes were likely exposed to someone with COVID-19 or who are later suspected of having come into contact with the virus. PUMs are not grouped with the general jail population, but are instead cohorted only with other PUMS, away from original exposure. PUMs are interviewed and examined daily for fourteen days for temperature and symptoms. A PUM who becomes symptomatic is tested for COVID-19 and, if positive, treated as a PCC. All PUMs are provided with face masks.

9. Nurses at intake wear masks throughout the intake screening process. After intake, all other healthcare personnel who deal with inmates falling into any of the three categories described above wear appropriate PPE

10. Parkland administers COVID-19 tests onsite at the Dallas County Jail. Parkland makes the determination of who should receive a COVID-19 based on CDC guidelines. Test swabs are sent to the Dallas County Department of Health and Human Services to get results. Results typically take about one day.

11. Parkland is also working with an infectious disease specialist, Dr. Ank Nijawan (of UTSW), who is working with Dallas County's infectious disease specialist and Parkland's own infectious disease specialist to identify, recommend, and assist in the implementation of practices for managing the COVID-19 pandemic.

I, Patrick Jones, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the foregoing is true and correct.

Dated this 15th day of April, 2020.

Patrick Jones

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

OSCAR SANCHEZ, *et al.*,	)	
	)	
Plaintiffs,	)	Civil Action
	)	Case No. 3:20-cv-00832
v.	)	
	)	
SHERIFF MARIAN BROWN, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF JEFF SEGURA

My name is Jeff Segura. Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. I am currently employed by Dallas County as the Pretrial Services Manager. I have been employed in this role since January 2018.

2. Prior to my appointment Pretrial Services Manager, I was Criminal Justice Advisory Board Program Manager.

3. As the Pretrial Services Manager, I am responsible for overseeing the operations of Dallas County Pretrial Services. I am familiar with Pretrial Services operations, and with Pretrial Services efforts to adapt to the new reality created by the spread of the Novel Coronavirus ("COVID-19").

4. The facts set forth in this declaration are drawn from information I have received in my work with Pretrial Services.

5. I have been informed that the Court has requested information on the availability of alternatives to incarceration (e.g., leg monitors, GPS location devices), including the number of such devices available and the cost per person per use.

6. Currently, Pretrial Services has 39 electronic monitoring devices available. On any given day, Pretrial has been placing 10-14 individuals on monitor. Currently, Pretrial Services supervises approximately 480 persons subject to ELM as a condition.

7. Pretrial Services employs 8 ELM officers. Pretrial Services currently operates at about a 60 to 1 arrestee-ELM officer ratio. Supervising additional persons subject to ELM would require additional ELM Officers as the recommended ratio is 30 to 1. The cost to Dallas County of hiring an additional ELM officer with salary and benefits is $78,465.87 annually.

8. Recently, I have observed an increase in the number of persons with ELM who manage to disable or destroy the monitor while they are released on supervision. In such a case, we lose both the arrestee and the equipment.

I, Jeff Segura, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the foregoing is true and correct.

Dated this ___ day of April, 2020.

Jeff Segura