UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL., *Petitioner*,	:	CIVIL NO. 3:20-CV-0534 (JBA)
v.	:	
NED LAMONT, ET AL., *Respondent.*	:	MAY 18, 2020

RESPONDENTS' MEMORANDUM IN OPPOSITION TO PEITITIONERS' MOTION FOR A PRELIMINARY INJUNCTION

This case is a proposed class action with mixed claims for relief under the federal habeas statutes and civil rights claims under 42 U.S.C. § 1983. Four of the named Petitioners are lawfully incarcerated inmates held by the Connecticut Department of Correction (DOC). One proposed class is comprised of inmates currently serving sentences imposed by judges of the Connecticut Superior Court. The other class is comprised of pre-trial detainees held on bonds set by Superior Court judges. Within each of the two putative classes, Petitioners propose subclasses of "medically vulnerable" inmates who have a greater risk should they contract the COVID-19 virus. Respondents are the Governor of Connecticut, Ned Lamont, and Commissioner of Correction Rollin Cook.

Respondents respectfully submit that the Court should deny the Petitioners' Motion for Preliminary Injunction. As set forth herein, and maintaining Respondents' challenges to this Court's jurisdiction, Petitioners have failed to meet the high burden of a mandatory injunction. Petitioners have failed to establish a "clear" or "substantial" showing of likelihood of success on the merits in that they cannot establish either Respondent has violated the Eighth or Fourteenth Amendment rights of any putative class members. Even if Petitioners could meet this heavy burden, their reckless request to release thousands of inmates *en masse* with no method of

monitoring them, no plan for their housing or medical care, and no plan for when, if, or how they would be returned to custody, is so inimical to the public interest as to warrant denial on these grounds alone.

I. FACTUAL BACKGROUND

A. Petitioners seek the mass release of inmates in both their Petition and their Motion for Preliminary Injunction.

On April 20, 2020, Petitioners filed the current action against Respondents. In their Petition (Doc. #1) the individually named Petitioners identify themselves as inmates held in various DOC facilities, and some allege that they have pre-existing health conditions or are otherwise in an age group that places them at "significantly higher risk of severe disease and death if they contract [COVID-19]." (Doc. #1 at 2, ¶1.) They seek the "immediate release" of numerous, indeed potentially thousands, of inmates who are "50 and older and those with medical conditions that place them at heightened risk of severe illness or death from COVID-19." (Id.) Critically, the Petition and the motion papers lack any allegations or requests for relief that would suggest how any putative class[1] members would be managed or cared for if released to the community.[2] They also make no allegation or requests explaining how, when or even *if*, these released inmates would be returned to custody.

[1] There is no motion pending for class certification, and Respondents will oppose class certification as the individual public safety risk issues that pertain to each offender, and the unique health concerns would necessarily require that the individual issues would predominate over the common issues to the putative class. Further, it is impossible to determine who is medically "vulnerable" and thus it would be impossible to determine who would be in the class and who would be excluded.

[2] Although unclear, it appears that Petitioners envision a state court process for reviewing individuals subject to release so that the State can hold in custody those individuals for whom there are "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." (Doc. #1 at 34.) Nowhere in their Petition or motion papers do they cite authority for the proposition that the State, its courts or any of its criminal justice agencies bear such a burden of proof anywhere and in any context. Nor do they explain how a state court would have jurisdiction to decide whether previously sentenced inmates "pose such a serious risk of flight or danger to others that no other conditions can mitigate." The state courts have already made such determinations in the first instance.

On May 10, 2020, Petitioners filed a motion for preliminary injunction. (Doc. #43.) Petitioners seek a mandatory, permanent injunction compelling Respondents to release state inmates from custody and to submit for court review certain plans for mitigating risk of infection. (Doc. #43 at 46, ¶¶1-3.) Petitioners make no effort to accommodate the significant and obvious public safety risks of releasing inmates into the community. In particular, their demand that certain class members be released "within twenty-four hours" is so cavalier as to be dangerous to the community at large.

B. The DOC has taken extraordinary steps to combat COVID-19 by implementing CDC recommendations for incarcerated individuals.

The DOC operates fourteen separate correctional facilities around the state, serving different inmate populations and providing housing options that vary greatly from facility to facility. Each facility is assigned a security level score ranging from 2 to 5, with a level 2 facility housing minimum security inmates and the level 5 facility designed to house maximum security inmates.[3] These facilities, their inmate counts, and their respective housing accommodations appear in the following chart:

FACILITY	INMATE COUNT AS OF 3/1/20	INMATE COUNT AS OF 5/18/20	NUMBER OF CELL BEDS	NUMBER OF DORMITORY BEDS
Brooklyn CI	426	355	0	456
Carl Robinson CI	1314	907	32 beds/16 cells	1480
Corrigan-Radgowski CC	1189	985	839	456
MacDougall-Walker CI	1938	1898	2218	0
New Haven CC	679	636	419	328

[3] As discussed *infra*, the DOC chose the level 5 facility, Northern Correctional Institution, to house inmates placed in medical isolation due to Covid-19 infection. DOC made this decision for a number of reasons unrelated to the high security level of the facility. (Declaration of Robert Richeson (Ex. A) at 1-2, ¶¶4-10; Declaration of Dr. Byron Kennedy (Ex. B) at 2-3, ¶¶10, 12.)

Northern CI	78	182	577 (564 minus RHU and infirmary beds)	0
Cheshire CI	1151	1125	1520	128
Willard-Cybulski CI	1079	613	0	1148
Bridgeport CC	690	597	301 which includes restrictive housing (22 beds). Number does not include medical beds which is a maximum of 26.	470
Garner CI	548	540	745	0
Manson YI	283	232	706	0
Osborn CI	1253	1058	448 regular units, 64 mental health unit	235
Hartford CC	876	799	555	480
York CI	883	627	140	1202

Every facility in the system is operating well below capacity and well below the inmate count of just two months ago. This is especially true of Brooklyn, Carl Robinson, Willard-Cybulski, Osborn and York, the facilities with significant population of inmates held in dormitory housing. (Declaration of Warden Faucher (Ex. C) at 1-2, ¶¶5-6; Declaration of Warden Caron (Ex. D) at 1-2, ¶5; Declaration of Warden Garcia (Ex. E) at 2, ¶¶5-6; Declaration of Warden Rodriguez (Ex. F) at 1, ¶5; Declaration of Warden Dougherty (Ex. G) at 1-2, ¶¶4, 6.) These significant population decreases have allowed custody staff to quarantine new admits and separate sick inmates from the remainder of the prison population while undergoing further evaluation for COVID-19. (Ex. B at 3-4, ¶¶18, 20.)

The following chart shows the number of COVID-19 positive inmates, by facility:

Total DOC COVID-19 Positives/Recovered by Facility

Total Offenders Positive 526 Total Offenders Recovered 419
Total Offender Deaths 6

Inmates from Facility to NCI	Total	Inmates Returned to Facility	Total
Bridgeport CC	62	Bridgeport CC	59
Brooklyn CI	0	Brooklyn CI	12
Cheshire CI	17	Cheshire CI	10
Corrigan-Radgowski	102	Corrigan-Radgowski	74
Garner CI	0	Garner CI	0
Hartford CC	35	Hartford CC	31
MacDougall-Walker	3	MacDougall-Walker	5
Manson	0	Manson	0
New Haven CC	52	New Haven CC	47
Northern CI	0	Northern CI	73
Osborn CI	123	Osborn CI	75
Carl Robinson CI	72	Carl Robinson CI	55
Willard-Cybulski	60	Willard-Cybulski	53
York CI	0	York CI	0
		Hospital	11
		Discharged	15
		Parole	0

DOC's three specialized facilities, York (females), MYI (21 and younger) and Garner (mental health) have had no reported inmate infections. Moreover, while Northern Correctional Institution ("NCI") houses individuals who have tested positive for the COVID-19 virus and are under quarantine or medical isolation, DOC officials have successfully managed their quarantine units to prevent the spread to other inmates at NCI .

On March 23, 2020 the Center for Disease Control (CDC) provided guidance to correctional and detention facilities. (Ex. B at 7-33.) In response, DOC cancelled social visits, quarantined new admissions, limited inmate transfers, cancelled volunteers, and limited contractor access. (Ex. B at 3-4, ¶18.) All staff members have their temperatures checked prior to entry. (Id.) If any staff member has a temperature greater than 100.4 or exhibits any symptoms, they are denied entry. (Id. at 4, ¶19.) If a staff member is exhibiting symptoms during their shift, they are immediately isolated and sent home, a review of who they have come into contact with is conducted, and those individuals are monitored for symptoms. (Ex. B at 5, ¶25.) These areas are then cleaned and disinfected. (Id.) Soap and cleaning supplies are widely distributed, common areas and frequently touched surfaces are cleaned and disinfected, and recreation was modified to increase social distancing measures. (Id. at 4, ¶20.) Where feasible,

inmates have been provided their meals in their cells to increase social distancing. (Id.) Inmates have been provided hygiene education via posters and/or memos handed to them. (Id. at 5, ¶26.)

DOC has created a COVID-19 Tracker and placed it online.[4] The tracker is updated daily. As of May 15, 2020, there have been 598 total inmates who have contracted SARS-CoV-2 with 444 of them being medically cleared and returned to their original facility. 369 staff members have contracted the virus with 299 being medically cleared to return to work. 66 inmates are currently being medically isolated at NCI.

DOC implemented protocols for the quarantine of possible infections and the medical isolation of those testing positive or exhibiting symptoms. (Ex. B at 4-5, ¶¶22-23.) As of April 7, 2020, NCI was designated as the medical isolation unit. (Id. at 2, ¶10.) NCI was chosen because it has single cells with individual bathroom facilities, solid walls and doors, and separate airflow from other parts of the facility, all in accordance with CDC Guidelines. (Ex. A at 1-2, ¶¶4-10; Ex. B at 2-3, ¶¶10, 12.) Prior to returning any inmate who had COVID-19 from NCI to their original housing facility, they must be fever free for at least 72 hours, their symptoms must have improved, and at least 14 days must have passed since the beginning of symptoms, which is longer than what CDC suggests. (Ex. B at 3, ¶15; *see* CDC Guidelines at 17.)

Wardens across DOC have implemented measures to comply with the CDC guidelines. For example, Warden Butricks at Cheshire has increased the opportunities for social distancing by modifying outdoor recreation to 50 inmates at a time, not allowing certain sports such as basketball due to the chance of contact between players, and cancelling congregate programming in lieu of individualized instruction. (Declaration of Warden Butricks (Ex. H) at 2, ¶7.) Cheshire has placed posters around the facility educating inmates about proper hygiene practices.

[4] https://portal.ct.gov/DOC/Common-Elements/Common-Elements/Health-Information-and-Advisories

(Id. at 2, ¶8) This information is reinforced by constant oral reminders by staff. (Id.) At Brooklyn CI, which has dorm style units, Warden Faucher has increased social distancing by allowing only one dorm at a time to go to outside recreation. (Ex. C at 2, ¶6.) Only five inmates may attend addiction programming at one time and all of them must be from the same housing unit. (Id.) Sanitation has been ramped up, phones are cleaned daily, and cleaning supplies are available for inmates to clean the phones between each use. (Id. at 3, ¶11.) At Corrigan-Radgowski, which has a mix of dorm style housing and cells, common areas are cleaned after every group of inmates is released to use the showers with frequently touched areas such as railings, doors, and handles cleaned constantly. (Declaration of Warden Martin (Ex. I) at 3, ¶8.) And inmates are provided supplies to clean the phones after each use. (Id.)

C. DOC, along with the State Judicial Branch and the Board of Pardons and Paroles, has significantly reduced the inmate population in response to the COVID-19 pandemic.

The most recent monthly report of data collected by the Criminal Justice Policy and Planning Division of the State of Connecticut Office of Policy and Management demonstrates that the prison population has been reduced significantly. As of April 1, 2020, the state prison population stood at 11,854, the lowest since 1993.[5] Since Governor Lamont declared a state of emergency on March 10, 2020, the daily prison count has declined from 12,366 to 10,556, a total reduction of 1,810 or 14.6% in a period of just over 2 months.[6]

This reduction stems from a number of factors. First, arrests have declined and the courts are setting lower bonds.[7] Second, there has recently been a significant increase of inmates

[5] See OPM Criminal Justice Policy & Planning Division, Monthly Indicators Report April 2020 at p. 1, https://portal.ct.gov/OPM/CJ-About/CJ-SAC/SAC-Sites/SAC-Homepage (last accessed on 5/17/20)
[6] See OPM, Daily Population Count, https://portal.ct.gov/OPM/CJ-About/CJ-SAC/SAC-Sites/SAC-Homepage (last accessed on 5/18/20)
[7] Id.

discharging from custody on discretionary release prior to completing their sentences. In March, 522 inmates were discharged from custody early—an increase of more than 70% from February—which was the second highest month on record in terms of early releases.[8] Of the 759 inmates released from DOC custody in March, 522, or 68%, left prison early under some form of discretionary release.[9] The April 2020 OPM Monthly Indicators Report further demonstrates that the Superior Courts remains open to handle criminal matters. Specifically, the monthly report shows that, during March 2020, 1,749 arraignments took place.[10]

D. DOC has made concerted efforts to evaluate inmates eligible and suitable for early release by utilizing a multi-factored, individualized, risk-assessment process, including consideration of likelihood of recidivism, the availability of an appropriate residence, and the safety and rights of victims.

DOC's current discretionary release process considers a number of factors which ensure that offenders released early have a stable home plan and supervision if necessary, to reduce recidivism and give offenders the best chance of success when released. (Declaration of Gavin Galligan (Ex. J) at 4-8, 14, ¶¶ 21-36, 65.) This risk assessment process is critical because a stable release plan results in a lower risk of recidivism and is particularly important at this time, when many community social services are unavailable. (Id. at 14-15, ¶¶65-66.)

In response to COVID-19, DOC has taken extensive steps to increase discretionary releases. Specifically, DOC has expedited the application process by conducting sponsor interviews remotely. (Id. at 8, ¶ 36.) DOC has identified inmates who were previously denied release for various reasons and assisted them in either completing facility programming, locating a sponsor, or re-reviewing release plans. (Id. at 9-10, ¶¶ 42-45.) For example, DOC identified inmates who had previously been approved for release but were not due to lack of a stable home

[8] Id. at 1-2.
[9] Id. at 2.
[10] Id. at 2.

plan, and assisted them in locating a sponsor or residence, allowing approximately 20% of the cases without a sponsor to identify one. (Id. at 10, ¶ 44.) DOC also identified inmates who may not have been eligible due to a restrictive status, disciplinary issues, or temporary ineligibility for review, to be reviewed for release. (Id. at 9, ¶ 41.)

DOC has also identified "high risk" inmates according to CDC Guidelines, reviewed all for eligibility, and prioritized their applications for release. (Id. at 9, ¶ 40.) DOC has also been working closely with the Board of Pardons and Paroles (BOPP) to identify these inmates and the most appropriate release mechanism for them. (Id.) The Commissioner expanded furloughs for offenders for Transitional Supervision, which the Community Release Unit (CRU) has utilized to release an additional 119 offenders prior to their release date. (Id. at 10, ¶ 46.) These redoubled efforts have resulted in the discretionary release of nearly 1,500 inmates since March 1, 2020, with 326 inmates scheduled for release in the next 60 days. (Id. at 17, ¶¶ 84-85.)

The current discretionary release process also involves victims and evaluates victim impact prior to making release decisions. (Id. at 15, ¶¶71-72.) There are currently 1,883 inmates age 50 and older. (Id. at 16, ¶74.) Within this group, 69 are serving life sentences for murder. (Id. at 13, ¶60.) As of April 2020, there are approximately 2,800 inmates with a Victim Notification flag, meaning that there is a registered victim who would require notification upon application for community release. (Declaration of Kristan Mangiafico (Ex. K) at 1, ¶4.) Out of the 1,883 offenders, the DOC has on file with its Victim Services Unit at least 515 confidential registered victims. (Ex. J at 16, ¶77.)

The number of victims contacting VSU has greatly risen during the COVID-19 crisis. (Id. at 16, ¶79.) These victims have expressed great concern about whether the DOC was going to release their assailants without their opposition being heard. (Id.) The DOC's Victim

Services Administrator reports that victims have "begged" her not to release her rapist or the man who killed their father." (Ex. K at 2, ¶10.)

DOC is particularly concerned about the victims of domestic violence. (Ex. J at 15, ¶71.) The Office of Policy Management Criminal Justice Policy & Planning Division reports that "between March and April, domestic related calls for service to the Hartford Police Department increased by 23%, comprising almost one-quarter of all calls." (Id. at 16, ¶72.)

Despite DOC's significant efforts to properly evaluate and release those inmates who are most suitable, there is concern that inmates who have been released are not abiding by the terms of that release, let alone recommended social distancing practices. (Id. at 15, ¶68.) Approximately 281 offenders have violated release terms since March 1, 2020. (Id. at 15, ¶69.) These include technical violations, criminal offenses, escapes, and absconding from supervision. (Id.) Some of these offenders have been returned, while others remain at large. (Id.)

II. ARGUMENT

A. Mandatory injunctive relief is an extreme and disfavored remedy, requiring litigants to meet an especially heavy burden, particularly when sought against state government officials and even more so against prison officials.

"Interim injunctive relief 'is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of persuasion.'" *Reiske v. Bruno*, No. 13CV1089 JBA, 2014 WL 496686, at *1 (D. Conn. Feb. 6, 2014) (quoting *Grand River Enterprise Six Nations Ltd. v. Pryor*, 481 F.3d 60, 66 (2d Cir.2007)). "In addition, a federal court should grant injunctive relief against a state or municipal official 'only in situations of most compelling necessity.'" *Cerilli v. Rell*, No. 3:08CV242(SRU), 2010 WL 1330998, at *1 (D. Conn. Mar. 31, 2010) (quoting *Vorbeck v. McNeal*, 407 F.Supp. 733, 739 (E.D.Mo.), *aff'd*, 426 U.S. 943 (1976)). "[M]ovants have a heavier burden when attempting to obtain a

preliminary injunction against the government than they do against any other party, reflecting the courts' sensitivity to the need to avoid interfering with government administration of its own programs, a concern that is *particularly acute* in the context of the State's management of prison affairs." *Hodge v. Sidorowicz*, No. 10 CIV. 428 PAC MHD, 2011 WL 6778524, at *7, n.6 (S.D.N.Y. Dec. 20, 2011), *report and recommendation adopted sub nom. Hodge v. Wladyslaw*, No. 10 CIV. 428 PAC MHD, 2012 WL 701150 (S.D.N.Y. Mar. 6, 2012) (citing *D.D. ex rel. V.D. v. New York City Bd. of Educ.*, 465 F.3d 503, 510 (2d Cir. 2006), *opinion amended on denial of reh'g*, 480 F.3d 138 (2d Cir. 2007)).

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *see also Benihana, Inc. v. Benihana of Tokyo, LLC*, 784 F.3d 887, 895 (2d Cir. 2015). "Obviously the state has a strong interest in ensuring the safety and well-being of its citizens." *Stevenson v. State & Local Police Agencies*, 42 F. Supp. 2d 229, 233 (W.D.N.Y. 1999).

"In the prison context, a request for injunctive relief must always be viewed with great caution so as not to immerse the federal judiciary in the management of state prisons." *Fisher v. Goord*, 981 F. Supp. 140, 167 (W.D.N.Y. 1997) (citing *Farmer v. Brennan*, 511 U.S. 825, 846–47 (1994)) (other citations omitted). "'[J]udicial restraint is especially called for in dealing with the complex and intractable problems of prison administration.'" *Burroughs v. Cty. of Nassau*, No. 13-CV-6784 JS WDW, 2014 WL 2587580, at *7 (E.D.N.Y. June 9, 2014) (quoting *Goff v. Harper*, 60 F.3d 518, 520–21 (8th Cir.1995)); *see also Milhouse v. Fasciana*, 721 F. App'x 109, 111 (3d Cir. 2018) ("a prisoner's request for injunctive relief must be viewed with great caution

because of the intractable problems of prison administration.") (quotation omitted). "This conforms with the Supreme Court's teaching that 'federal courts ought to afford appropriate deference and flexibility to state officials trying to manage a volatile environment ... especially ... in the fine-tuning of the ordinary incidents of prison life.'" *Burroughs*, 2014 WL 2587580, at *7 (E.D.N.Y. June 9, 2014) (quoting *Sandin v. Conner*, 515 U.S. 472, 482–83 (1995)).

"Courts in this Circuit refer to injunctions as either 'prohibitory,' if they maintain the status quo, or 'mandatory,' if they change the status quo." *Madej v. Yale Univ.*, No. 3:20-CV-133 (JCH), 2020 WL 1614230, at *5 (D. Conn. Mar. 31, 2020) (quoting *N. Am. Soccer League, LLC v. United States Soccer Fed'n, Inc.*, 883 F.3d 32, 36–37 (2d Cir. 2018)). "The relevant status quo is the status quo ante—that is, 'the last actual, peaceable uncontested status which preceded the pending controversy.'" *Id*. (quoting *Mastrio v. Sebelius*, 768 F.3d 116, 120 (2d Cir. 2014) (per curiam) (internal quotation omitted)). "Because mandatory injunctions disrupt the status quo, a party seeking one must meet a heightened legal standard by showing 'a clear or substantial likelihood of success on the merits,' *as opposed to* a 'likelihood of success on the merits' or 'serious questions on the merits and a balance of hardships decidedly favoring the moving party.'" *Id*. (quoting *N.Y. Civil Liberties Union v. N.Y.C. Transit Auth.*, 684 F.3d 286, 294 (2d Cir. 2012) (emphasis added).

The plaintiff is required to "carry the burden of persuasion by a clear showing for each factor." *Bergamaschi v. Cuomo*, No. 20 CIV. 2817 (CM), 2020 WL 1910754, at *6 (S.D.N.Y. Apr. 20, 2020) (quoting *Abbott Labs. v. Adelphia Supply USA*, No. 15 CV 5826, 2015 WL 10906060, at *5 (E.D.N.Y. Nov. 6, 2015), *aff'd sub nom. Abbott Labs. v. H&H Wholesale Servs., Inc.*, 670 Fed. Appx. 6 (2d Cir. 2016)).

"[M]andatory injunctive relief is disfavored at a preliminary stage of the litigation." *Mitchell v. Perales*, No. 88-CV-382, 1988 WL 44768, at *2 (N.D.N.Y. May 6, 1988) (*Harris v. Wilters*, 596 F.2d 678 (5th Cir.1979)). "A mandatory injunction, like a mandamus, is an extraordinary remedial process, which is granted, not as a matter of right, but in the exercise of a sound judicial discretion. It issues to remedy a wrong, not to promote one." *Morrison v. Work*, 266 U.S. 481, 490 (1925).

Petitioner's recognize that they seek a mandatory injunction in that they concede their requested relief would be "altering the status quo. . ." (Doc. #43 at 25.) However, Petitioners misstate and minimize their burden by suggesting they only "must show (1) irreparable harm in the absence of immediate relief, (2) that relief is in the public interest, and (3) *either* a substantial likelihood of success on the merits, or, that there are sufficiently serious questions on the merits rendering them fair for litigation and a balance of hardships decidedly pointing toward relief." (*Id*) (emphasis added). This is incorrect. *See Munaf v. Geren*, 553 U.S. 674, 690 (2008) ("A difficult question is . . . of course, no reason to grant a preliminary injunction."); *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 19 (2008) (vacating preliminary injunction entered on the basis of lower court finding "serious question" regarding interpretation of environmental regulations).

To support this novel test, Petitioners cite two cases: *Trump v. Vance*, 941 F.3d 631, 639 (2d Cir. 2019) *cert. granted*, 140 S. Ct. 659 (2019) and *N. Am. Soccer League, LLC*, 883 F.3d at 36–37. But *Trump* is a case where "the President sought injunctive relief in federal court to restrain enforcement of [a] subpoena [seeking his personal tax returns]." 941 F.3d at 634. The injunction would not have changed the status quo and the Court did not treat it as such. In *N. Am. Soccer League*, the plaintiff sought a preliminary injunction ordering the defendant to

designate it as the "Division II league" of men's professional soccer. 883 F.3d at 34. That case turned entirely on whether to apply the "heightened standard" of "a clear or substantial likelihood of success on the merits." *Id*. at 37. The Court held the heightened standard did apply because the plaintiff was seeking to alter the status quo and affirmed the district court's denial because they had not shown a "clear likelihood of success on the merits." *Id*. at 45.

There is no support for Petitioner's formulation of the standard here. This Court cannot overrule the Second Circuit and adopt Petitioner's test. Petitioners cannot meet their heavy burden here and their efforts to manipulate the law to avoid it should be rejected by this Court.

B. Petitioners cannot meet their burden because their alleged harm is speculative, their likelihood of success is minute, and the public interest is not served by recklessly releasing inmates with no plan or mechanism for their care, housing, monitoring, or return to confinement.

1. Petitioners cannot show irreparable harm because they merely speculate that their likelihood of contracting SARS-CoV-2 is higher while confined than in the community and the mortality rate based on the best available data is magnitudes lower than in the community.

"Although a showing that irreparable injury will be suffered before a decision on the merits may be reached is insufficient by itself to require the granting of a preliminary injunction, it is nevertheless the most significant condition that must be demonstrated." *Cerilli*, 2010 WL 1330998, at *1 (quoting *Citibank, N.A. v. Citytrust*, 756 F.2d 273, 275 (2d Cir.1985)). "To demonstrate irreparable harm, plaintiff must show an 'injury that is neither remote nor speculative, but actual and imminent and that cannot be remedied by an award of monetary damages.'" *Id*. (quoting *Forest City Daly Hous., Inc. v. Town of N. Hempstead*, 175 F.3d 144, 153 (2d Cir. 1999)). District courts across the country have held that fear of COVID-19 is not enough to warrant the release of prisoners.[11]

[11] *See e.g. Riggs v. Louisiana*, No. CV 3:20-0495, 2020 WL 1939168, at *2 (W.D. La, April 22, 2020) ("[E]ven if [plaintiff's] claims are properly asserted, whether under § 1983 or habeas, several federal courts have considered

Although Petitioners go to great lengths describing the grave nature of the current COVID-19 pandemic, the question of speculative versus imminent is still relevant. Respondents have never taken the position, and do not now, that the pandemic is anything less than a significant medical crisis. However, Petitioners assume that inmates are inherently at greater risk of both infection and worse health consequences as a result of infection than the community at large. (Doc. #43 at 10.) This is a speculative conclusion.

It cannot be gainsaid that COVID-19 is a novel health crisis and the facts of this pandemic, including infection and mortality rates, are constantly fluctuating. *See Ramirez v. Culley*, No. 220CV00609JADVCF, 2020 WL 1821305, at *4 (D. Nev. Apr. 9, 2020) ("[t]he COVID-19 global pandemic is undisputedly a grave and dynamic situation. . ."); *United States v. Eberhart*, No. 13-CR-00313-PJH-1, 2020 WL 1450745, at *1 (N.D. Cal. Mar. 25, 2020) (noting "the dynamic nature of the COVID-19 pandemic").[12]

Petitioners hinge their argument in large part on the premise that "DOC system's infection rate continues to vastly outpace that of every single locality in Connecticut." (Doc. #43 at 8; Doc. #1 at 18, ¶43.) But there is simply no way to know the true infection or mortality rate

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arguments like those of Riggs and have universally found that prisoners are not entitled to release or transfer based solely on generalized COVID-19 fears and speculation."); *United States v. Clark*, No. 19-40068-01-HLT, 2020 WL 1446895 at *3 (D. Kan. March 25, 2020) (Denial of release pursuant to 18 U.S.C. § 3142(i)); *United States v. Eberhart*, No. 13-CR-00313-PJH-1, 2020 WL 1450745 at *2 (N.D. Cal. March 25, 2020) (Denial of modification of his sentence under the compassionate release provision of 18 U.S.C. § 3582(c)(1)(A)(i)); *Carter v. Santa Fe Adult Det. Ctr.*, No. CV 20-00271 RB/GJF, 2020 WL 1550888 (D.N.M. Apr. 1, 2020). (denial of Emergency Injunction); *United States v. Santana*, No. 1:19-CR-251, 2020 WL 1692010 (M.D. Pa. Apr. 7, 2020) (asthmatic prisoner with sleep apnea denied temporary release); *United States v. Williams*, Crim. No. PWG-19-8, 2020 WL 1643662, at *2 (D. Md. Apr. 2, 2020) (denying defendant's motion for release from facility where five detainees tested positive for COVID-19 and defendant suffered from allergies and asthma); *United States v. Teon Jefferson*, No. CCB-19-487, 2020 WL 1332011 (D. Md. Mar. 23, 2020) (denying asthmatic defendant's motion for release due to COVID-19 outbreak).

[12] https://www.cdc.gov/nchs/nvss/vsrr/covid19/tech_notes.htm. ("the data shown on this page may be incomplete, and will likely not include all deaths that occurred during a given time period, especially for the more recent time periods."); https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm. (CDC notes that data on "excess dates" related to COVID-19 are "incomplete," "should be treated with caution," and that "Connecticut" has "historically low levels of completeness.").

among the non-inmate population of Connecticut, particularly where Petitioners themselves allege "that around 60% of COVID-19 cases are asymptomatic." (Doc. #1 at 23, ¶55.) Indeed, Petitioners' own recently disclosed expert Dr. Goldenson estimates that "80% of [COVID-19] cases are selflimited and generally mild" and points out that "95% of those who tested positive [at an Ohio prison] were asymptomatic and would otherwise not have been tested." (Declaration of Dr. Goldenson (Ex. L) at 1, 7; ¶¶7, 32.)

Thus, Petitioners cannot simply posit that releasing inmates into the community makes them less likely to contract SARS-CoV-2, especially here where Petitioners make no allowances for where or how Petitioners will live when they are released. Providing inmates—some of whom have been serving life sentences—a piece of paper instructing them "that they should self-isolate" for 14 days (Doc. #43 at 46, ¶6) would be comically naïve if it were not so dangerous. As James Madison presciently observed, "if men were angels, no government would be necessary." *Federalist No. 51*, p. 349. But people, including and especially Petitioners, are not angels and their proposed injunction will most likely increase, rather than decrease, the risk to both them and the public at large. (Ex. J at 15-16, ¶¶67-73.) They cannot show irreparable harm based on such speculation and unavoidably murky facts and they certainly cannot meet their heavy burden in the context of a mandatory injunction.

Even if all of the numbers here were as accurate as a study conducted after this crisis had passed, there are still insufficient facts to show that the DOC is unable to properly manage the current health crisis. Per the US Census, Connecticut has approximately 3,565,000 residents.[13] As of May 15, 2020, Connecticut has 37,419 people who have tested positive for the COVID-19

[13] https://www.census.gov/quickfacts/CT

virus, with 3,408 COVID-19 associated deaths.[14] That translates to a 1% positive infection rate with a mortality rate of 9.1% of those infected.

As of May 15, 2020, the total population of DOC facilities stands at 10,556[15], with 598 total inmates testing positive for the COVID-19 virus with 6 COVID-19 related deaths.[16] That translates to a 5.6% infection rate, but just a 1% mortality rate. So comparing the DOC to the general community, while there is a greater infection rate, there is a significantly lower mortality rate. Additionally, 444 inmates who had COVID-19 and were thus quarantined at NCI, have been medically cleared in accordance with CDC guidelines and returned to their original facilities.[17] That is a recovery rate of 74% and the numbers of inmates who have recovered is increasing significantly by the day, as evidenced by the dramatic drop of inmates housed at NCI, which currently stands at 66.

Based on the available data, a DOC inmate who does unfortunately contract SARS-CoV-2, has a 99% chance of survival and the vast majority of inmates have *already* recovered pursuant to CDC guidelines. Given these circumstances, Petitioners cannot show a substantial risk of serious harm in the form of death or serious illness. Put simply, if one has a 1% risk of death, one cannot argue he faces a "substantial" risk, particularly when juxtaposed against the 9.1% mortality rate in the general community where he seeks to be released. Nor can one argue that he faces a "substantial" risk of serious illness, where inmates are making full recoveries—as determined by following CDC guidelines—at a rapid pace.

Respondents are not minimizing this crisis. Even Petitioners' designated expert avers that this virus has a "mild" impact on the vast majority of those infected and Petitioners

[14] https://portal.ct.gov/coronavirus
[15] https://cjis-dashboard.ct.gov/CJPPD_Reports/rdPage.aspx?rdReport=Extracted_Data
[16] https://portal.ct.gov/DOC/Common-Elements/Common-Elements/Health-Information-and-Advisories
[17] https://portal.ct.gov/DOC/Common-Elements/Common-Elements/Health-Information-and-Advisories.

themselves allege that 60% of these cases are asymptomatic. (Ex. L at 1, ¶7; Doc. #1 at 23, ¶55.) The harm itself must be "serious" and the risk "substantial." Based on the available data, it is at least arguable that neither is true. And since it is arguable, it cannot be said that Petitioners' have met their heavy burden to show irreparable harm, a burden that applies to *all* factors of the mandatory injunction test. *Bergamaschi*, 2020 WL 1910754, at *6 (required to "carry the burden of persuasion by a clear showing for each factor.").

2. Petitioners cannot show that they are far more likely to succeed than not.

Petitioners "must show 'a clear and substantial likelihood of success on the merits.'" *Bergamaschi*, 2020 WL 1910754, at *5 (quoting *N.Y. Civil Liberties Union v. N.Y.C. Transit Auth.*, 684 F.3d 286, 294 (2d Cir. 2012)). "This requires proof 'that their cause is considerably more likely to succeed than fail.'" *Id*. (quoting *Abdul Wall v. Coughlin*, 754 F.3d 1015, 1026 (2d Cir. 1985), *overruled on other grounds*, *O'Lone v. Estate of Shabazz*, 482 U.S. 342 (1987)); *see also Eng v. Smith*, 849 F.2d 80, 81 (2d Cir.1988). "It is not enough for a plaintiff seeking a mandatory injunction to demonstrate just a 'likelihood of success on the merits;' and it is certainly not a enough for him to demonstrate the existence of a 'serious questions on the merits and a balance of hardships decidedly favoring the moving party,' which has traditionally been an alternative to a likelihood of success on the merits in this Circuit." *Id*. (citing *N. Am. Soccer League, LLC*, 883 F.3d at 37).

"When courts refer to 'a probability of success,' they are presumably using the word 'probability' (or its cognate 'probable') in the sense of a substantial degree of likelihood, rather than in the sense of some ratio of the likelihood of a particular outcome to a number of possible outcomes." *Mohammed v. Reno*, 309 F.3d 95, 101 (2d Cir. 2002). A party seeking a prohibitory injunction "need only make a showing that the probability of his prevailing is better than fifty

percent." *Eng*, 849 F.2d at 82 (quoting *Abdul Wall*, 754 F.3d at 1025). Therefore, in practical terms, Petitioners must meet a burden greater than a mere preponderance of the evidence. *See C Tennant, Sons & Co of New York v. Dill*, 158 F. Supp. 63, 69 (S.D.N.Y. 1957) (noting that the plaintiff had failed to meet the "clear and convincing" standard "which would seem to be necessary to warrant a grant of a mandatory injunction"); *see also Bristol Tech., Inc. v. Microsoft Corp.*, 42 F. Supp. 2d 153, 175 (D. Conn. 1998) (Judge Hall denying mandatory injunction because "[a]lthough the record currently supports the conclusion that [the plaintiff] is more likely than not to succeed . . . it cannot be said that a clear showing has been made. . .").

Petitioners are not merely seeking a preliminary injunction. They are not even just seeking a mandatory injunction. Petitioners are seeking a mandatory injunction compelling state *prison* officials, to not only correct supposedly deficient conditions of confinement, but to *release* potentially thousands of inmates, including six dozen murderers. Petitioners are asking this Court to ignore federalism, separation of powers, the Prison Litigation Reform Act, Second Circuit and Supreme Court precedent, the rights of crime victims under the Connecticut Constitution, common sense, and the safety of Connecticut's law-abiding citizens, to do something that no court has ever done in American history: order the Governor to release numerous inmates with no plan for monitoring, housing or return, *prior* to trial, and despite the fact that they have not even attempted to exhaust their state court or administrative remedies, and despite the fact that there has been no violation of any interim court order to address unconstitutional conditions. It is no exaggeration to submit that Petitioners face the highest possible burden a litigant could face when requesting preliminary injunctive relief. They cannot meet this properly onerous burden.

a. Petitioners cannot meet the deliberate indifference standard.

i. Petitioners do not describe in what way Respondents are failing to "provide appropriate medical care."

"To state a claim for deliberate indifference to safety or failure to protect him from harm, [an inmate] must show that the conditions of his confinement posed a substantial risk of serious harm and that the defendants were deliberately indifferent to his safety." *Llewellyn v. Aldi*, No. 3:19-CV-1030 (KAD), 2019 WL 4139484, at *7 (D. Conn. Aug. 30, 2019) (citing *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). "Deliberate indifference exists when the defendant knows of and disregards an excessive risk to an inmate's safety." *Id*.; *see also Bridgewater v. Taylor*, 698 F. Supp. 2d 351, 357 (S.D.N.Y. 2010) (explaining that defendants must be aware of facts supporting an inference that the harm would occur and must actually draw that inference). There are both objective and subjective components to the deliberate indifference standard. *Deegan v. Doe #1*, No. 3:19CV1356(MPS), 2019 WL 5964816, at *3–4 (D. Conn. Nov. 13, 2019).

"There are two elements to a claim of deliberate indifference to a serious medical condition: The plaintiff must show that she or he had a serious medical condition and that it was met with deliberate indifference." *Reddick v. Lantz*, No. CIV307CV1793JBA, 2010 WL 1286992, at *4–5 (D. Conn. Mar. 29, 2010) (quoting *Caiozzo v. Koreman*, 581 F.3d 63, 72 (2d Cir.2009)).

"[The Second Circuit applies] a two-part inquiry to determine whether an alleged deprivation is objectively serious." *Benjamin v. Pillai*, 794 F. App'x 8, 11 (2d Cir. 2019) (quoting *Salahuddin v. Goord*, 467 F.3d 263, 279-80 (2d Cir. 2006)). "[A] prisoner must demonstrate that (1) he 'was actually deprived of adequate medical care,' and (2) the 'inadequacy in medical care [wa]s sufficiently serious.'" *Id*. (quoting *Salahuddin*, 467 F.3d at 280).

"Deliberate medical indifference claims can generally arise in two kinds of cases." *Id*. "First, in cases where the prisoner is deprived of all medical care, 'courts examine whether the inmate's medical condition is sufficiently serious.'" *Id*. (quoting *Salahuddin*, 467 F.3d at 280). "Second, in cases where a prisoner alleges 'a temporary delay or interruption in the provision of otherwise adequate medical treatment, it is appropriate to focus on the challenged delay or interruption in treatment rather than the prisoner's underlying medical condition alone.'" *Id*. (quoting *Smith*, 316 F.3d at 185).

"As the Second Circuit has made clear, there is an important distinction between cases involving a denial of treatment and cases involving a delay in treatment." *Benjamin v. Pillai*, No. 3:16-CV-01721 (JAM), 2018 WL 704998, at *3 (D. Conn. Feb. 5, 2018), *aff'd*, 794 F. App'x 8, 11 (2d Cir. 2019) (citing *Salahuddin*, 467 F.3d at 280). "For cases involving a claimed delay in treatment, 'the seriousness inquiry is narrower' . . ." *Id*. (quoting *Salahuddin*, 467 F.3d at 280). Thus, to determine whether any delay in receiving appropriate treatment was an unreasonable delay, the court must evaluate whether the delay exacerbated the injury or condition. *Washington v. Artus*, 708 F. App'x 705, 709 (2d Cir. 2017) (citing *Smith*, 316 F.3d at 185). "In considering whether a delay caused a risk of harm, a court may consider the absence of adverse medical effects or demonstrable physical injury." *Valdiviezo v. Boyer*, 752 F. App'x 29, 32 (2d Cir. 2018).

Courts have found that a plaintiff's allegations fail to meet the objective prong where the alleged "delay in providing medical attention is neither the underlying cause of a plaintiff's condition nor contributed to a worsening in the condition. . ." *Cuffee v. City of New York*, No. 15CV8916 (PGG) (DF), 2017 WL 1232737, at *9 (S.D.N.Y. Mar. 3, 2017), *report and recommendation adopted*, No. 15CIV8916PGGDF, 2017 WL 1134768 (S.D.N.Y. Mar. 27,

2017) (citing cases); *see also McCoy v. Goord*, 255 F.Supp.2d 233, 260 (S .D.N.Y.2003) (granting motion to dismiss on pro se plaintiff's deliberate indifference claim, since plaintiff did not allege "for what serious medical condition he sought and was denied treatment, [or] what harm, if any, resulted from the delay in treatment").

Thus, even "a delay in treatment of a life-threatening condition may not violate the Eighth Amendment if the delay does not cause additional harm beyond that which would have occurred even with earlier medical attention." *Guerrero v. White-Evans*, No. 06CIV5368SCRGAY, 2009 WL 6315307, at *3 (S.D.N.Y. Sept. 17, 2009), *report and recommendation adopted*, No. 06CIV.5368(SCR), 2010 WL 1257537 (S.D.N.Y. Mar. 30, 2010); *see also Smith*, 316 F.3d at 186 (finding no constitutional violation because of two alleged episodes of missed HIV medication where plaintiff failed to present evidence of permanent or on-going harm or an unreasonable risk of future harm stemming from missed doses).

Petitioners' assert that Respondents "Do Not Provide Appropriate Medical Care." (Doc. #43 at 15.) Setting aside whether an allegation of providing "inappropriate" medical care even states a deliberate indifference claim, Petitioners make no allegations about any inmates who sought specific care and were denied or provided alternative care. (Doc. #43 at 15-18.) Petitioners instead allege that there is an "utter lack of medical staffing at DOC facilities." (*Id*. at 17.) But Petitioners make no argument as to how the supposed lack of staffing has actually impacted any of them and the numbers they rely on for their contentions of inadequate staffing are all based on unsworn hearsay.[18]

[18] Litigants are permitted to submit hearsay in preliminary injunction motions. *See Mullins v. City of New York*, 626 F.3d 47, 52 (2d Cir. 2010) ("The admissibility of hearsay under the Federal Rules of Evidence goes to weight, not preclusion, at the preliminary injunction stage."). However, in the preliminary injunction context, "there is a preference for live testimony regarding disputed issues of fact." *Flores v. Town of Islip*, No. 218CV3549ADSGRB, 2019 WL 1515291, at *2 (E.D.N.Y. Apr. 8, 2019). Petitioners make liberal use of unsworn and unverified newspaper articles throughout their papers. "It is well-established that 'newspaper articles offered for the truth of the matters asserted therein are inadmissible hearsay. . .'" *Outerbridge v. City of New York*, No. 13 CIV. 5459

The closest Petitioners come are allegations of delay: "[p]eople are kept in their congregate housing units for days or even weeks after reporting COVID-19 symptoms and requesting medical care. Some are refused medical care altogether. The first prisoner to die from COVID-19 in custody had reportedly had a fever of 101 degrees and been begging to be seen before he finally was transferred to a hospital." (Doc. #43 at 22-23.) But to support these allegations, Petitioners rely on hearsay.

For example, the support for the allegation that "some are refused medical care altogether" comes from the affidavit of Marcus Champagne. But he simply says "I've seen 3 or 4 people sick with coronavirus symptoms, and only 2 have gone to medical. One of those people had been asking repeatedly for the entire day. Both of the people who have been to medical didn't come back to the dorm." (Doc. #43-7 at 3, ¶10.) He does not name these inmates or the DOC officials they spoke with, what kind of symptoms they had, whether the "3 or 4" all had even asked to go to medical, whether they submitted a grievance or written request, and what kind of treatment they received once these phantom people were seen by medical. This illustrates the problem with relying on this kind of hearsay when trying to meet the heavy burden of a mandatory injunction.

Petitioners can submit hearsay, but this Court is not required to accept it without question. Indeed, even properly sworn affidavits are insufficient to settle a disputed issue of fact. *See Davis v. N.Y.C. Hous. Auth.*, 166 F.3d 432, 437-48 (2d Cir. 1999) ("We note for purposes of remand that while affidavits may be considered on a preliminary injunction motion, motions for preliminary injunction should not be resolved on the basis of affidavits that evince disputed

(AT/DCF), 2015 WL 5813387, at *4 (S.D.N.Y. Sept. 30, 2015) (quoting *Odom v. Matteo*, 772 F.Supp.2d 377, 404 (D. Conn. 2011)) Given this fact, Respondents submit that Petitioners' overreliance on inadmissible media reports, often containing hearsay within hearsay, be discounted or "be afforded little or no weight." *Flores*, 2019 WL 1515291, at *3.

issues of fact. When a factual issue is disputed, oral testimony is preferable to affidavits.") (citation omitted). Petitioners cannot make vague allegations based on unverifiable and unconfronted claims to satisfy their heavy burden for a preliminary injunction. Based on their submissions, there is no likelihood of success on the merits, let alone a substantial one.

COVID-19 likely is a "serious medical condition" to the 20% of people Petitioners allege "will have more severe disease requiring medical intervention and support." (Ex. L at 1, ¶7.) But as to the remaining 80% of cases that Petitioners assert are "mild," this cannot be a serious medical condition. *See Salaam v. Adams*, No. 03-cv-517, 2006 WL 2827687, at *10 (N.D.N.Y. Sept. 29, 2006) (medical condition was not serious where, among other things, the plaintiff's complaints "to medical staff were sporadic and moderate or mild in nature (i.e., not characterized by [the p]laintiff as 'severe,' 'extreme,' 'agonizing,' 'excruciating,' etc.)").

Petitioners also cannot meet their burden to demonstrate deliberate indifference to medical needs simply by saying a condition generally exists in DOC facilities. If they are claiming a lack of treatment, they must explain how, why, and to whom that has happened. If they are claiming delay in treatment, Petitioners must explain the length of the delay and what, if any, negative health consequences resulted therefrom. Petitioners have the burden here and it is not incumbent on Respondents to prove that they are providing "appropriate" medical care, especially where Petitioners offer only vague allegations to the contrary.

ii. Petitioners cannot demonstrate that Respondents have the requisite mental state for deliberate indifference under either the Eighth or Fourteenth Amendments.

"To satisfy the subjective prong of the deliberate indifference standard, 'the official must have acted with the requisite state of mind, the equivalent of criminal recklessness.'" *James v. Suffolk Cty. Corr. Facility*, No. 13CV2344JFBSIL, 2018 WL 3966688, at *12 (E.D.N.Y. June

26, 2018), *report and recommendation adopted*, No. 13CV2344JFBSIL, 2018 WL 3966241 (E.D.N.Y. Aug. 17, 2018) (quoting *Collazo v. Pagano*, 656 F.3d 131, 135 (2d Cir. 2011)). Thus, an allegation of "mere negligen[t]" conduct is insufficient. *See Farmer*, 511 U.S. at 835.

"In the case of pretrial detainees, 'the subjective prong (or *mens rea* prong) ... is defined objectively.'" *Harris v. Viau*, No. 17-CV-9746 (KMK), 2019 WL 1331632, at *4 (S.D.N.Y. Mar. 25, 2019) (quoting *Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017)). "After *Darnell*, pretrial detainees asserting conditions of confinement claims under the Fourteenth Amendment must allege 'that the defendant-official acted intentionally to impose the alleged condition, or recklessly failed to act with reasonable care to mitigate the risk that the condition posed to the pretrial detainee even though the defendant-official knew, or should have known, that the condition posed an excessive risk to health or safety.'" *Id*. (quoting *Darnell*, 849 F.3d at 35). Despite the application of an objective standard, deliberate indifference still requires more than mere negligence. *See Charles v. Orange Cty.*, 925 F.3d 73, 87 (2d Cir. 2019) (holding that "something more than mere negligence" or "mere medical malpractice," is necessary to establish deliberate indifference in the Fourteenth Amendment context).

"Because mere negligence will not support a Section 1983 claim, not all lapses in prison medical care constitute a constitutional violation." *Reddick v. Lantz*, 2010 WL 1286992, at *4–5 (quoting *Smith v. Carpenter*, 316 F.3d 178, 184 (2d Cir.2003)). "In addition, inmates are not entitled to the medical treatment of their choice." *Id*. (citing *Dean v. Coughlin*, 804 F.2d 207, 215 (2d Cir.1986)). "Mere disagreement with prison officials about what constitutes appropriate care does not state a claim cognizable under the Eighth Amendment." *Id*. "So long as the treatment given is adequate, the fact that a prisoner might prefer a different treatment does not give rise to an Eighth Amendment violation." *Id*. (quoting *Chance v. Armstrong*, 143 F.3d 698,

703 (2d Cir.1998)). "The conduct complained of must 'shock the conscience' or constitute a 'barbarous act.'" *Id*. (quoting *Hathaway v. Coughlin*, 99 F.3d 550, 553 (2d Cir.1996)).

"Medical judgment usually is not sufficient to support an Eighth Amendment violation." *Id*. (citing *Hernandez v. Keane*, 341 F.3d 137, 146–47 (2d Cir.2003) (deliberate indifference claim rejected where relying on delay in providing risky treatment), *cert. denied*, 543 U.S. 1093 (2005); *see also Revels v. Corr. Med. Care, Inc.*, 2018 WL 1578157, at *4 (N.D.N.Y. Mar. 28, 2018) ("A mere disagreement with a prescribed course of treatment is not sufficient to establish a violation of the Eighth or Fourteenth Amendment."). "The judgment of prison doctors is presumed valid unless the prisoner provides evidence that the decision was 'such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such judgment.'" *Reddick*, 2010 WL 1286992, at *4–5 (quoting *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir.1990)).

"In addition, physicians can and do differ in their diagnoses and their determinations of the appropriate treatment for a particular patient. That difference of opinion does not establish a claim of deliberate indifference." *Id*. (citing *Estelle*, 429 U.S. at 107 (holding that questions of diagnosis and treatment implicating medical judgment are at most medical malpractice, not deliberate indifference to serious medical needs)). "Thus, the mere fact that treating physicians considered two possible diagnoses does not establish deliberate indifference to serious medical needs." *Id*.; *see also Brown v. Beard*, 445 F. App'x 453, 455 (3d Cir. 2011) ("A professional disagreement between doctors as to the best course of treatment does not establish an Eighth Amendment violation."). "A difference of opinion between a prisoner and prison officials regarding medical treatment does not, as a matter of law, constitute deliberate indifference."

Reddick, 2010 WL 1286992, at *4–5 (citing *Chance*, 143 F.3d at 703 ("It is well-established that mere disagreement over the proper treatment does not create a constitutional claim.")).

Petitioners fail the subjective prong. Petitioners acknowledge that Respondents have been taking steps to combat COVID-19, but they simply characterize these steps as "inadequate" or "insufficient." (Doc. #43 at 1, 9, 12, 22.) Allegations of inadequate treatment sound in negligence and are therefore insufficient to state a deliberate indifference claim, whether under the Fourteenth or Eighth Amendments. *See Pettus v. Lemmott-Taylor*, 219 F. App'x 81, 82 (2d Cir. 2007) (State prisoner's allegations that medical personnel rendered inadequate medical care, at most, claimed mere negligence, which was insufficient to state a claim of deliberate indifference).

As has been the case since this litigation began in the state court, Petitioners' issue with Respondents is not that they have taken no actions or that they have ignored this pandemic. It is that Respondents have not taken the actions Petitioners prefer, namely mass release of inmates. But allegations that Respondents have not done enough to combat COVID-19 is insufficient to satisfy the subjective prong of the deliberate indifference test, under either the Eighth or Fourteenth Amendments.

The CDC Guidelines do not anticipate or recommend the release of *any* number of inmates from prison as a method of addressing COVID-19. (Ex. B, CDC Guidelines.) Indeed, the only mentions of releasing any inmates in the Guidelines have to do with the *limitations* prison officials should place on inmates leaving prisons. (*See* Id. at 12 ("Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility"), Id. at 14 ("Screen all releasing individuals for COVID-19 symptoms and perform a temperature check . . . 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), Id. at 17 ("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.") Petitioners do not simply disagree with DOC's plan. They disagree with the CDC as well. Either way, this is not enough to prove deliberate indifference.

The best example of this mere disagreement is Petitioners' complaints about NCI. (Doc. #43 at 18-21.) Petitioners must acknowledge that Respondents have been using NCI for medical isolation cases. However, Petitioners object to the use of NCI as a medical isolation site, mainly because they contend that its "inherently punitive nature" make inmates less likely to report their symptoms. (Id. at 21.) There are naturally significant factual disputes between the parties as to the conditions at NCI, disputes that can only be settled at a hearing. But these disputes ultimately do not matter because at best Petitioners submit opinions from their experts disagreeing with the use of NCI as a medical isolation facility.

Respondents did not choose NCI on a whim or in an effort to "punish" people for contracting SARS-CoV-2. They did so based on the considered advice of medical professionals, considering such factors as space, ventilation, availability of medical staff, and most importantly, the guidance of the CDC for managing incarcerated individuals. (Ex. A at 1-2, ¶¶4-10; Ex. B at 2-3, ¶¶10, 12.) Per the CDC Guidelines, facilities should place suspected confirmed cases under medical isolation individually. (Ex. A at 2, ¶5; CDC Guidelines at 15.) The Guidelines also suggest single cells should have solid walls and doors and a private bathroom. (Id.; CDC Guidelines at 16.) NCI also has a ventilation system which helps minimize the risk of airborne

spread of the virus. (Id. at 2, ¶7; Ex. B at 2-3, ¶12.) NCI is the best fit to accomplish all goals for medical isolation during this pandemic. Respondents made their choices based on the guidance of their medical experts, upon whom they are entitled to rely. *See Terbush v. Mitchell*, No. 3:15CV01339(SALM), 2017 WL 663198, at *6 (D. Conn. Feb. 17, 2017) (holding that a supervisory official is "generally entitled to delegate medical responsibility to medical staffs and [is] entitled to rely on the opinion of medical staff concerning the proper course of treatment."); *see also Graham v. Wright*, No. 01-CV-9613, 2003 WL 22126764, at *1 (S.D.N.Y. Sept. 12, 2003) ("supervisory officials are generally entitled to delegate medical responsibility to facility medical staffs and are entitled to rely on the opinion of medical staff concerning the proper course of treatment.").

Therefore, Petitioners' complaints at best boil down to a dispute between doctors as to the best way to manage this entirely novel and dynamic crisis. Petitioners and their experts disagree with the conclusions of Dr. Kennedy, Robert Richeson and the Respondents, and contend that the efforts of DOC have been "insufficient," while at the same time ignoring the impressive recovery and mortality rates of COVID-19 within DOC. They are entitled to this disagreement, but Petitioners are not entitled to the extraordinary relief of a mandatory injunction based on this disagreement. *See Gumns et. al. v. Edwards, et. al.*, No. 20-231-SDD-RLB, 2020 WL 2510248, at *15 (M.D. La. May 15, 2020) (denying inmates' request for TRO prohibiting their transfer from jails to a state prison, holding "the existence of an alternative plan–even a better plan–is not evidence that the challenged plan is unconstitutional or illustrative of deliberate indifference.").

Prison officials, particularly medical personnel, are given breathing room and discretion under ordinary circumstances. *See Cruz v. Beto*, 405 U.S. 319, 321 (1972) (stating that prison

officials must be afforded latitude in administering prison affairs); *Vega v. Lantz*, No. 3:04CV1215(DFM), 2005 WL 8166179, at *1 (D. Conn. July 27, 2005); *Gonzalez v. Narcato*, 363 F. Supp. 2d 486, 493 (E.D.N.Y. 2005) ("it is not the job of the federal courts to engage in detailed supervision of the prisons"). It would be a distortion of this well-held principle to rob prison officials of their due deference in the midst of a crisis, where the medical facts and evidence are changing daily, and there is no settled knowledge regarding this disease, its spread, or its treatment.

It is also important to keep in mind the nature of the relief sought. Petitioners are seeking release of inmates. However, there is nothing in the CDC Guidelines for incarcerated individuals that anticipates the mass release of inmates as a method of combating COVID-19. On the contrary, the Guidelines make it clear that they are flexible and recognize the need for prisons and the need to incarcerate individuals, even in the midst of COVID-19. Furthermore, even if Petitioners could demonstrate that Respondents are somehow failing to meet the CDC Guidelines by refusing to simply fling open the prison doors, they cannot demonstrate how mere failure to meet professional guidelines, despite best efforts, could constitute anything other than negligence. The mere fact that the CDC Guidelines do not anticipate, nor recommend releasing inmates proves that the Respondent's refusal to do so cannot be "'such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such judgment.'" *Reddick*, 2010 WL 1286992, at *4–5 (quoting *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir.1990)).

As the Fifth Circuit recently observed in an almost identical context, it is error to treat "inadequate measures as dispositive of the Defendants' mental state." *Valentine v. Collier*, 956 F.3d 797, 802–03 (5th Cir. 2020). "Such an approach resembles the standard for civil

negligence, which *Farmer* explicitly rejected." *Id*. "Though the district court cited the Defendants' general awareness of the dangers posed by COVID-19, it cited no evidence that they subjectively believe the measures they are taking are inadequate. To the contrary, the evidence shows that TDCJ has taken and continues to take measures—informed by guidance from the CDC and medical professionals—to abate and control the spread of the virus." *Id*. So too here.

Petitioners may disagree with Respondents. They may object to Respondents' policy decision made based on medical advice, a balancing of risks, and due consideration for the safety of all of Connecticut's people. They are free to do so in a republic. But they cannot invoke the federal courts to force Respondents to reverse their policy decisions, especially when the best they can do is demonstrate a disagreement amongst doctors as to the proper course of action.

b. Petitioners cannot show a substantial likelihood of success on their Substantive Due Process claim, because there is clearly no intent to punish and the presence of COVID-19 does not render confinement in and of itself as "excessive."

"[S]ubstantive due process is violated if the pretrial conditions are punitive." *Caves v. Payne*, No. 3:20-CV-15 (KAD), 2020 WL 1676916, at *6 (D. Conn. Apr. 6, 2020) (quoting *Bell v. Wolfish*, 441 U.S. 520, 535 (1979)). "In considering such a claim, the 'court must decide whether the [condition] is imposed for the purpose of punishment or whether it is but an incident of some other legitimate governmental purpose.'" *Id*. (quoting *Bell*, 441 U.S. at 538). Absent evidence of an "expressed intent to punish on the part of detention facility officials, that determination generally will turn on 'whether an alternative purpose to which the restriction may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned to it.'" *Id*. (quoting *Bell*, 441 U.S. at 538). "[I]f a restriction or condition is not reasonably related to a legitimate goal—if it is arbitrary or purposeless—a court

permissibly may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees qua detainees." *Id*. (quoting *Bell*, 441 U.S. at 539).

"Conversely, 'if a particular condition or restriction of pretrial detention is reasonably related to a legitimate governmental objective, it does not, without more, amount to 'punishment.'" *Id*. (quoting *Bell*, 441 U.S. at 539). "Legitimate government objectives include 'maintain[ing] security and order at the institution and mak[ing] certain no weapons or illicit drugs reach detainees,' 'ensuring the detainees' presence at trial,' and managing the facility where the detainee is held." *Id*. (quoting *Bell*, 441 U.S. at 539). It is well-held that "public safety" is a legitimate government objective. *See, e.g*., *Marcavage v. City of N.Y*., 689 F.3d 98, 104 (2d Cir. 2012) (recognizing City's "significant interest in keeping its public spaces safe"); *United for Peace and Justice v. City of N.Y.*, 243 F.Supp.2d 19, 29 (S.D.N.Y. 2003) (describing the "significant government interest of public safety"). In the current context, ensuring the healthcare infrastructure of Connecticut not be overwhelmed, preventing a second wave of infections, preventing recidivism, and protecting the rights of victims in accordance with the Connecticut Constitution are all "legitimate governmental objectives" as well.

Petitioners give lip service to this argument, essentially repeating their points about deliberate indifference. (Doc. #43 at 32.) The only law they cite to support this is from District Court decisions dealing with civil immigration detainees. But all of these cases are inapposite for the same reason Petitioners' argument ultimately fails. They do not involve people accused of crimes and who have consequently been ordered incarcerated on bond, and therefore do not consider the public safety risk associated with releasing numerous *criminal* detainees *en masse*.

Petitioners also make no mention of how any of the detainees they seek to release will be monitored, whether they have housing, whether they have access to medical care, and whether

they would ever return to confinement. Thus, Petitioners do not grapple with the very real risk that releasing people that they specifically allege may be asymptomatic carriers of SARS-CoV-2 might not abide by the "instructions" to self-quarantine. They do not consider that these inmates may not have the ability to self-quarantine. Perhaps they have no place to live or perhaps the only place they can go would require them to live with many other people. Petitioners' facile plan demonstrates the many legitimate government interests in keeping detainees confined, while either reconsidering their status on a case-by-case basis, or allowing the state courts to do the same, as they have been since the beginning of this crisis. Indeed, Petitioner Void-Williams had a hearing for a bond reduction and was denied 2 weeks before bringing this case. (Transcript of Apr. 3, 2020 bond reduction hearing in State v. Williams-Void (Ex. M.); Void-Williams' Motion for Bond Reduction dtd Mar. 24, 2020 (Ex. N.)) Petitioner McPherson also had such a hearing and was actually released.

Finally, Petitioners do not consider that the Connecticut Constitution has robust protections for victims and therefore Respondents have a legitimate interest in upholding those laws. This will be discussed in further detail *infra*. There is no good faith argument that refusing to massively release thousands of inmates in an effort to ensure public safety is "arbitrary or purposeless." Petitioners cannot meet their heavy burden on their Substantive Due Process claim and the injunction should therefore not issue.

c. The PLRA bars this Court from ordering the relief sought by Petitioners.

"Running a prison is an inordinately difficult undertaking that requires expertise, planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government." *Turner v. Safley*, 482 U.S. 78, 84-85 (1987).

Federal courts may order prospective relief "in any civil action with respect to prison conditions," provided the relief "extend[s] no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." 18 U.S.C. § 3626(a)(1)(A). Should this court deem such relief necessary it must be narrowly tailored or proportional to the scope of the violation and extending no further than necessary to remedy the violation. *Brown v. Plata*, 563 U.S. 493, 530 (2011). A court should not issue "remedial orders that unnecessarily reach out to improve prison conditions other than those that violate the Constitution." *Id*.

Petitioners request habeas relief and the release of thousands of inmates. However, the PLRA, 18 U.S.C. § 3626, titled "Appropriate remedies with respect to prison conditions," places strict limits on Courts' ability to order the release of inmates "in any civil action with respect to prison conditions," and precludes a single district judge from doing so. *Id.* § 3626(a)(3)(A)-(B). That law applies to "any civil proceeding arising under Federal law with respect to the conditions of confinement or the effects of actions by government officials on the lives of persons confined in prison, but does not include habeas corpus proceedings challenging the fact or duration of confinement in prison." *Id.* § 3626(g)(2).

In such a suit, the Court "may enter a temporary restraining order or an order for preliminary injunctive relief," but such injunctive relief "must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm." 18 U.S.C. § 3626(a)(2). Under Section 3626, a "prisoner release order"—which "includes any order, including a temporary restraining order or preliminary injunctive relief, that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or nonadmission of prisoners to a prison," 18

U.S.C. § 3626(g)(4)—may "be entered only by a three-judge court," *id.* § 3626(a)(3)(B), and then only if certain conditions have been met.

Among other requirements, "no court shall enter a prisoner release order unless—(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and (ii) the defendant has had a reasonable amount of time to comply with the previous court orders." *Id.* §3626(a)(3)(A).

Congress enacted the PLRA "to oust the federal judiciary from day-to-day prison management." *Inmates of Suffolk County Jail v. Rouse*, 129 F.3d 649, 655 (1st Cir. 1997); *see also Benjamin v. Jacobson*, 172 F.3d 144, 182 (2d Cir. 1999) (*en banc*) (Calabresi, J., concurring) ("The *in banc* majority argues at length that Congress meant to get the federal courts out of the business of running jails, and it cites any number of congressional statements to that effect."). "Congress intended the PLRA to revive the hands-off doctrine," which was "a rule of judicial quiescence derived from federalism and separation of powers concerns." *Gilmore v. California*, 220 F.3d 987, 991, 997 (9th Cir. 2000). "Courts must be sensitive to the State's interest in punishment, deterrence, and rehabilitation, as well as the need for deference to experienced and expert prison administrators faced with the difficult and dangerous task of housing large numbers of convicted criminals." *Brown v. Plata*, 563 U.S. 493, 511 (2011).

Section 3626 thus "restrict[s] the equity jurisdiction of federal courts," *Gilmore*, 220 F.3d at 999, and, "[b]y its terms . . . restricts the circumstances in which a court may enter an order 'that has the purpose or effect of reducing or limiting the prison population.'" *Plata*, 563 U.S. at 511 (quoting 18 U.S.C. § 3626(g)). The PLRA's "requirements ensure that the 'last resort remedy' of a population limit is not imposed 'as a first step.'" *Plata*, 563 U.S. at 514 (quoting

Inmates of Occoquan v. Barry, 844 F.2d 828, 843 (D.C. Cir. 1988)). "The release of prisoners in large numbers . . . is a matter of undoubted, grave concern." *Plata*, 563 U.S. at 501.

Section 3626 prevents this Court from granting Petitioners' requested relief. Under Section 3626, "[t]he authority to order release of prisoners as a remedy to cure a systemic violation of the Eighth Amendment is a power reserved to a three-judge district court, not a single-judge district court." *Plata*, 563 U.S. at 500 (citing 18 U.S.C. § 3626(a)); 18 U.S.C. § 3626(a)(3)(B) ("In any civil action in Federal court with respect to prison conditions, a prisoner release order shall be entered only by a three-judge court.").

Moreover, such an order may not be entered unless "(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and (ii) the defendant has had a reasonable amount of time to comply with the previous court orders." 18 U.S.C. § 3626(a)(3)(A). And even a three-judge court may only order prisoners released to remedy unconstitutional prison conditions "only if the court finds by clear and convincing evidence" that "crowding is the primary cause of the violation" and "no other relief will remedy [it]." *Id.* § 3626(a)(3)(E)(i)-(ii). Here, there can be no dispute that the instant lawsuit is a "civil action with respect to prison conditions" governed by §3626, which defines "civil action with respect to prison conditions" broadly to mean "any civil proceeding arising under Federal law with respect to the conditions of confinement or the effects of actions by government officials on the lives of persons confined in prison, but [that term] does not include habeas corpus proceedings challenging the fact or duration of confinement in prison." 18 U.S.C. § 3626(g)(2).

One court recently reached this conclusion in an identical case. In *Money v. Pritzker*, Nos. 20- CV-2093 & 20-CV-2094, 2020 WL 1820660 (N.D. Ill. Apr. 10, 2020), inmates from

various Illinois Department of Correction facilities brought purported class action lawsuits seeking release of over 12,000 prisoners in light of the COVID-19 pandemic. The Court held that the PLRA prevented it from entering the relief requested. *Id.* at, *14; *see also Jones v. Smith*, 720 F.3d 142, 145 n. 3 (2d Cir. 2013) (assuming that the PLRA applies to conditions of confinement habeas claims brought under Section 2241).

Clearly, a mass release of all DOC inmates, or a subclass thereof including Petitioners, is one of the least narrowly drawn and most intrusive means imaginable. Thus, Petitioners'' requested relief is barred by statute. *See* 18 U.S.C. § 3626(a)(2); *see also Jones*, 720 F.3d 142, 145 n. 3 (2d Cir. 2013) (assuming that the PLRA applies to conditions of confinement claims brought under Section 2241). Even if Petitioners could somehow show a substantial likelihood of irreparable harm and success on the merits, their requested relief is barred.

3. The balance of equities and public interest weigh strongly in favor of Respondents.

"A balance of hardships tipping decidedly toward the party requesting a preliminary injunction means that, as compared to the hardship suffered by other party if the preliminary injunction is granted, the hardship suffered by the moving party if the preliminary injunction is denied will *be so much greater* that it may be characterized as a 'real hardship.'" *Doe v. Zucker*, No. 117CV1005GTSCFH, 2019 WL 111020, at *6 (N.D.N.Y. Jan. 4, 2019) (emphasis added) (quotation omitted). "'A balance of equities tipping in favor of the party requesting a preliminary injunction' means a balance of the hardships against the benefits." *Id*. (citing *Ligon v. City of New York*, 925 F. Supp. 2d 478, 539 (S.D.N.Y. 2013) (characterizing the balancing "hardship imposed on one party" and "benefit to the other" as a "balanc[ing] [of] the equities");

"[A] preliminary injunction is 'in the public interest' if the preliminary injunction would not 'cause harm to the public interest.'" *Doe*, 2019 WL 111020, at *7 (quoting *SEC v. Citigroup*

Global Mkts. Inc., 673 F.3d 158, 163 n.1 (2d Cir. 2012). "The 'public interest' is defined as '[t]he general welfare of the public that warrants recognition and protection,' and/or '[s]omething in which the public as a whole has a stake[,] esp[ecially], an interest that justifies governmental regulation.'" *Id*. (quoting Black's Law Dictionary at 1350 (9th ed. 2009)).

As argued *supra*, given the uncertainty regarding the actual infection rate in the community and the corresponding uncertainty as to the actual mitigation of any risk of infection in the community, the benefit of the injunction to Petitioners is likewise uncertain. At first glance, an order releasing Petitioners from confinement seems beneficial to Petitioners. But the complete lack of any plan to address their housing and/or their medical care contradicts that. Petitioners cannot simply argue that the Court has "broad" power to fashion a remedy, ask for a mass release and leave all of the practical issues to this Court. They carry a heavy burden. Petitioners are bound by what they are actually requesting, which is mass release.

The harm to Respondents and the public are myriad and also largely overlap. The risks to public safety are obvious. Once released, inmates could re-offend. (Ex. J at 15, ¶69.) A mass release of inmates could overwhelm the healthcare system at a time when the State is just preparing to loosen lockdown procedures. Inmates could refuse to abide by the "instructions" to self-quarantine and thereby further spread COVID-19. This presents even more logistical problems. Who will set conditions of release and monitor releasees for compliance? What happens if an inmate does refuse to self-quarantine? Would he be re-arrested and confined again? If so, by state authorities or federal authorities? Where would be confined this time? Petitioners are completely silent as to all of these very serious logistical and practical issues. Indeed, based on the actual language of their requests for relief, Petitioners are seeking the release of sentenced inmates with no mention of their return to DOC custody. Petitioners are

seeking a *de facto* pardon of a huge number of convicted felons, including six dozen murderers serving life sentences. It would undoubtedly not be in the public interest for a federal court to invalidate well over one thousand convictions and sentences issued by the state courts.

The one thing Petitioners offer is a requirement that Respondents prove via "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." (Doc. #43 at 40.) Petitioners are silent as to what this means. The state courts would have no jurisdiction to re-evaluate "risk of flight or danger" of already sentenced inmates. Petitioners are also taking contrary positions regarding bond arguments. They asserted in opposition to Respondents' motion to dismiss that the state courts were effectively "closed," despite two of them had already had bond reduction hearings, one of which was successful. Now they suggest Respondents go to these same courts they argue, incorrectly, are "closed" to get a lightning fast evaluation of potentially thousands of inmates, their risk of flight, and the danger they pose to the public. Petitioners inconsistent approach to an essential element of releasing offenders into the community severely undercuts any claim that the balance of hardships weighs in their favor.

Furthermore, there is a large segment of the population that has gone ignored during the course of this litigation: the hundreds of registered victims who have substantial rights under the constitution and laws of the State of Connecticut. Conn. Const. art. I, § 8b; Conn. Gen. Stat. §§ 54-227, 52-230, 54-230a, 54-231. No one has considered their rights to be notified or consulted, to make a statement, or to register their fears or objections that one or more of their attackers is about to be released into the community. The harm in granting the mandatory injunction to this class of individuals is massive, and as is the case with all the other practical realities of what they seek, this goes completely unaddressed by Petitioners. Indeed, the victims are already suffering

intense anxiety simply as a result of this litigation and the confusion Petitioners' broad and illegal requested relief has caused. The Victim Services Administrator attests to this: "when a victim calls me and begs me to not let out the monster who viciously raped and beat her or brutally killed their father because that's what they're 'hearing on the news' I do my best to reassure them, that yes although the Department of Correction is reviewing potential releases; they need not worry." (Ex. K at 2, ¶10.) If the injunction is granted, these reassurances will have proven false. The Petitioners are not the only people that have rights.

Respondents are fulfilling their duties to inmates, including by thoughtfully evaluating who can be released early and implementing a plan designed by the medical director that complies with CDC guidelines. The plan is working. Any death is tragic, but DOC has kept the mortality rate nine times lower than in the community. Almost 75% of those infected have already recovered and returned from NCI to their original facilities.

Respondents also have a duty to every citizen of Connecticut. Petitioners' plan to mass release inmates, without accounting for monitoring, housing, or if they will return, and without even contacting the victims is ill-conceived, reckless, and dangerous. It would thwart Respondents' ability to do right by *all* of Connecticut's citizens. Petitioners have not met their heavy burden to demonstrate the equities weigh in their favor and that the public interest would be best served by granting their Motion. Therefore, this Court must deny Petitioners' request.

III. CONCLUSION

For all the foregoing reasons the Respondents respectfully request this Court deny the Petitioners' motion for Preliminary Injunction.

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CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT A

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL., *Petitioner,*	:	CIVIL NO. 3:20-CV-0534 (CSH)
v.	:	
NED LAMONT, ET AL., *Respondent.*	:	MAY 8, 2020

DECLARATION OF ROBERT RICHESON, DC

I, Robert Richeson, DC, DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.

2. I received my undergraduate degrees in Chemistry from Sacred Heart University in Fairfield CT and Human Biology from National University of Health Sciences in Lombard IL. I received my Doctor of Chiropractic from National University of Health Sciences in Lombard IL. I Currently hold the position of Chief Operating Officer of the Health Services Unit for the Connecticut Department of Corrections ("DOC"). I have worked for the DOC since August 2018 initially as the Regional Chief Operating Officer.

3. The DOC is well aware of the potential for infection within correctional facilities and, therefore, has taken extraordinary measures to prevent and reduce the spread of COVID-19. Part of those measures include following the CDC Guidelines for Management of Coronavirus Disease in Correctional and Detention Facilities. (Exhibit A).

4. On April 7, 2020 Northern CI ("NCI") was designated the primary housing for all COVID-19 positive inmates. Inmates who are considered part of a specialized population may be excepted from this policy. Members of specialized populations include inmates currently housed at: Garner CI (mental health), Manson Youth (young offenders), and York CI (female inmates). Inmates with chronic medical conditions that do not warrant transfer to NCI will also be considered as excepted on a case by case basis. According to the tracker as of May 7, 2020, there are 97 COVID-19 positive inmates housed in isolation at NCI[1].

[1] https://portal.ct.gov/DOC/Common-Elements/Common-Elements/Health-Information-and-Advisories

5. Per the Guidelines, facilities should make every possible effort to place suspected and confirmed cases under medical isolation individually[2]. Inmates should be assigned their own housing space and bathroom where possible[3]. Additionally, the CDC Guidelines indicate that where possible, housing should consist of single cells with solid walls and solid doors that close fully[4].

6. NCI is ideally suited to accomplish the above requirements.

7. NCI also has minimal risk of airborne spread due to airflow in and out of each cell from the outside. This flow is separate from other areas of the building.

8. Due to NCI's minimal inmate population it has sufficient available housing that would cause minimal to no disruption to other facilities in creating medical isolation areas for COVID-19 positive inmates. The housing consists of cells that, with the current population, can be occupied by one individual. The cells include bathroom facilities (toilet and sink).

9. Other than the CDC Guidelines for medical isolation, NCI provides significant safety, security, and transport logistics necessary for correctional facility operations.

10. The structure of the facility allows for movement of inmates in and out of the facility without having them go through other areas occupied by non-positive inmates. The structure also allows for easy access for ambulance assistance in case of a medical emergency.

11. CDC Guidelines also suggest that staff should be dedicated to the monitoring of the inmates in medical isolation[5].

12. Currently the medical staff at NCI COVID-19 isolation area consists of 19 nurses running at 12-hour shifts every day of the week. Additionally, there is at least 1 medical provider (i.e. APRN, Infectious Disease Doctor) per day with 4 days a week having 2 providers. There is also physician on call coverage 24 hours a day 7 days a week.

13. Where necessary the DOC has been able to secure outside agency nurses and providers to accommodate the above stated coverage.

14. For those inmates who currently show symptoms nurses do rounds on their unit every shift. At least once per day nurses perform routine blood pressure, temperature, pulse, respiration, lung sound, pulse oximeter, and pain scale checks. Additional monitoring is done each shift.

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[2] CDC Guidelines at 15.
[3] *Id.*
[4] *Id.* at 16.
[5] *Id.*

Should any inmate require re-evaluation or have additional needs, nursing staff conduct rounds as needed[6].

15. At NCI for medication line and sick call, clinical staff go to the inmates' individual cells in order to reduce inmate movement through the facility.

16. Prior to returning any previously COVID-19 positive inmate to their original housing facility they must be; fever free for at least 72 hours, the inmates symptoms have improved, and at least 14 days have passed since the beginning of symptoms which is longer than what is indicated in the guidelines[7].

17. NCI was chosen as the medical isolation facility as it was the best match to meet the CDC Guidelines noted above. NCI was not intended for and is not considered as a punishment for inmates who are COVID-19 positive or suspected of being COVID-19 positive. When an inmate is healthy enough to return following the guidelines listed above, he is returned to his previous facility.

18. According to the Covid-19 Tracker as of May 7, 2020, 345 inmates have been medically cleared and returned to their original facility.

19. Since April 7, 2020, when NCI became the designated treatment location for COVID-19 positive patients, a total of 345 inmate patients have recovered from viral infection and have been medically cleared and returned to their originating facilities.

20. A copy of the numbers of inmate patients that have been housed, as set forth in a graph, Table A, attached, reflects that the DOC is experiencing a downward trend in admissions to Northern CI for Covid-19 treatment and not merely a flattening of the curve, but also a deceleration in the number of new admissions to Northern CI.

21. SEE TABLE A BELOW, ON NEXT PAGE

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[6] *Id.* at 16.
[7] *Id.* at 17.

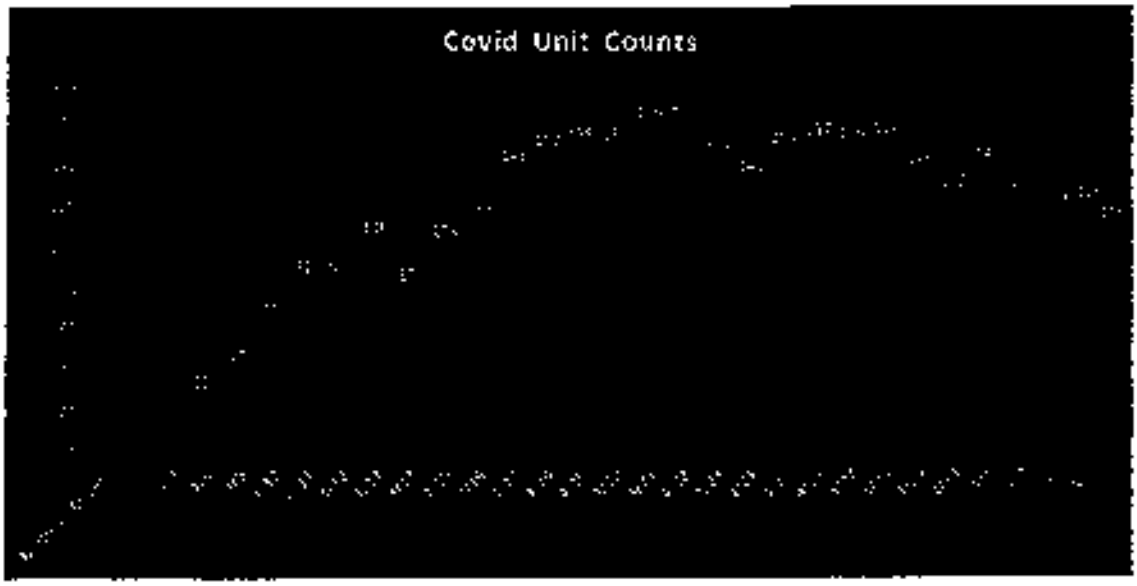

TABLE A

DECLARATION UNDER PENALTY OF PERJURY PURSUANT TO 28 U.S.C. § 1746

1. Robert Richeson, DC. declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 8, 2020.

Robert Richeson, DC

EXHIBIT A
TO DECLARATION OF
ROBERT RICHESON, DC

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?
- Why is this guidance being issued?
- What topics does this guidance include?
- Definitions of Commonly Used Terms
- Facilities with Limited Onsite Healthcare Services
- COVID-19 Guidance for Correctional Facilities
- Operational Preparedness
- Prevention
- Management
- Infection Control
- Clinical Care of COVID-19 Cases
- Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons
- Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

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.

[redacted]

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 those 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.**

- o 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.
- o 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.

[redacted]

√ **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.**

- Discuss work from home options with their staff and determine whether they have the supplies and technological equipment required to do so.
- 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.

- Allow staff to work from home when possible, within the scope of their duties.
- Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
- 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.
- 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.

- 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.**

- Standard medical supplies for daily clinic needs
- Tissues
- Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
- Hand drying supplies
- Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
- Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19

[redacted]

- 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.**

[redacted]

- √ **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.**

[redacted]

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.

[redacted]

- **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.

[redacted]

- √ **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).

[redacted]

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

Prevention Practices for Visitors

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

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

[redacted]

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.

[redacted]

√ **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.

[redacted]

- 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.**

[redacted]

√ **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).

[redacted]

√ **Hard (non-porous) surface cleaning and disinfection**

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- 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**

- 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**

- 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.**

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- 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.

[redacted]

- 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.

[redacted]

- 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.

[redacted]

- √ **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.**

[redacted]

- √ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.
- √ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
  - o If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
  - o If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

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

- √ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
  - o Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
- √ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See Screening section for a procedure to safely perform a temperature check.
- √ **Consider additional options to intensify** social distancing within the facility.

Management Strategies for Staff

- √ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- √ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
  - o See above for definition of a close contact.
  - o Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

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

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

[redacted]

- 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.**

[redacted]

- 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.

[redacted]

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

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT B

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL., *Petitioner*,	:	CIVIL NO. 3:20-CV-0534 (CSH)
v.	:	
NED LAMONT, ET AL., *Respondent*.	:	MAY 8, 2020

DECLARATION OF BYRON KENNEDY, MD, PhD, MPH, FACPM

I, Byron Kennedy, MD, MPH, DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.

2. I received my medical degree and master's in public health from Yale University and am board certified in preventative medicine. I am also familiar with, and have published articles on, Communicable Disease Outbreaks. I currently hold the position of Chief Medical Officer for the Connecticut Department of Correction("DOC").

3. The DOC is well aware of the potential for infection within correctional facilities and, therefore, has taken extraordinary measures to prevent and reduce the spread of COVID-19. Part of those measures include following the CDC Guidelines for Management of Coronavirus Disease in Correctional and Detention Facilities. (Exhibit A)

4. Additionally, the DOC understands that the current COVID-19 pandemic is fluid and requires routine review of procedures and protocols. The DOC adjusts their procedures and protocols as necessary to maintain current with the CDC Guidelines and any adjustments that are made to them.

5. As of May 7, 2020, the total inmate population stands at 10,813. This number includes both sentenced inmates of 7,804 and unsentenced detainees of 3,009. This is a reduction of 1,596 from March 1, 2020 total of 12,409[1].

6. The DOC has created a COVID-19 tracker[2] to show the current numbers of staff and inmates who have been tested and includes numbers for positive tests. The tracker has been placed on the DOC website which is updated routinely. This website page also has sections for Frequently Asked Questions (FAQs), DOC Operational Response Plan, memos circulated to staff and inmates, and other information regarding COVID-19[3].

7. According to the tracker as of May 7, 2020, 361 staff members have contracted COVID-19 and 214 have been medically cleared and returned to work.

8. According to the tracker as of May 7, 2020, 484 inmates have contracted COVID-19 and 345 have been medically cleared and returned to their original housing facility.

9. According to the tracker as of May 7, 2020, there have been 6 inmate deaths as a result of contracting COVID-19.

10. On April 7, 2020 Northern CI ("NCI") was designated the primary housing for all COVID-19 positive inmates with the exception of inmates currently housed at Garner CI (mental health), Manson Youth (youth offenders), and York CI (female inmates) due to their specialized populations. Exceptions may also be made on a case by case basis for inmates with chronic medical conditions that do not warrant transfer to NCI. According to the tracker as of May 7, 2020, there are 97 COVID-19 positive inmates housed in isolation at NCI. (See Robert Richeson, DC Declaration)

11. NCI currently has a dedicated COVID-19 medical staff which consist of at least one provider/APRN per day shift and nursing staff 24 hours a day, 7 days a week. (See Robert Richeson, DC Declaration.)

12. NCI was chosen as the medical isolation facility as it was the best match to meet the CDC Guidelines. Reasons why NCI best fit the guidelines include: available space would be completely separate from other non-COVID-19 positive inmates[4], solid walls and doors[5], and airflow into and out of the cells from outside and separate from other areas of the building

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[1] https://cjis-dashboard.ct.gov/CJPPD_Reports/rdPage.aspx?rdReport=Extracted_Data

[2] https://portal.ct.gov/DOC/Common-Elements/Common-Elements/Health-Information-and-Advisories

[3] Exhibit A, CDC Guidelines at 8.

[4] *Id.* at 15.

[5] *Id.* at 16.

reducing risk of air-borne spread. In addition, NCI best met the needs of the DOC regarding safety, security, and transport logistics.

13. At NCI for medication line and sick call, clinical staff go to the inmates' individual cells in order to reduce inmate movement through the facility.

14. For those inmates who currently show symptoms, nurses do rounds on their unit every shift. At least once per day nurses perform routine blood pressure, temperature, pulse, respiration, lung sound, pulse oximeter, and pain scale checks. Additional monitoring is done each shift. Should any inmate require re-evaluation or have additional needs, nursing staff conduct rounds as needed[6].

15. Prior to returning any previously COVID-19 positive inmate to their original housing facility they must be; fever free for at least 72 hours, the inmate's symptoms have improved, and at least 14 days have passed since the beginning of symptoms which is longer than what is indicated in the CDC guidelines[7].

16. At the outset of the pandemic, DOC administrative staff reviewed all existing facility and health service pandemic flu plans, and by March 9, 2020 all updated plans were in place at all 14 DOC facilities and health services plans were in place agency wide[8]. The DOC continues to make adjustments to the plans when necessary due to the fluid nature of the current pandemic.

17. DOC health services leadership is continually in contact and in collaboration with the Connecticut Department of Public Health, local hospitals, companion health facilities, and other public health experts[9]. These relationships are intended to facilitate consistent and up to date coordination of pandemic responses and to share information regarding the spread and treatment of the infection[10].

18. In compliance with the CDC guidelines, the following measures were undertaken to reduce the chance of introduction of the infection into DOC facilities: canceling social visits[11], limiting inmate transfers among facilities to those that are required medical/mental health treatment needs and transfers necessary for safety and security[12], quarantining all new admits from the

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[6] *Id.* at 16.
[7] Id. at 17.
[8] *Id.* at 6.
[9] Experts include Emily Wang, M.D., and Lisa Puglisi, M.D.
[10] CDC Guidelines at 5, 8.
[11] *Id.* at 13.
[12] *Id.* at 9.

general population for fourteen days[13], canceling volunteer and limiting contractor access to facilities to only those who are the most essential[14], and performing temperature checks on incoming staff members prior to allowing them entry[15].

19. If any staff member is either shown to have a temperature above 100.4 or exhibits other symptoms related to COVID-19 infection they are denied entry into the facility.

20. Ongoing measures taken to prevent or further limit the spread of the COVID-19 virus within the DOC facilities include: widely distributing soap and other cleaning supplies among the inmate population[16], thoroughly cleaning common areas and frequent touch points[17], instituting quarantines of units when an inmate displays any symptoms of COVID-19[18],having inmates eat their meals in their units or cells where feasible[19], and modifying recreation to include only outside recreation and enforcement of social distancing guidelines[20].

21. All inmates with COVID-19 symptoms are placed in medical isolation and all those who have been lab tested as positive are further separated. Additionally, any inmate without COVID-19 symptoms, but known exposure to COVID-19, are placed in quarantine[21].

22. The CDC defines medical isolation as: separating sick people with a contagious disease from people who are not sick[22]. Inmates who are symptomatic or have confirmed tested COVID cases shall be placed in medical isolation, separate from individuals who are not symptomatic. All symptomatic or confirmed cases shall remain in medical isolation for a minimum of 14 days since symptom onset. Counting of days is based on the date of symptom onset and not the date of the test. If the inmate tested positive but did not have symptoms (i.e., inmate had exposure that warranted a test) counting of days shall begin from date of exposure.

23. The CDC defines quarantine as: separating and restricting the movement of people who were exposed to a contagious disease to see if they become sick[23]. Inmates who are not symptomatic and do not have confirmed COVID lab results but have been exposed shall be placed in Quarantine, separate from the general population and separate from those who have symptoms

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[13] *Id.* at 14.
[14] *Id.*
[15] *Id.* at 12.
[16] *Id.* at 8.
[17] *Id.* at 9.
[18] *Id.* at 19.
[19] *Id.* at 11.
[20] *Id.*
[21] *Id.* at 19.
[22] https://www.cdc.gov/quarantine/
[23] *Id.*

or a positive COVID test. Exposure includes those who have been within 6 feet of a COVID case for a prolonged period of time and/or have had unprotected direct contact with the infectious secretions from a COVID case.

24. As mentioned above, serving inmates their meals in their cells ("feed-back") has been implemented at facilities where possible. Feed-back was instituted to avoid large gatherings thereby promoting social distancing. It further helps reduce movement of inmates through the corridors and common areas[24].

25. If an employee who previously passed screening when coming into work, but subsequently exhibits symptoms during their shift; they are immediately isolated then sent home, a review is completed to determine who that employee has come into contact with, those identified individuals are then monitored for symptoms, and any area that the employee has come into contact with is cleaned and disinfected[25].

26. Additional measures taken in compliance with CDC Guidelines include; suspending co-pays for persons seeking medical evaluation for possible COVID-19 exposure[26], posting signage and distributing memos to all staff and inmates around the facility to educate proper hygiene practices.[27]

27. Masks in compliance with CDC recommendations for the general public were provided to inmates[28], and approximately 5,700 blue level 3 masks have been distributed to DOC staff[29].

28. Inmates are required to wear protective masks when; exiting cells, exiting cubicles, and in a common area.

29. In addition, we have increased staff use of Personal Protective Equipment ("PPE") including authorizing the use of personally owned PPE. Protective masks, appropriate for their exposure risk category (i.e., cloth, surgical, and/or N95) have been provided to staff[30]. Staff are further required to wear their mask while on duty whenever social distancing is not possible.

30. DOC health services staff are reviewing inmates who have been identified by the parole department as eligible for possible early release. This health review considers risk factors such as heart conditions, respiratory conditions, or other risk indicators identified by the CDC. If

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[24] *Id.* at 11.
[25] *Id.* at 12, 17.
[26] *Id.* at 9.
[27] *Id.* at 10.
[28] *Id.* at 8.
[29] *Id.*
[30] *Id.*

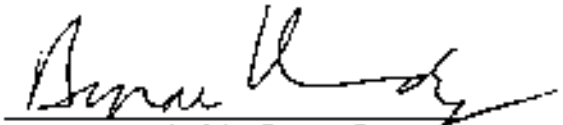
shown they will have sufficient stable assistance in the community to ensure they are not being placed at greater risk of contracting COVID-19, they may be released prior to their end of sentence.

31. When sentenced inmates are being released there is a re-entry procedure at all facilities. The procedure is intended to give Discharge Planners and Correctional Counselor Supervisors guidance on what actions to take depending on the different release mechanisms. As part of the re-entry process, Health Services and the Re-Entry unit notify the Department of Health of COVID-19 patients or otherwise screen patients being released into the partners jurisdiction. Releasees are also given re-entry fact sheets regarding COVID-19 with helpful information[31].

32. Wherever possible DOC's Human Resources unit has identified hundreds of staff members who are currently working remotely in response to the pandemic. Human Resources continues to review additional opportunities for staff who can work remotely. DOC has established alternative work schedules and is carefully considering other job classifications for possible measured reduction of services. DOC will continue to do so for the duration of the pandemic[32].

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Byron Kennedy, MD, PhD, MPH, FACPM, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 8, 2020.



Byron Kennedy, MD, PhD, MPH, FACPM

[31] *Id.* at 14.
[32] *Id.* at 7.

EXHIBIT A
TO DECLARATION OF DR. KENNEDY

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?
- Why is this guidance being issued?
- What topics does this guidance include?
- Definitions of Commonly Used Terms
- Facilities with Limited Onsite Healthcare Services
- COVID-19 Guidance for Correctional Facilities
- Operational Preparedness
- Prevention
- Management
- Infection Control
- Clinical Care of COVID-19 Cases
- Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons
- Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

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.

[redacted]

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.

[redacted]

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

[redacted]

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.

[redacted]

- √ **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

[redacted]

- 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.**

[redacted]

- √ **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.**

[redacted]

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.

[redacted]

- **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.

[redacted]

- √ **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).

[redacted]

√ **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.

[redacted]

√ **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.

[redacted]

- o 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:**

- o Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- o Separately, in single cells with solid walls but without solid doors
- o As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
- o 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.
- o As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- o As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- o 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.)

- o 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.
- o 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.**

[redacted]

- √ **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).

[redacted]

√ **Hard (non-porous) surface cleaning and disinfection**

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- 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**

- 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**

- 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.**

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- 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.

[redacted]

- 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.

[redacted]

- √ **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.**

[redacted]

- √ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.
- √ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
  - o If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
  - o If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

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

- √ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
  - o Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
- √ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See Screening section for a procedure to safely perform a temperature check.
- √ **Consider additional options to intensify** social distancing within the facility.

Management Strategies for Staff

- √ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- √ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
  - o See above for definition of a close contact.
  - o Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

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

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

[redacted]

- 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.**

[redacted]

- 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**

[redacted]

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 analyses 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.

[redacted]

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

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT C

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al, *Defendants*,	:	MAY 18, 2020

DECLARATION OF WARDEN FAUCHER

I, STEPHEN FAUCHER DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 28 years.
3. Currently I hold the position of Warden of Brooklyn Correctional Institution.
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility at least once per week though usually more often, and I am present in at least some housing units within the facility at least once per week, though usually more often. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. Brooklyn Correctional Institution is a correctional facility that consists of four units of dorm style spaces with each unit having 114 beds for a total of 456 dormitory beds.
6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each

inmate has contact. As of May 7, 2020, the inmate population at my facility has dropped from 426 inmates as of March 1, 2020 to 362 inmates. See **Exhibit A:** Inmate count per facility. At my facility, we have no indoor recreation, no visits, no religious services, and very limited programming as of right now. Recreation is done outdoors and only one dorm participates in recreation at a time for a maximum of fifty (50) inmates. We have limited addiction services programming occurring in groups of no more than five (5) inmates at a time, all from the same housing unit.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided informs the inmates to social distance if they are able to within the dorms and to regularly wash their hands. We have posted guidance in the units in the form of CDC posters. I am aware that this guidance has been distributed because I have seen the posters in the units. I have also spoken to inmates about safe practices relating to the COVID-19 pandemic.

8. All areas of the facility are regularly cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms and bathrooms were cleaned every shift for a total of three times per day. Due to the pandemic, this has continued and increased to as frequently as needed. Lemon Aid disinfectant is left in the bathroom for the inmates to clean the area as needed. Beginning on the week of May 4, 2020, and continuing once a month, we are completing a deep cleaning of the dorms during which time the inmates are moved out of the dorm. During the deep cleaning, all surfaces are disinfected using backpack sprayers. Cleaning is performed using Lemon Aid and, sometimes, diluted bleach, both diluted per the manufacturers' recommendation. It would be dangerous to the inmates' health and safety to

provide them with undiluted cleaning solutions. I know that this cleaning has been occurring because I have personally observed it occurring. Each housing unit has inmates responsible for cleaning certain areas which they now do more frequently. As of May 6, 2020, there are twenty-three (23) inmate worker positions allotted for each housing unit, each with specific duties. When the pandemic began, we increased the number of positions in each housing unit from twenty-one (21) to twenty-three (23). We have adequate cleaning supplies for use by staff and inmates.

9. My facility has communal showers that are used by inmates. There are approximately ten inmates per shower. Communal showers are cleaned frequently, specifically, at minimum once per shift. Due to the time it takes for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know this cleaning is occurring because I have had conversations with unit staff who have told me that showers are being cleaned during first and second shifts. Since inmates generally do not use the showers during third shift, they are not cleaned at that time.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates assigned to cubicles are responsible for cleaning those areas. From 8:30 a.m. to 10:30 a.m., inmates can clean their sleeping areas with supplies provided to them. An increased supply of Lemon All and floor cleaner are available to inmates due to the pandemic. I know this cleaning is occurring because I have witnessed it during my tours of the facility.

11. There are approximately six (6) phones per housing unit at my facility. They are cleaned daily and inmates have supplies available to clean the phones in between the daily cleanings.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for order through commissary, but it has also been given to all inmates, even those who are not indigent. In my facility, bars of soap were distributed for free to inmates on March 18, 2020, April 1, 2020, April 15, 2020, and April 29, 2020 and will continue to be distributed on a biweekly basis for the duration of the pandemic. I know this soap distribution is occurring because of conversations I have had with my staff.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. There are hand sanitizer stations available for staff use and hand sanitizer bottles on post. Staff are also permitted also bring their own hand sanitizer into the facility. I have personally observed officers using hand sanitizer on my tours.

14. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. As of May 6, 2020, every inmate at my facility has received at least two (2) cloth masks. The inmates have the opportunity to exchange one of the two masks they have once per week. Masks are not laundered, rather, they are replaced with new masks weekly. Inmates are required to wear a cloth mask whenever they are outside of their cubicle. I have noticed that inmates are generally compliant with the order to wear masks

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html

pursuant to the Governor's order to wear masks when social distancing is not feasible. Staff instruct inmates to wear the masks when they witness non-compliance.

15. Staff have also all been issued at least a cloth mask. Pursuant to the Governor's order to wear a cloth mask when social distancing is not feasible, staff are required to wear at least a cloth mask at all times while inside the facility when they are unable to social distance, and, to the best of my knowledge, they have been doing so. I know this because I have seen staff wearing face masks around the facility.

16. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. Gloves are available for staff use. Medical staff have been provided masks and gloves as well.

17. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick or symptomatic, they must stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

18. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else among the staff population could have been potentially infected. The areas where staff are working are cleaned on a regular basis as well as when they take post. Inmates are not usually quarantined when a staff member tests positive for COVID-19.

19. If an inmate displays symptoms of COVID-19, he is transferred to Corrigan-Radgowski Correctional Center where he is tested and further evaluated. If a housing unit has an inmate

who ultimately tests positive, then the housing unit is isolated from the rest of the facility to watch for symptom development. These isolated units have regular temperature checks. These units are also cleaned as scheduled. If an inmate self-reports symptoms of COVID-19, he is escorted to the medical unit, evaluated, and a determination is made whether he needs to be transferred to Corrigan-Radgowski Correctional Center. As my facility does not have medical staff constantly available, if an inmate is reporting symptoms at a time when medical staff is unavailable, the lieutenant will call Corrigan-Radgowski Correctional Center's medical staff and consult with them as to whether the inmate needs to be transferred there. Additionally, if an officer notices that an inmate is not doing well, the officer will notify the medical unit and/or a supervisor so that the inmate can be evaluated

20. If an inmate tests positive for COVID-19 he is transferred to Northern Correctional Institution.

21. As of May 6, 2020, I have had my facility's records reviewed and William Bruno (#394880) has not filed a grievance about the issues raised in his affidavit. Chad Petipas (#251989) has written to me frequently and even prior to the COVID-19 pandemic regarding early release.

22. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. The grievance process has not changed since the beginning of the pandemic.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Stephen Faucher, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden Faucher

EXHIBIT A

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Brooklyn CI	476	767	0	456
Carl Robinson CI	1214	936	32 beds 16 cells	1440
Corrigan-Radgowski CC	1188	1019	864	576
MacDougall-Walker CI	1938	1921	576	0
New Haven CC	672	624	288	528
Northern CI	78	222	576 RHU and 64 mental health	0
Osborne CI	1152	1152	1056	384
Willard-Cybulski CI	1070	684	0	384
Bridgeport CC	947	947	48 beds. Two beds counted as boxes. Numbers do not include medical beds which is a maximum of 96	470
Cheshire CI	946	947	192	0
Manson YI	284	230	576	0
Robinson CI	1253	1094	448 non-segregation 64 mental health unit	288
Hartford CC	879	791	384	480
York CI	886	624	1056	160

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT D

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al, *Defendants*,	:	MAY 18, 2020

DECLARATION OF WARDEN CARON

I, Zelynette Caron DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 19 1/2 yrs.
3. Currently I hold the position of Warden of Carl Robinson Correctional Institution.
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility one to two times per week (which has increased to two to three times a week due to the pandemic), and I am present in at least some housing units within the facility two to three times per week. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. Carl Robinson Correctional Institution is a correctional facility that consists of dormitories divided into seventeen dorms of varying sizes from a maximum of 32 inmates to a maximum of 90 inmates per side, and a Restricted Housing Unit with 16 cells (32 beds). Our population density has decreased significantly since the pandemic began and none of our dorms are filled

to their full capacity. On March 1, 2020, there were 1,314 inmates at Carl Robinson. On May 7, 2020, there were 946.

6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have canceled many congregate activities, such as congregate religious activities, congregate school activities, recreation. Inmates do not engage in any activities with other inmate housing units. Commissary and medication are delivered to the housing units. Chow occurs in the housing unit and not in the chow hall. Programming and orientation occurs within the housing units.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided consists of posters in the housing units regarding keeping themselves and others safe. It is attached at Exhibit A. I am aware that this guidance has been distributed because I have observed it on my tours. I have also toured all housing units to verbally give updates to the inmates and answer questions.

8. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned twice a day. Due to the pandemic, this has been increased to continuous cleaning. We have inmates who have work assignments as janitors, but other inmates volunteer to help them clean; before the pandemic, we would not have allowed the volunteer cleaners. Cleaning is performed using bleach and Lemon All. Both the bleach and Lemon All are diluted per the manufacturers' recommendations. We did not previously allow the use of bleach, but have

relaxed the rule against bleach due to the pandemic. I know that this cleaning has been occurring because I have personally observed it.

9. My facility has communal showers that are used by inmates. There are approximately ten to twelve inmates per shower. Communal showers are cleaned frequently. Before the pandemic, they were cleaned twice a day. Now they are cleaned two to three times per shift. I know this from personal observation. Due to the fact that the showers for inmates at Carl Robinson Correctional Facility are within the dorms themselves and there is no way to restrict inmates from taking showers when they want to do so, it is not possible to ensure the showers are cleaned between each use.

10. In addition to common areas, inmates are responsible for cleaning their own bunk areas. They are provided with Lemon All, bleach, and paper towels upon request in order to do so. The cleaning supplies are stored in the officers' bubble and the janitors' closet. If an inmate requests additional cleaning supplies, they are provided with the same.

11. There are approximately sixteen inmates per telephone at my facility. They are cleaned frequently by inmates wiping them down while cleaning common areas. I know this is occurring because of personal observation. Inmates sometimes use a sock to hold the phone so that they are not touching it.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap were distributed

for free to inmates and will continue to be distributed for the duration of the pandemic. I know this soap distribution is occurring because I have been informed that it is occurring.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Officers have access to hand sanitizer (as well as bathrooms with sinks where they can wash their hands) inside the control bubbles.

14. Handcuffs are cleaned between each use and cleaned by the armory once a week.

15. Until I was informed of the content of the affidavit of inmate Robert Miller #303392, I had not heard any inmate complain that the food was rancid, old, or moldy, and I have not observed the food to be rancid, old, or moldy.

16. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least one cloth mask, which they can exchange for a clean mask once a week. Inmates have been required to wear a cloth mask when they exit their cubicles or in a common area.

17. Staff have also all been issued at least a cloth mask and one KN95 mask. As of April 22, 2020, staff are required to wear at least a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. I know this because of personal observation.

18. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand, particularly in quarantine areas.

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html. Attached hereto as Exhibit B.

19. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick or symptomatic, they must stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

20. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected and which areas must be sanitized.

21. If an inmate displays symptoms of COVID-19, they go to medical and are placed in quarantine status, tested for COVID-19, and placed under medical observation. Their dormitory is deep cleaned.

22. If an inmate tests positive for COVID-19, they are given their results, sent to the COVID-19 unit at Northern Correctional Institution. They are told that they will return to Robinson when medically cleared.

23. In order to decrease the possibility of dorms cross contaminating each other, the facility has been ordering extra cleaning supplies to make sure that each side of a unit has their own cleaning materials and are not sharing. Officers are also not moving from one housing unit to another housing unit.

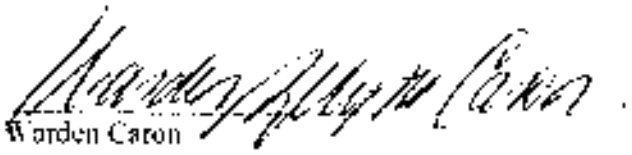
24. I have had my facility's records reviewed and as of May 8, 2020, Robert Miller #303392 and Kenneth Pierce #306309 had not filed a grievance about the issues raised in their affidavits.

25. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. As of May 13, 2020, there have been five (5)

grievances about issues related to COVID-19 and one has been sent to the District Office for a level 2 response. I do not believe that, as of May 13, 2020, any of these grievances has been fully exhausted. I have instructed staff to expedite the processing of grievances related to COVID-19.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Zelnyette Caron declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.



Warden Caron

EXHIBIT A

COVID 19 INFO SHEET

WHAT IS COVID 19?

- It's a new strain of the coronavirus, which causes a cold that can lead to pneumonia. It didn't exist before this winter. This means NO ONE is immune.
- It's very contagious. It spreads like the common cold or worse. It lives in (saliva) spit and (mucus) snot. It lives on metal or plastic surfaces (phones, tables, hand rails) for DAYS.
- Current estimates are that about half (50%) of all people in the world will get coronavirus this year. That's 1 in 2.
- Fortunately, most folks will be fine. If you catch, it you might not even notice, because most people don't get super sick. In fact, some people, especially young people, get infected and don't feel a thing.
- Because it's so contagious, even if you don't feel sick when you catch it, it uses you to reproduce The virus turns your nose into a virus making machine, so you'll spread it without even knowing it.

HOW DOES THIS AFFECT ME?

- If you're young and healthy- it might not affect you at all.
- If you are older and have asthma, high blood pressure or diabetes, you are at higher risk that the virus could turn into pneumonia (an infection goes to a person's lungs making it difficult to breathe).
- Because its so contagious, social visits have been stopped (for now).
- Movement within facilities will be limited.
- Limited group programming
- Smaller number of people out for rec (if at all)
- If you have symptoms, you may be kept separate (quarantined) to be monitored more closely and cared for appropriately.
- Medications will be reviewed and renewed to reduce face to face contact, to prevent interruption in care.

HOW CAN I PROTECT MYSELF?

- As much as possible, stay away from people. Don't touch things. Don't touch people. Avoid being around others as much as possible.
- Cover your mouth with your elbow when you sneeze or cough.
- ***Wash your hands often –*** Soap actually works. If you need more, please alert staff.
- Clean your cell.
- Don't shake hands/ hug/ or fist bump.
- When possible, keep 6 feet from you and another person (social distancing).
- If you feel l ke you have a fever, tell someone immediately

COVID 19 INFO SHEET

WHAT YOU CAN DO TO HELP SLOW THE SPREAD

- Avoid unnecessary requests to be seen by medical. The fewer people in medical, the better.
- Let medical staff be available for those folks who do get sick and need their attention.
- If you are sick, or having problems with medications, please write to be seen
  - We ask that you write specific requests; so, if possible, staff can triage the request and, if able, address your request in writing.
  - *As always*, tell staff if you are having a medical emergency
- Avoid close contact with others, avoid shaking hands, fists bumps and hugs
- Cover your mouth with your elbow if you sneeze or cough
- Wash your hands often

WHAT STAFF IS DOING

- We are taking temps of all employees before entering their facilities to reduce the possible spread to our population.
- We are taking temps of all Inmates when they are leaving and returning into our facilities inc uding a COVID 19 screening.
- Staff is practicing social distancing and good handwashing techniques
- Staff is going to work together to make sure you have what you need to get through this time.

WHAT WE CAN DO TOGETHER

- Stay patient and understand that this is a situation we have never been in before
- It takes EVERYONE's commitment to practice the above to slow the spread.
- We will need to be flexible and adapt to this situation as we learn more- What we do today may need to change tomorrow. We will make every effort to keep you all informed as soon as we can.
- We don't know how quickly things will change. Our goal is to keep **EVERYONE** safe and healthy. **ALL** decisions being made are for that goal
- We understand this is going to be difficult. If at any time you are having difficulty dealing with this and have thoughts to hurt yourself, **PLEASE TELL** STAFF **IMMEDIATELY.**

To all people on psychiatric medication

Given the current situation with COVID 19 and the CDC recommendation of limiting social contact, we plan to limit unnecessary clinical contact. People will be seen on an as needed basis.

What does that mean?

- we will be starting a 6 month follow up for people who are currently stable on their medication
- lab monitoring will continue as indicated.
- We will continue to see people as clinically indicated if med changes are occurring, there are side effects or if a person is having symptoms.

We are asking for everyone's understanding in limiting the spread of this virus. HAND WASHING AND SOCIAL DISTANCING ARE CRITICAL

- If you were seen within the past month and had a follow up appointment scheduled in 90 days, your medications will be renewed for 6 months and your appointment will be scheduled near the expiration of your medication
- We will be reviewing records and if you have been stable for the last few appointments we will continue your meds for 6 months

If you feel that you can wait to be seen and are not having any acute issues, PLEASE write to MH and let them know that your meds are working and you want to wait to be seen within 6 months

At any time if you feel you need to be seen for medication concerns, PLEASE write what the exact concerns are so the request can be triaged.

As Always: if you are experiencing any thoughts to hurt/ kill yourself please tell staff immediately- we are here to help everyone get through this!

We appreciate everyone's understanding and help in making sure people get care when they need it, and that we ALL do our part to limit the spread of Covid 19.

Please continue to put any request for MH services in the medical box

A todas las personas en medicaciónes psiquiátra

Dada la situación con el COVID-19 y la recomendación de el CDC para limitar el contacto social, planeamos limitar los contactos clinicos innecesario. Seran evaluado por el personal del medico segun sea necesario.

Qué significa esto?

- Estaremos comenzando un seguimiento de 6 meses para personas que actualmente están estables en su medicación
- El monitoreo del laboratorio continuará segun indicado.
- Seguiremos atendiendo a esas personas que tienen cambios de medicinas, si hay efectos secundarios, o otros sintomas.

Estamos pidiendo la cooperación en limitar la contaminación de este virus. LAVARSE LAS MANOS Y MANTENER DISTANCIA SOCIAL ES CRÍTICA.

- Si lo han visto en el último mes y tienes una cita fijada en los proximos 90 días, su medicamentos seran llenado por un tiempo extendido de 6 meses y su cita medica sera fijada cerca de las expiración de su medicamento.
- Revisaremos su record medico y si usted ha estado estable durante las últimas citas, continuaremos sus medicamentos por 6 meses.

Si usted puede esperar ha ser evaluado y no está teniendo problemos que necesiten asistencia inmediata, favor de escribir a Salud Mental y dejarle saber que sus medicamentos están funcionando y desea esperar por su cita dentro de 6 meses.

Sin en algun momento se siente que necesita ser evaluado por asuntos de medicamentos, escribale a su consejero de salud mental, indicandole el problema para que se le pueda dar atencion inmedicata.

Como Siempre: Si esta pensando en hacerce daño, favor de comunicarse con el personal de la unidad Inmediatamente- ¡estamos aquí para apollar a todos con esta situación.

Le apreciamos su cooperación y entendimiento en asegurarse que las personas resiban tratamientos adecuados, y haciendola posible para limitar la contaminación del COVID 19.

Favor de someter las solicitudes en la caja marcada de Salud Mental.

NOTICE TO INMATE POPULATION

Information related to DOC releases

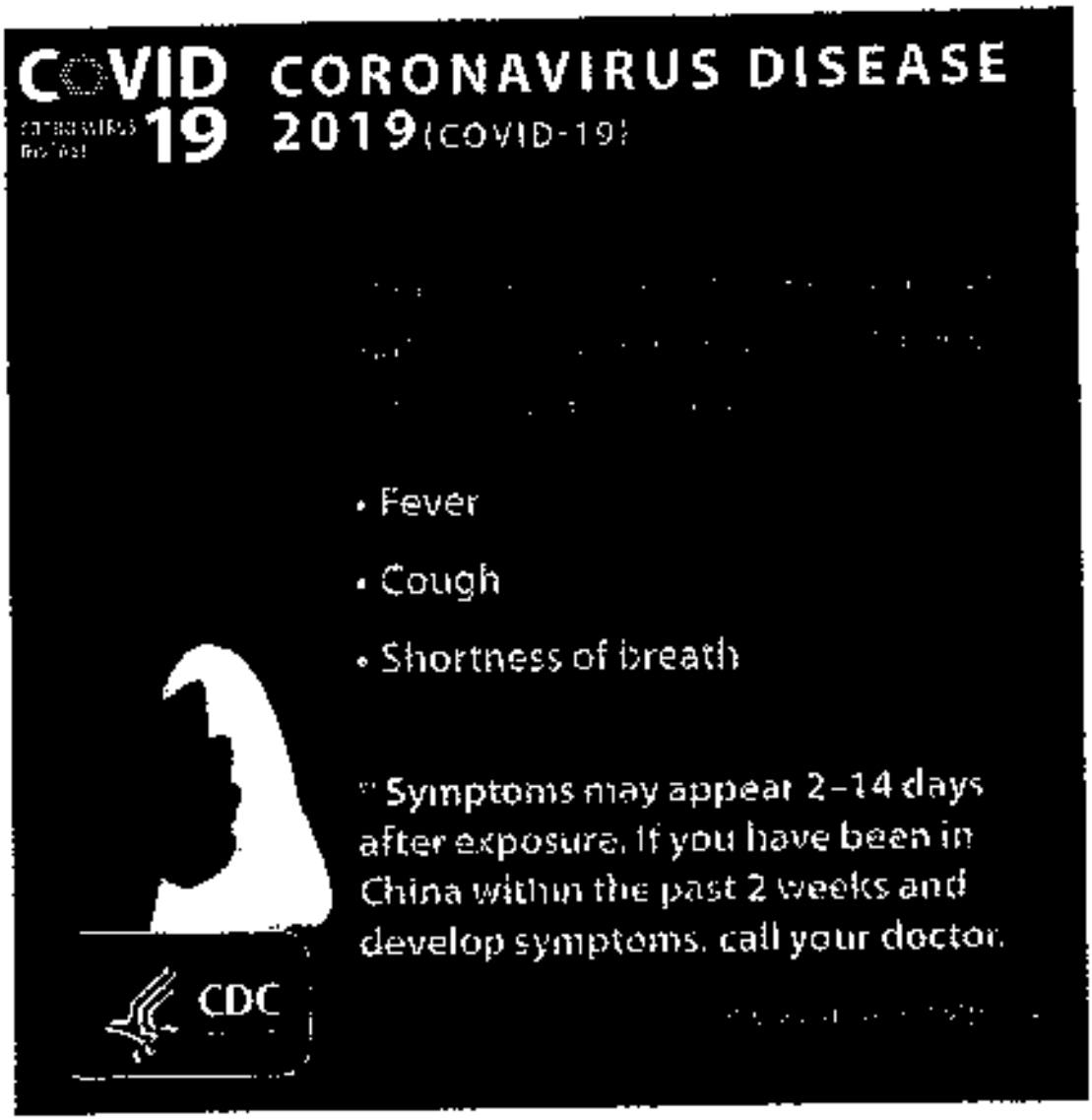
3/23/2020

- End-of-sentence discharges will continue without disruption
- Discretionary releases (TS, Halfway house, Parole, etc.) are continuing without disruption
- Bond-outs will continue without disruption
- There is an emphasized focus on release reviews/approvals and community placements in light of the COVID-19 pandemic
- Releasing offenders will receive a Fact Sheet containing information related to COVID-19 as well as information related to community support options.
- Release reviews are automatically being considered based on the routine eligibility factors. You do not need to write to your counselor for consideration.
- Denied applications are not being reconsidered
- If you are approaching end-of-sentence (next 30 days) and without somewhere to go, please see your counselor for critical reentry planning

INMATE NOTICE

Please be advised, effective immediately there will be no social visits or volunteer programming until further notice at any Facilities.

/Name Cannot
3/12/2020



Risk Assessment

Outbreaks of novel virus infections among people are always of public health concern. The risk from these outbreaks depends on characteristics of the virus, including how well it spreads between people, the severity of resulting illness, and the medical or other measures available to control the impact of the virus (for example, vaccine or treatment medications). The fact that this disease has

caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic. As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.

The potential public health threat posed by COVID-19 is high, both globally and to the United States.

But individual risk is dependent on exposure.

- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- Under current circumstances, certain people will have an increased risk of infection, for example healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.

However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, the risk assessment would be different.

If you are feeling ill and experience the above symptoms submit a request to medical to be seen.

COVID 19 CORONAVIRUS DISEASE

What to do if you are sick with coronavirus disease 2019 (COVID-19)

If you are sick with COVID-19 or suspect you are infected with the virus that causes COVID-19, follow the steps below to help prevent the disease from spreading to people in your home and community.

Stay home except to get medical care

You should restrict activities outside your home, except for getting medical care. Do not go to work, school, or public areas. Avoid using public transportation, ride-sharing, or taxis.

Separate yourself from other people and animals in your home

People: As much as possible, you should stay in a specific room and away from other people in your home. Also, you should use a separate bathroom, if available.

Animals: Do not handle pets or other animals while sick. See [illegible] for more information.

Call ahead before visiting your doctor

If you have a medical appointment, call the healthcare provider and tell them that you have or may have COVID-19. This will help the healthcare provider's office take steps to keep other people from getting infected or exposed.

Wear a facemask

You should wear a facemask when you are around other people (e.g., sharing a room or vehicle) or pets and before you enter a healthcare provider's office. If you are not able to wear a facemask (for example, because it causes trouble breathing), then people who live with you should not stay in the same room with you, or they should wear a facemask if they enter your room.

Cover your coughs and sneezes

Cover your mouth and nose with a tissue when you cough or sneeze. Throw used tissues in a lined trash can; immediately wash your hands with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60 to 95% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty.

Avoid sharing personal household items

You should not share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people or pets in your home. After using these items, they should be washed thoroughly with soap and water.

Clean your hands often

Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

Clean all "high-touch" surfaces every day

High-touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Also, clean any surfaces that may have blood, stool, or body fluids on them. Use a household cleaning spray or wipe, according to the label instructions. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves and making sure you have good ventilation during use of the product.

Monitor your symptoms

Seek prompt medical attention if your illness is worsening (e.g., difficulty breathing). **Before** seeking care, call your healthcare provider and tell them that you have, or are being evaluated for, COVID-19. Put on a facemask before you enter the facility. These steps will help the healthcare provider's office to keep other people in the office or waiting room from getting infected or exposed.

Ask your healthcare provider to call the local or state health department. Persons who are placed under active monitoring or facilitated self-monitoring should follow instructions provided by their local health department or occupational health professionals, as appropriate.

If you have a medical emergency and need to call 911, notify the dispatch personnel that you have, or are being evaluated for, COVID-19. If possible, put on a facemask before emergency medical services arrive.

Discontinuing home isolation

Patients with confirmed COVID-19 should remain under home isolation precautions until the risk of secondary transmission to others is thought to be low. The decision to discontinue home isolation precautions should be made on a case by case basis, in consultation with healthcare providers and state and local health departments.

CDC

For more information: www.cdc.gov/COVID19

STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION
Health Service Unit

Ned Lamont
Governor

Rollin Cook
Commissioner

To: CT DOC Inmate Population
From: Robert Richeson COO Health Services
Subject: Temporary Suspension of $3 Copay for Medical
Date: 3/9/20

The CT Department of Correction has temporarily suspended the $3 copay for inmate Medical Services until further notice when an inmate submits a request to be evaluated by health services for feeling ill. Due to concerns about the spread of Corona Virus, inmates are encouraged to seek medical attention if you are feeling ill.

Robert Richeson,

COO Health Services
CT Department of Correction

IMPORTANT NOTICE TO OUR INMATE POPULATION

As part of the Department of Correction's efforts to contain the spread of the coronavirus

All social visits have been suspended until further notice.
Meals will take place inside the unit

Only USD#1 classes will be held

Religious Services will be conducted by DOC Chaplains

Volunteers services have been suspended

Commissary and Laundry services will continue as usual

Securus is providing each offender two free phone calls per week for the next 30 days.

Your cooperation in helping to minimize the spread of the coronavirus is greatly appreciated.

Continue to follow these preventative practices:

- Frequent handwashing with soap and water
- Avoid touching your face, eyes, nose and mouth
- Avoid greeting others with a handshake

Please contact a staff member if you are experiencing any of these symptoms:

Fever, Cough, Shortness of breath

We are well aware of the impact these restrictions will have. However, these precautions are necessary at this time to ensure everyone's health and safety. We are continually reassessing the situation and will keep you updated on any new developments.

NOTICE TO INMATE POPULATION

The Department of Correction is following all precautions related to the COVID-19 coronavirus as dictated by the Centers for Disease Control and Prevention (CDC). Please contact a staff member if you are experiencing any of the three common symptoms below:

Fever

Cough

Shortness of breath

The $3 co-pay has been temporarily suspended until further notice so that

anyone exhibiting signs of illness can seek medical attention and remain healthy.

Continue following these preventative practices:

- Frequent handwashing with soap and water
- Avoid touching your face, eyes, nose and mouth
- Avoid greeting others with a handshake

As a reminder the annual influenza shot, recommended by the CDC, is still available to the population. Please write to health services.

Aviso importante
A nuestro recluso Población

Como parte del departamento de Los esfuerzos de corrección para contener el propagación del coronavirus

Todas las visitas sociales han sido suspendidas hasta Aviso adicional.

Las comidas se llevarán a cabo dentro de la unidad.

Solo se realizarán clases de USD # 1.

Los servicios religiosos serán conducidos por los capellanes del DOC.

Los servicios voluntarios han sido suspendidos.

Los servicios de comisaria y lavandería continuarán como de costumbre.

Securus proporciona a cada delincuente dos llamadas telefónicas gratuitas por semana de los próximos 30 días.

Su cooperación para ayudar a minimizar la propagación del coronavirus es muy apreciada.

Continúe siguiendo estas prácticas preventivas:

- Lavado frecuente de manos con agua y jabón.
- Evite tocarse la cara, los ojos, la nariz y la boca.
- Evite saludar a los demás con un apretón de manos.

Comuníquese con un miembro del personal si tiene alguno de estos síntomas:

Fiebre, tos, falta de aliento

Somos conscientes del impacto que tendrán estas restricciones. Sin embargo, estas precauciones son necesarias en este momento para garantizar la salud y la seguridad de todos. Continuamente estamos reevaluando la situación y lo mantendremos informado sobre cualquier novedad.

IMPORTANT NOTICE TO OUR INMATE POPULATION

As part of their effort to minimize the spread of COVID-19

EFFECTIVE March 17, 2020

DUE TO THE PRESENT COVID-19 SITUATION ALL NON-EMERGENCY APPOINTMENTS OUTSIDE OF THE FACILITY FOR THE NEXT 30 DAYS WILL BE CANCELLED TO ALLOW HEALTH WORKERS TO FOCUS ON COVID-19 CARE.

These cancellations apply to everyone, including members of the public.

The DOC Health Services Staff will continue to provide you with the best care possible within our facilities.

Please contact a staff member if you are experiencing any of these symptoms:

Fever, Cough, Shortness of breath

AVISO IMPORTANTE AL CONFINADO

Como parte de nuestro esfuerzo para contener el virus de COVID-19

EFECTIVO 17 DE MARZO DEL 2020

DEBIDO A LA SITUACIÓN ACTUAL DE COVID-19:
TODAS LAS CITAS MEDICAS QUE NO SON EMERGENCIAS AFUERA DE LA INSTITUCION
SERÁN CANCELADAS POR LOS PRÓXIMOS 30 DÍAS. ESTO ES PARA PERMITIR QUE LOS TRABAJADORES DE SALUD SE ENFOQUEN EN EL CUIDADO DE COVID-19.

Estas cancelaciones se aplican a todos incluidos los miembros del público.

El personal de DOC Servicio de Salud continuara proveyendo la mejor atención posible dentro de nuestras instituciones .

Comuníquese con un miembro del personal si tienes algunos de estos síntomas:
Fiebre, tos o dificultad para respirar.

NOTICE TO INMATE POPULATION

Re: Commissary

As of Monday, April 6, 2020

Each General Population or Restricted bubble sheet order placed with Commissary will include the following:

1. Two FREE stamped envelopes

2. One Deck of FREE playing cards
(During the first week only)

also,

All Soaps Sold at Cost

effective until further notice

Aviso a la poblacion de confinado

RE: Comisaria

A partir del lunes, 6 de Abril de 2020

Cada orden pedido de comisaria incluira lo sigiente:

1. Dos sobre sellado GRATIS
2. Una baraja de cartas GRATIS

(solamente durante la primera semana)

Ademas,

Todos los jabones se venden al costo

efectivo hasta nuevo aviso

Notice to Inmate Population

Effective Wednesday, April 22, 2020

inmates must wear protective masks when they are:

- **exiting their cells**
- **exiting their cubicle**
- **in a common area**

To be in compliance, the masks need to cover both your nose and your mouth completely.

Failure to comply will result in progressive discipline, up to a Class B Disciplinary Report for Disobeying a Direct Order.

The wearing of masks is being required for your personal safety.

Aviso Al Confinado

Efectivo el Miércoles 22 de Abril del 2020

El confinado tiene que usar mascarillas protectoras cuando:

- **Al salir de sus celdas**
- **Al salir de su cubículo**
- **Y cuando estén en un área común**

Para estar en cumplimiento, las mascarillas deben cubrir completamente su nariz y boca.

El incumplimiento de instrucciones le resultara en disciplina progresiva, hasta incluir un reporte Clase B por Desobedecer las Órdenes.

Se requiere el uso de mascarilla para la protección de su salud y los otros confinados.

To all people on psychiatric medication

Given the current situation with COVID 19 and the CDC recommendation of limiting social contact, we plan to limit unnecessary clinical contact. People will be seen on an as needed basis.

What does that mean?

- we will be starting a 6 month follow up for people who are currently stable on their medication.
- lab monitoring will continue as indicated.
- We will continue to see people as clinically indicated if med changes are occurring, there are side effects or if a person is having symptoms.

We are asking for everyone's understanding in limiting the spread of this virus. HAND WASHING AND SOCIAL DISTANCING ARE CRITICAL

- If you were seen within the past month and had a follow up appointment scheduled in 90 days, your medications will be renewed for 6 months and your appointment will be scheduled near the expiration of your medication.
- We will be reviewing records and if you have been stable for the last few appointments we will continue your meds for 6 months

If you feel that you can wait to be seen and are not having any acute issues, PLEASE write to MH and let them know that your meds are working and you want to wait to be seen within 6 months

At any time if you feel you need to be seen for medication concerns, PLEASE write what the exact concerns are so the request can be triaged.

As Always: if you are experiencing any thoughts to hurt/ kill yourself please tell staff immediately- we are here to help everyone get through this!

We appreciate everyone's understanding and help in making sure people get care when they need it, and that we ALL do our part to limit the spread of Covid 19.

Please continue to put any request for MH services in the medical box

Taking medications for mental health?

The Corona Virus (COVID19) is spreading. The CDC recommends physical distancing and limitation of gatherings. If you are someone who is on medications and currently stable, we plan to limit your visits with DOC mental health staff. People will be seen on an as needed basis.

What does that mean?

- we will be starting a 6 month follow up for people who are currently stable on their medication.
- lab monitoring will continue as indicated.
- We will continue to see people as clinically indicated if med changes are occurring, there are side effects or if a person is having symptoms.

We are asking for everyone's understanding in limiting the spread of this virus. HAND WASHING AND PHYSICAL DISTANCING ARE CRITICAL.

- If you were seen within the past month and had a follow up appointment scheduled in 90 days, your medications will be renewed for 6 months and your appointment will be scheduled near the expiration of your medication.
- We will be reviewing records and if you have been stable for the last few appointments we will continue your meds for 6 months

If you feel that you can wait to be seen and are not having any acute issues, PLEASE write to MH and let them know that your meds are working and you want to wait to be seen within 6 months

At any time if you feel you need to be seen for medication concerns, PLEASE write what the exact concerns are so the request can be triaged.

As Always: if you are experiencing any thoughts to hurt/ kill yourself please tell staff immediately- we are here to help everyone get through this!!!

We appreciate everyone's understanding and help in making sure people get care when they need it, and that we ALL do our part to limit the spread of COVID 19.

Please continue to put any request for MH services in the medical box

A todas las personas en medicaciónes psiquiátra

Dada la situación con el COVID-19 y la recomendación de el CDC para limitar el contacto social, planeamos limitar los contactos clinicos innecesario. Seran evaluado por el personal del medico segun sea necesario.

Qué significa esto?

- Estaremos comenzando un seguimiento de 6 meses para personas que actualmente están estables en su medicación
- El monitoreo del laboratorio continuará segun indicado.
- Seguiremos atendiendo a esas personas que tienen cambios de medicinas, si hay efectos secundarios, o otros sintomas.

Estamos pidiendo la cooperación en limitar la contaminación de este virus. LAVARSE LAS MANOS Y MANTENER DISTANCIA SOCIAL ES CRÍTICA.

- Si lo han visto en el último mes y tienes una cita fijada en los proximos 90 dias, su medicamentos seran llenado por un tiempo extendido de 6 meses y su cita medica sera fijada cerca de las expiración de su medicamento.
- Revisaremos su record medico y si usted ha estado estable durante las últimas citas, continuaremos sus medicamentos por 6 meses.

Si usted puede esperar ha ser evaluado y no está teniendo problemos que necesiten asistencia immediata, favor de escribir a Salud Mental y dejarle saber que sus medicamentos están funcionando y desea esperar por su cita dentro de 6 meses.

Sin en algun momento se siente que necesita ser evaluado por asuntos de medicamentos, escribale a su consejero de salud mental, indicandole el problema para que se le pueda dar atencion inmedicata.

Como Siempre: Si esta pensando en hacerce daño, favor de comunicarse con el personal de la unidad inmediatamente- ¡estamos aqui para apollar a todos con esta situación.

Le apreciamos su cooperación y entendimiento en asegurarse que las personas resiban tratamientos adecuados, y haciendolo posible para limitar la contaminación del COVID-19.

Favor de someter las solicitudes en la caja marcada de Salud Mental.

NOTICE TO INMATE POPULATION

Information related to DOC releases

3/23/2020

- End-of-sentence discharges will continue without disruption
- Discretionary releases (TS, Halfway house, Parole, etc.) are continuing without disruption
- Bond-outs will continue without disruption
- There is an emphasized focus on release reviews/approvals and community placements in light of the COVID-19 pandemic
- Releasing offenders will receive a Fact Sheet containing information related to COVID-19 as well as information related to community support options.
- Release reviews are automatically being considered based on the routine eligibility factors. You do not need to write to your counselor for consideration.
- Denied applications are not being reconsidered
- If you are approaching end-of-sentence (next 30 days) and without somewhere to go, please see your counselor for critical reentry planning

COVID 19 INFO SHEET

WHAT IS COVID 19?

- It's a new strain of the coronavirus, which causes a cold that can lead to pneumonia. It didn't exist before this winter. This means NO ONE is immune.
- It's very contagious. It spreads like the common cold or worse. It lives in (saliva) spit and (mucus) snot. It lives on metal or plastic surfaces (phones, tables, hand rails) for DAYS.
- Current estimates are that about half (50%) of all people in the world will get coronavirus this year. That's 1 in 2.
- Fortunately, most folks will be fine. If you catch, it you might not even notice, because most people don't get super sick. In fact, some people, especially young people, get infected and don't feel a thing.
- Because it's so contagious, even if you don't feel sick when you catch it, it uses you to reproduce. The virus turns your nose into a virus making machine, so you'll spread it without even knowing it.

HOW DOES THIS AFFECT ME?

- If you're young and healthy- it might not affect you at all.
- If you are older and have asthma, high blood pressure or diabetes, you are at higher risk that the virus could turn into pneumonia (an infection goes to a person's lungs making it difficult to breathe).
- Because its so contagious, social visits have been stopped (for now).
- Movement within facilities will be limited.
- Limited group programming
- Smaller number of people out for rec (if at all)
- If you have symptoms, you may be kept separate (quarantined) to be monitored more closely and cared for appropriately.
- Medications will be reviewed and renewed to reduce face to face contact, to prevent interruption in care.

HOW CAN I PROTECT MYSELF?

- As much as possible, stay away from people. Don't touch things. Don't touch people. Avoid being around others as much as possible.
- Cover your mouth with your elbow when you sneeze or cough.
- ***Wash your hands often*** – Soap actually works. If you need more, please alert staff.
- Clean your cell.
- Don't shake hands/ hug/ or fist bump.
- When possible, keep 6 feet from you and another person (social distancing).
- If you feel like you have a fever, tell someone immediately

COVID 19 INFO SHEET

WHAT YOU CAN DO TO HELP SLOW THE SPREAD

- Avoid unnecessary requests to be seen by medical. The fewer people in medical, the better.
- Let medical staff be available for those folks who do get sick and need their attention.
- If you are sick, or having problems with medications, please write to be seen.
  - We ask that you write specific requests; so, if possible, staff can triage the request and, if able, address your request in writing.
  - As always, tell staff if you are having a medical emergency
- Avoid close contact with others, avoid shaking hands, fists bumps and hugs
- Cover your mouth with your elbow if you sneeze or cough
- Wash your hands often

WHAT STAFF IS DOING

- We are taking temps of all employees before entering their facilities to reduce the possible spread to our population.
- We are taking temps of all inmates when they are leaving and returning into our facilities including a COVID 19 screening.
- Staff is practicing social distancing and good handwashing techniques
- Staff is going to work together to make sure you have what you need to get through this time.

WHAT WE CAN DO TOGETHER

- Stay patient and understand that this is a situation we have never been in before
- It takes EVERYONE's commitment to practice the above to slow the spread
- We will need to be flexible and adapt to this situation as we learn more- What we do today may need to change tomorrow. We will make every effort to keep you all informed as soon as we can.
- We don't know how quickly things will change. Our goal is to keep **EVERYONE** safe and healthy. **ALL** decisions being made are for that goal.
- We understand this is going to be difficult. If at any time you are having difficulty dealing with this and have thoughts to hurt yourself, **PLEASE TELL STAFF IMMEDIATELY.**

IF YOU ARE NOT FEELING WELL, COUGHING OR HAVE A FEVER DON'T USE IBUPROFEN. *CONTACT MEDICAL IMMEDIATELY*.

ATTENTION

Due to Public Health Concerns related to the coronavirus, and for the safety of the inmate population, public and staff

NO VISITS

UNTIL FURTHER

NOTICE

EXHIBIT B

CDC Centers for Disease Control and Prevention

Handwashing: Clean Hands Save Lives

Show Me the Science – When & How to Use Hand Sanitizer in Community Settings

Note: For hand hygiene guidance in healthcare settings, please visit the Clean Hands Count webpage.

CDC recommends washing hands with soap and water whenever possible because handwashing reduces the amounts of all types of germs and chemicals on hands. But if soap and water are not available, using a hand sanitizer with at least 60% alcohol can help you avoid getting sick and spreading germs to others. The guidance for effective handwashing and use of hand sanitizer in community settings was developed based on data from a number of studies.

Alcohol-based hand sanitizers can quickly reduce the number of microbes on hands in some situations, but sanitizers do *not* eliminate all types of germs.

Why? Soap and water are more effective than hand sanitizers at removing certain kinds of germs, like *Cryptosporidium*, norovirus, and *Clostridium difficile*.[1] Although alcohol-based hand sanitizers can inactivate many types of microbes very effectively when used correctly,[2-4] people may not use a large enough volume of the sanitizers or may wipe it off before it has dried.[5]

Hand sanitizers may not be as effective when hands are visibly dirty or greasy.

Why? Many studies show that hand sanitizers work well in clinical settings like hospitals, where hands come into contact with germs but generally are not heavily soiled or greasy.[6] Some data also show that hand sanitizers may work well against certain types of germs on slightly soiled hands.[7,8] However, hands may become very greasy or soiled in community settings, such as after people handle food, play sports, work in the garden, or go camping or fishing. When hands are heavily soiled or greasy, hand sanitizers may not work well.[9,10] Handwashing with soap and water is recommended in such circumstances.

Hand sanitizers might not remove harmful chemicals, like pesticides and heavy metals, from hands.

Why? Although few studies have been conducted, hand sanitizers probably cannot remove or inactivate many types of harmful chemicals. In one study, people who reported using hand sanitizer to clean hands had increased levels of pesticides in their bodies.[11] If hands have touched harmful chemicals, wash carefully with soap and water for as directed by a poison control center.

If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.

Why? Many studies have found that sanitizers with an alcohol concentration between 60-95% are more effective at killing germs than those with a lower alcohol concentration or non-alcohol-based hand sanitizers [1]. Hand sanitizers without 60-95% alcohol 1) may not work equally well for many types of germs, and 2) merely reduce the growth of germs (rather than kill them outright).

When using hand sanitizer, apply the product to the palm of one hand (read the label to learn the correct amount) and rub the product all over the surfaces of your hands until your hands are dry.

Why? The steps for hand sanitizer use are based on a simplified procedure recommended by CDC. Instructing people to cover all surfaces of both hands with hand sanitizer has been found to provide similar disinfection effectiveness as providing detailed steps for rubbing-in hand sanitizer [2].

Swallowing alcohol-based hand sanitizers can cause alcohol poisoning.

Why? Ethyl alcohol (ethanol)-based hand sanitizers are safe when used as directed — but they can cause alcohol poisoning if a person swallows more than a couple of mouthfuls [3].

From 2011 – 2015, U.S. poison control centers received nearly 85,000 calls about hand sanitizer exposures among children [4]. Children may be particularly likely to swallow hand sanitizers that are scented, brightly colored, or attractively packaged. Hand sanitizers should be stored out of the reach of young children and should be used with adult supervision. Child-resistant packaging could also help reduce hand sanitizer-related poisonings among young children [5]. Older children and adults might purposefully swallow hand sanitizers to become drunk [3].

References

[illegible]

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Beltorti
Assistant Attorney General

EXHIBIT E

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT., et al, *Defendants,*	:	MAY 18, 2020

DECLARATION OF WARDEN GARCIA

I, EULALIA GARCIA DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 15 years.
3. Currently I hold the position of Warden of Willard-Cybulski Correctional Institution.
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility four times per week, and I am present in at least some housing units within the facility four or five times per week. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. Willard-Cybulski Correctional Institution is a correctional facility that consists of dorms and four cells that are used for inmates pending transfer to higher level facility. As of May 7, 2020, we have 1,148 dormitory beds. In the Willard building, there are four units of dorm style spaces with each unit having 114 beds and in the Cybulski building, there are six units of dorm style

spaces with each unit having between 110 and 118 beds (units E and F have 110 beds, units G, H, I, and J have 118 beds each). One of our units, H Unit, was cleared of the general population inmates and now houses symptomatic offenders pending their COVID-19 test results.

6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. As of March 1, 2020, my facility had 1,079 inmates. This has been reduced to 684 inmates as of May 7, 2020. See Exhibit A: Inmate population per facility. At my facility, we have cancelled many group activities including school as the teachers have not been in the facilities. We are working with teachers to compile packets for the inmates participating in schooling to continue their education. We are no longer permitting inmates to eat their meals in the chow halls to allow for some social distancing. Currently, the inmates participate in recreation by half the unit going out for recreation at a given time. The gym facility is not being utilized currently to limit the amount of time inmates are in close contact with one another. We are presently providing in-unit programming regarding domestic violence so as to allow those inmates who need to complete this program prior to discharge to do so. Currently, we are not permitting social or legal visits.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. It has been provided in the form of posters that are hung around the housing units. I am aware that this guidance has been distributed because I have personally viewed them when I tour the units.

8. All areas of the facility are regularly cleaned, and now are cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the day rooms, and bathrooms were

cleaned once per shift. Due to the pandemic, this has been increased to multiple times per shift and we have environmental committees with implementation guides. Cleaning is performed using Lemon All and diluted bleach, both of which are diluted per the manufacturers' recommendations. I know that this cleaning has been occurring because I have seen the cleaning occur during tours including mopping, wiping down tables, and cleaning bathrooms. I have reviewed and downloaded camera footage depicting cleaning occurring in the facility. My facility has an adequate amount of cleaning supplies which are delivered every Monday, Wednesday, and Friday. Prior to the COVID-19 pandemic, cleaning supplies were delivered each Monday

9. My facility has communal showers that are used by inmates. There is approximately one shower per ten inmates. Communal showers are cleaned multiple times per shift. The handicapped shower in each unit is also cleaned multiple times per shift. Due to the time it takes for cleaning and the number of inmates who need to shower, it is not possible to clean the shower between each use of the shower. I know this cleaning is occurring because I have seen the showers being cleaned and staff have reported to me that the showers are being cleaned. Unit cleanings are also documented in the logbooks.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates are responsible for cleaning their own sleeping areas and are provided Lemon All and diluted bleach three times per week and can request more. The inmates have been provided more cleaning supplies and toilet tissue during the pandemic. We currently do not have a protocol in place for cleaning the bunks of inmates who test positive for COVID-19. As soon as practicable, we clean and disinfect the area where the positive inmate was housed. All

personal belongings, including linens and mattresses, are removed from the bunk area once the positive offender leaves the unit. I have seen the inmates clean their sleeping quarters during my tours.

11. There are approximately seven (7) telephones per unit in the Willard building and five (5) telephones per unit in the Cybulski building. They are cleaned after each use. We have posted signage to remind inmates to clean the phones after use. Disinfectant and napkins are provided near the telephone areas. I have witnessed inmates clean the phones after use during my tours. Regardless of cleaning after each use, the phones are cleaned daily.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap were distributed for free to inmates and will continue to be distributed weekly and on an as needed basis for the duration of the pandemic regardless of whether the inmate is indigent. The inmate must go to the officers' bubble to request the soap beyond what is provided on a weekly basis. I know this soap distribution is occurring because I have had conversations with my staff about the distribution of soap.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Officers have been provided with hand sanitizer as a preventative measure as

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html

they typically have less frequent access to handwashing than inmates, who have sinks in their dorms. I have personally observed officers using hand sanitizer on my tours.

14. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE") Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least two cloth masks as of Monday, March 30, 2020. The inmates who work in the kitchen were given at least three masks. Inmates have been required to wear a cloth mask whenever they are outside of their cubicle. We have had some issues with compliance; however, staff is reiterating the importance of wearing the masks to the inmate population. Inmates are able to have the masks laundered once per week. They are also allowed to hand wash the masks in the units. At each officer's bubble, additional masks are available to inmates upon request.

15. Staff have also all been issued at least a cloth mask. As of April 9, 2020, staff were required to wear at least a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. I know this because when I do my tours, I see staff wearing the masks. As of April 22, 2020, an Order was issued by Governor Lamont requiring all state employees to wear masks. Among the masks issued to staff -surgical masks, cloth masks, and N95 masks- the type of mask issued is dependent upon the housing unit to which the staff member is assigned.

16. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. Officers working with symptomatic inmates wear N95 masks, gloves, and protective eyewear. Officers who are working with non-symptomatic inmates wear a surgical mask with

a cloth mask on top of it. Medical staff wear the surgical and cloth masks at all times and the N95 mask when in the quarantine unit or when treating a presumptive positive inmate.

17. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick or symptomatic, they must stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19 or caring for someone with the illness.

18. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. When we are notified that a staff member has tested positive for COVID-19, the area where the staff member spent a significant amount of time is disinfected immediately by other staff members. We do not quarantine inmates that have had limited contact with a positive staff member. If the staff member was within 6 feet of the inmate for more than 15 minutes, then the inmate would be quarantined. Staff are generally keeping a distance of six feet from the inmates.

19. If an inmate displays symptoms of COVID-19, the inmate informs the medical staff who proceed to do an evaluation and screening. If the medical staff deem it necessary to isolate the inmate, he is transferred to the quarantine unit where he is then swabbed and will remain in quarantine pending results. If he is negative for COVID-19, he will remain in the quarantine unit pending the antibody testing. Initially, daily temperature checks were done in the unit when the facility had a significant number of positive COVID-19 inmates. This has now

stopped per CDC guidelines as the symptomatic inmates are quarantined and the positive inmates do not remain at the facility.

20. If an inmate tests positive for COVID-19, he is transferred to Northern Correctional Institution where he will remain until he is symptom free for 72 hours, after a fourteen-day isolation period.

21. I have had my facility's records reviewed and, as of May 6, 2020, Roger Johnson, Zaiu Hussain, and Anthony Tuscano have not filed grievances about the issues raised in their affidavits.

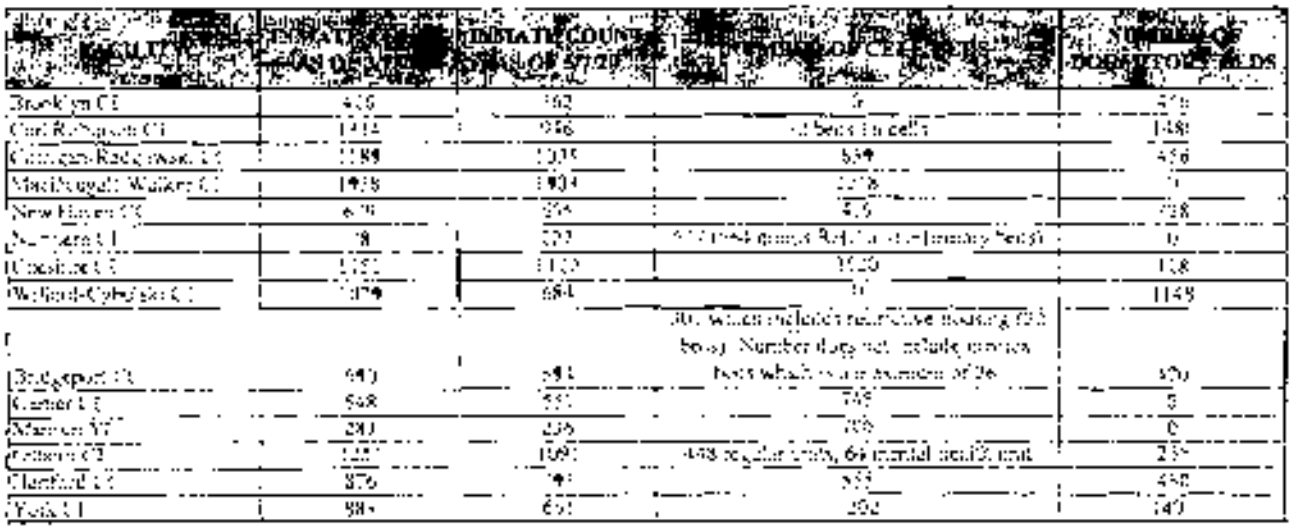
22. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. While all grievances are handled in a prompt manner, we are flagging COVID related grievances to review them more quickly.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Eulalia Garcia, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Eulalia Garcia
Warden Garcia

EXHIBIT A



CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT F

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al. *Defendants*.	:	MAY 18, 2020

DECLARATION OF WARDEN HIPOLITO N. RODRIGUEZ

I, HIPOLITO N. RODRIGUEZ, DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 26 years.
3. Currently I hold the position of Warden of Osborn Correctional Institution ("OCI").
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility at least once per week, and I am present in at least some housing units within the facility twice per week. I also maintain regular communication with my Deputy Wardens and my Unit Supervisors.
5. OCI is a correctional facility that consists of cells and dorms divided into 14 units. Since the onset of the pandemic, we have reduced our population through community release options (e.g., parole, halfway house placement, supervised community release programs). On March 1, 2020, the total inmate count was 1,253. On May 7, 2020, it was 1,091, with 264 inmates housed in the dorms and 827 inmates in cells (68 inmates are assigned to single cells).

6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have suspended visiting, group programming, outdoor and indoor (gymnasium) recreation, and inmates eat in their cells or dorms. In the cell blocks, and only if the housing unit is not under a medically declared 14-day quarantine, one fourth of a tier is allowed out of their cells at any one time, meaning that between five and eight inmates are out at one time (when eight inmates are out, four inmates use the telephones while the other four use the showers; they then switch). Prior to May 16, housing units under a medically declared quarantine were not allowed to shower (per the direction of CMO Dr. Kennedy) due to the COVID-19 virus being transmittable through steam and vapor. They were also not allowed to use the phones due to the high probability of transmitting the disease through the surface of the phone and reception holes. This changed on May 16, when all inmates began to be afforded the opportunity to shower outside and were given the opportunity to use telephones. See below. Between May 8th and May 9th, all bunks in the Loft 1 and Loft 2 housing units (dormitory style) were spaced six feet apart.

7. On May 13, 2020, we began mass testing of inmates. A total of 617 inmates were tested. 146 inmates tested positive for COVID-19; 471 tested negative. Approximately 420 inmates opted out of testing. All positive inmates were moved to B Block and all negative inmates were moved to D Block. C Block is reserved for those inmates who opt out of testing or whose results are inconclusive. On May 14, 2020 the entire facility was placed on quarantine lockdown status due to the large number of inmates yielding positive results following the mass testing that occurred on May 13, 2020.

8. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to wash their hands frequently for 20 seconds, to maintain six feet of social distance whenever possible, and advises them of symptoms of COVID-19. It has been provided in the form of posters that have been placed in all housing units, including dorms and cell blocks, as well as in the medical unit, kitchen, and all inmate work areas. Notices have distributed to the inmates. I am aware that this guidance has been distributed because I have personally observed it and such distribution has also been reported to me by my staff.

9. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned every day, both first and second shift. Since the pandemic, cleaning has been continuous throughout all shifts. The units are deep cleaned every day. Floors are mopped at least three times per shift, showers are cleaned after each use, and walls are sprayed down daily. Cleaning is performed using a 10% bleach solution or Lemonall. Cleaning solutions are diluted pursuant to the manufacturers' directions. It would be dangerous to inmates' health and safety to expose them to undiluted cleaning solutions. Osborn also has two or three cleaning backpacks for disinfecting. I know that this cleaning has been occurring because I have personally observed it. I have checked log books and camera footage, and I have spoken with staff, shift commanders, and inmate workers.

10. My facility has communal showers that are used by inmates. The number of shower heads varies per housing unit, but it is common practice for inmates to shower one at a time, for privacy. Prior to the pandemic, showers were cleaned three times per shift. Since the

pandemic, showers are cleaned after each use with the 10% bleach or Lemonall. I have personally observed this cleaning and have spoken with staff. Cleaning is also documented in the log book. Camera footage has been secured. As stated, prior to May 16, inmates in the quarantine unit were not permitted to shower. As of May 16, however, with the entire facility in lockdown status, we activated the six shower heads that are in the outdoor rec yard and all inmates may shower outside.

11. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates have been instructed to clean their sleeping areas frequently and are given spray bottles filled with bleach or Lemonall and paper towels upon request. While the inmates may not keep the cleaning solution in their cells, they have been informed that it is available to them at any time. All inmates have access to the cleaning supplies. I have personally observed inmates cleaning their sleeping areas, observed camera footage, and spoken with staff.

12. There are approximately 89 telephones available for inmate use at OCI. The number of telephones varies by housing unit. For example, in H Block, there are 16 telephones for 186 inmates. However, in F Block, there are seven telephones for the 23 inmates housed there. As noted, in the cell blocks, only between five and eight inmates are able to be out of their cells at any one time and inmates have access to the telephones at that time. In both Loft 1 and Loft 2, which are dorms, there are three telephones for 58 inmates. All telephones are cleaned after each use. Cleaning supplies are provided and are kept next to the phones and inmates have been instructed to clean the telephone after use. Beginning May 15, 2020, all inmates were allowed one 15-minute phone call on first and second shifts regardless of quarantine status.

The housing units were provided with phone receiver sleeves that are launderable. I have personally observed this cleaning and staff have told me it is occurring.

13. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap were distributed for free to inmates on March 31, 2020, and will continue to be distributed upon request for the duration of the pandemic. I know this soap distribution is occurring because I personally observed the initial distribution of free soap and it has never been reported as an issue since. Furthermore, I am aware that additional boxes of soap have been delivered to each unit.

14. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer. The high alcohol content poses a danger because inmates could ingest the hand sanitizer. See also https://www.cdc.gov/handwashing/hand-sanitizer-use.html. Staff have been given hand sanitizer and I have personally observed them using it.

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC"), the level of PPE issued depends on the situation. At my facility, every inmate has received two cloth masks as of April 6, 2020. Housing unit tier men and other inmate janitors are issued a surgical mask, in addition to the two cloth masks, every week, beginning on April 17, 2020. Inmate janitors assigned to clean quarantine areas with symptomatic inmates are issued N-95 masks. Inmates are required to wear a cloth mask anytime they are out of their cell or, in the dorms, whenever they are off

of their bunk. Masks are laundered once per week. Based on my personal observation and reports from staff, I know that inmates are compliant with this instruction.

16. Staff have all been issued two cloth masks on April 3, 2020. On April 15, 2020, all staff were provided an N95 mask. Staff are required to wear a mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. I know this because I have personally observed staff wearing masks. If staff are not wearing a mask, a supervisor will address this issue with them.

17. In addition to masks, staff may be required to don other PPE, depending on the situation at hand. In the Restrictive Housing Unit which contains the quarantine unit (where symptomatic inmates are placed pending the results of their COVID-19 test), staff wear their N95 mask, with a surgical mask on top, as well as a face shield and gloves. Staff are similarly equipped with PPE when in the Hospital 2 Unit, which is where inmates who have tested positive are held pending their transfer to one of the three designated COVID-19 units at Northern Correctional Institution. A COVID-positive inmate is transferred to Northern either by the end of the day or by 9:00 a.m. the following morning. On May 15, 2020, B-Block became designated as the housing unit for asymptomatic COVID positive inmates. At this point, once a COVID positive inmate becomes symptomatic, they are moved from B-Block to Hospital 2 Unit pending transfer to NCI.

18. Staff are screened prior to entry to the facility and upon exit. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to and upon exit from the facility. If staff are

sick, they can stay home; all staff have been given an additional 14 days of paid leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. The potentially infected areas are deep cleaned with 10% bleach or Lemonall. The inmates in those housing units are quarantined.

20. If an inmate displays symptoms of COVID-19, he is sent to Medical immediately, given a swab test and, pending the results of the test, is isolated in F Block. If the inmate had a cell mate, the cell mate is also isolated in F Block, on the opposite side of the tier. Both inmates stay in F Block for 14 days.

21. If an inmate tests positive for COVID-19, he is transferred to Hospital 2 (Covid-Dorm), where he is isolated while he awaits transfer to Northern (by the end of the day or by 9:00 a.m. the following morning).

22. I have been in constant contact with staff, providing correspondence generated by the Commissioner, issuing Roll Call memos, sending emails. Staff educates inmates as to all emerging direction and guidance.

23. I have had my facility's records reviewed and Darien Rosario has not filed a grievance about the issues raised in his affidavit.

24. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. As of May 7, 2020, I have not received one COVID-related grievance.

DECLARATION UNDER PENALTY OF PERJURY PURSUANT TO 28 U.S.C. § 1746

I, Hipolito N. Rodriguez, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden Hipolito N. Rodriguez

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT G

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT., et al, *Defendants*,	:	MAY 1, 2020

DECLARATION OF ACTING WARDEN DANIEL DOUGHERTY

I, DANIEL DOUGHERTY DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for Seventeen (17) yrs.
3. Currently I hold the position of Deputy Warden of York Correctional Institution ("York CI"). I have been Acting Warden at York CI for various dates in March and April, 2020 and I am currently the Acting Warden. I was previously the Deputy Warden at York CI since April 13, 2018.
4. York CI is the only facility for women inmates in the Connecticut DOC system. As of May 7, 2020, the York CI facility count has been greatly reduced to 661 inmates. EXHIBIT A. The population counts have been dropping dramatically, and are as follows:

    1/1/20 = 842
    2/1/20 = 858
    3/1/20 = 883

4/1/20 = 786
5/1/20 = 675

5. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility one (1) time per week, and I am present in at least some housing units within the facility one (1) time per week. I also maintain regular communication with my deputy wardens and my unit supervisors.

6. York Correctional Institution is a correctional facility that consists of cells and dorms divided into fourteen (14) units. Of the 14 units, there are 10 celled units, and 4 dorm units.

7. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have discontinued all social visits, implemented feeding back in the units to eliminate mass groupings in the chow hall, cancelled all collective religious services in lieu of one on one meetings in the units and frequent tours, limited programming to five (5) inmates per group with no mixing of units, education has been limited to individual handouts and assignments for continued education. Medication distribution has been from Medline to medication being delivered to each unit, inmate workers have been broken into two separate groups and are housed in different units to decrease the number of workers in one area at a time, outside tours have been suspended, volunteer led programs have been suspended, and outside community work details have been suspended. Inmates are eating in their cells or in the dayrooms, and are encouraged to socially distance while in the dayrooms.

8. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to contact a staff member if they are experiencing a fever, cough or shortness of breath. Also to continue to

follow preventative practices of frequent handwashing with soap and water, avoid touching their face, eyes nose and mouth, avoid greeting others with a handshake. The memo also reminds them that the annual influenza shot is still available and that the $5 co pay for medical has been temporarily suspended until further notice. It has been provided in the form of notices to the inmate population that are posted in each housing unit. I am aware that this guidance has been distributed because this was sent out via email to all Supervisors and Unit Managers on March 10, 2020 with instructions to post in their designated areas and I have personally seen them posted in the units.

9. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned daily. Due to the pandemic, this has been increased to multiple times per day. Cleaning is performed using Fresh N' Up, Freedom Non-Acid Bowl Cleaner mint, Quat 64 Lemon, GC-32 Glass Cleaner, MP-32 Multi-Purpose Cleaner, Pure Bright Germicidal Ultra Bleach. Cleaning solutions are diluted pursuant to the manufacturers' instructions. It would be dangerous to the inmates' health and safety to provide them with undiluted cleaning solutions. I know that this cleaning has been occurring because I have personally observed it and the Unit Managers have verified that this continues to occur. York CI has also recently obtained two Field King Max Backpack Sprayers that are currently in use throughout the facility.

10. My facility has communal showers that are used by inmates. There is approximately one shower per every 3.5 inmates. There are also some cells that contain their own showers. Communal showers are cleaned frequently (minimum of twice a day). Due to the time it takes

for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know this is occurring because the Unit Managers are reporting that this continues to occur.

11. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Each inmate is responsible for cleaning their own cells with the following supplies: Fresh N' Up, Freedom Non-Acid Bowl Cleaner mint, Quat 64 Lemon, GC-32 Glass Cleaner, MP-32 Multi-Purpose Cleaner, Pure Bright Germicidal Ultra Bleach. We have also done deep cleaning, where the inmates are evacuated from their housing units and all areas including cells were cleaned by a separate inmate work crew. I know this is occurring because the Unit Managers are reporting that this continues to occur.

12. There is approximately one (1) phone per every 9 inmates at my facility. They are cleaned multiple times per day. I know this is occurring because direction has been put out to the supervisors and they are reporting that this is being done.

13. Inmates have access to soap for hand washing. Inmates receive soap for free if they are indigent, and soap is always available for purchase at cost in the commissary. Soap continues to be available for commissary purchase, but soap has also been currently given out to all inmates (even those who are not indigent). While inmates are not permitted hand sanitizer because of the high alcohol content of the product and inmates may ingest the hand sanitizer, we were able to obtain non-alcohol based hand sanitizer for the inmates to utilize and dispensers have been installed in every housing unit in addition to the soap they may have. Officers have been provided with hand sanitizer as a preventative measure as they typically

have less frequent access to handwashing than inmates, who have sinks in their cells/ dorms. I have personally observed officers using hand sanitizer on my tours.

14. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least two (2) cloth masks and we have an ample supply if an inmate requests a replacement. We are currently in the process of issuing out additional masks to the inmate population. Inmates have been required to wear a cloth mask since April 22, 2020 anytime they exit their cells. For the most part inmates are compliant with this direction however, sometimes need to be reminded by staff. Inmates are able to launder their cloth masks through the laundry workers of Facility Laundry.

15. Staff have also all been issued at least a cloth mask. As of April 21, 2020 staff are required to wear at least a cloth mask at all times while inside the facility when social distancing is unavoidable and, to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by a supervisor. I know this because I have seen staff wearing them and direction has been put out to all staff related to this.

16. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. Surgical (procedural) masks are issued to any personnel tasked to monitor work in an area with isolated inmates. N95 masks are issued to personnel who are tasked to monitor work in an area with confirmed/presumptive COVID positive individuals.

17. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are

denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick, they can stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID.

18. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. In an event like this, the affected unit would be quarantined if deemed necessary by our Medical Leadership and the Infectious Disease Doctor. The affected area(s) would be cleaned utilizing an inmate work crew and the following supplies: Fresh N' Up, Freedom Non-Acid Bowl Cleaner mint, Quat 64 Lemon, GC-32 Glass Cleaner, MP-32 Multi-Purpose Cleaner, Pure Bright Germicidal Ultra Bleach.

19. If an inmate displays symptoms of COVID-19, that inmate and her cellmate (if applicable) will be placed in a negative pressure room within our Medical unit. The inmate will be screened by Medical and administered a COVID test. While awaiting the test results the inmate(s) will remain in said negative pressure room until the test results come back. The Unit the inmate was housed in will also be isolated from the rest of the inmate population. Once the test comes back and the inmate(s) are deemed negative for COVID, they will be transitioned from the negative pressure room to an isolation cell within Medical and monitored for 14 days from the initial signs of symptoms and the unit will go back to normal operations. In a situation like this, the housing unit and affected cell is cleaned utilizing inmate workers and the following supplies: Fresh N' Up, Freedom Non-Acid Bowl Cleaner mint, Quat 64 Lemon, GC-32 Glass Cleaner, MP-32 Multi-Purpose Cleaner, Pure Bright Germicidal Ultra Bleach.

20. If an inmate tests positive for COVID-19 that inmate will be placed in a negative pressure room within our Medical unit. The inmate will be monitored by Medical and treated as necessary. The Unit the inmate was housed in will also be isolated from the rest of the inmate population. The positive inmate will remain in a negative pressure room until medical deems it appropriate to release them. The unit they were housed in will also remain quarantined and monitored until such time Medical determines it's appropriate to release them from quarantine.

21. The Administration has continually been proactively addressing concerns and educating staff and inmates related to COVID-19.

22. As of May 14, 2020, I have had my facility's records reviewed and Inmate Williams-Void, Patikate #297643 has not filed a grievance about the issues raised in her affidavit.

23. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed.

24. In the event that a York CI inmate complains of possible symptoms of coronavirus infection, for example, feverish over 100 degrees, or dry short cough, shortness of breath, or any other of the possible signs of infection, the two inmates are removed from the cell and brought to our medical unit, where they are separated, and placed in negative pressure rooms, separate from one another. The inmate showing signs or symptoms is then tested. Both the inmates are quarantined until the test results come back. York CI has six negative pressure rooms to deal with this situation.

25. Since the onset of the COVID-19 pandemic, York CI has tested about 8-10 inmates, and to the present date, York CI has not had a single case of a positive COVID-19 test. Therefore, in my professional opinion, to a reasonable degree of professional certainty, York CI is following

CDC guidelines for correctional facilities and has significantly reduced the risk of potential coronavirus contagion. Indeed, in my view, there is less risk and greater supervision and surveillance of such infection at York CI than in the general non-incarcerated community.

DECLARATION UNDER PENALTY OF PERJURY PURSUANT TO 28 U.S.C. § 1746

I, Daniel Dougherty declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 19, 2020.

Acting Warden Daniel Dougherty

EXHIBIT A

Brooklyn CI	429	392	0	416
Carl Robinson CI	1224	936	32 beds 16 cells	1488
Cheshire CI	1389	1049	848	956
Cheshire, Walker C.	1948	1803	2218	0
New Haven CC	676	676	676	338
Northern CI	78	90	5 cells (4 males RHU and infirmary beds)	0
Osborn CI	354	1121	1329	126
Willard-Cybulski CI	1078	984	0	1136
Bridgeport CC	693	484	201 "at risk" eligible beds (low risk housing 237 beds). Number does not include medical beds which has a maximum of 36	470
Garner CI	956	951	945	0
Manson YI	593	576	576	0
Osborn CI	1255	1209	448 segregation beds 64 mental health beds	576
Northern CC	896	781	556	480
York CI	884	961	1092	240

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT H

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
ROLLIN COOK, *et al* *Respondents.*	:	MAY 1, 2020

DECLARATION OF WARDEN KENNETH BUTRICKS

I, KENNETH BUTRICKS DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for twenty-eight (28) years.
3. Currently I hold the position of Warden of Cheshire Correctional Institution ("Cheshire CI")
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five (5) days a week. I physically tour the entire facility a minimum of one (1) time per week, and I am present in at least some housing units within the facility four to five (4-5) times per week. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. As of May 7, 2020, the Cheshire CI facility count was 1122 inmates. As of March 1, 2020 the Cheshire CI facility count was 1151 inmates. EXHIBIT A

6. Cheshire CI is a correctional facility that consists of mostly cells (16 units), and one small unit of dorms, totaling 17 units. While our dorm unit has the capacity for 128 inmates, as of a May 7, 2020, there are 22 inmates in this unit. The celled units range from 20-52 cells per unit.

7. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have canceled indoor recreation and limited outdoor recreation to a maximum of fifty inmates at a time in a recreation yard approximately the size of two football fields. We do not allow basketball to be played during recreation due to the increased risk of personal contact. We have canceled all visits and suspended group programming. Congregate religious programming has been suspended and pastoral care is provided on an individual basis while maintaining social distancing. Classroom teaching has been suspended and lesson plans are being handed out individually. Constant reminders are provided to the inmate population regarding congregation. Meals are delivered via food cart from the kitchen to the North and South Blocks, and inmates eat in their respective dayrooms. Meals are delivered in the same way to the East Block, but inmates are handed a tray and eat in their cells. Before the pandemic, inmates housed in CHU and East Block ate in the dining hall.

8. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to practice proper social distancing, practice frequent handwashing, avoid touching face, eyes, nose and mouth, wear the provided masks and inform someone if they are not feeling well. It has been provided in the form of posters that are placed in all housing units, and reinforced with constant oral

reminders. I am aware that this guidance has been distributed because I have seen it in all housing units and posted throughout the facility as I tour the facility.

9. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned daily. Due to the pandemic, this has been increased to a continuous, ongoing cleaning, occurring all day long. Cleaning is performed using mops, spray bottles, sponges, brooms, scouring pads, paper towels, bleach, LemonAll, multipurpose cleaner, gloves, masks, etc. Cleaning solutions are diluted pursuant to the manufacturers' instructions. It would be dangerous to the inmates' health and safety to provide them with undiluted cleaning solutions. I know that this cleaning has been occurring because I have personally observed it, I have spoken to unit managers regarding this, and spoken to inmate works regarding this. As of May 6, 2020, Cheshire CI has also obtained two Field King Max Backpack Sprayers. As of May 14, 2020, we have completed disinfecting 15 of 17 units as well as common areas.

10. My facility has communal showers that are used by inmates. There are approximately four to ten (4-10) showers per unit. Communal showers are cleaned frequently, and at least two to three (2-3) times per day. Due to the time it takes for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know this is occurring because I have personally observed it and been advised by the unit managers that it is occurring in accordance with the prescribed schedule.

11. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates are allowed to clean their cells three times a week (increased from two times per week prior to the pandemic). Inmates are supplied with mops, buckets, water, LemonAll and

cleaning detergents to conduct this cleaning. I know this is occurring because I have personally observed it.

12. There are approximately seven to twelve (7-12) telephones per unit at my facility. They are cleaned routinely and continually during the day. Inmates can also clean the phones before they use them with Fermin All and paper towels. I know this is occurring because I have personally observed it and remind staff continually while I tour.

13. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap were distributed for free to inmates beginning on or about April 1, 2020, and will continue to be distributed on a weekly basis for the duration of the pandemic. If inmates run out of soap, they can request and will receive additional soap. I know this soap distribution is occurring because I have personally observed this.

14. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, per Centers for Disease Control ("CDC") guidelines, soap is known to be more effective against COVID-19 than hand sanitizer[1]. EXHIBIT B The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Officers and staff have been provided with and have access to hand sanitizer as a preventative measure as they typically have less frequent access to handwashing than inmates, who have sinks in their cells/ dorms. I have personally observed officers using hand sanitizer on my tours.

[1] See https://www.cdc.gov/handwashing/hand-sanitizer-use.html

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the CDC guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least four cloth masks. Inmates can receive additional masks upon request. Inmates have been required to wear a cloth mask since April 22, 2020, although all inmates were provided with masks prior to that date. Inmates are able to have their cloth masks laundered with their weekly laundry, as well as wash/rinse them out with soap and water within their cell. I have found that nearly all of inmates are compliant with wearing their masks, and I address it with any inmates I find non-compliant.

16. Staff have also all been issued multiple cloth masks. As of April 22, 2020, staff are required to wear at least a cloth mask at all times while inside the facility, and to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by a supervisor. I know this because I have personally observed and discussed this with a number of staff members.

17. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. In addition to the cloth mask mentioned above, staff has now been provided with multiple surgical masks, KN95/N95 masks, and face shields are available upon request. Staff in our quarantine unit are also provided with gowns, gloves, goggles and face shields.

18. Staff are screened prior to entry to the facility. They have their temperatures taken prior to entry to and exit from the facility and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility.

If staff are sick, they can stay home; all staff have been given an additional two (2) calendar weeks of paid leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19 and reports that they were symptomatic while at work, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. The facility will also disinfect the area where the staff member was stationed while symptomatic.

20. If an inmate displays symptoms of COVID-19, the medical unit is called and reports to the inmate's cell to triage the situation. If the inmate is symptomatic, and needs further evaluation, staff donned in gloves and masks escort the inmate to the cell/quarantine unit. The inmate's cell is closed off until test results are provided.

21. If an inmate tests positive for COVID-19, the medical unit notifies me and I notify the tactical unit to arrange transportation to Northern Correctional Institution. This transportation occurs within twenty-four (24) hours. The inmate's cell is deep cleaned and the inmate's cellmate is sent to the quarantine unit for observation for fourteen days.

22. As of May 14, 2020, I have had my facility's records reviewed and Joshua Wilcox has not filed a grievance about the issues raised in his affidavit.

23. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Kenneth Butricks, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 16, 2020.

Warden Kenneth Butricks

EXHIBIT A

Bridgeport CC	426	352	0	426
Carl Robinson CI	1314	946	32 beds 16 adjs	1450
Cheshire CI	1184	1014	8x8	156
Cybulski, Walker CI	1458	1403	2218	0
New Haven CC	670	615	439	218
Northern CI	78	222	64 mens RTU and infirmary beds	0
Osborn CI	1156	1132	1570	156
Willard-Cybulski CI	1074	694	0	1148
Bridgeport CC	440	344	96 adj w/ 64 beds converted to mens TRU beds. Numbers also include medical beds which have maximum of 16	470
Garner CI	484	447	448	0
Manson YI	240	230	0	0
Osborn CI	1245	1047	448 regular cut 64 mental health unit	235
Stafford CC	856	795	559	680
York CI	884	640	1502	140

EXHIBIT B

CDC Centers for Disease Control and Prevention

Handwashing: Clean Hands Save Lives

Show Me the Science – When & How to Use Hand Sanitizer in Community Settings

Note: For hand hygiene guidance in healthcare settings, please visit the Clean Hands Count webpage

CDC recommends washing hands with soap and water whenever possible because handwashing reduces the amounts of all types of germs and chemicals on hands. But if soap and water are not available, using a hand sanitizer with at least 60% alcohol can help you avoid getting sick and spreading germs to others. The guidance for effective handwashing and use of hand sanitizer in community settings was developed based on data from a number of studies.

Alcohol-based hand sanitizers can quickly reduce the number of microbes on hands in some situations, but sanitizers do *not* eliminate all types of germs.

Why? Soap and water are more effective than hand sanitizers at removing certain kinds of germs, like *Cryptosporidium*, norovirus, and *Clostridium difficile*.[1] Although alcohol-based hand sanitizers can inactivate many types of microbes very effectively when used correctly,[2-4] people may not use a large enough volume of the sanitizers or may wipe it off before it has dried.[5]

Hand sanitizers may not be as effective when hands are visibly dirty or greasy.

Why? Many studies show that hand sanitizers work well in clinical settings, like hospitals, where hands come into contact with germs but generally are not dirty, soiled or greasy.[6-8] Some data also show that hand sanitizers may work well against certain types of germs on slightly soiled hands.[9-11] However, hands may become very greasy or soiled in community settings, such as after people handle food, play sports, work in the garden, or go camping or fishing. When hands are heavily soiled or greasy, hand sanitizers may not work well.[12] Handwashing with soap and water is recommended in such circumstances.

Hand sanitizers might not remove harmful chemicals, like pesticides and heavy metals, from hands.

Why? Although few studies have been conducted, hand sanitizers probably cannot remove or inactivate many types of harmful chemicals. In one study, people who reported using hand sanitizer to clean hands had increased levels of pesticides in their bodies.[13] If hands have touched harmful chemicals, wash carefully with soap and water (or as directed by a poison control center).

If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.

Why? Many studies have found that sanitizers with an alcohol concentration between 60-95% are more effective at killing germs than those with a lower alcohol concentration or non-alcohol-based hand sanitizers [1]. Hand sanitizers without 60-95% alcohol 1) may not work equally well for many types of germs, and 2) merely reduce the growth of germs rather than kill them outright.

When using hand sanitizer, apply the product to the palm of one hand (read the label to learn the correct amount) and rub the product all over the surfaces of your hands until your hands are dry.

Why? The steps for hand sanitizer use are based on a simplified procedure recommended by CDC. Instructing people to cover all surfaces of both hands with hand sanitizer has been found to provide similar disinfection effectiveness as providing detailed steps for washing in hand sanitizer [2].

Swallowing alcohol-based hand sanitizers can cause alcohol poisoning.

Why? Ethyl alcohol (ethanol)-based hand sanitizers are safe when used as directed - but they can cause alcohol poisoning if a person swallows more than a couple of mouthfuls.

From 2011 – 2015, U.S. poison control centers received nearly 85,000 calls about hand sanitizer exposures among children [3]. Children may be particularly likely to swallow hand sanitizers that are scented, brightly colored, or attractively packaged. Hand sanitizers should be stored out of the reach of young children and should be used with adult supervision. Child-resistant caps could also help reduce hand sanitizer-related poisonings among young children [4]. Older children and adults might purposefully swallow hand sanitizers to become drunk [5].

References

[illegible]

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT I

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT., et al, *Defendants*,	:	MAY 18, 2020

DECLARATION OF WARDEN MARTIN

I, ROBERT MARTIN DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for twenty-five (25) years.
3. Currently I hold the position of Warden of Corrigan-Radgowski Correctional Center.
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week. I physically tour the entire facility two times per week and I am present in at least some housing units within the facility two times per week. I also maintain regular communication with my deputy wardens and unit supervisors.
5. Corrigan-Radgowski Correctional Center is a correctional facility that consists of cells in the Corrigan building and dorms in the Radgowski building. The Corrigan building has eight (8) housing units with 48 cells per housing unit and the Radgowski building has four (4) housing units with 114 beds per housing unit. In the Radgowski building, we have opened the Annex

West Wing and Annex cell block. In the Annex West Wing, 39 beds are occupied with capacity for 106 inmates. The Annex cell block has 38 inmates housed there with capacity for 106 inmates. The inmates who were assigned the top bunk in the Radgowski building were moved to the Annex West Wing so that the top bunks are empty to allow for more social distancing.

6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. Our inmate population has decreased from 1,189 inmates on March 1, 2020 to 1,035 inmates as of May 7, 2020. See Exhibit A: Inmate population by facility. At my facility, we have eliminated all social and legal visits. Inmates housed in the Corrigan building are permitted to leave their cells six (6) inmates at a time for thirty (30) minutes per day to shower and make a phone call. In the Radgowski building, there is no time limit on indoor recreation time or showers due to the nature of the dorm setting. The gymnasium facilities in both the Corrigan and Radgowski buildings are closed. Inmates in the Corrigan building are eating in their cells and inmates in the Radgowski building are eating in their cubicles.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to increase the cleaning in their cells and dorms, wear masks, and social distance where possible. In the dorm setting, we have put lines on the ground from the officers' station to measure six feet between the staff and inmates. When officers witness inmates congregating in the dorm unit, the inmates are instructed to disperse. There are CDC posters in the housing units which I have seen.

8. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were

cleaned in between shifts or during recreation periods by tier workers. Due to the pandemic, this has been increased to cleaning after every group of inmates are released to use the showers and telephones. Common areas are cleaned by tier workers even though they are not presently being utilized. The handles, railings, and doors in the facility are constantly cleaned. Cleaning is performed using Lemon All and diluted bleach. Both are diluted per the manufacturers' recommendation. I know that this cleaning has been occurring because I have personally witnessed the cleaning. Shift commanders and supervisors are providing shift reports and including within those reports which inmates are performing the cleaning within the facility. Cleaning is occurring on every shift. The third shift cleaning is focused on common areas, hallways, and areas in the facility without movement.

9. My facility has communal showers that are used by inmates. As of May 6, 2020, there are approximately 3 showers for 44 inmates in the Corrigan building and 8 showers for 114 inmates in the Radgowski building. Communal showers are now sprayed after each use due to the pandemic. In the Radgowski building, the showers are cleaned after the inmates are secured. Due to the time it takes for cleaning and the number of inmates who need to shower, it is not possible to clean the shower between each use. I know this cleaning is occurring because I have witnessed it and I check the showers for cleanliness during my tours. In the Radgowski building, maintenance staff has power washed the showers once.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. In the Corrigan building, inmates are given a weekly supply of cleaning supplies to clean their cells during recreation time. They are provided bleach, paper towels, and Lemon All in a medicine cup. The amount of cleaning supplies provided is sufficient to clean their personal

space. The bleach and Lemon All are diluted with water according to the manufacturers' recommendation. The Deputy Warden and I check with officers to ensure that inmates have an adequate amount of cleaning supplies. Inmates are not provided with mops or brooms. In the Radgowski building, inmates are permitted to clean during the day at any time during their recreation period. I have witnessed the inmates in the dorms cleaning during the recreation time. Furthermore, there is a bi-weekly cleaning of the entire units in the Radgowski building, whereupon the unit is cleaned without the inmates in the unit, including the sleeping areas.

11. There are approximately twenty (20) telephones in the Corrigan building and eight (8) telephones in the Radgowski building. They are cleaned after each use by the inmates. Inmates are provided Lemon All and paper towels to clean the phone after each use and the phones are cleaned at the end of every shift by the tier workers. I know this is occurring because I have seen inmates receive the cleaning products prior to use of the telephone. The phones in the Corrigan building have been spaced out to practice social distancing. The Restrictive Housing Unit in the Corrigan building has one phone in the unit housing about twenty (20) inmates.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates for free (even those who are not indigent). In my facility, bars of soap were distributed for free to inmates beginning on April 2, 2020 and will continue to be distributed on a weekly basis for the duration of the pandemic. I know this soap distribution is occurring because I tasked the unit managers to be present for the soap distribution to the inmates and instructed them to report back when that is complete. The inmates can ask for additional soap

beyond the weekly distribution. The soap that is distributed to the inmates is for personal use and not to clean their cells.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. There are hand sanitizer stations for staff to use in both the Corrigan and Radgowski buildings. I have personally used the hand sanitizer and have seen staff use the hand sanitizer stations.

14. The handcuffs are wiped down with alcohol wipes after every use in segregation. Handcuffs are not re-used on different inmates without first being disinfected. If the handcuffs are soiled, they are soaked in the Lemon All cleaning solution.

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. As of May 6, 2020, every inmate at my facility has received at least two cloth masks and they are given brand new masks every other week. Inmates have been required to wear a cloth mask since late March, prior to Commissioner Cook's order to wear masks when social distancing is not possible. Inmates are to wear the masks at all times when social distancing is not possible. Staff have addressed inmates who are not wearing their masks appropriately.

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html

16. Staff have also all been issued at least a cloth mask. When we received cloth masks, staff were required to wear at least a cloth mask when social distancing is not possible. I know this because I have witnessed staff wearing the masks.

17. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. Staff who are working in the quarantine unit or escorting inmates to and from the quarantine unit have been issued N95 masks which they are required to use. They have also been issued a suit, gloves, and goggles which they may use at their discretion. The suits are available in the quarantine unit for staff to take post. Gloves are available in every unit.

18 Staff are screened prior to entry to the facility and during each shift. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick or symptomatic, they must stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff and inmates) could have been potentially infected. No additional cleaning is performed, as cleaning is already done regularly.

20. If an inmate displays symptoms of COVID-19, he is evaluated by medical staff who then determine whether he needs to be monitored and/or tested. All symptomatic inmates are moved to quarantine (H Pod) where they are monitored by medical staff for 14 days and tested for COVID-19. If, after the testing, the inmate is negative for COVID-19, he remains in quarantine for 14 days. In the Radgowski building, if an inmate shows symptoms or if staff receives

intelligence that someone is sick, the inmate is seen by medical staff who determine whether quarantine is necessary. If more than one inmate is pulled out of a housing unit for symptoms of COVID-19, medical staff will test the temperature of everyone in the housing unit and then, if necessary, isolate the unit and symptomatic inmates are sent to the Corrigan building.

21. If an inmate tests positive for COVID-19, the inmate is transferred to Northern Correctional Institution.

22. Trash removal in the cells is being conducted during each meal delivery.

23. Medical staff has a list of all the inmates they are monitoring for COVID-19 and, on a daily basis, checks the vital signs of each inmate in quarantine.

24. I have had my facility's records reviewed and Thomas Caves (#387020), Angel Caballero (#214362), and Austin Kerr (#425449), have filed grievances about the issues raised in their affidavits. As of May 6, 2020, Chaz Gulley (#301973), and Johnathan Pape (#385417) have not filed a grievance about the issues raised in their affidavits.

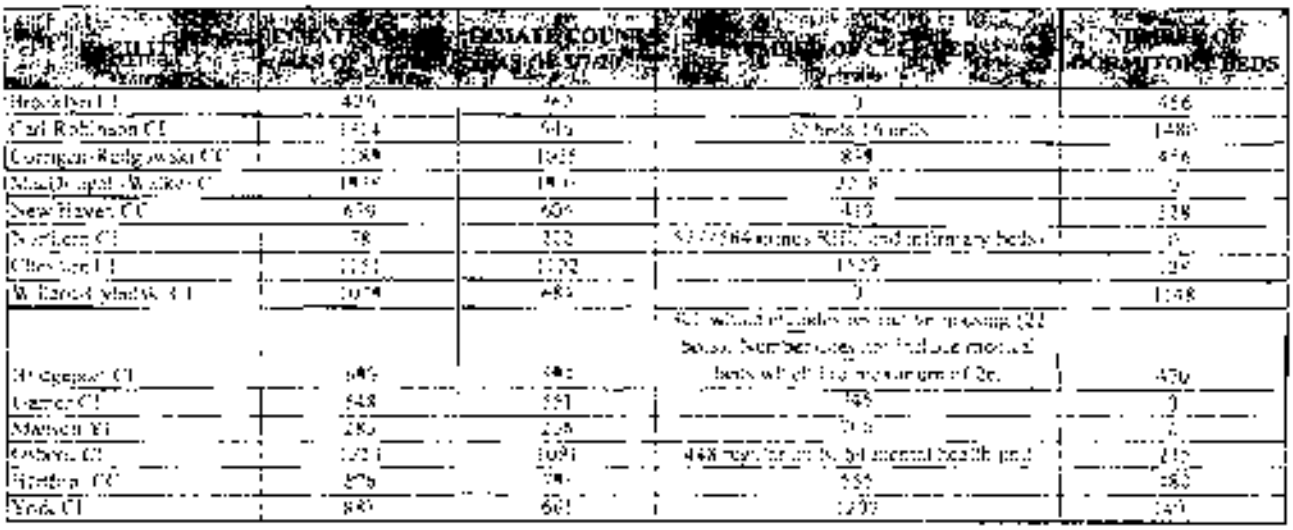
25. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed in accordance with Administrative Directive 9.6 (Inmate Administrative Remedies).

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Robert Martin, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden Martin

EXHIBIT A



CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT J

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al. *Defendants.*	:	MAY 15, 2020

DECLARATION OF GAVIN GALLIGAN

I, Gavin Galligan, being duly sworn, declare under penalty of perjury, pursuant to Conn. Gen. Stat. §1-24a, §53a-157b, and 28 U.S.C. §1746 and state:

1. I am over 18 years of age and understand the obligation of an oath.

2 I am employed by the State of Connecticut, Department of Correction (DOC) in the position of Director of the Community Release Unit (CRU).

3. I have held this position since October 1st of 2019. Prior to my appointment to this position, Thomas Hunt served as the Director of the CRU, and I worked in the CRU as a Correctional Counselor Supervisor. My duties included, in part, reviewing individuals incarcerated in DOC who might be eligible for some form of community release under the release discretion of the DOC. I have personal knowledge of the matters stated herein.

4. I have been employed by the DOC since August of 2001. Prior to my appointment as Director of the CRU, I served in various positions within the DOC. During my 18 years of service, I have worked in the positions of: Correctional Officer, Correctional Counselor Trainee, Correctional Counselor and Correctional Counselor Supervisor. In these positions I have gained expertise in classification and risk assessment of inmates.

5. Community Release provides eligible inmates an opportunity to reintegrate into the community prior to the completion of their sentence. Community Release is discretionary release granted or denied by the designee of the Commissioner of Correction.

6. There are several different avenues for offenders incarcerated in Connecticut to be released from prison prior to the end of their sentence. Community Release through the CRU is one of those avenues.

7. Historically, prior to the creation of the CRU, discretionary release decisions had been made by each facility Warden, and at the time of opening CRU in 2015, there were 15 different decision makers.

8. On March 30, 2015 the total inmate facility count for the DOC was 16,157. This was the date in which DOC opened its then newly formed CRU, with the goal of having one decision maker for discretionary release applications under the authority of the Commissioner.

9. The goal of CRU was not only to have consistent release decisions being made, but also to coordinate and track the cases across all facilities to ensure that cases eligible for release consideration were being reviewed in a timely manner. Efficiencies were maximized for the review processes and timeliness of release decisions were vastly improved.

10. Fast forward to 2020, the CRU has conducted over 46,000 case reviews in just over a five-year time period. During the same time period, other initiatives were taking place pertaining to criminal justice reforms have contributed to a lower overall DOC count, as covered in OPM reports. See **Exhibit A**, OPM April 2020 monthly indicators report https://portal.ct.gov/OPM/CJ-About/CJ-SAC/SAC-Sites/Monthly-Indicators/Monthly-Indicators-2019

11. Community Release includes transitional supervision, residential program placement, transitional placement, nursing home release, DOC home confinement, re-entry furlough and in some cases dual supervision for cases that are serving Special Parole. The re-entry mechanisms are provided by statute. The Commissioner does not have the discretion to release inmates prior to the completion of their sentences except as provided by statute.

12. An offender, if eligible, may be released to a variety of different locations after being approved for community release through the CRU. For example, an inmate reviewed for community release could be released to a halfway house, to community supervision with a sponsor such as a family member in the community, a sober house or even to a medical facility.

13. Alternatively, inmates may, if eligible, also be released prior to their end of sentence to either a halfway house or community supervision by virtue of the parole system under the Board of Pardons and Paroles (BOPP). BOPP review includes but may not be limited to such things as discretionary parole, special parole and compassionate parole.

14. The CRU is not involved in the BOPP parole process. CRU is managed by the DOC, not the BOPP.

15. Parole through the BOPP and community release processes through the CRU are independent mechanisms of release. The Board of Parole is a separate state agency, with different statutory release mechanisms.

16. Parole eligibility and eligibility for community release are entirely independent.[1]

[1] All references to "community release" hereinafter refer to community release through the DOC's Community Release Unit, and do not include parole.

17. As a result, an offender may, in some cases, be reviewed for both discretionary parole by the BOPP and community release through CRU. Depending upon the offender's eligibility for parole and/or community release, the offender may be reviewed first for parole, then for community release, or vice versa.

18. A denial for community release by the CRU does not prevent an offender from discretionary parole eligibility. To my knowledge, a denial for community release does not preclude a grant of discretionary parole.

19. Conversely, a denial of discretionary parole does not preclude approval for community release through the CRU. They are independent processes, both of which allow an offender to be released to the community through different State Statues and release mechanisms, managed by two different agencies- DOC and BOPP.

20. The timeliness of the applications for community release from beginning of application to decision averages 10-15 days. It should be noted that prior to the establishment of CRU, this average was 36-45 days for these reviews to take place.

21. The current process for discretionary community release through the CRU is as follows: once an offender has been identified by facility classification staff (typically a counselor) as eligible for community release, facility staff assemble materials required for the offender to be reviewed, and submit the offender's application electronically to CRU.

22. The materials included or reviewed in the offender's application for community release include such things as: Criminal record check (rap sheet), Police report or Pre-Sentence Investigation (PSI), agreement of community release conditions, notice of application to DOC and Judicial Victim Services, proposed sponsor contact information and criminal record check, program evaluation (s) (when available or required). DOC programming

electronic records, check of protective order registry, review of institutional behavior, review of performance while on community release, parole or probation, victim impact statement(s), letters of support, letters of opposition, verification of eligibility of release, review of sentencing mitts, if the offender has community support- such as employment upon release and/or recommendations from the facility (if provided).

23. Different programs under the umbrella of community release have different eligibility requirements. For example, sentences of two years or less may be eligible for Transitional Supervision, sentences greater than two years may be eligible for Community Release-Halfway House. Sentences specific to convictions under Conn. Gen. Stat. §§ 14-227a, 14-215, 21a-267, 21a-279c and 14-227m may be eligible for release to DCF Home Confinement.

24. Some of the eligibility requirements are set forth in DOC A.D. 9.2 Objective Classification, attached hereto as **Exhibit B**.

25. Once an offender's application is submitted, CRC reviews the application and the director makes a decision on community release for that offender.

26 When reviewing an application for community release, the following factors are taken into consideration: the nature of the instant offense, the offender's criminal history, statements regarding the impact of release to the victim or the victim's family, compliance with the offender accountability plan (OAP), program participation and/or program removal, institutional behavior and/or disciplinary infractions (DRs), history while on supervision of any kind, out of state or federal criminal history (if any), and successes or failures while on supervision.

27. Careful consideration of these factors and in depth review of the application materials are critical to release decisions. The CRU seeks to ensure that offenders have the best chance of success when released: these factors and the application materials are essential to that determination. Additionally, the CRU reviews each offender with public safety in mind, and therefore attempt to ensure that the offender does not have a high risk of re-offending and does not pose a substantial risk to public safety.

28. Each offender eligible for review is afforded an individual review before a discretionary decision on the community release application is rendered.

29. An offender who is initially reviewed for community release may be approved, denied, waived, continue and reapply, or closed interest. For cases that are approved, the offender may face additional action on their case and not all case approved end up being released to supervision. New charges, disciplinary action, if they are no longer interested or if they do not have an adequate time for placement or supervision are all factors that may lead to these additional actions taking place. These actions, recorded and notified to the offender, would include the case being: rescinded, offset, waived, close interest.

30. Waived indicates the offender has chosen not to be reviewed for community release, or have refused to participate in the review process.

31. Offset approved indicates that the case remains approved but the date of earliest release has been modified. The date may be set prior to the original date, or after the original review date. It could have been based upon a program being completed earlier than first anticipated, a modification of a sentence or change in jail credit- thus changing eligibility, disciplinary action that resulted in a request to change the earliest release date- could be

based upon loss of risk reduction earned credit (RRPC) also resulting in change of eligibility.

32. Closed interest are cases which an offender is too short for supervision and/or placement in a halfway house in the community. They may also be cases in which an offender would be required to complete programming prior to release, but they do not have adequate time to complete the mandatory programming and then have time for supervision. These cases are being reviewed to determine if these requirements can be waived or if the offender is eligible for a furlough. In response to the COVID-19 outbreak, as further discussed below, redoubled efforts are being made to review all individuals eligible for release with a solid home plan.

33. A decision to deny a community release application is final and may not be appealed. If an offender is denied, the offender is generally not reviewed again for community release during then current sentence of incarceration. There may be instances where offenders denied may be eligible for a re-entry furlough, if eligible. There are also cases that may be denied, but the offender may be in a situation where they have declined medically, and after evaluation and approval, they may be approved for release to a nursing home under the Commissioner's release authority. There also may be cases in which an offender was denied, but then began a new controlling sentence, in which the offender may be eligible for a re-review based upon that new sentence being controlling.

34. Reasons for a denial of a community release application are: criminal history, inadequate institutional program participation, refusal to complete stipulated programming, deemed inappropriate for outpatient sex offender treatment, injury and/or impact to victim (or) victim's family, multi-state offender, nature and/or circumstances of the current offense,

poor institutional adjustment, insufficient time for placement, poor performance on community release, parole, or probation.

35. After review, the CRU notifies correctional facility staff of the release decision. The Parole and Community Services Unit would receive all approved cases, to then process for release into the community.

36. The Parole and Community Services (PCS) Unit would then conduct a second discretionary review to determine if the offender has a valid release plan. Prior to the COVID-19 emergency, this usual practice involved home investigation by a DOC PCS parole officer to interview the sponsor, conduct a home visit and determine whether the residence is appropriate. To expedite the process, and to protect the health and safety of the parole officers, these sponsor interviews are now being conducted telephonically, which has greatly facilitated and expedited the approval process of the release plan.

37. However, Halfway House ("HWH") review, even if approved, is in the discretion of the CRU, and placement is generally not effectuated until 4-6 months prior to end of sentence ("EOS"), because HWH beds are an extremely limited resource and the same bed-use can be implemented for four offenders, for four months each, rather than have one offender occupy a HWH bed for the full 16 months remaining on a sentence. Therefore, best practice and utilization means offenders may be placed in halfway houses for the last 4-6 months of a sentence prior to EOS.

38. In addition, HWH placements were suspended briefly at times the month of April at the request of the HWH private contractual providers to DOC, to allow for a short pause, to ensure the health and safety of the present HWH residents and staff is not endangered by an exposure to a person who may be contagious with the COVID-19 virus. This HWH

temporary suspension gave time for the providers to identify proper additional space for quarantine measures and safe-distance measures to be implemented in the various HWH locations. This was based on evolving advice and recommendations from the CDC, DPH, and advice from the Chief Medical Officer of the DOC, Dr. Byron Kennedy, and other factors.

39. Recently, based upon the COVID-19 crisis, CRC has been continuing to ensure that all eligible offenders are being reviewed for discretionary release within current DOC policies and under the Commissioner's statutory authority.

40. Under DOC's current practice, we are continuing to eligible offenders for discretionary release and taking efforts to identify the "at risk" population for the various forms of discretionary release. We utilize a computerized process which greatly assists the agency in the process of identification of eligible offenders, processing of applications and tracking of cases.

41. In response to the COVID-19 crisis, the CRC has given direction to the correctional facilities to review all cases for accuracy to increase and include those who may be eligible, but had not currently been reviewed based upon restrictive status, disciplinary issues or even temporality ineligible for review.

42. We also requested that the facilities review all cases that were previously stipulated to complete programming, to see if the programming was completed or where the offender was in the process of the program participation. Staff within CRC also reviewed all of these cases.

43. Under direction of the Director of Programs and Treatment, CRC also looked at cases we stipulated prior for programming, to see if the offender had completed other programming.

that could be substituted for the original program stipulation or even waived the program completion requirement for the purpose of release.

44. CRU directed the facilities to meet with all offenders who were approved for Transitional Supervision, but had no sponsor/residence, to see if they now were able to obtain a sponsor. Additional phone calls were allowed and approximately 20% of the cases that previously did not have a sponsor, were able to provide a sponsor/residence.

45. CRU worked with the facilities and Parole and Community Services to review cases that were "past due" or past their approved release date. These dates are "on or after dates," as they are discretionary releases. For the most part, the "on or after date" which is given is the earliest date an individual could be released, pending a second review of the release plan, which is a required second step in the discretionary process. a second discretionary review to determine if the offender has a sponsor, and an approved, solid home plan. Some of these past due cases had sponsor issues in which information needed to be clarified, review of cases to obtain medical transfer summaries that would then allow the case to move forward with placement in a halfway house, or simple requests to update classification information were also attempted to be resolved in order to process releases. These case reviews continue on a daily basis.

46. On April 2, 2020, Commissioner Cook approved, signed off and authorized a revision to AD 9.8 Furloughs, (copy attached Exhibit C), which authorized the use of furloughs for offenders approved for Transitional Supervision based upon the Governor's declaration of a State of Emergency. This has allowed the release of approximately 119 offenders up to 45 days prior to their Transitional Supervision release date, and continues to be utilized as a release mechanism (attached, Exh. C).

47. The CRU and Parole and Community Services (PCS) Division and the BOPP are working collaboratively to review appropriate release eligible offenders that have a solid home plan. Community release decisions include a risk assessment process which evaluates the risk of the offender to the public and for recidivism.

48. We have added a process to prioritize those that are considered high risk if exposed to COVID-19 following the Centers for Disease Control and Prevention (CDC) guidelines.

49. For example, CT DOC Health Services has been working to identify offenders that may be at risk if they were to contract COVID-19, based upon age 50 or older and medical scores of 3 or greater. In these cases Health Services are looking for comorbidities, the presence of two or more chronic diseases or conditions. DOC Health Services is working to get opinion letters, signed by physicians or other Primary Care Providers (PCPs) sent to the BOPP for consideration for Compassionate Parole and Medical Parole. The BOPP has stated that they would be willing to look at any cases that DOC sent over.

50. DOC does not have statutory authority to grant "compassionate" medical release, like the BOPP does through Compassionate Parole.

51. DOC Health Services has also been working to assist in the identification of potential cases for release to Medical Furlough and or Nursing Home release during the Covid-19 crisis.

52. Under DOC AD 9.8 Furloughs, a Medical Furlough is, "*The discretionary release of an inmate to obtain medical services not otherwise available*" and can be granted up to 15 days, and may be renewed if required. Medical furloughs have been used to provide medical services that cannot be provided by way of Internal Health Services Staff or

medical services that could not be provided by an outside hospital, by way of escorted visit into the community. (See **Exhibit D** Administrative Directive 9.8 Furloughs).

53. However, medical furlough is not often used or requested. This is because medical services are nearly always available within the DOC, or are provided through contracted providers or through transfer to a hospital without need for a formal medical furlough.

54. The last example of a medical furlough, known to me, was for an offender that needed to get medical treatment outside the State of Connecticut, and at a medical facility that had previously conducted a lung transplant on that offender. That offender was granted a medical furlough to that medical facility, based upon risk of organ rejection, if not returned to that medical facility.

55. Currently based upon the Covid-19 crisis, there have been approximately 10 formal requests sent to me for medical furlough consideration, and each of these has not met the definition *"The discretionary release of an inmate to obtain medical services not otherwise available"*. Each of these requests are investigated by our Health Services Unit to determine if the DOC cannot currently provide medical services not otherwise available by way of internal treatment and or transfer to an outside hospital.

56. Each of these medical furlough cases have presented proposed sponsor(s), but none have presented any formal treatment plans at outside hospitals or medical facilities, to treat the medical conditions that the offenders are afflicted with for which there are not medical services available within the DOC.

57. Several of the requests for medical furlough were for offenders that had currently no or low medical needs and were deemed low risk if they were to contract Covid-19. In one

example of request for a medical furlough, the offender's only routine need for health services through DOC was administration of eye-drops.

58. One of the requests for medical furlough was for an offender that is serving a sentence for Capital Felony offense and if they had met the definition, there was a question as to the legal authority of granting such a release, given that the sentence of "*Life without possibility of release*" was imposed by the Court.

59. There is also no reasonable belief that any of these offenders would willingly return to Confinement after a period of 15 days in the community, especially for an offender who is facing the rest of their life incarcerated. These cases pose a great flight risk to avoid re-incarceration.

60. It should be noted that there are 69 offenders that are serving life sentences for the offenses of Capital Felony, Murder, Criminal Liability and other offenses out of the 1,883 incarcerated offenders over the age of 50.

61. Under DOC AD 8.16 Nursing Home Release, this release provides the ability to release an offender, who needs nursing home level of care, to a nursing home. General Provision and Eligibility: "*An inmate may be classified for release to an authorized private nursing home at the discretion of the Warden by authority of the Commissioner in consultation with the Medical Director with the exception of the following: a. An inmate convicted of a capital felony under the provisions of section 53a-54b of the general statutes in effect prior to April 25, 2012, or; b. An inmate convicted of murder with special circumstances under the provisions of section 53a-54b of the general statutes in effect on or after April 25, 2012.*". (See **Exhibit E.** Administrative Directive 8.16 Nursing Home Release)

62. Under this AD, the definition of a Nursing Home is defined as: "*A licensed nursing home available for inmates who are suffering from a terminal condition, disease or syndrome, or is so debilitated or incapacitated by a terminal condition, disease or syndrome as to (1) require continuous palliative or end-of-life care, or (2) be physically incapable of presenting a danger to society*". (Exhibit E)

63. To date and to the best of my knowledge, in light of the Covid-19 crisis, there have been no applications for Nursing Home release presented to the Commissioner for review.

64. And, if such application were to be presented, there would be great concern to any release to any offender to a nursing home given the Covid-19 crisis, based upon the great number of cases reported in the news throughout the country, of Covid-19 outbreaks and the resulting high number of deaths at these nursing homes. A release of a Covid-19 negative offender to a nursing home, could potentially put that person at great risk to their health.

65. The discretionary release mechanisms discussed herein incorporate having a solid home plan. Plaintiff's proposal in this action would essentially eliminate the DOC's thoughtful, coordinated, and balanced approach to community releases, and would disregard the lack of a safety net available for most offenders when they are released from incarceration. Under the current release process, a solid home plan is investigated and ensured to give offenders the best chance of success in the community. Without a stable home plan, offenders are more likely to re-offend, pose a higher risk to public safety, and are more likely to return to the DOC. In addition, a home plan is something that is needed in order to self-quarantine. See **Exhibit F**, THE CT REENTRY COLLABORATIVE; COVID-19 & REENTRY IN CONNECTICUT (posted at https://portal.ct.gov/-/media/DOC/Pdf/Coronavirus-3-20/COVID19-Reentry-Factsheet-English-031920.pdf?la=en).

66. Moreover, the social support networks in the communities in the cities and towns in which these offenders would be released has been dramatically impacted by the COVID-19 public health

emergency. At this point in time the DOC is making extreme efforts to avoid shelter placements for inmates discharging end-of-sentence ("EOS"), as well as for inmates considered for discretionary release prior to EOS. This number is typically 40-50 inmates per month claiming homelessness. A copy of the DOC's COVID-19 Response for Individuals Discharging to Homelessness is attached hereto as **Exhibit G.**

67. Keeping this Response, as set forth in Exhibit G in mind, a dramatic increase in releases would make this process not only much more difficult, but also would inevitably increase the risk to the public and to offenders by releasing individuals prematurely, without adequate risk assessments, health reviews, referrals and transition plans developed by DOC discharge planners.

68. There is evidence that offenders that have been released are not following the recommended shelter in place order and or self-quarantine guidelines given to the public.

69. The Department has already witnessed approximately 281 offenders commit violations of release since March 1, 2020. Some of these violations include technical, criminal, escapes and absconding from supervision. Some of these offenders have been returned, while others remain at large.

70. There is no reasonable expectation that offenders requesting to be released to "shelter in place" will do such a thing based upon the violation numbers the Department is already seeing.

71. Additionally, in these present days and times in light of the COVID-19 health emergency and stay-at-home orders, particular concern and attention, as mentioned above, is being paid to victims, and domestic violence cases, as the requirement for many individuals to remain inside under stay-at-home orders may very well increase the risks to victims for domestic violence.

72. Information from the Office of Policy Management (OPM) Criminal Justice Policy & Planning Division presented data on 4/30/2020 at the Connecticut Justice Policy Advisory Commission (CJPAC), does give merit to this concern, as *"Between March and April, domestic related calls for service to the Hartford Police Department increased by 23%, comprising almost one-quarter of all calls."* **Exhibit H** p 4.

73. At this point in time, it would be unreasonably dangerous to the community and the public, the victims of offenses as well as irresponsible to release at one time large numbers of inmate's ineligible for release consideration within the guidelines of State Statute and Commissioners authority, and without the careful, considered review currently provided by the CRU and PCS.

74. There are an estimated 1,883 offenders age 50 and older currently in DOC custody. Of these, 371 are un-sentenced and 1,454 are sentenced.

75. Under the current CRU process, victim impact is considered prior to a release decision. Victims have the ability to write statements for any discretionary release review completed by the DOC.

76. Victims also have the ability to attend parole hearings (now being done via video conference) and/ or provide statements.

77. Out of the 1,883 offenders age 50 and older in DOC custody, the DOC has on file with its victim services unit at least 515 confidential registered victims. In other words, over 27% have one or more than one registered victim. Victim safety is an important factor in any release consideration. Safety plans for victims may be complicated if the victims are on quarantine themselves.

78. These are victims that are family members of murder victims, victims of sexual assaults, victims of violent assaults- some whom are even hospital or medical facility bound and victims that have suffered debilitating injury either physically or mentally and victims of domestic violence.

79. The number of victims contacting our victim services unit has greatly risen during the Covid-19 crisis, relaying a great deal of concern that the DOC was going to release their assailants, without their voice of opposition being heard.

80. As recently as one year ago, on May 15, 2019, there were a total of 13,003 offenders in DOC facilities.

81. As of January 1, 2020, there were 12,284 individuals in DOC custody, a reduction of 719 inmates in DOC facilities in a seven-month time period.

82. On March 1, 2020, there were 12,409 individuals in DOC custody, an increase from January 1, 2020 of 125 and can be described as the "post-holiday" bump, which is often seen after the holiday season.

83. As of May 15, 2020, there are presently 10,563 inmates in DOC facilities, a reduction of 1,846 inmates since March 1, 2020. This is a reduction of the inmate population by 14.8% in under two months, in part, due to the redoubled efforts described below.

84. To put this reduction in population in perspective, a reduction of 1,846 inmates is the equivalent of closing multiple medium sized correctional facilities. This reduction is not solely attributed to offenders who are discharging by way of end of sentence, but rather the larger number of release by way of discretionary release, 1,428. This reduction of population has assisted ongoing efforts to promote social distancing within facilities.

85. The CRU receives regular reports of the numbers on inmates scheduled to be released each month. There are an estimated 189 inmates scheduled to be released within 30 days, and another estimated 137 inmates in the following 30 days for a total of 326 inmates in the next 60 days. Each one of those inmates is reviewed, on an individualized case-by-case basis, to determine if they are eligible to be released prior to their DOS date, if in the discretion of the DOC there is acceptable risk to the community and there is an appropriate release plan.

86. Connecticut Department of Correction continues to review discretionary releases of eligible offenders in its custody and based upon Connecticut General Statute, Department Administrative Directives and Department Policies. These efforts by the Department's

Community Services Unit and Board of Pardons and

releases since March 1, 2020.

period of time is unprecedented and has been

the Department's own initiatives in response to the

opportunities to review cases identified or presented

for release.

requiring DOC to identify a large classification

risk factors," would result in an

risks to public safety, likelihood of

, and risks to the public health, safety

without regard to whether there is statutory

remaining on their sentences would be

would greatly endanger the public.

Pursuant to 28 U.S.C. §1746, I declare under the pains

are true and accurate to the best of my

Director, CRU

Department of Correction

EXHIBIT A

OPM - Criminal Justice Policy & Planning Division

Monthly Indicators Report

Highlights

- On April 1, Connecticut's correction population (jail and prison) was 11,854, a level last seen in 1993.
- Between the beginnings of March and April, the number of people in Connecticut's jails and prisons fell 4.5%, the largest monthly percent drop on record. In absolute terms, the 557-person decrease, from 12,411 to 11,854, was the second-largest monthly decrease on record.
- Statewide arrests in March 2020 were 11 percent lower than March 2019 (chart 5). The drop in March 2020 contrasts with the first two months of the year, when arrests essentially matched the first two months of 2019. The factors causing the drop in arrests, which are the criminal justice system's primary external driver of growth, is an issue warranting further analysis as more data become available.
- March's pretrial admissions to the DOC (741) were the lowest on record. By contrast, the 2019 average monthly pretrial admission (1,200) was 62 percent higher. Pretrial admissions typically comprise approximately three quarters of DOC admissions. Admissions for the other three admission categories also dropped significantly in March (see Table 2a).
- Between February and March, the number of discretionary releases from prison increased 72 percent, from 303 to 522, as human resources were diverted to prepare for the release of approved, suitable, discretionary populations prior to the end of their term of incarceration (see Chart 2a).

Prison Population Forecast

This is the first Monthly Indicators Report to analyze data obtained following Governor Lamont's March 10 emergency declarations regarding the COVID-19 pandemic. The public-health emergency has required the criminal justice system to adapt to ever-changing circumstances, address challenges around the clock, and prepare for countless contingencies. In March, thanks to exhaustive work and collaboration among practitioners and community partners, the criminal justice system maintained essential operations during the disruption caused by the public-health emergency.

With less than a month of data to analyze following the emergency declarations, we are reluctant to note beginnings of trends or offer hypotheses about the impact of societal factors on the criminal justice system. We do observe several phenomena which are noted under Highlights and Chart 2a.

Numerous factors, namely the sharp decrease in admissions and the increased use of discretionary release, drove to the record monthly percent drop in the correction population. After the significant changes in March, it is not surprising that the forecasted correction population published in in January is 483 people above the actual population.

TABLE 1 – **Prison Population Forecast**

	Avg. Daily Count	OPM 2020 Forecast	Forecast difference
JAN 31	12,315	-	
[illegible]	12,411	12,413	-
MAR	12,360	12,279	80
APR	11,754	12,234	-480
MAY		12,194	
JUN		12,153	
JUL		12,127	
AUG		12,094	
SEP		12,044	-
OCT		12,006	
NOV		11,965	
DEC		11,922	-
JAN 21		11,877	
FEB		11,867	

Avg. Daily Count (ADC) for 1st week of month

Chart 1 – Actual prison population against the OPM forecasts
January 1, 2019 through February 1, 2021

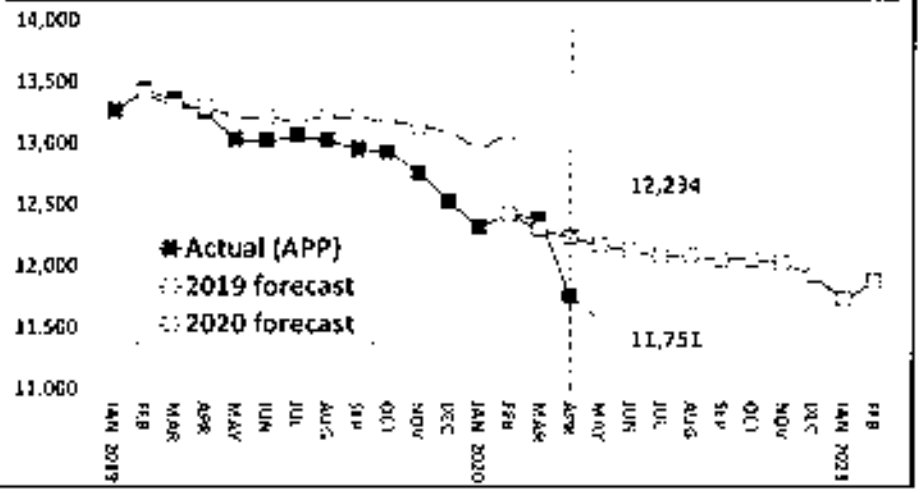


Chart 2 - Criminal justice, monthly counts and flows

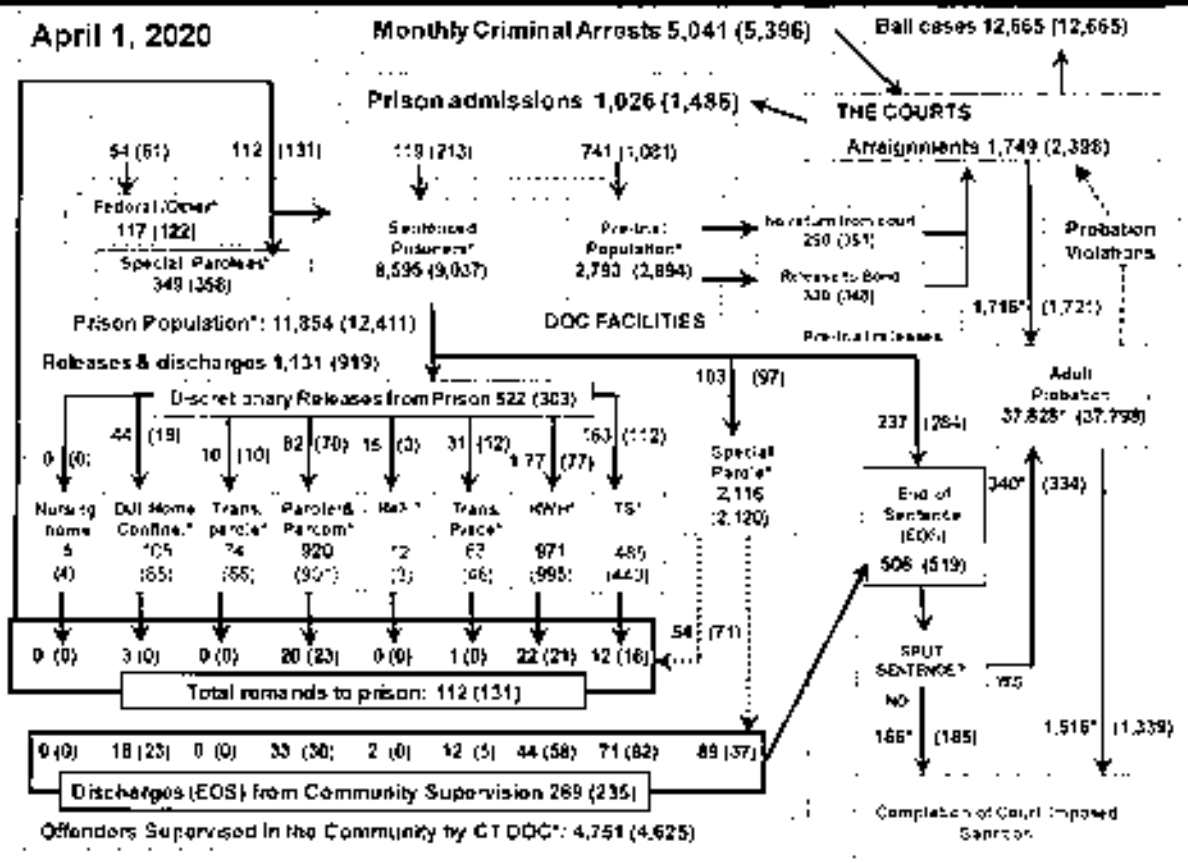
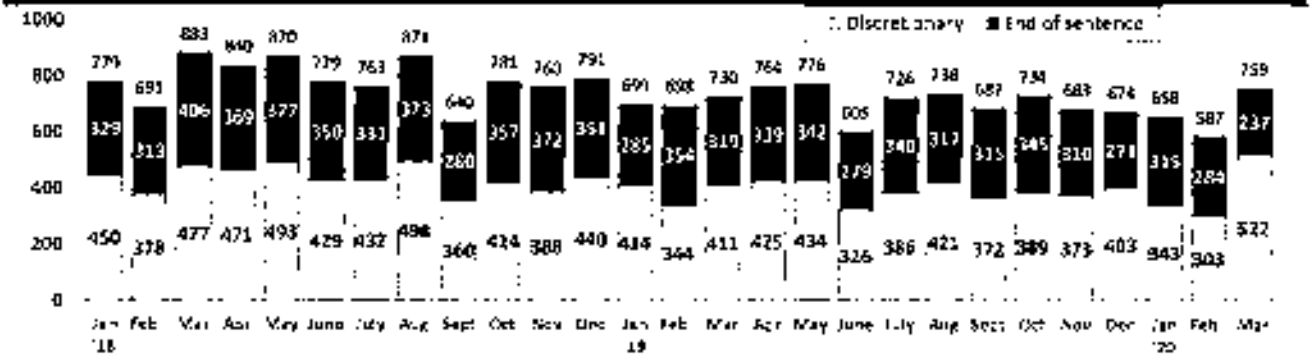


Chart 2 contains monthly operations data for March, 2020 and daily counts reported on April 1, 2020. Asterisks (*) indicate the daily count on April 1st. Figures for last month are enclosed by parentheses. Sources: Arrests – CRMVS, Court and probation data - CSSD, all other data - CT DOC.

Chart 2a – Discretionary vs. End-of-sentence releases



In March, more sentenced inmates (532) were released prior to the end of their sentence through discretionary release than during any month since August 2017, when the sentenced population was 20 percent higher than today.

Every month, between 600 and 900 sentenced inmates (excluding special parolees) leave prison. On average, a little more than half are released using one of the statutory release mechanisms shown on Chart 2, before completing the full term of the sentence. In March, however, this rate rose to nearly seven out of 10.

Transition plans, using approved home plans, halfway houses. These efforts resulted in the most discretionary

people released from correction facilities to the community without supervision. (The DOC is legally required to release inmates from its custody at the conclusion of their court-imposed sentence.)

A tertiary effect of DOC's shifting of human resources, in partnership with its criminal justice and community partners, to focus on transition planning is the bed space created across its system. The additional space is helping the department respond to the impact of the public-health emergency in its facilities.

Table 2 - First-of-month totals

	2020	2020	2020	2019	% Change	
	Feb. 1	Mar. 1	Apr. 1	Apr. 1	Monthly	Annual
DOC Facilities						
Total						
DOC Community						
Total						

Table 2a - Monthly admissions, releases & discharges

	2019	2020	2020	2019	% Change	
	Jan.	Feb.	Mar.	Mar.	Monthly	Annual
Admissions						
Total						
Releases and Discharges						
Total						
Pre-trial Releases						

DOC - Community Release Unit (CRU)

Table 3 - Case reviews and release metrics

	Cases				Approval
	Reviewed	Approved	Denied	Continued	Rate
Jan. '19					
Feb.					
Mar.					
Mar. '19	787	361	183	135	46%

Note: Figures published here are based on the operational data available at the time of publication. Data in subsequent issues may not agree.

Board of Pardons and Paroles

Table 4 - Parole hearings, new cases

Jan. '20					
Feb.					
Mar.					

Table 4a - Other BOPP actions

Jan.					
Feb.					
Mar.					

The pre-trial population

Table 5 - Bond ranges for pre-trial detainees

	Feb. 1	Mar. 1	Apr. 1	Apr. 1, 2019
Less than $250				
$250 to less than $500				
$500 to less than $1,000				
$1,000 or greater				
Persons detained				
Bond $175*				

Table 5a - Pre-trial, weeks since admission

Weeks since admission	Feb. 1	Mar. 1	Apr. 1	Apr. 1, 2019
Total				
Less than 1 week				
1 to less than 2 weeks				
2 to less than 3 weeks				
3 to less than 4 weeks				
4 weeks or more				
Pre-trial population				

Table 5b - Pre-trial admits, new offenders

	Feb. 2020	Mar. 2020	Mar. 2019
Bond granted			
Remand to Admin.			
Non-bondable			
Total			

Court Support Services Division

Table 6 - The Jail Re-interview Program

	Pre-trial admissions	Interviews completed	Interviews waived
Jan. '20			
Feb.			
Mar.			

Table 6a - Pre-trial bail and probation caseloads

Jan.				
Feb.				
Mar.				

Chart 3 – Prison population

Final week of the month, avg. daily count (ADC)

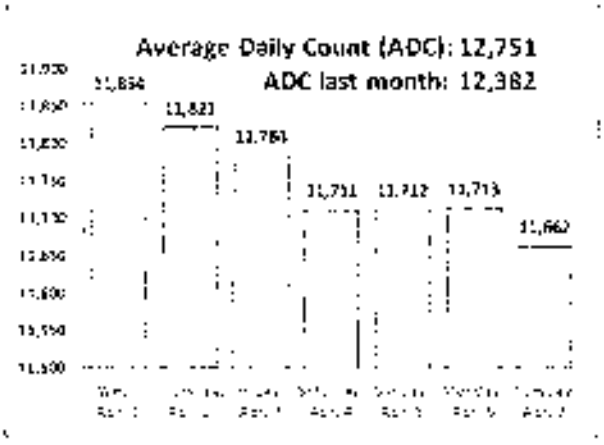


Chart 4 – Prison population, first-of-month

2017, 2018, 2019 and 2020

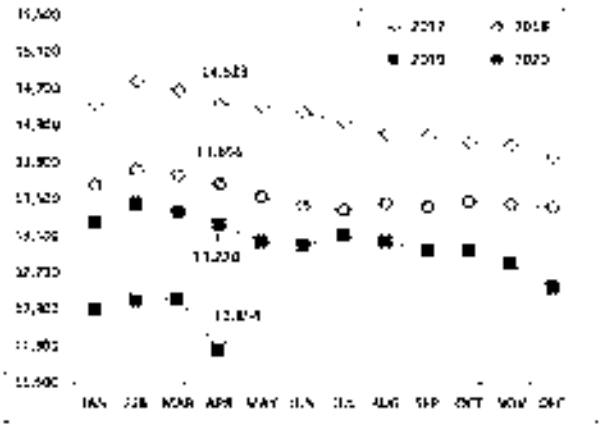


Chart 5 – Statewide criminal arrests

2019 and 2020

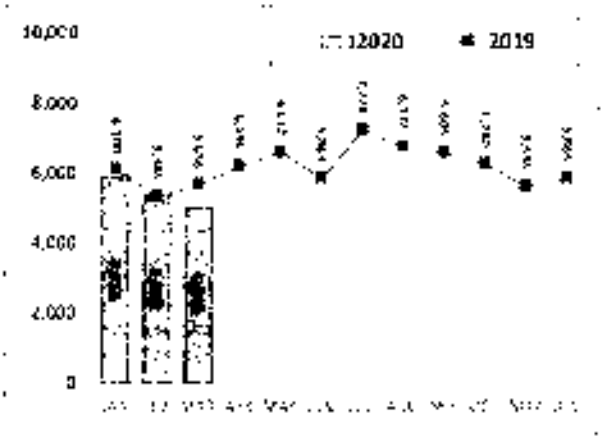


Chart 6 – Monthly DOC Admissions

February 2015 through March 2020

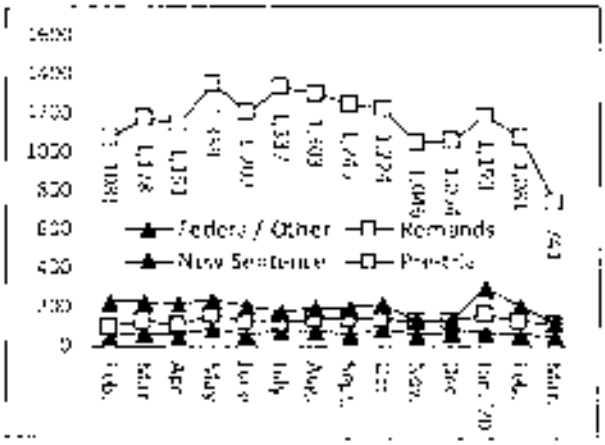


Chart 7– Remands from community release

March 2020

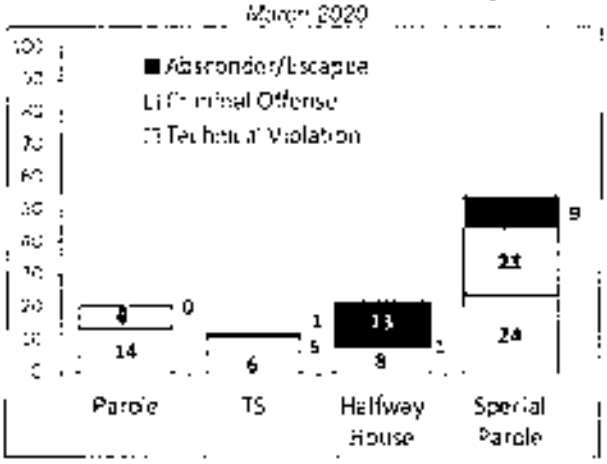
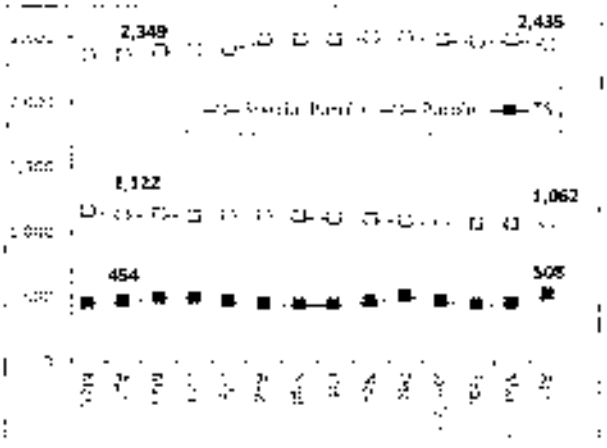


Chart 8 – DOC community supervision

Mar. 1, 2019 through April 1, 2020



Note: Data for all charts, except for Chart 5, was supplied by CT DOC. Data for Chart 5 are for new court starts in the state Criminal Motor Vehicle System (CRMVS). Chart 5 includes offenders in halfway houses.

EXHIBIT B

State of Connecticut
Department of Correction

ADMINISTRATIVE DIRECTIVE

Approved By

Directive Number 9.2 | Effective Date 7/1/2006 | Page 1 of 14

Supersedes
Inmate Classification, dated 3/5/2003

Title

Offender Classification

1. Policy. Each inmate under the custody of the Commissioner of Correction shall be classified to the most appropriate assignment for security and treatment needs to promote effective population management and preparation for release from confinement and supervision. The Department's classification of inmates shall normally utilize a classification instrument based on objective factors. The classification system shall not foster discrimination in status, including housing, programming, job assignment, or on the basis of race, religion, creed, color, or national origin.

2. Authority and Reference.

A. Connecticut General Statutes, Sections 14-227(a), 14-215(c), 18-78,18-81, 18-86, 18-100, 18-100c, 21a-277(d) and 21a-279(a).
B. American Correctional Association, Standards for Administration of Correctional Agencies, Second Edition, April 1993, Standards 2-CO-4B-01, 2-CO-4B-03 and 2-CO-4B-04.
C. American Correctional Association, Standards for Adult Correctional Institutions, Fourth Edition, January 2003; Standards 4-4286, 4-4295 through 4-4298 and 4-4300 through 4-4305.
D. American Correctional Association, Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June 2004, Standards 4-ALDF-2A-30 through 4-ALDF-2A-32.
E. Administrative Directives, 6.4, Transportation and Community Supervision of Inmates; 6.6, Reporting of Incidents; 6.14, Security Risk Groups; 8.5, Mental Health Services, 9.4, Restrictive Status; 9.5, Code of Penal Discipline; and 9.8, Furloughs.

3. Definitions. For the purposes stated herein, the following definitions apply:

A. Classification. The ongoing process of collecting and evaluating information about each inmate to determine the inmate's risk and need level for appropriate confinement location, treatment, programs, and employment assignment whether in a facility or the community.
B. Commitment. The status of an inmate when legal custody is maintained by the Department of Correction. Custody may be in a correctional institution or the community.
C. Community Release Program. A correctional program based in the community for eligible inmates, which includes transitional supervision and residential program placement.
D. Newly Admitted Inmate. An accused, convicted or sentenced inmate who enters the Department of Correction under a new period of commitment. If an inmate has not left the custody of the Department prior to re-admittance, the inmate shall not be treated as newly admitted. For the purposes of this directive, an inmate admitted as a temporary surrender shall not be considered a newly admitted inmate.

E. Override. A documented condition of fact warranting an increase or decrease in the overall risk level of an inmate.

4. Classification Goals. The goals of the Department's classification system are to:

A. ensure the safety and well being of the community, facility, staff and the inmate.
B. apply a consistent and reliable classification and assessment system that assigns inmates a level of confinement consistent with the protection of the community, staff, and inmates.
C. recommend inmate programs and activities according to specific needs.
D. involve the staff and the inmate in developing an incarceration plan and a plan for community release and reintegration, where appropriate.
E. develop, record and analyze data necessary for individual decision making and program and facility planning.
F. ensure that staff and inmates understand the procedures and criteria used in the classification process.

5. Classification Management. The Director of Offender Classification and Population Management shall be responsible for the Department of Correction's classification system. The Director of Offender Classification and Population Management shall develop a classification manual containing detailed information concerning offender classification procedures which shall be reviewed annually and updated as necessary. The Unit Administrator shall be responsible for administering the classification procedures under this Directive. However, nothing in this Directive shall preclude the Director of Offender Classification and Population Management, the Director of the Programs and Treatment Division, a Deputy Commissioner or the Commissioner from intervening in any classification decision at any time. The Director of Offender Classification and Population Management shall be responsible for an annual audit to determine compliance with the Department's classification directives and manual.

6. Classification Levels. Each inmate shall be classified according to risk and needs, and shall be assigned an overall risk score of one (1) to five (5). A risk score level 1 shall represent the lowest security level and 5 the highest. A needs score level 1 shall represent the lowest need level and 5 the highest.

7. Admissions and Assessment.

A. MacDougall-Walker Correctional Institution. Any male inmate 18 years of age or older and sentenced to greater than two (2) years shall normally be admitted to MacDougall-Walker Correctional Institution. Risk and comprehensive needs assessment shall be completed over a period of 10 business days. Upon completion of the classification assessment, the inmate shall be transferred to an appropriate facility.
B. Direct Admission Facilities. Any male inmate in pretrial status or sentenced to two (2) years or less shall be admitted to the direct admission facility serving the court of jurisdiction (i.e., Hartford, Bridgeport, New Haven or Corrigan-Radgowski

Correctional Centers). Risk and needs assessments shall be completed in accordance with Section 8 of this Directive.

C. York Correctional Institution. Any sentenced and/or pretrial female inmate shall be admitted to York Correctional Institution. Risk and needs assessments shall be completed as required in Section 8 of this Directive.

D. Manson Youth Institution. Any sentenced and/or pretrial male inmate age 14-17 shall be directly admitted to Manson Youth Institution. Risk and needs assessments shall be completed as required in Section 8 of this Directive.

E. Juvenile Offenders (ages 14 and 15). Manson Youth Institution shall house all male juvenile offenders and York Correctional Institution shall house all female juvenile offenders. No other facility shall knowingly accept a juvenile offender. Any facility receiving an offender in this category shall immediately report the admission to the Offender Classification and Population Management Unit. The receiving facility shall also make an immediate psychiatric referral to ensure that qualified staff evaluate the offender as soon as possible upon admission in accordance with Administrative Directive 8.5, Mental Health Services. In addition, the receiving facility shall place the juvenile in Administrative Detention and make an immediate request for priority transfer to Manson Youth Institution as appropriate. Whenever possible, prior to transfer, facility classification staff shall complete, at a minimum, an initial risk assessment. Both Manson Youth Institution and York Correctional Institution shall develop Unit Directives that provide for the unique orientation, housing, and program needs of the juvenile offender.

8. Classification Assessment. Offender classification assessments shall be based upon the individual risk and needs of the inmate.

A. Risk Assessment. An inmate's risk assessment shall represent the inmate's potential for violence, escape, or disruption of the orderly functioning of a facility or other place of confinement. The level of risk is determined by rating the following factors:

1. History of escape;
2. Severity/violence of the current offense;
3. History of violence;
4. Length of sentence;
5. Presence of pending charges, bond amount and/or detainers;
6. Discipline history; and,
7. Security Risk Group membership.

B. Inmate Needs Assessment. An inmate's needs shall be assessed in the following areas:

1. Medical and health care;
2. Mental health care;
3. Education;
4. Vocational training and work skills;
5. Substance abuse treatment;
6. Sex offender treatment; and,
7. Community resources.

Assessment of inmate needs shall be accomplished by classification staff in conjunction with staff responsible for the evaluation and provision of services for the need area.

C. Overall Risk Score. An overall classification assessment score shall be determined for each inmate. An overall risk score is determined by the highest rating assigned to any of the seven (7) factors outlined in section 8(A) of this Directive, with the exception of the sex offender treatment need score in Section 8(B) of this Directive. No inmate with a sex offender treatment need score of 2 or greater shall be assigned an overall score below level 3 without authorization from the Commissioner or designee. The overall score shall be assigned taking into account the inmate's risk assessments and behavior during confinement.

D. Overrides. An overall risk score may be increased or decreased through an override. An override of the inmate's overall risk score shall be documented in writing and approved by the Unit Administrator in consultation with the Director of Offender Classification and Population Management or designee. An override shall not be used to decrease an inmate's risk level score more than once during any term of continuous sentenced incarceration. No inmate shall be overridden to level 1.

9. Initial Classification Review. A preliminary classification risk assessment shall begin within the first two (2) business days of commitment. A preliminary risk classification shall be determined prior to transfer to a level 3 or higher risk level confinement. Full initial classification shall be completed prior to any transfer to any level 2 facility. Within 14 days of commitment to the Department, the initial overall risk score shall be assigned. Within 30 days, the needs assessment and full initial classification shall be completed.

10. Reclassification Review. After initial classification, the inmate's risk level and needs shall be regularly reviewed or immediately following any change in an inmate's status that may affect the risk score as follows:

A. Regular Reclassification. An inmate's risk and needs shall be reviewed every six (6) months after the initial classification has been established with the exception of the following:

1. annually for level 3 and 4 general population inmates with greater than five (5) years remaining on their sentence; and,
2. inmates currently in the custody of the Department being held solely for federal authorities, to include inmates held for the United States Department of Homeland Security (Bureau of Immigration and Customs Enforcement), with no pending Connecticut charges, and no Connecticut sentence to serve, need only to have a regular review conducted annually.

B. Risk Level Reductions. A reduction of the inmate's risk level shall be reviewed as follows:

1. Reduction from Overall Risk Level 5. All inmates assigned to overall risk level 5 will be assigned to Administrative Segregation. Inmates approved for removal from

Administrative Segregation as per Administrative Directive 9.4, Restrictive Status, shall be reduced to the appropriate overall risk level 4 status. Any inmate assigned to Administrative Segregation shall not have the risk level reduced without the approval of the Commissioner or designee. Any inmate assigned to risk level 5 shall be reviewed at a minimum, annually for regular review or upon completion of the Administrative Segregation Phase Program.

2. Reductions from Risk Level 4 to 3 and Risk Level 3 to 2. Reductions of risk level shall be considered after a sentenced inmate has completed a prescribed amount of time in confinement as noted below. Any inmate serving a life sentence with no possibility of parole or release is not eligible for a risk level decrease without the review and approval of the Director of Offender Classification and Population Management. The percentage of time served for determinate sentences shall be computed on the estimated release date for offenses committed prior to October 1, 1994, and on the maximum release date for offenses committed on or after October 1, 1994. The percentage of time served for indeterminate sentences shall be computed based on the projected discharge date. Parole status shall only be considered when a firm Voted to Parole (VTP) Date has been granted by the Board of Pardons and Paroles, at which time the VTP Date may be considered the release date for percentage of time calculations. Any inmate serving a sentence for a sex related offense or having a history of sex related offenses shall be approved by the Commissioner or designee prior to being classified below risk level 3. If not approved, the reason for a denial of a routine level reduction shall be documented on the Offender Classification Form (OCF). The schedule for risk level reductions and eligibility criteria for these reductions shall be as follows:

a. Level 4 to 3. Inmates must serve 35% of their time since their last risk score change and must be free from Class A disciplinary action for the preceding 120 days and Class B disciplinary action for the preceding 90 days.

b. Level 3 to 2. Inmates must serve 30% of their time since their last risk score change and must be free from Class A disciplinary action for the preceding 120 days and Class B disciplinary action for the preceding 90 days.

Once an inmate meets the eligibility criteria above, a risk level reduction review shall be completed.

An overall level 4 inmate with more than fifteen (15) years left to serve on a sentence shall not be reduced to an overall level 3 without consulting with the Director of Offender Classification and Population Management or designee. An overall level 3 inmate with more than seven (7) years left to serve on a sentence shall not be reduced to an overall level 2 without consulting with the Director of

Offender Classification and Population Management or designee.

3. Reduction to Risk Level 1. Reduction to risk level 1 shall be in accordance with Section 11 of this Directive.

4. Reduction Based on New Information. Receipt of new information regarding the inmate may also require a classification review and a risk level reduction. A reduction may be prompted for one of the following reasons:

a. A reduction of charges against the inmate;
b. A removal of a detainer;
c. Sentence modification and reduction of sentence;
d. Reduction in bond; and/or
e. Successful Security Risk Group Renunciation.

5. Reduction Exclusion Based on Assignment Refusal. A sentenced inmate who refuses to participate in an available educational or programmatic assignment, consistent with assessed needs in accordance with Section 8(B) of this Directive, may be precluded from a classification reduction until the inmate complies with a mandatory classification program assignment as identified in the Program Index Compendium.

6. Disciplinary History Factor Reduction. During an initial assessment, an inmate's discipline history factor shall be reviewed to determine whether or not any change is warranted. If the inmate has not been found guilty of a class A or B disciplinary violation in accordance with Administrative Directive 9.5, Code of Penal Discipline for one (1) year, (six (6) months for inmates under 16 years of age), a reduction of one (1) level may be made to this factor.

11. Community Release Programs. The community release program shall provide an eligible inmate with the opportunity to reintegrate into the community. Any inmate who refuses to participate in an available educational or program assignment, consistent with the inmate's assessed needs in accordance with Section 8(B) of this Directive, may be excluded from community transfer consideration until the inmate complies with the classification assignment. A member of a Security Risk Group in accordance with Administrative Directive 6.14, Security Risk Groups, shall be excluded from community transfer consideration. Program placement may include Transitional Supervision or Residential Program Placement as follows:

A. Transitional Supervision.

1. Eligibility Criteria. An inmate incarcerated by the Department of Correction for a definite total effective sentence of two (2) years or less shall, subject to the following criteria, be eligible for consideration for Transitional Supervision. The two (2) years maximum sentence shall include any unpaid fine calculated consecutively at the daily cost of incarceration per day. In addition, the following criteria must be met:

a. Be classified below level 5;
b. Served at least 50 percent of the sentence imposed less jail credit on the controlling sentence;
c. Must not be serving the mandatory portion of Driving While Intoxicated, Section 14-227(a) of the Connecticut General Statutes or a Driving under Suspension offense that originally was related to a Driving while Intoxicated, Section 14-215(c) sentence of the Connecticut General Statutes;
d. Favorable recommendations for inmates with a sex offense treatment need score greater than 1 shall be forwarded to the Director of Offender Classification and Population Management for review and approval in consultation with appropriate Mental Health staff;
e. Favorable recommendations for inmates with mental health need scores greater than three (3) shall be forwarded to the Director of Health and Addiction Services for review to further ensure continuity of care;
f. Remain discipline free of a class A offense during the preceding 120 days;
g. Remain discipline free of a class B offense during the preceding 60 days;
h. Remain escape free from any community release program, to include absconding from parole, during the preceding 120 days, may be waived at the discretion of the Unit Administrator;
i. Have no pending charges or detainers unless bond has been posted, except pending out of state charges below risk level 4 with official verification that the state will not extradite;
j. Not designated as a Security Risk Group member; and,
k. Have an approved sponsor and/or have secured housing at an acceptable residence approved by Parole and Community Services.

Class A and B disciplinary reports may be waived at the discretion of the Unit Administrator.

2. Eligibility Date and Notification. Within two (2) weeks of sentencing, unit classification staff shall determine the date that an eligible inmate may be placed on Transitional Supervision. When an inmate is not recommended for placement on Transitional Supervision at the facility level, the Transitional Supervision package shall be forwarded to the appropriate District Administrator for review. The District Administrator, who may consult with the Director of Offender Classification and Population Management regarding the suitability of placement, shall review the package and either uphold or overturn the decision and establish a placement date. If a placement date is established, the District Administrator shall notify the Unit Administrator of the facility housing the inmate and the Parole and Community Services Unit. The Unit Administrator shall then inform the inmate of the placement date.

3. Risk Level. Upon approval for Transitional Supervision an inmate shall be classified to overall risk level 1.

B. Residential Program Placement.

1. Eligibility Criteria. An inmate may be eligible for transfer to a residential work or education program when the following criteria are met:

a. Be classified level 2 or 3;
b. Be within 18 months of estimated discharge date or Voted to Parole date;
c. Must not be serving the mandatory portion of Driving While Intoxicated, Section 14-227(a) of the Connecticut General Statutes or a Driving under Suspension offense that originally was related to a Driving While Intoxicated, Section 14-215(c) sentence of the Connecticut General Statutes;
d. Remain disciplined free of a Class A offense during the preceding 120 days;
e. Remain disciplined free of a Class B offense during the preceding 60 days;
f. Have no return from escape, to include absconding from parole, within the past six (6) months (may be waived at the discretion of the Unit Administrator);
g. Remain free of community release program failure during the preceding 120 days;
h. Have no pending charges or detainers unless bond has been posted except pending out of state charges below risk level 4 with official verification that the state will not extradite;
i. Met the requirements for participation in job opportunities, employment preparation, educational placement or substance abuse training and education;
j. Must not be a designated Security Risk Group member;
k. Favorable recommendations for inmates with a sex offense treatment need score greater than 1 shall be forwarded to the Director of Offender Classification and Population Management for review and approval in consultation with appropriate Mental Health staff; and,
l. Must submit to felony DNA requirements, if applicable.

Class A and B disciplinary reports may be waived at the discretion of the Unit Administrator.

2. Risk Level. Upon approval for residential program placement an inmate shall be classified to overall risk level 1.

C. Pretrial Supervision.

1. Eligibility Criteria. A pretrial offender shall be eligible for pretrial supervision when the following criteria are met:

a. Pretrial confinement for no offense other than class D felony or misdemeanor. The following class D felonies are excluded from consideration:

1. 53a-60a, Assault in the second degree with a firearm;
2. 53a-60b, Assault on a victim 60 or older, second degree;
3. 53a-60c, Assault on a victim 60 or older, with a firearm;
4. 53a-60d, Assault in the second degree, with a motor vehicle;
5. 53a-72a, Sexual Assault in the third degree;
6. 53a-73a, Sexual Assault in the fourth degree; and,
7. 53-18ic, Stalking in the first degree;

b. No community release violation during the preceding 120 days, may be waived at the Unit Administrator's discretion;
c. Must not have been found guilty of a Class A disciplinary report within 120 days, may be waived at the Unit Administrator's discretion;
d. Must not have been found guilty of a Class B disciplinary report within 60 days, may be waived at the Unit Administrator's discretion;
e. No escape or absconder status within the past 6 months; and,
f. Favorable recommendations for inmates with mental health need scores greater than 3 shall be forwarded to the Director of Health and Addiction Services for approval and to further ensure continuity of care.

Upon approval, an offender shall be classified to overall risk level one (1).

2. Supervision Level for Pretrial Offenders. Any pretrial offender assigned to overall risk level one (1) shall be supervised by electronic monitoring or any other monitoring technology or services while on pretrial supervision. A pretrial release agreement shall specify that the inmate must:

a. not change residence without prior approval of the supervising officer;
b. appear for all court appearances as required;
c. participate in substance abuse programming if required by the Department; and,
d. participate in any other conditions imposed by the Department.

12. Risk Level Increases. Risk level increases shall occur as required upon receipt of new information pertinent to the inmate's risk classification or inmate's disciplinary adjustment.

A. Disciplinary Increases. Poor disciplinary adjustment may result in an inmate's Overall Risk Factor being increased and a corresponding increase of the Discipline History Factor to the level of the Overall according to the schedule detailed in the Classification Manual.

An inmate who is found guilty of a level 2 assault on a Department of Correction employee as defined in Administrative Directive 6.6, Reporting of Incidents, shall be classified to overall risk level 4 with a corresponding increase in the Discipline Risk Factor.

In the event of multiple disciplinary charges arising from a single disciplinary incident, only the highest chargeable class of offense shall be used.

An inmate assigned to Close Custody for Chronic Discipline shall automatically be classified to Overall and Discipline Risk Factor 4.

Reviews resulting in an overall risk level increase which will require a transfer to another facility shall require the approval of the Director of Offender Classification and Population Management.

B. Conviction of a Felony. Conviction of a felony committed while incarcerated shall result in a level increase review.

C. Assignment to Overall Risk Level 5/Administrative Segregation. Assignment to Overall Risk Level 5/Administrative Segregation shall be considered when any totality of facts, information or circumstances which indicates an immediate threat to safety and/or security of the public, staff or other inmates. An inmate shall be automatically placed in Administrative Detention and be reviewed for placement on Overall Risk Level 5/Administrative Segregation, under any of the following conditions:

1. Level 1 assault on a Department of Correction employee as defined in Administrative Directive 6.6, Reporting of Incidents;
2. Hostage holding of a Department of Correction Employee;
3. Riot;
4. Homicide while confined;
5. An inmate is sentenced to death;
6. Escape from the security perimeter of a facility;
7. Continues to present a threat to safety, security and/or orderly operation after one (1) year in Close Custody for Security Risk Groups;
8. Continues to present a threat to safety security and/or orderly operation after six (6) months in Close Custody for Chronic Discipline; and.
9. An inmate is in pretrial or pre-sentence status for a Capital Felony Murder charge.

All increases to Overall Risk Level 5/Administrative Segregation shall be made by the Director of Offender Classification and Population Management.

D. Security Risk Group Members. Any inmate designated as a Security Risk Group Member shall not be classified lower than overall risk level 3 and placed in a Close Monitoring unit in accordance with Administrative Directive 6.14, Security Risk Groups. An inmate released from the Department while designated as a Security Risk Group Member shall be readmitted on the same status. The Director of Security shall review the designation in accordance with Administrative Directive 6.14, Security Risk Groups.

E. Security Risk Group Safety Threat Members. Any inmate designated as a Security Risk Group Safety Threat Member shall be classified to overall risk level 4 and placed in a Close Custody unit in accordance with Administrative Directive 6.14, Security Risk Groups. An inmate released from the Department while designated as a Security Risk Group Safety Threat Member shall be readmitted on the same status. The Director of Security shall review the designation in accordance with Administrative Directive 6.14, Security Risk Groups.

13. Risk Level Reclassification from Community Placement. Risk level increases from overall risk level 1 for inmates remanded to custody and whose community transfer has been revoked, requires a risk reclassification hearing. Also, the parole supervisor shall provide the inmate with the following:

A. Within 72 hours of the re-incarceration, a statement of reasons for the proposed increase from risk level 1 status except those that may cause a security problem or undue harm to the public;

B. A copy of any documents pertaining to such statement of reasons unless the security of the facility and public warrants otherwise.

C. A notification of the date, time, and location of a hearing on such proposed revocation. This notice shall state that the inmate may appear at such hearing with a correctional advocate as a representative and present documents at such hearing on the inmate's behalf.

Any inmate in community placement status and returned to a level 2 or higher security facility shall have a classification hearing within 14 days of return to the facility. This time limit may be extended for cause. A disciplinary hearing shall not substitute for a classification hearing. A classification hearing shall not consider disciplinary matters unless the inmate has been found guilty of an offense under Administrative Directive 9.5, Code of Penal Discipline. A classification hearing may consider reclassification for a non-chargeable matter and return the inmate to a higher security facility prior to a disciplinary hearing on a chargeable offense. Classification shall not be used to avoid a disciplinary hearing for an inmate. Records of the disciplinary hearing, including information provided by the inmate, shall be forwarded to the counselor supervisor or higher authority as appropriate. If the inmate's assignment to risk level 1 is revoked, the counselor supervisor or higher authority shall state the reasons in writing and change the risk level. The risk score will be increased to overall risk level 2, except in the case where new information would result in a level increase due to a change in one of the risk factors.

D. Not withstanding the above provisions, this criterion shall not interfere with the use of discretion invoking incremental sanctions by a parole officer or higher authority for technical, non-criminal violations to include, but not be limited to intervention, increased programming, detoxification and electronic monitoring through the Community Release Intervention Program as enumerated below:

1. When necessary, inmates shall be temporarily remanded to custody by the Parole and Community Services Unit. All remands to custody shall be documented on CN 9202, Offender Classification History Form and placed in the inmate's master file;
2. No classification transaction shall be required, unless it has been determined that the inmate will not be placed back into the community;
3. Classification staff shall notify Addiction Services when an inmate is returned for a positive urinalysis so as to provide necessary intervention;
4. The Parole and Community Services Unit shall review and track each case and make necessary modifications to the inmate's conditions of release for reinstatement into the community; and,
5. If it is determined by the Unit Administrator, in consultation with the Director of Parole and Community Services, that the inmate is not appropriate for re-release, the inmate shall then be scheduled for a reclassification hearing and reviewed for an overall level increase as appropriate and considered for a transfer to a sentenced facility if the inmate has greater than 15 days to discharge.

14. Risk Level Reclassification Resulting from New Information. Whenever new information is received that is relevant to an inmate's risk or needs classification, a reclassification review shall occur.

15. Inmate Involvement. An inmate should be involved in program decisions to the extent feasible. The inmate shall be seen by classification staff for every objective classification action except Percentage-of-Time Reviews unless the inmate is denied. The inmate may appear before the classification staff as required by this Directive, as long as the appearance does not jeopardize the safety and security of the facility, staff, or other inmates. If an appearance of the inmate is required, the inmate shall receive notice 48 hours prior to classification review. An inmate may waive, in writing, the notice requirement or any appearance. Within five (5) days of a classification decision, the decision, including the overall risk score and need ratings assigned the inmate as well as any changes of these ratings shall be shared with the inmate in writing. A classification decision may be appealed to the Unit Administrator or designee within 15 days of the decision.

16. Level of Review Required for Classification Reviews. The Unit Administrator shall designate staff within the unit responsible for classification reviews and assignments. With the exception of classification assignments made by the Director of Offender Classification and Population Management, classification decisions may

be appealed to the Unit Administrator. The Unit Administrator shall respond in writing within 15 business days of receipt of the appeal.

17. Inmate Supervision Requirements. Supervision requirements during transport shall be in accordance with Administrative Directive 6.4, Transportation and Community Supervision of Inmates. All other inmate supervision outside the facility's perimeter with the exception of Administrative Directive 9.8, Furloughs, shall be governed by an inmate's risk level in accordance with the following:

A. An inmate classified as level 3, 4 or 5 shall be excluded from a job or program assignment that is outside the facility's security perimeter. Any security classification level 3, 4 or 5 inmate, who is to be moved beyond the facility's security perimeter, shall be managed in accordance with Administrative Directive 6.4, Transportation and Community Supervision of Inmates.

B. Any inmate who is placed on facility-based outside clearance, shall be intermittently observed by a Department of Correction employee at a minimum of once every hour or continuous if deemed appropriate by the Unit Administrator or designee.

C. An inmate placed on a community service work detail shall be intermittently observed by an approved trained agent of the municipality or other state agency at a minimum of every 15 minutes, or continuously if deemed appropriate by the Unit Administrator or designee. Additional stipulations and supervision requirements shall be pursuant to the provisions of Administrative Directive 10.5, Public Service Work, and enumerated in a Memorandum of Understanding between the Department of Correction and the requesting town, municipality or state agency.

18. Other Classification Actions.

A. Outside Work Assignments. The Unit Administrator shall be the approving authority for any inmate placed on facility-based outside clearance, community service work detail, or work or education release. Prior to authorization to participate in the above listed programs, a review of the inmate's special management information and any discretionary release denial or return within the past 30 days (if any), shall be conducted to determine the inmate's suitability for such programming. Authorization to participate shall be based on the following minimum eligibility criteria utilizing CN 9201, Outside Work Assignment Application:

1. Risk level 1 or 2;
2. No sex offender treatment score greater than a 1;
3. No level 4 convictions, past or current offense;
4. Mental Health and Medical need scores less than 3 unless cleared by Health Services;
5. Within 36 months of end of sentence or voted to parole date;
6. No return from escape within 1 year;
7. No Class A disciplinary reports within 120 days and no Class B disciplinary reports within 60 days;
8. No detainer score greater than a 1; and,
9. No history of classification as an overall risk level 5.

Any inmate already approved or being considered for outside clearance who has been denied or has returned from any discretionary release program such as community release or parole within the last 30 days, shall be evaluated by the Unit Administrator to assess the appropriateness of an outside work assignment.

Any inmate already approved for outside clearance that has received a disciplinary report or has been involved in any incident shall also be evaluated by the Unit Administrator for continued placement on outside clearance.

B. Indeterminate Sentences. The Commissioner may release any inmate sentenced to an indeterminate sentence pursuant to Sections 21a-277(d) or 21a-279(e) of the Connecticut General Statutes, at any point during that sentence. The Unit Administrator may recommend release at any time during the sentence. Only favorable recommendations shall be forwarded to the Commissioner's Office via the Director of Offender Classification and Population Management. The initial review shall be made after the completion of initial classification and a 30-day period of confinement. If denied, the Unit Administrator shall set another review date not more than six (6) months from the decision date. Each review and disposition shall be documented on CN 9202, Offender Classification History Form in Section 5 of the inmate's master file.

19. Forms and Attachments. The following forms are applicable to this Administrative Directive and shall be utilized for the intended function.

A. CN 9201, Outside Work Assignment Application; and,
B. CN 9202, Offender Classification History Form.

20. Exceptions. Any exceptions to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.

EXHIBIT C

Request for Inclusion or Revision to an Administrative Directive

Connecticut Department of Correction

CN 1301
REV 05/29/18

Administrative Directive Number: 9.8 | Title: Furloughs

☒ I recommend the following inclusion or revision to the above referenced Administrative Directive ***(provide detailed explanation regarding reason for change):***

As a response to COVID 19 the following language is recommended to be added to Administrative Directive 9.8 Furloughs. Specifically, the language shall be added under section 9 Reentry Furloughs to Voted-to-Parole Date.

Reentry Furloughs to Transitional Supervision. Inmates approved for Transitional Supervision may be granted furloughs for up to 45 days in advance of the inmates Transitional Supervision hold date and at the discretion of the Commissioner or designee. Furloughs may be granted in order to limit an inmate's exposure to COVID-19 and may be renewed at the discretion of the Commissioner or designee. This practice shall only be effective during the period of public health and civil preparedness emergency as declared by Governor Lamont on March 10, 2020.

☐ See attached documents

[redacted]

Name: Gavin Galligan | Title: Director | Date: 4/1/20

Signature: | Facility/Unit: CRU

[redacted]

☒ Office of Standards and Policy Staff signature: | Date 4/1/20

[redacted]

☐ ☐ Unit Administrator's signature: | Date: 4/1/20

☐ ☐ District Administrator's signature (only needed if orig rating from facility) | Date:

☐ ☐ Division Administrator's signature: | Date:

[redacted]

This request is: ☒ APPROVED ☐ DENIED | Effective date of request:

☒ The language/provisions of this inclusion/revision shall be effective as of and subsequently added to the Administrative Directive at the next update. | Date 4/2/2020

☐ This inclusion/revision shall be added to the Administrative Directive prior to: | Date

☐ This inclusion/revision shall be added immediately to the Administrative Directive

Commissioner's signature: | Date: 4/2/2020

EXHIBIT D

State of Connecticut
Department of Correction

ADMINISTRATIVE DIRECTIVE

Approved By

Commissioner Scott Semple

Directive Number	Effective Date	Page 1 of 8
9.8	7/20/15	

Supersedes
Furloughs, dated 11/13/2012

Title
Furloughs

1. Policy. The Department of Correction may provide furlough opportunities to eligible inmates consistent with public safety, rehabilitation and sound correctional practices.

2. Authority and Reference.

   A. Connecticut General Statutes, Sections 14-215(c), 14-227(a), 18-81, 18-101a (as amended by Public Act 09-7, Section 35, September Special Session), 53a-169, 54-127 and 54-231.
   B. Administrative Directives 4.5, Victim Services; 6.6, Reporting of Incidents; 7.5, Escapes; 9.5, Code of Penal Discipline; 9.6, Inmate Administrative Remedies; 10.5, Public Service Work; and 11.3, Remand of Offenders to Actual Custody.
   C. American Correctional Association, Standards for the Administration of Correctional Agencies, Second Edition, April 1993, Standard 2-CO-4C-01.
   D. American Correctional Association, Standards for Adult Correctional Institutions, Fourth Edition, January 2003, Standard 4-4443.
   E. American Correctional Association, Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June 2004, Standard 4-ALDF-5B-16.

3. Definitions and Acronyms. For the purposes stated herein, the following definitions and acronyms apply:

   A. COLLECT. Connecticut Online Law Enforcement Communications Teleprocessing.
   B. Deathbed/Funeral Furlough. The discretionary release of an inmate to visit a dying relative or to attend the funeral of a relative.
   C. Furlough. The discretionary release of an inmate to community supervision for an authorized purpose as outlined in Section 4 of this Directive and permitted by Section 18-101a of the Connecticut General Statutes (as amended by Public Act 09-7, Section 35, September Special Session).
   D. Medical Furlough. The discretionary release of an inmate to obtain medical services not otherwise available.
   E. Reentry Furlough. The discretionary release of an inmate to an approved residence in the community for any compelling reason consistent with rehabilitation, prior to a planned discharge or release to discretionary parole supervision during which the inmate must report to a parole officer in lieu of returning to a correctional facility.
   F. Relative. A member of the inmate's immediate family (i.e., legal spouse, parent, grandparent, child, grandchild, or sibling; to include a step/foster relationship).
   G. Reintegration Furlough. The discretionary furlough of an inmate participating in a community reintegration program for any authorized purpose consistent with rehabilitation that supports the inmate's preparation for successful community reintegration upon discharge from the Department of Correction.

4. Authorized Purposes for Furlough. The Commissioner of Correction or designee, may extend the limits of the place of confinement of an inmate as to whom there is reasonable belief he or she will honor his or her trust, by authorizing the inmate under prescribed conditions to visit a specifically designated place or places, within or without the state, for periods not exceeding 45 days and return to the same or another institution or facility. Such periods may be renewed at the discretion of the Commissioner or designee. Such furlough may be granted only to permit:

A. a visit to a dying relative;
B. the attendance at a funeral of a relative;
C. the obtaining of medical services not otherwise available;
D. the contacting of prospective employers; or,
E. any compelling reason consistent with rehabilitation.

Any inmate who fails to return from furlough as provided in the furlough agreement shall be guilty of the crime of escape in the first degree in accordance with Section 13 of this Directive.

5. Duration and Frequency of Furlough.

A. Deathbed/funeral furloughs may be authorized for up to 72 hours. Such furloughs may be extended by the Unit Administrator for up to an additional 72 hours for an unforeseen legitimate extraordinary reason not anticipated at the beginning of the furlough. Such extensions shall be reported in writing with justification to the appropriate District Administrator by the next business day. Furloughs for such inmates shall not be restricted by frequency but shall be limited to the time required for such programs. Furloughs shall not be required for inmates in community release (level 1).
B. Medical furloughs may be authorized for up to 15 days and renewed as required.
C. The frequency of furloughs for community release (level 1) inmates shall be at the discretion of the director of the community program. Duration shall be in accordance with Section 5(A) of this Directive.
D. A reentry furlough may be authorized for up to 45 days prior to a scheduled discharge from incarceration or a parole date established by the Board of Pardons and Paroles. Upon approval of the furlough by the Unit Administrator, the Victim Services Unit shall be notified of the impending reentry furlough in accordance with Administrative Directive 4.5, Victim Services. Reentry furloughs shall be in compliance with Section 6 of this Directive.
E. An inmate in a halfway house, inpatient program, or on work or educational release may be allowed to participate in community release programming and a furlough shall not be required for such participation.

6. Eligibility. The following criteria shall be used to determine furlough eligibility:

A. The inmate shall be classified as an overall level 1, 2 or 3.
B. Class A, B and C disciplinary reports, which are not deemed to impact staff or public safety, may be waived at the discretion of the Unit Administrator. An inmate found guilty of an intentional/direct assault on a Department of Correction employee, shall be ineligible for furlough consideration during the current incarceration unless waived by the appropriate District

Administrator. Deathbed/funeral and medical furloughs shall not be restricted by this criterion.

C. The inmate shall have a verified reason for the furlough and an approved residence/destination, transportation and sponsor.
   1. Approved destinations for inmates participating in community reintegration programs may include but are not limited to; job interviews, employment, pre-employment or vocational training, schools and academic institutions, treatment programs, community service programs and religious services.
   2. Transportation to and from approved community reintegration destinations may be provided by the business, organization or community program that is sponsoring the inmate, but is subject to verification and approval.

D. The inmate shall have served a minimum of 30 days or forty percent (40%) of the estimated length of confinement, whichever is greater. Deathbed/funeral and medical furloughs shall not be restricted by this criterion. An inmate serving a sentence of 45 days or less must serve a minimum of 50% before participating in a reentry furlough. Inmates shall serve a minimum of 30 days in order to be eligible for a Reintegration Furlough.

E. An inmate's eligibility for furlough shall be based on the maximum release date or voted to parole date and shall not be based on parole eligibility.

F. With the exception of a medical furlough, an inmate shall not be eligible for a furlough during the mandatory portion of a sentence for Driving While Intoxicated (Section 14-227(a) of the Connecticut General Statutes) or driving under suspension offense that originally was related to Driving While Intoxicated (Section 14-215(c) of the Connecticut General Statutes). An inmate may be considered for a medical furlough under this subsection if authorized by the Commissioner.

G. With the exception of a medical furlough, a Level 5 inmate shall not be eligible for a furlough.

H. Inmates who are an overall Level 1, 2 or 3 and have been incarcerated for conviction of a level 4 offense shall not be eligible for a furlough until within 12 months of discharge or voted to parole date. Medical furloughs or Reintegration Furloughs shall not be restricted by this criterion.

I. Pretrial and sentenced inmates with cases pending for which bond has not been posted shall be ineligible for all furloughs except deathbed/funeral and medical furloughs. This includes all charges pending even if the other jurisdiction has indicated that they will not extradite the inmate, except that if official documentation from another state exists which informs the Department that the other jurisdiction will not extradite and the charge equates to a risk level 3 or lower offense; then the detainer score for this (these) charge(s) shall be removed.

J. There shall be no current parole violations for which a revocation hearing has not been held.

K. No inmate shall be entitled to participation in the furlough program. Discretion concerning the frequency, length of furlough and the conditions imposed on each furlough shall be consistent with this Directive and otherwise within the authority of the Unit Administrator. Approval for a furlough carries no implied consent for subsequent furloughs.

7. Community-Based Eligibility. A level 1 inmate in a halfway house shall be eligible for consideration for furlough at the discretion of the Director of Parole and Community Services or designee, and shall not be subject to Section 6 of this Directive with the exception of Section 6(F), which shall apply.

8. Suitability Factors. The Unit Administrator or the Director of Parole and Community Services shall consider the following factors when reviewing an inmate for furlough participation.

   A. Public safety.
   B. Criminal history, to include: severity and patterns of violence; sexual offenses; escape; institutional behavior; significant history of domestic violence; and Security Risk Group affiliation.
   C. Program need or benefit to include: substance abuse; mental health status; and prior program participation/failure.
   D. Any record of victim concerns to include any active restraining orders or victim notifications.
   E. Any prior performance on community supervision.

9. Reentry Furloughs to Voted-to-Parole Date. Reentry furloughs up to 45 days in advance of an inmate's voted-to-parole date may be authorized at the discretion of the Director of Parole and Community Services or designee(s) in order to provide inmates with an extended opportunity to participate in assessments and/or programs, for employment and educational opportunities, to secure a stable residence, and/or to make recommendations to the Board of Pardons and Paroles regarding parole conditions.

   The procedures detailed in Section 6(A through C) of this Directive shall be waived for this purpose only. The remaining eligibility criteria, Section 6(D through K) shall apply. The procedures detailed in Section 10(A through C) of this Directive shall not apply and Parole and Community Services form PCS 4102, Sponsor Questionnaire and Verification shall replace form CN 9802, Furlough Sponsor Questionnaire/Agreement in this case (reentry furloughs to voted-to-parole date) and shall be completed by designated parole staff. All other sections including Section 10(D) of this Directive shall still apply.

   The electronic release authorization sent by the Parole and Community Services Division to the facility housing the inmate with the language "approved for REF effective" with a specific date shall serve as notice to the facility of the approval of the reentry furlough. Upon receipt of the release authorization, the designated facility staff shall transcribe the additional conditions on the inmate's parole agreement onto form CN 9804, Reentry Furlough Agreement, and shall have the inmate sign the Reentry Furlough Agreement in accordance with Section 12(A) of this Directive and shall forward a copy to the supervising parole officer via facsimile machine or scanned as an e-mail attachment. The original CN 9804 shall be placed in the inmate's master file.

   The following situations shall make an inmate ineligible for release to reentry furlough to parole supervision:

   A. Inmates being released directly to transfer parole;
   B. Inmates being released directly to special parole unless extenuating circumstances exist (e.g., the availability of residential placement);

C. Inmates whose parole has been rescinded and who have been re-paroled;
D. Inmates whose parole has been revoked and who have been re-paroled;
E. Inmates whose parole has been revoked and reinstated or rescinded and reinstated;
F. Inmates for whom the voted-to-parole date has been off-set by the Board of Pardons and Paroles; and,
G. Inmates whose parole conditions include the completion of a mandatory residential treatment program or inpatient program unless the inmate has satisfactorily satisfied this stipulation.

If, based on the factors detailed in Section 8 of this Directive, a parole manager has reason to believe that an inmate is NOT suitable for a reentry furlough to voted-to-parole date; the parole manager may conduct a case conference with the Deputy Director of Parole and Community Services or higher authority. Any denial of an inmate's release to a reentry furlough to voted-to-parole date must be authorized by the Deputy Director of Parole and Community Services or higher authority.

Inmates assigned to either the Special Management Unit or the Mental Health Unit may be released to reentry furlough at the discretion of the parole managers assigned to either of those units or higher authority.

10. Application and Decision.

A. When considering an inmate for a furlough, the Unit Administrator or designee shall initiate form CN 9801, Furlough Application/Decision. The Unit Administrator or designee shall forward a copy of CN 9802, Furlough Sponsor Questionnaire/Agreement to the inmate's proposed sponsor which the sponsor shall complete and return. In the case of a reentry furlough, this process may be conducted telephonically using form CN 9802, Furlough Sponsor Questionnaire/Agreement. The Unit Administrator or designee shall verify that CN 9802, Furlough Sponsor Questionnaire/Agreement has been completed to include the:

1. reason for the furlough;
2. reliability of the transportation;
3. identity and residence of sponsor;
4. proposed furlough residence (which shall be with the sponsor); and,
5. suitability of the sponsor. The sponsor shall:

a. not be a Department employee except an immediate family member as defined in Section 3(E) of this Directive;
b. not be a co-defendant;
c. not have an outstanding criminal sanction or criminal justice supervision except immediate family as defined in Section 3(E) of this Directive (in order to determine this, facility staff shall run COLLECT checks on sponsors for reentry, medial and regular furloughs);
d. be responsible and a positive influence;
e. sign CN 9802, Furlough Sponsor Questionnaire/Agreement and agree to notify facility of any violations; and,
f. not be the inmate's victim, unless approved by the appropriate District Administrator.

B. Upon authorization from the Commissioner, the Unit Administrator may approve all initial furloughs through the use of CN 9803, Furlough Agreement and CN 9804, Reentry Furlough Agreement or CN 9805 Reintegration Furlough Passbook, as appropriate.

C. The Unit Administrator or designee may deny a furlough request. The reason for denial shall be stated in writing and delivered to the inmate via page 2 of form CN 9801, Furlough Application/Decision. The denial shall be documented on form CN 9202, Inmate Classification History Log in Section 5 of the inmate's master file. An inmate may appeal the decision to deny a furlough in accordance with Administrative Directive 9.6, Inmate Administrative Remedies.

D. An inmate serving a sentence for a sex-related offense or having a history of sex-related offenses other than prostitution may be approved by the Commissioner or designee for furlough participation or by the Director of Parole and Community Services for reentry furloughs to voted-to-parole or special parole dates.

11. Community Notification.

A. Law Enforcement Agency Notification. Local and state law enforcement authorities shall be notified of any inmate approved for a reentry furlough placement. Such notification shall be made by parole staff by completing a release authorization and a file 17 (FL-17).

B. Judicial Office of Victim Services. In accordance with Section 54-231 of the Connecticut General Statutes and Administrative Directive 4.5, Victim Services, the Department shall notify the Judicial Office of Victim Services when an inmate is granted a furlough that allows the inmate to reintegrate into the community immediately preceding discharge or release to parole. Notification and documentation shall be through an automated process in accordance with Administrative Directive 4.5, Victim Services.

C. Victim Notification. Victim notification shall be made in accordance with Administrative Directive 4.5, Victim Services.

12. Program Requirements.

A. Furlough Agreement. An inmate approved for a furlough, other than a reentry furlough, shall agree by signature to the furlough conditions as enumerated on form CN 9803, Furlough Agreement. CN 9803, Furlough Agreement shall be issued to the inmate prior to leaving the facility.
1. An inmate approved for a furlough other than a Reintegration Furlough shall carry CN 9803, Furlough Agreement at all times while on furlough status.
2. An inmate approved for a Reintegration Furlough shall carry CN 9805, Reintegration Furlough Passbook at all times while on furlough status.

B. Reentry Furlough Agreement. An inmate approved for a reentry furlough shall agree by signature to the furlough conditions as enumerated on form CN 9804, Reentry Furlough Agreement. CN 9804, Reentry Furlough Agreement shall be issued to the inmate prior to leaving the facility. An inmate approved for a reentry or reintegration furlough shall carry CN 9804, Reentry Furlough Agreement at all times while on furlough status.

C. Out-of-State Furlough. An inmate approved for an out-of-state furlough shall waive extradition prior to each release on furlough.

Notification shall be in accordance with Section 11(A) of this Directive.

D. Compliance. An inmate approved for furlough shall comply with the conditions outlined on form CN 9803, Furlough Agreement or CN 9804, Reentry Furlough Agreement, as applicable. Failure to comply may result in disciplinary action, criminal prosecution, loss of furlough privilege and/or any other appropriate action.

13. Escape/Late Return from Furlough.

A. Furlough (Other Than a Reentry Furlough). Any furloughed inmate who fails to return from a furlough (other than a reentry furlough) pursuant to Section 53a-169 of the Connecticut General Statutes shall be declared an escapee and referred for criminal prosecution in accordance with Administrative Directive 7.5, Escapes. Any failure to return on time shall result in disciplinary action in accordance with Administrative Directive 9.5, Code of Penal Discipline.

B. Reentry Furlough. Any inmate on a reentry furlough who fails to report or notify his/her parole officer of a change of residence may be referred for criminal prosecution in accordance with Administrative Directive 7.5, Escapes.

C. Reintegration Furlough. Any inmate on a reintegration furlough who fails to return from a reintegration furlough pursuant to Section 53a-169 of the Connecticut General Statutes shall be declared an escapee and referred for criminal prosecution in accordance with Administrative Directive 7.5, Escapes. Any failure to return on time shall result in disciplinary action in accordance with Administrative Directive 9.5, Code of Penal Discipline.

14. Remands from Furlough. The decision to remand an inmate from furlough shall be at the discretion of the Director of Parole and Community Services or designee in consultation with the Unit Administrator or the facility duty officer. The remand of inmates to custody shall be governed by Administrative Directive 11.3, Remand of Inmates to Actual Custody.

15. Furlough Violations. Violations of furlough conditions shall be documented on CN 6601, Incident Report in accordance with Administrative Directive 6.6, Reporting of Incidents. CN 9503, Disciplinary Report shall be completed and issued to the inmate in accordance with Administrative Directive 9.5, Code of Penal Discipline. If the inmate is on a furlough other than a reentry furlough, the facility shall complete CN 9503, Disciplinary Report. If the inmate is on a reentry furlough, the parole officer shall complete CN 9503, Disciplinary Report. The Unit Administrator shall review the situation to determine if the inmate did violate any provision(s) of this Directive, and if transfer to a higher-level security facility is necessary. Additionally, a notation shall be made to form CN 9202, Inmate Classification History Log in Section 5 of the inmate's master file.

16. Furlough Monitoring. All inmates on furlough shall be monitored for compliance with program requirements in accordance with the provisions enumerated on form CN 9803, Furlough Agreement or CN 9804, Reentry Furlough Agreement, as applicable.

17. Reentry Furlough and Reintegration Furlough Supervision. Inmates granted reentry furlough or reintegration furlough shall be supervised by the Division of Parole and Community Services. The Director of Parole and Community Services shall develop, implement and update (as necessary) procedures for the supervision of inmates on reentry furlough and reintegration furlough.

18. Off-Grounds Work Details. Off grounds work details consistent with Administrative Directive 10.5, Public Service Work shall not be considered as furloughs.

19. Speaking Engagements/Escorted Functions. Unit Administrators shall be authorized to allow inmate participation in speaking engagements and other escorted functions as appropriate. Such engagements or functions shall be escorted by state, municipal or authorized contract personnel as appropriate.

20. Forms and Attachments. The following forms are applicable to this Administrative Directive and shall be utilized for the intended function.

A. CN 9801, Furlough Application/Decision;
B. CN 9802, Furlough Sponsor Questionnaire/Agreement;
C. CN 9803, Furlough Agreement; and,
D. CN 9804, Reentry Furlough Agreement;
E. CN 9805, Reintegration Furlough Passbook.

21. Exceptions. Any exceptions to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.

EXHIBIT E

State of Connecticut
Department of Correction

ADMINISTRATIVE DIRECTIVE

Approved By

Commissioner James E. Dzurenda

Directive Number	Effective Date	Page 1 of 2
8.16	11/29/2013	

Supersedes 03/07/2013

Title

Nursing Home Release

1. Policy. Inmates selected for placement shall be based on the discretionary authority of the Commissioner of Correction in consultation with the Medical Director in accordance with the Connecticut General Statutes and the provisions set forth in this policy.

2. Authority and Reference.

   A. Connecticut General Statutes, Sections 17b-372a, 18-81, 18-86c,18-87a through 18-87f and 53a-54b.
   B. Public Act 12-1, Section 104; June 12 Special Session ,2012.
   C. American Correctional Association, Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, January 2003, Standards 4-4142 and 4-4144
   D. American Correctional Association, Performance-Based Standards for Adult Local Detention Standards for Adult Local Detention Facilities, Fourth Edition, June 2004, Standard 4-ALDF-4c-19.
   E. Administrative Directive 9.2, Inmate Classification.

3. Definitions and Acronyms. For the purposes stated herein, the following definitions and acronyms apply:

   A. Nursing Home. A licensed nursing home available for inmates who are suffering from a terminal condition, disease or syndrome, or is so debilitated or incapacitated by a terminal condition, disease or syndrome as to (1) require continuous palliative or end-of-life care, or (2) be physically incapable of presenting a danger to society.

4. General Provision and Eligibility. An inmate may be classified for release to an authorized private nursing home at the discretion of the Warden by authority of the Commissioner in consultation with the Medical Director with the exception of the following:
   a) An inmate convicted of a capital felony under the provisions of section 53a-54b of the general statutes in effect prior to April 25, 2012, or;
   b) An inmate convicted of murder with special circumstances under the provisions of section 53a-54b of the general statutes in effect on or after April 25, 2012.

5. Assessment. No inmate shall be released to a nursing home unless a medical assessment has been completed, reviewed and approved by the DOC Medical Director. The inmate must be reviewed and diagnosed as meeting the nursing home criteria.
   Upon completion of the assessment, the DOC Medical Director shall complete CN 81601 Medical Director Nursing Home Release Authorization form attesting to

the inmate's eligibility for release to a licensed community based nursing home.

6. Supervision. An inmate shall be supervised by the Parole and Community Services Unit while classified to Nursing Home Release. The Parole and Community Services Division shall establish conditions for Nursing Home Release in consultation with nursing home staff. As a condition of release, the Medical Director may conduct periodic medical review and diagnosis of the inmate during such release. If the Medical Director determines that the inmate no longer meets the criteria for Nursing Home Release, the inmate shall be returned to the custody of the Commissioner of Correction.

7. Reclassification from Nursing Home Release. If, for any reason a person released to the nursing home no longer meets nursing home eligibility criteria or for any other reason even for reasons over which a person has no control, he may be returned to the custody of the Commissioner for a risk level reclassification in accordance with A.D. 9.2.

8. Forms and Attachments. The following forms are applicable to this Administrative Directive and shall be utilized for its intended function.

A. CN 8160I, Medical Director Nursing Home Release Authorization Form

9. Exceptions. Any exceptions to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.

EXHIBIT F

THE CT REENTRY COLLABORATIVE

COVID-19 & REENTRY IN CONNECTICUT

The CT Reentry Collaborative is made up of 10 reentry roundtables across the state with each representing a collaboration of state and local organizations working together to foster successful reentry, eliminate barriers, reduce recidivism and increase public safety. With COVID-19 significantly impacting our state, nation and world, the Collaborative is here to assist you as much as possible while you transition to the community.

For updated information and to connect with a Reentry Collaborative member, reach out to us!

Phone: 203-699-6316
Email: ctreentry@ccsu.edu
Website(s): www.ctreentry.org OR http://ctreentry.org/reentry-community-updates-covid-19

IMPORTANT UPDATES FOR YOU

As of Wednesday, 3/18/20, the U.S. Treasury Department pitched the details of the President's $1 trillion economic stimulus proposal to Congress, which would authorize two $250 billion rounds of direct payments to individual taxpayers. If approved, the first payment would be issue beginning early April and another wave of payments would be distributed to taxpayers beginning mid-May.

CT Department of Social Services
DSS Field Offices are closed to the public from March 17 to March 27, 2020. DSS will continue to provide services during this time. You can access benefit and application information at any time/day by visiting **www.connect.ct.gov** and **www.ct.gov/dss/apply**; or by calling **1-855-6-CONNECT**.

CT Department of Labor
DOL's phone system for filing weekly unemployment claims and performing an account status inquiry will no longer is no longer available. You must file a claim or check your account status at: **www.FileCTUI.com**.

CT Department of Motor Vehicles
DMV branch offices are closed to the public for the transaction of business until further notice. DMV is providing services online, through the mail and by phone.

Public Transportation:
CT Transit Bus is requiring passengers to board from the rear door with the exception of passengers who are in wheelchairs and others who require the bus to kneel. The normal schedules are currently active.
Metro-North is not currently accepting for fare payments on trains or at ticket counters. The change is intended to reduce hand-to-hand contact to stop the spread of COVID-19. Only credit and debit card payments will be accepted for ticket transactions.

The CT Reentry Collaborative
Institute for Municipal & Regional Policy
Central Connecticut State University, Downtown Campus
185 Main Street, Suite 212 & 215
New Britain, CT 06050

Email: ctreentry@ccsu.edu
Website: www.ctreentry.org

THE CT REENTRY COLLABORATIVE

COVID-19 & You

What is coronavirus disease 2019?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can I get COVID-19?

Yes. COVID-19 is spreading from person to person in parts of the world. Risk of infection from the virus that causes COVID-19 is higher for people who are close contacts of someone known to have COVID-19, for example health care workers or household members. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19.

Learn more about places with ongoing spread at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html#geographic.

The current list of global locations with cases of COVID-19 is available on CDC's web page at https://www.cdc.gov/coronavirus/2019-ncov/locations-confirmed-cases.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but is now spreading from person to person. The virus is thought to spread mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or sneezes. It is also possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

- Fever
- Cough
- Shortness of breath

What are severe complications from this virus?

Some patients have pneumonia in both lungs, multi-organ failure and in some cases death.

People can help protect themselves from respiratory illness with everyday preventive actions.

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol, if soap and water are not available.
- If you are sick, to keep from spreading respiratory illness to others, you should:
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled from an area with ongoing spread of COVID-19?

If you have traveled from an affected area, there may be restrictions on your movements for up to 2 weeks. If you develop symptoms during that period (even mild), you should get special medical advice. Call the office of your health care provider before you go and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While you are in contact with people, don't go out and do not travel. This reduces the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to take everyday preventive actions, like avoiding close contact with people who are sick and washing your hands often.

Is there a treatment?

There is no specific antiviral treatment for COVID-19.

People with COVID-19 can seek medical care to help relieve symptoms.

CDC

For more information: www.cdc.gov/COVID19

EXHIBIT G

COVID-19 Response for Individuals Discharging to Homelessness

The Connecticut Department of Correction (DOC) has a legal obligation to discharge individuals who have served their sentence. For the approximately 30 individuals who have identified as homeless upon discharge, DOC has collaborated with DOH, CCEH, United Way, Hartford Reentry Center, Transitions Clinic, IMRP and the CT Reentry Collaborative to identify safe housing options that (1) reduce shelter placements and (2) reduce the risk of transmission of COVID-19 in congregate settings.

OPM has allocated $150,000 in JAG funds that will be utilized to facilitate shelter diversion, rapid exit, rapid rehousing strategies, and provide housing assistance (security deposit, rent, hotel/motel, etc.). Summary of priority steps are as follows:

- Determine most appropriate sub-grantee for JAG funds based on current infrastructure to meet and support the housing needs of approximately 30 homeless individuals discharging within 30 days [OPM, DOC, DOH, CCEH];
- Facilitate early identification of incarcerated individuals reporting homeless upon discharge [DOC];
- Conduct pre-release phone screening and triage for homeless individuals returning to the Greater Hartford area [DOC, Hartford Reentry Center];
- Review current FUSE/CCR vacancies [CCEH];
- Assess housing capacity of CANs and re-housing providers that provide housing search navigation/case management, etc. [CCEH];
- Assist individuals in obtaining ID required for housing programs [DOC];
- Review logistics of removing the felony restriction for Section 8 housing with Senator Blumenthal and Senator Murphy [CCEH, CT Reentry Collaborative];
- Inquire about streamlining qualification process for Life Line cell phones [DOC, CT Reentry Collaborative];
- Review release mechanisms to determine if homeless individuals could be eligible for discretionary release to access housing services [DOC];
- Coordinate free health care, screenings, medications, medical and mental treatment for individuals releasing from DOC with Yale Medical School and networks of community providers [Transitions Clinic];
- Coordinate efforts with state work group that is compiling an inventory of state, private, and public facilities that could be used as housing/locations for quarantine [CCEH];
- Review suitability of empty state colleges/university dorm rooms as housing options for those discharging from incarceration (CCSU, etc.) [IMRP];
- Extend the timeframes for DOC to call 211 and conduct shelter placement phone screenings prior to discharge (as a last resort) [CCEH];
- Provide case management services to individuals who receive housing services [CT Reentry Collaborative, IMRP];
- Evaluate sustainability of housing supports given lack of employment opportunities [CCEH].

EXHIBIT H

Criminal Justice
Policy & Planning Division

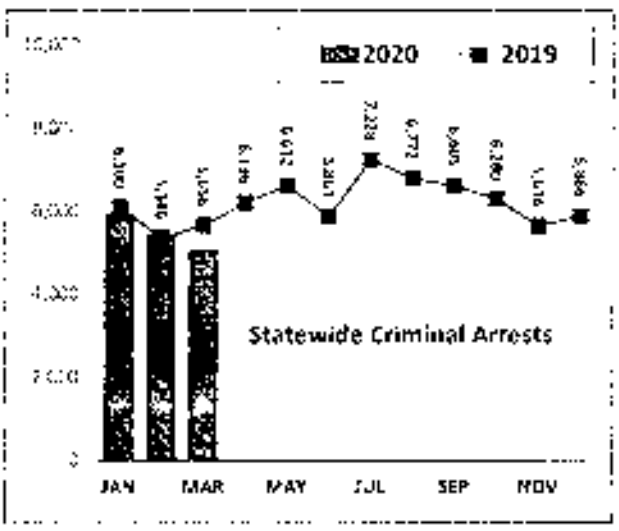
Initial Analysis of March and April 2020 Criminal Justice System Trends

Presented to
Connecticut Justice Policy Advisory Commission

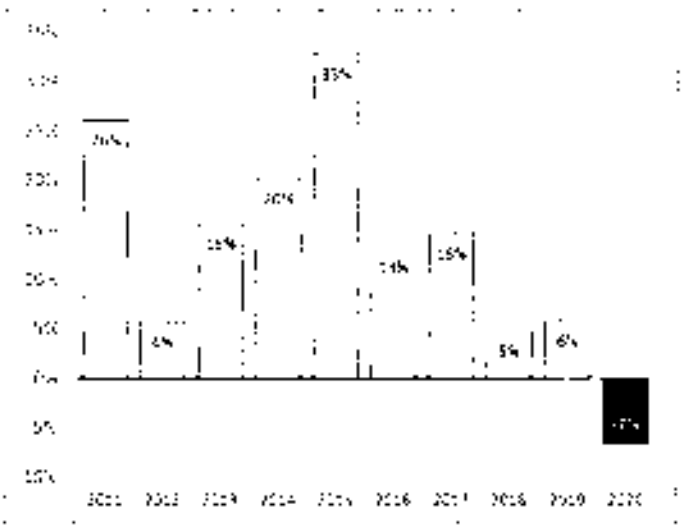
April 30, 2020

Arrests dropped between February and March 2020, in contrast to every other such period over the last ten years, when they increased.

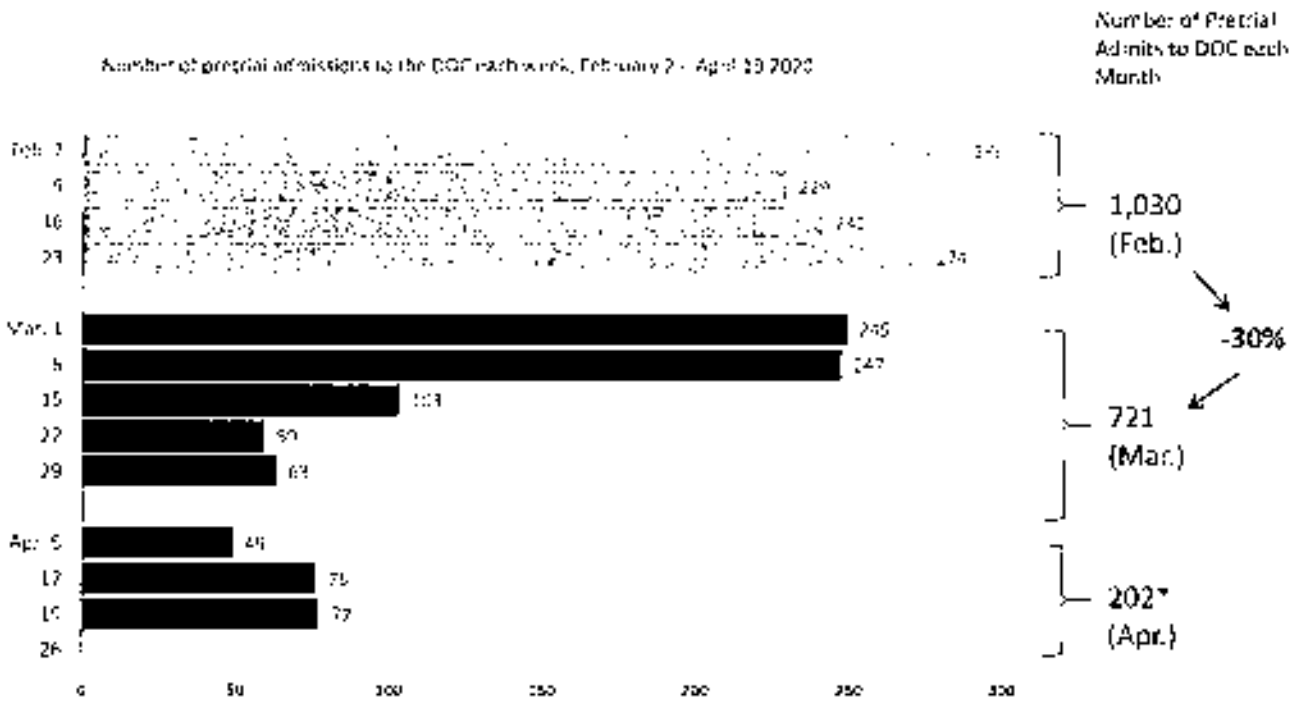
2020's monthly arrest trends were tracking 2019's until March, when they dropped 7%.



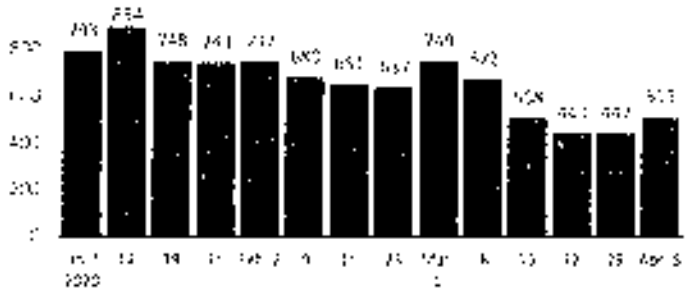
Except for between February-to-March 2020, every other such period in the last ten years increased, most by double digits.



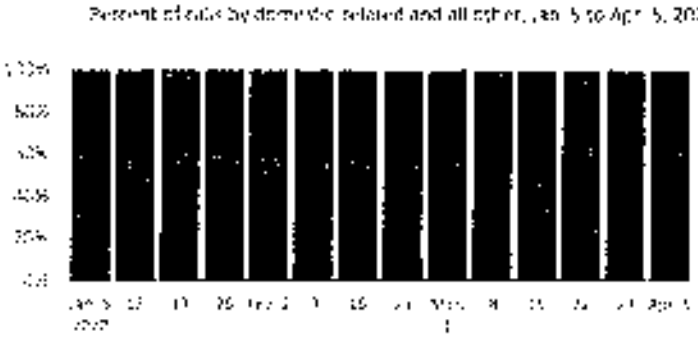
Pretrial admissions to the DOC shrank further each week in March, and April's totals are on track to be even lower.



Between March and April, domestic-related calls for service to the Hartford Police Department increased 23%, comprising almost one-quarter of all calls.



	Change from weeks of March 1 to April 5
Total Calls	-32%
All other calls	-40%
Domestic-related calls*	+23%



From March to April 2020, domestic-related calls for service increased from 13 to 23 percent of total calls.

April 5-11	139
April 12-18	169
April 19-25	177

*Additional analysis of domestic-related call data by location.

Source: [illegible] data portal: https://data.hartford.gov/Public-Safety/Police-Calls-for-Service-2013-Year-to-Current/[illegible]
Generated using the [illegible]

In March 2020, lethality screens statewide increased from the prior year, with a larger percentage scoring high-danger and a 19 percent jump in officer calls to the program LAP-line.

Lethality Assessment Program Data, March 2019 and 2020

	Lethality Screens Conducted	Avg. Screens Per Day
March 2019	809	26
March 2020	876	28
Difference	+8%	+2

8% increase in lethality screens conducted

	% High Danger	% Non-High Danger	% Did Not Answer
March 2019	50%	37%	14%
March 2020	54%	34%	12%
Difference	+4 points	-3 points	-2 points

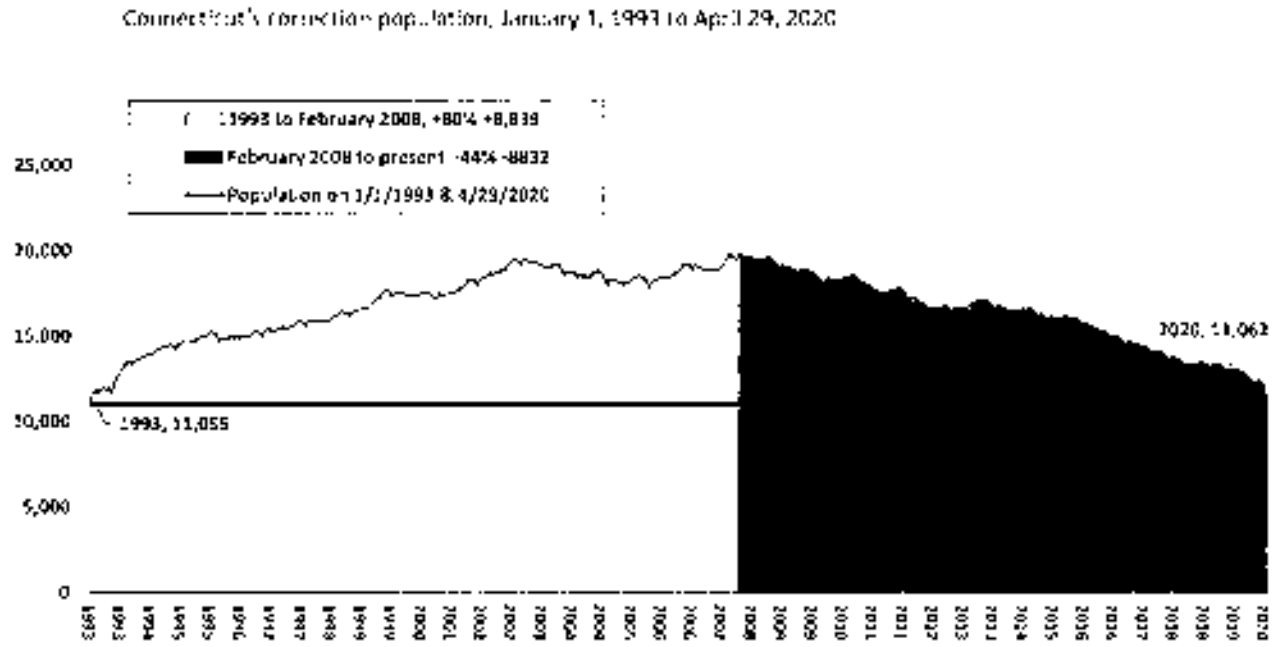
4 percentage point increase in lethality screens scored high danger

	Officer calls to LAP-line after lethality screens	% Calls to LAP-line that were high danger
March 2019	333	83%
March 2020	396	84%
Difference	+19%	+1 point

19% increase in officer calls to LAP-line after screens.

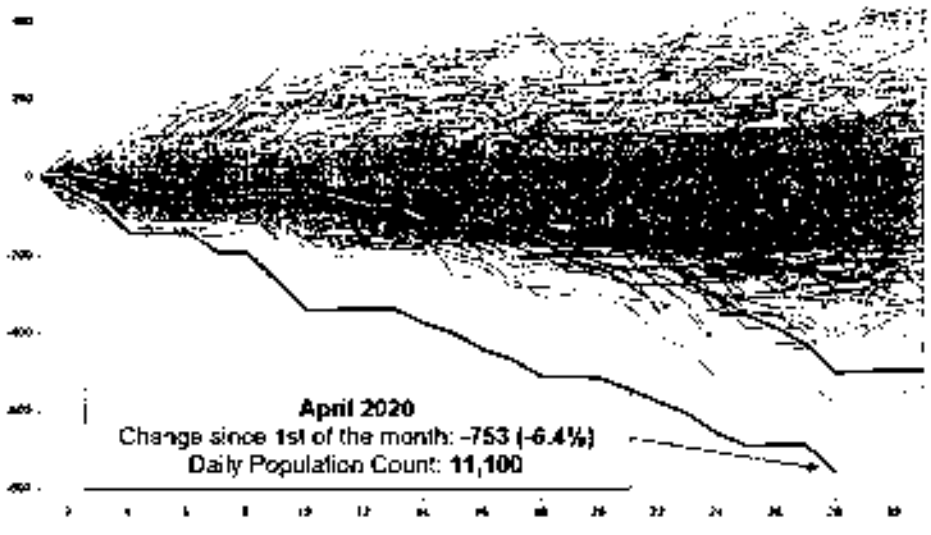
Source: LAP Data Reports

On April 29, 2020, the correction population fell to 11,062 — a level last seen 27 years prior, on January 1, 1993.



In March 2020, the correction population decreased by the largest monthly percent on record and, with current trends, April is on pace to eclipse March.

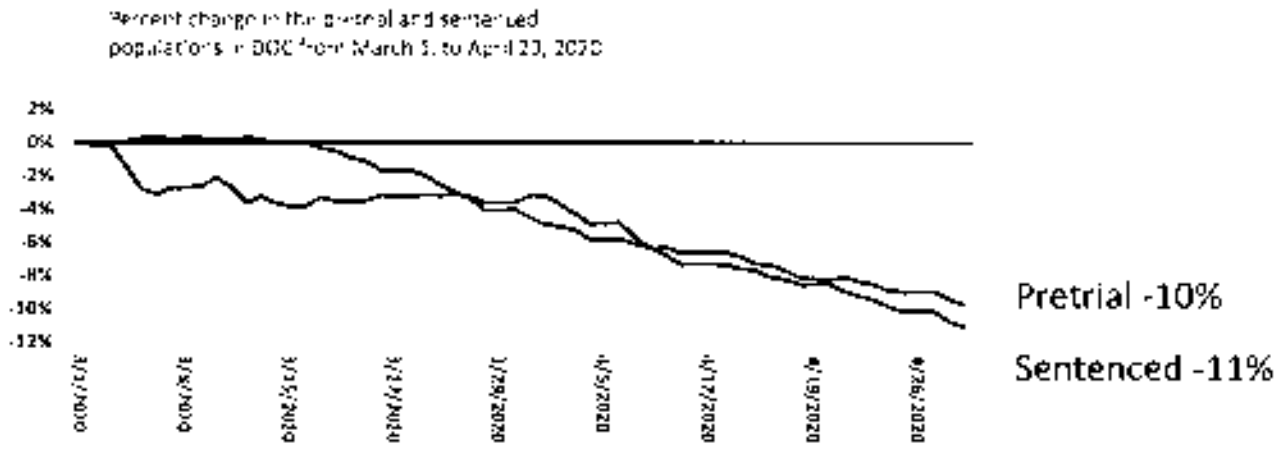
Daily percent change of correction population from start of the month, every month since 2000



March 2020's percent decrease in the correction population from the start of the month exceeds all previous periods since 1988.

The drop in April 2020 has already surpassed the historic month of March

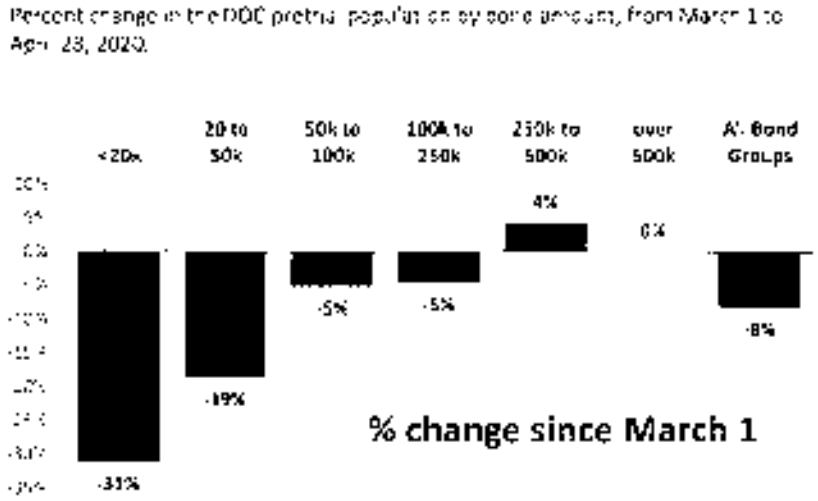
Between March and April 29, the correction population dropped by 1,347 people, with nearly equal percent declines in the pretrial and sentenced subgroups.



Connecticut correction population, March 1 to April 29, 2020

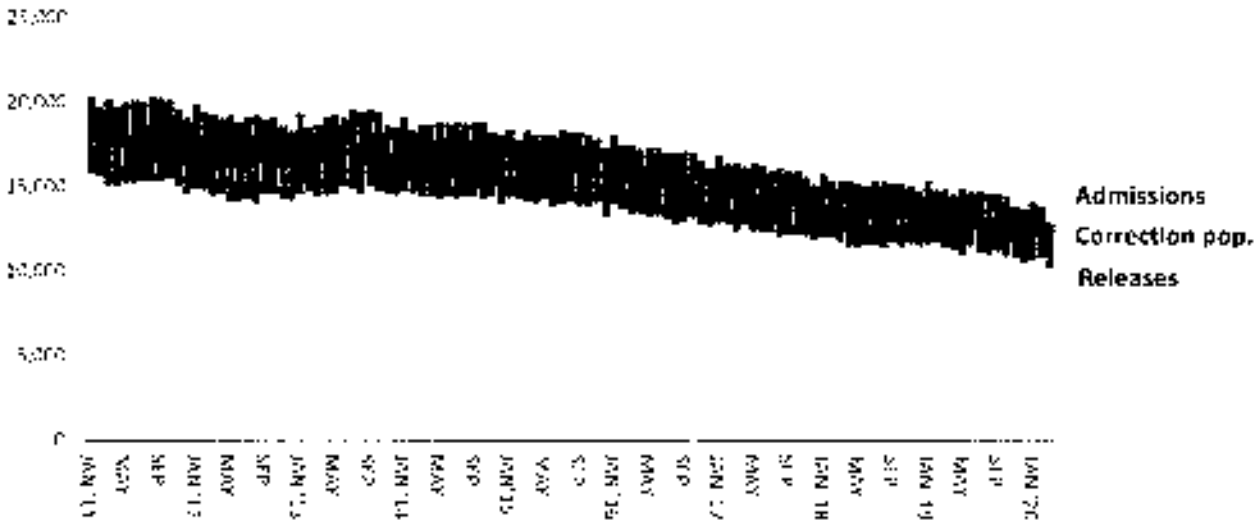
Correction Group	March 1	April 29	% Change	Net Change
Sentenced	9,036	8,040	-11%	-996
Pretrial	3,049	2,753	-10%	-296
Other	324	269	-17%	-55
Total	12,409	11,062	11%	1,347

The pretrial population dropped for all bond groups by 8 percent, with larger reductions for people with lower bond amounts.



In March, the correction population decreased because admissions dropped sharply and releases increased.

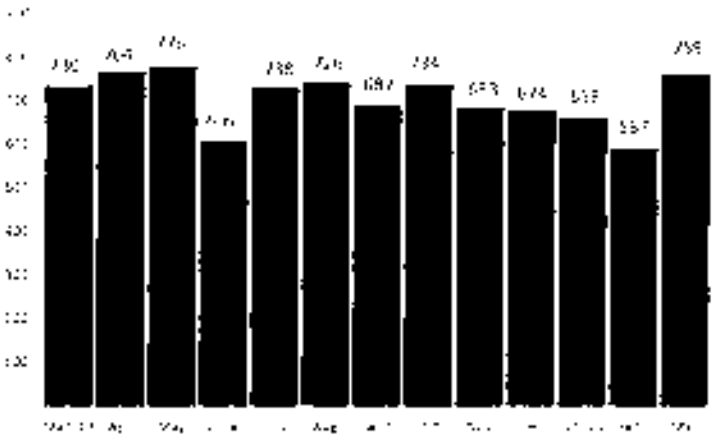
Connecticut correction admissions and releases, Jan. 2011 to Mar. 2020



Source: [illegible]

Between February and March 2020, discretionary releases of people sentenced to DOC climbed 72 percent while end-of-sentence releases fell 17 percent.

Number of people releasing from DOC sentenced population by discretionary release vs. end of sentence release, March 2019 to March 2020



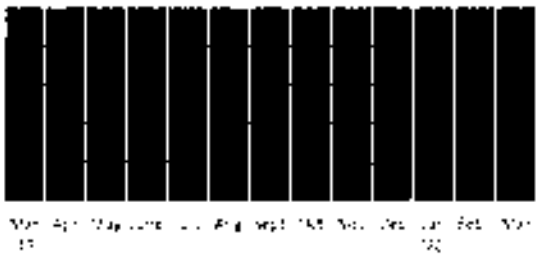
Percent Diff., Feb and March 2020

+29% — Total

+72% — Discretionary Release

-17% — End of Sentence

Percent of sentenced releases by discretionary and end of sentence

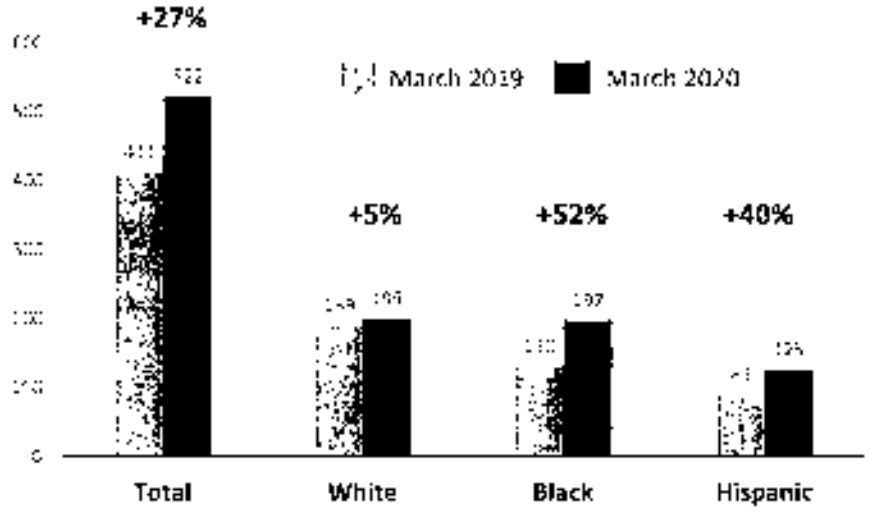


The increase in discretionary releases had the secondary benefit of reducing the number of people released from correctional facilities with no community supervision. (The DOC is legally required to release all inmates at the conclusion of their court-ordered sentence.)

Source: Department of Correction Daily Count Report, IBM Monthly Performance Reports. For data and methodology see appendix slide 111.

The increase in discretionary releases between March 2019 and 2020 was larger for Black and Hispanic people than the total population.

People [illegible] from ISO sentenced population on [illegible] release by [illegible], and total, Mar. 2019 and 2020



Source: Data from [illegible]

Thank you.

For more information, please visit
https://portal.ct.gov/OPM/CJ-About/Homepage/CJPPD

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT K

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL., *Petitioners,*	:	CIVIL NO. 3:20-CV-0534 (JBA)
v.	:	
NED LAMONT, ET AL., *Respondents.*	:	MAY 18, 2020

DECLARATION OF KRISTAN MANGIAFICO

The undersigned declarant, Kristan Mangiafico, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I work for the Department of Correction ("DOC"), in the Victims Services Unit at the DOC Central Office, 24 Wolcott Hill Rd., Wethersfield, CT. I have been with the DOC for over (20) twenty years and in the Victim Services Unit for approximately (3) three years.

2. As the DOC's Victims Services Administrator, my duties include but are not limited to: Registering a victim of crime or the victim's survivor or representative of notification when an offender in the custody of the Department of Correction is (1) reviewed for any type of (supervised or not) release; (2) released from custody (end of sentence, bond out, court ordered release); (3) transferred to community release; (4) dies while incarcerated; (5) applies for any type of furlough, sentence modification, or sentence review; (6) is scheduled to appear before the Board of Pardons and Parole.

3. While the foregoing describes the "specific job duties" what isn't listed here is the following: I am a voice for the victim when they feel they have none. I am here to listen to their fears and be their ear to scream and yell about what THEY have gone through when no one else has listened. They have been through the most traumatic experiences, crimes you or I cannot fathom. They've been

victimized by the offenders and then in many cases by our Judicial system. Reduced sentences, early release, parole, good time, plea bargains….they are forgotten in the Criminal Justice System.

4. For April 2020, there are approximately 2800 inmates with a Victim Notification (VN) flag, meaning that there is a registered victim who would require notification upon application for community release. There are a total of 3933 registered victims with the DOC, but that also includes for inmates who may already be in the community..

5. I explain to them that they do have a voice and they are allowed to submit a Victim Impact Statement in regard to early release reviews. Then they are ripping that band-aid off again, reliving the whole experience in the hope that someone will listen to their side and maybe that offender will actually serve the sentence a Judge imposed.

6. Imagine now, a global pandemic and these victims are AGAIN being asked to quiet their voices because someone else may decide that the offender matters more than they do. That the offender should just be let out, to protect them from the possibility of contracting a virus they have just as good a chance of contracting outside of prison.

7. The phone calls I have listened to from mothers, fathers, children, brothers, sisters or any loved one of a victim whose fear now lies with our Judicial system letting domestic violence abusers, rapists, murderers, and sexual deviants out of prison. They are seeing the media cover the offenders' story, the risk the offender may face; who is covering the risk the public faces by letting these monsters out? Is this where we are now?

8. We in DOC have properly reviewed and released offenders back into the community. We have looked at those who pose little to no risk to your neighborhoods and communities, and now we're being asked to let the most dangerous offenders out? What is being reviewed is absurd and socially irresponsible.

9. Victims have a right to have their voices be heard; you cannot take away that right. Also the public should be made aware that offenders convicted of the most heinous of crimes will walk away from the prisons they have been living in for years.

10. COVID has alarmed everyone and rightfully so; but when a victim calls me and begs me to not let out the monster who viciously raped and beat her or brutally killed their father because that's what they're "hearing on the news" I do my best to reassure them, that yes although the Department of Correction is reviewing potential releases; they need not worry.

11. That's what I tell them, that person who tore their family or life apart is not eligible. NOT ELIGIBLE….the criteria is different for that offender and no virus should now erase that terminology. There is a reason that person is incarcerated for as long as he or she was sentenced to. I am an advocate for the Victim, that is my job.

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 18th day of May, 2020.

Kristan Mangiafico, Counselor Supervisor
Victim Services Unit
Department of Correction

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT L

Declaration of Joe Goldenson, MD

1. I am a medical physician with 33 years of experience in correctional health care. For 28 years, I worked for Jail Health Services of the San Francisco Department of Public Health. For 22 of those years, I served as the Director and Medical Director. In that role, I provided direct clinical services, managed public health activities in the San Francisco County jail, including the management of HIV, tuberculosis, Hepatitis C and other infectious diseases in the facility and the planning and coordination of the jail's response to H1N1, and administered the correctional health enterprise, including its budget, human resources services, and medical, mental health, dental, and pharmacy services.

2. I served as a member of the Board of Directors of the National Commission on Correctional Health Care for eight years and am past President of the California chapter of the American Correctional Health Services Association. In 2014, I received the Armond Start Award of Excellence from the Society of Correctional Physicians, which recognizes its recipient as a representative of the highest ideals in correctional medicine.

3. For 35 years, I held an academic appointment as an Assistant Clinical Professor at the University of California, San Francisco.

4. I have worked extensively as a correctional health medical expert and court monitor. I have served as a medical expert for the United States District Court for the Northern District of California for 25 years. I am currently retained by that Court as a medical expert in *Plata v. Newsom*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to inmate patients in the California Department of Correctional Rehabilitation. I have also served as a medical expert and monitor at Cook County Jail in Chicago; Los Angeles County Jail; at other jails in Washington state, Texas, and Florida; and at prisons in Illinois, Ohio, and Wisconsin.

5. My curriculum vitae is attached as exhibit A.

The nature of COVID-19

6. The SARS-nCoV-2 virus, and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the World Health Organization ("WHO").

7. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.1 to 3.5%, which is up to 35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.

8. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical

conditions including cardiovascular disease, respiratory disease, diabetes, and immune compromise.

9. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS), which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and in parts of China.

10. COVID-19 is widespread. Since it first appeared in China in late 2019, outbreaks have subsequently occurred in more than 160 countries and all populated continents; heavily affected countries include Italy, Spain, Iran, South Korea, and the U.S. The U.S. is now the world's most affected country. As of May 13, 2020, there have been 4,343,269 confirmed human cases globally and 296,784 known deaths.[1] It is not contained, and cases are growing exponentially.

11. In the United States alone, the Centers for Disease Control and Prevention ("CDC") reports 1,364,061 cases and 82,246 deaths as of May 13,2020.[2] The Connecticut Department of Health reports 34,855 cases and 3,125 dead as of May 13, 2020.[3] All these numbers are likely underestimates because of limited availability of testing.

12. SARS-nCoV-2 is now known to be fully adapted to human-to-human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

13. The U.S. CDC estimates that the reproduction rate of the virus, the R0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20–30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

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[1] Johns Hopkins COVID-19 Dashboard, https://coronavirus.jhu.edu/map.html (last accessed May 13, 2020).

[2] CDC COVID Data Tracker, https://www.cdc.gov/covid-data-tracker/index.html (last accessed May 13, 2020).

[3] Conn. Dep't of Health, COVID-19 Update May 13, 2020, https://portal.ct.gov/-/media/Coronavirus/CTDPHCOVID19summary513202O.pdf (last accessed May 13, 2020).

14. CDC has recently added to the list of possible signs and symptoms of COVID-19 to include fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.[4] This means the numbers of suspect cases will increase.

15. There is currently no vaccine for COVID-19, and no cure. The only known ways to prevent the spread of SARS-nCoV-2 involve measures such as thorough handwashing, frequent decontamination of surfaces, and maintaining six feet of physical distance between individuals ("social distancing").

The risks of COVID-19 in detention facilities

16. COVID-19 poses a serious risk to prisoners, workers, and anyone else in correctional facilities. These facilities have long been associated with high transmission probabilities for infectious diseases, including tuberculosis, multidrug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.

17. The severe epidemic of tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities surrounding a prison.

18. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as social distancing and proper decontamination of surfaces are virtually impossible.

19. For example, several deaths were reported in the U.S. in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May 2019.

20. Current recommendations for social distancing, frequent hand washing, and frequent cleansing of surfaces to prevent infection and the spread of the virus are extremely difficult, if not impossible, to implement in the correctional setting. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as population density in close confinement; insufficient ventilation; shared toilet, shower, and eating environments; and limits on hygiene and personal protective equipment such as masks and gloves in some facilities. Shared spaces and equipment (such as telephones) are commonly not adequately disinfected, especially during the current pandemic when more frequent cleaning and disinfecting are required. Limits on soap (copays are common) and hand sanitizer, since they can contain alcohol, are also risks for spread. The

[4] Centers for Disease Control and Prevention, Symptoms of Coronavirus, https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (last accessed May 13, 2020).

nationwide shortage of personal protective equipment (PPE), as well as ancillary products (such as cleaning supplies and thermometer probes) further impacts the ability of correctional facilities to implement necessary precautions.[5]

21. The risk of exposure to and transmission of infectious diseases, as well as the risk of harm from developing severe complications or death if infected, is significantly higher in jails, prisons, and detention centers than in the community.

22. Close, poorly ventilated living quarters in these facilities foster the rapid transmission of infectious diseases, particularly those transmitted by airborne droplets through sneezing, speaking, or coughing. In these congregate settings, large numbers of people are closely confined and forced to share living spaces, bathrooms, eating areas, and other enclosed spaces. Groups of persons are often moved from space to space, for example, from a dormitory to a cafeteria. Persons congregate and come in close contact while standing in lines for medication, commissary, fresh laundry, telephones, or court appearances. These group movements, which may cluster large numbers of people together in small spaces, increase the risk of transmission. It is common for detainees in a given housing unit to routinely be subjected to such group movements multiple times each day. They are physically unable to practice social distancing, which the CDC has identified as a "cornerstone of reducing transmission of respiratory diseases such as COVID-19."[6]

23. This forced congregation spreads infection from one area of a prison to other areas, too. In addition, detention facilities often rely on detainees to perform work that supports the operation of the facility, such as food service, laundry, and cleaning. To perform these work assignments, they typically travel from their housing units to other parts of the facility. Officers and other detention facility staff routinely have direct physical contact with detainees, especially when handcuffing or removing handcuffs from detainees who are entering or exiting the facility. Staff members also move around within the facility, which creates opportunities for transmission both among staff in different parts of the facility and transmission to and from detainees in different parts of the facility. This regular circulation makes the spread of infection throughout a prison all but inevitable.

24. While jails, prisons, and detention centers are often thought of as closed environments, this is not the case. Custody, medical, and other support staff and contractors enter and leave the facility throughout the day. New detainees arrive on a frequent basis. Since there is no effective way to screen for newly infected or asymptomatic individuals, they can unknowingly transmit COVID-19 to those housed in the facility. Detainees and

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[5] *See Study of COVID-19 in Correctional Facilities*, Harvard University and National Commission on Correctional Health Care, April 9, 2020.

[6] CDC, Coronavirus Disease 2019: Guidance for Correctional & Detention Facilities (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html/.

inmates are often transferred between housing units, to other facilities, and to and from court. This further increases the likelihood of transmission of COVID-19.

25. It has long been known that jails, prisons, and detention centers can be hotbeds of disease transmission. Due to the frequent ingress and egress of employees at these facilities, an outbreak within a jail, prison, or detention center can quickly spread to surrounding communities. For example, the tuberculosis epidemic that broke out in New York City in the early 1990s began in jails and was spread to the community by jail employees who became infected and then returned home to their families and communities.

26. In addition to the nature of the prison environment, prison and jail populations are also at additional risk due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to death or severe illnesses after infection from COVID-19 disease.

27. Testing continues to be problematic. Testing kits are not always available, and it can take anywhere from a day to a week or more to obtain test results. Someone who is tested shortly after he or she was infected may test negative. Non-test-based screens like taking people's temperatures or asking them for subjective reports of symptoms cannot adequately screen for new, asymptomatic or pre-symptomatic infections. COVID-19 has a typical incubation period of 2 to 14 days, commonly five days, and transmission often occurs before presentation of symptoms. According to the CDC, up to 25 percent of people infected with COVID-19 will remain asymptomatic.[7] Similarly, infected individuals may experience only mild symptoms. These newly infected, asymptomatic, and mildly symptomatic individuals can, and do, transmit the virus, contributing to its rapid spread. As a result, such inadequate screening presents a critical problem. The strong possibility of asymptomatic and presymptomatic transmission[8] means that monitoring staff and incarcerated people for symptoms and fever is inadequate to identify all who may be infected and to prevent transmission.

28. While every effort should be made to reduce exposure in detention facilities through internal mitigation efforts, this may be extremely difficult to achieve and sustain quickly enough. Further, no mitigation effort can change the inherent nature of detention facilities, which force people to live in close proximity to one another. It is therefore an urgent priority in this time of national public health emergency to reduce the number of

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[7] Apoorva Mandavilli, *Infected but Feeling Fine. The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html.

[8] Studies have documented high rates of pre-symptomatic transmission; for example, one study found that nearly half of secondary cases were infected by pre-symptomatic individuals. Xi He et al., *Temporal Dynamics in Viral Shedding and Transmissibility of COVID-19*, Nature Medicine (Apr. 15, 2020), https://www.nature.com/articles/s41591-020-0869-5.

persons in detention as quickly as possible. Indeed, that is the only public health solution available at this time to reduce the spread of COVID-19 and potentially save lives.

29. Given the experience in China as well as the literature on infectious diseases in jail, additional, continual outbreaks of COVID-19 among the U.S. jail and prison populations are highly likely. Releasing as many inmates as possible is important to protect the health of inmates, correctional facility staff, health care workers at jails and other detention facilities, and the community as a whole. Indeed, according to the WHO, "enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages."[9]

30. For these reasons, the pandemic has prompted prisoner releases around the world. France has freed 5,000 inmates, and, in the United States, California officials are planning to release up to thousands of prisoners. In Britain, the Ministry of Justice is planning to grant thousands of prisoners early release within weeks in an effort to contain the spread of the virus in cells and facilities where it said social distancing rules are impossible to maintain. Many cities and counties across the US, including San Francisco, Los Angeles, Chicago, Cleveland and New York, are also releasing prisoners to reduce the risk of COVID-19.

31. I understand that DOC is already dealing with COVID-19 outbreaks at most of its facilities, despite testing only those who are symptomatic. Without mitigation measures, it is difficult to overstate the devastation that COVID-19 could inflict on Connecticut's correctional system. Two Ohio prisons, Marion Correctional Institution and Pickaway Correctional Institution, have emerged as the largest-known sources of U.S. coronavirus infections, according to data compiled by The New York Times. To date, nearly 4,000 cases have been connected to the two prisons.[10] Over 80% of the approximately 2,500 prisoners in Marion tested positive.[11] In addition, 177 staff have tested positive for

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[9] World Health Organization, *Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention: Interim guidance* (Mar. 15, 2020), http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf.

[10] *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. Times, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?action=click&module=Top%20Stories&pgtype=Homepage&action=click&module=Spotlight&pgtype=Homepage=states (last accessed May 13, 2020).

[11] Ohio Department of Rehabilitation & Correction, COVID-19 Inmate Testing Updated 5/13/2020, https://coronavirus.ohio.gov/static/DRC_COVID-19_Information.pdf (last accessed May 13, 2020).

COVID-19.[12] Eight of the ten largest-known infections sources in the U.S. are jails or prisons.[13]

32. At Ohio's Marion Correctional, close to 95% of those who tested positive were asymptomatic and would otherwise not have been tested. This underscores the risk of the spread of COVID-19 by asymptomatic individuals.[14]

33. As of today, DOC has reported 526 confirmed positive tests among incarcerated people. Even these numbers may represent the tip of the iceberg, since newly-infected people typically do not show symptoms for 2 -14 days, many infected individuals are asymptomatic, and since the infection spreads rapidly to additional people. DOC's current death toll stands at six. It is likely to mount rapidly given the way the disease has progressed elsewhere.

34. It is my understanding that Connecticut has multiple facilities with dormitory housing units that hold anywhere from 50, to 100, to 250 people in a single unit, and that the majority of remaining prisoners are double-celled. It also my understanding that DOC has multiple facilities that hold more than 1,000 people on any given day; that staff enter and leave the facility regularly; and that those in custody share restroom and shower facilities and eat communally prepared food. Finally, I understand that DOC has faced chronic and severe medical staff shortages.

35. Based on these understandings, it is my opinion that the exponential infection of rate for COVID-19 we already see in the community would be magnified within DOC. Adequate social distancing would be impossible to achieve. What's more – and as evidenced by the 367 staff who have already tested positive – the infection in DOC facilities would not stay limited to those facilities, but would worsen infection rates in the broader community. The number at risk for death is substantial.

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[12] *Id.*

[13] C.J. Ciaramella, *8 of The Top 10 Biggest U.S. Coronavirus Hotspots Are Prisons and Jails*, Reason (Apr. 29, 2020). https://reason.com/2020/04/29/8-of-the-top-10-biggest-u-s-coronavirus-hotspots-are-prisons-and-jails.

[14] Linda So and Grant Smith, *In Four U.S. State Prisons, Nearly 3,300 Inmates Test Positive for Coronavirus -- 96% Without Symptoms*, Reuters (Apr. 25, 2020), https://www.reuters.com/article/us-health-coronavirus-prisons-testing-in/in-four-u-s-state-prisons-nearly-3300-inmates-test-positive-for-coronavirus-96-without-symptoms-idUSKCN2270RX.

Conclusions

36. For the reasons above, it is my professional opinion that persons currently incarcerated in DOC facilities are at significantly greater risk of contracting COVID-19 than if they were permitted to shelter in place in their home communities. If infected, many are at increased risk of suffering severe complications and outcomes.

37. It is my professional opinion that conditions in DOC threaten the health and safety of every individual within the prison—detained persons and staff alike—and in their surrounding communities.

38. It is my professional opinion that a necessary component of bringing DOC into compliance with the recommendations of the CDC and best practices to minimize the risk of COVID-19 transmission within the facility and to the larger community is to substantially reduce the population. Doing so will allow DOC facilities to significantly reduce the risk of infection for both incarcerated people and correctional officers, which in turn protects the communities where corrections staff live.

39. It is my professional opinion that those who are medically vulnerable[15] need to be moved out of DOC facilities to the absolute maximum extent possible. In addition, the overall population needs to be significantly lowered to allow for adequate social distancing, to minimize the strain on DOC's medical care system, and to ensure adequate space is available for necessary quarantining.

40. It is my public health recommendation that a public health expert be appointed to oversee operations related to preventing further spread of COVID-19 within DOC, which may include authorizing further staggered release of incarcerated people until it is possible to maintain consistent social distancing and appropriate hygiene within DOC's facilities.

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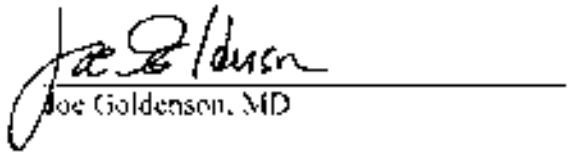
[15] Persons held in DOC over the age of 50, as well as all current and future persons held in DOC of any age who experience (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as congenital heart disease, congestive heart failure and coronary artery disease, or other chronic conditions associated with impaired heart function; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) neurological and neurologic and neurodevelopment conditions [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; (l) a current or recent (last two weeks) pregnancy; and/or severe obesity.

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

Executed this 14 day of May, 2020 in Alameda County, California.



Joe Goldenson, MD

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James M. Belforti
Assistant Attorney General

EXHIBIT M

DOCKET NOS:	:	SUPERIOR COURT
H15NCR20032526S H15NCR20032526S H15NCR20032526S		
STATE OF CONNECTICUT	:	G.A. #15
v.	:	AT NEW BRITAIN, CONNECTICUT
PATTIKATE WILLIAMS-VOID	:	APRIL 3, 2020

BEFORE THE HONORABLE LISA K. MORGAN, JUDGE

A P P E A R A N C E S :

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Recorded By:
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Court Recording Monitor
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New Britain, CT 06051

ATTY. PRZEZDZIECKI: We have on the regular docket appearing at lines 5 through 7 is Patrikate Williams-Void. That is a matter down for a motion for bond reduction. I believe the Court has that motion. The State would like to be heard briefly in connection with it.

THE COURT: The Court has not seen that motion. If someone has it, I'd be happy to review it. Let me ask you first, Counsel, are you opposing it?

ATTY. PRZEZDZIECKI: I do.

THE COURT: Okay.

ATTY. PRZEZDZIECKI: And the State's position, Judge, is - and I will be brief - these are three sales of - they're hand-to-hand sales of Fentanyl. The reality is I don't - and I'm handling all of these emergency motions for release. And, in fact, the next thing I'm going to do when I finish with this is I'm going to ask the Court to write [illegible] three individuals who are being held who I'd like to be released on promises to appear. But these are three hand-to-hand sales of Fentanyl.

Right now the epidemiologists tell us that Connecticut can expect to have somewhere around 900 deaths as a result of the COVID-19 virus. We've had over 1,000 deaths each year for the past three years as a result of opioid overdoses. An individual who is selling Fentanyl on the street, as this individual

is, is, quite frankly, in the aggregate, if we look at total deaths, more dangerous than the virus that we're currently facing.

So the State's contention is that this is not someone who is a non-violent offender. This is someone whose release places peoples' lives at risk and I oppose that. I will also note, this is an individual with a prior conviction for sale and the bonds that were set on the warrants have already been reduced by half by Judge Keegan. Thank you.

THE COURT: Counsel.

ATTY. EDDY: Thank you, Your Honor. The motion was filed by my colleague, Attorney Hercules, and sets forth the basis for the relief for which we are requesting and I believe in the body of the motion indicates that the prior conviction highlighted by the State is from 2002 and it also sets forth her various health conditions that make her a high risk. So I'd ask the Court to grant the motion.

THE COURT: How old is she?

ATTY. FRELINSKI: She's either 62 or 63.

ATTY. EDDY: I don't have a copy of the docket. Unfortunately, I've never had the opportunity to meet the client.

THE CLERK: 1957.

THE COURT: And how long has she been held?

THE CLERK: March 6th. Let me see. Hang on one

second.

ATTY. DRUSKI: I believe you're correct.

THE CLERK: March 6th.

THE COURT: You don't know whether she's showing any signs of COVID. You've just asking that she be released because of her advanced age, although I'll say 61 is not a very advanced age in my personal opinion, advanced age and other medical conditions?

ATTY. KUDY: Well, I believe she's also wheelchair bound and she has diabetes, so it's not just age related.

THE COURT: Okay.

ATTY. KUDY: But I think the big picture she would be living at home and would be on electronic monitoring, so I don't see her as being a risk to offend.

ATTY. DRUSKI: And I would just note that each of the sales was out of her house.

THE COURT: Out of her own house. Okay. Under these circumstances, the motion is denied.

DOCKET NOS: : SUPERIOR COURT

H15NCR2103252558 H15NCR2103252643
H15NCR2103252660

STATE OF CONNECTICUT : G.A. #15

v. : AT NEW BRITAIN, CONNECTICUT

FATTIKAYE WILLIAMS-VOID : APRIL 3, 2020

C E R T I F I C A T I O N

I hereby certify the foregoing pages are a true and correct transcription of the audio recording of the above-referenced case, heard in Superior Court, G.A. #15 New Britain, Connecticut, before the Honorable Lisa K. Morgan, Judge, on the 3rd day of April, 2020.

Dated this 8th day of May, 2020, in New Britain, Connecticut.

Linda Burbige
Court Recording Monitor

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

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James M. Belforti
Assistant Attorney General

EXHIBIT N

Docket No.	H15N-CR20-0325253-S CR20-0325254-S CR20-0325256-S	SUPERIOR COURT G.A. 15
STATE OF CONNECTICUT		AT NEW BRITAIN
v.		
PATTIKATE WILLIAMS-VOID		March 24, 2020

2020 MAR 24 P 3:30

Introduction

Pursuant to section 54-53a(d) of the General Statutes, the Defendant moves the Court for a, immediate bail hearing and an order granting his release. Ms. Pattikate Williams-Void, who is a pretrial defendant currently detained at the York Niantic Correctional Facility is among the group of people the Centers for Disease Control and Prevention ("CDC") has categorized as most-at-risk for contracting COVID-19, a dangerous illness spreading rapidly across the world and throughout Connecticut.

The health risk to Ms. Williams-Void is heightened because of her advanced age and medical condition including asthma having recently undergone hip replacement surgery, and a compromised immune system given the conditions at the York Correctional Facility as described in detail below, necessitates pretrial release with non-financial conditions and supervision until this pandemic has ended.

During the period of release Williams-Void will reside at her residence, with her family under either electronic monitoring with supervision of ASIST.

Factual Background

Changed Circumstances: COVID-19 Outbreak

As of March 12, 2020, the new strain of coronavirus which causes COVID-19, has

STATE OF CONNECTICUT
SUPERIOR COURT
JUDICIAL DISTRICT OF NEW BRITAIN
PART A CRIMINAL / G.A. 15

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CLERK

infected over 132,300 people, leading to at least 4,954 deaths worldwide.[1] On March 11, 2020, the World Health Organization officially classified COVID-19 as a pandemic.[2] Governor Ned Lamont declared a State of Emergency on March 10. Additional protective measures have been taken including limiting public gatherings, ordering that all public schools be closed and closing bars, restaurants and gyms. The Connecticut Judicial Branch has limited court operations to Priority 1 matters. As of March 23, 2020 there are 327 positive cases of COVID-19 in Connecticut.

The CDC has issued guidance that individuals at higher risk of contracting COVID-19--adults over 60 years old and people with chronic medical conditions such as lung disease, heart disease, and diabetes--take immediate preventative actions, including avoiding crowded areas and staying home as much as possible.[3] With confirmed cases in Connecticut that indicate community spread, we must take every necessary action to protect vulnerable populations and the community at large.

Conditions of Confinement and Spread of Coronavirus

Conditions of pretrial confinement create the ideal environment for the transmission of contagious disease.[4] Inmates cycle in and out of detention facilities from all over the world and the country, and people who work in the facilities including correctional officers, and care and service providers leave and return daily, without screening. Incarcerated people have poorer

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[1] *Coronavirus Map: Tracking the Spread of the Outbreak*, The New York Times (March 12, 2020), *at* https://nyti.ms/2U4kmqd (updating regularly).
[2] *WHO Characterizes COVID-19 as a Pandemic*, World Health Organization (March 11, 2020) *at* https://bit.ly/2WSdwpS.
[3] *People at Risk for Serious Illness from COVID-19*, CDC (March 12, 2020) *at* https://bit.ly/2vgUt1P.
[4] Joseph A. Bick (2007). Infection Control in Jails and Prisons. *Clinical Infectious Diseases* 45(8):1047-1055, *at* https://doi.org/10.1086/521910.

health than the general population, and even at the best of times, medical care is limited..[5] Many people who are incarcerated also have chronic conditions, like diabetes or HIV, which makes them vulnerable to severe forms of COVID-19. According to public health experts, incarcerated individuals "are at special risk of infection, given their living situations," and "may also be less able to participate in proactive measures to keep themselves safe;" "infection control is challenging in these settings."[6] Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases.[7] In China, officials have confirmed the coronavirus spreading at a rapid pace in Chinese prisons, counting 500 cases.[8] Secretary of State Mike Pompeo has called for Iran to release Americans detained there because of the "deeply troubling" "[r]eports that COVID-19 has spread to Iranian prisons," noting that "[t]heir detention amid increasingly deteriorating conditions defies basic human decency."[9] Courts across Iran have granted 54,000 inmates furlough as part of the measures to contain coronavirus across the country.[10] In the U.S. steps are already being taken in some jurisdictions to facilitate the release of elderly and sick prisoners and to reduce jail populations by discouraging and refusing the admission of individuals arrested on non-violent misdemeanor

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

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

[7] *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, The Verge (Mar. 7, 2020) *at* https://bit.ly/2TNcN2Y.

[8] Rhea Mahbubani, *Chinese Jails Have Become Hotbeds of Coronavirus As More Than 500 Cases Have Erupted, Prompting the Ouster of Several Officials*, Business Insider (Feb. 21, 2020) *at* https://bit.ly/2vSzSRT.

[9] Jennifer Hansler and Kylie Atwood, *Pompeo calls for humanitarian release of wrongfully detained Americans in Iran amid coronavirus outbreak*, CNN (Mar. 10, 2020) *at* https://cnn.it/2W4OpV7.

[10] Claudia Lauer and Colleen Long, *US Prisons, Jails On Alert for Spread of Coronavirus*, The Associated Press (Mar. 7, 2020) *at* https://apnews.com/ad98b0a38aeaaedbcb059092db356697.

charges.[1]

Specific Conditions at York CI

1. As of February 2020 there are 884 inmates in custody at York CI with an average of 1-2 people entering each day;
2. York CI is the only State correctional facility for female offenders.
3. Activities to carry out representation are severely limited right now that all state correctional facilities have ceased visitations.
4. Like most facilities in the state dealing with the outbreak of COVID-19 in real time, York Correctional lacks the resources necessary to engage in screening and testing of inmates, correctional staff, law enforcement officers and other care and service providers who enter the facility.

As additional female offenders are arrested who have been out in the community as the coronavirus spreads, if they are not symptomatic, they will be brought into YORK CI and held with the existing population, potentially bringing COVID-19 into this population held in large numbers, close quarters, and low sanitary conditions

C.G.S Sec 54-69 allows for modification of bond if the bond set is excessive given the circumstances of the accused. The circumstances that existed when Ms. Williams-Void was ordered detained have now drastically changed. There is a pandemic that poses a direct risk that

[1] In New York Brooklyn District Attorney Eric Gonzalez, joined by public health experts, has asked Governor Cuomo to grant emergency clemencies to elderly and sick prisoners (Sarah Lustbader, *Coronavirus: Sentenced to COVID-19*, The Daily Appeal (Mar. 12, 2020) *at* https://theappeal.org/sentenced-to-covid-19/.); Cuyahoga County (Ohio) is holding mass pleas and bail hearings to reduce the current jail population (https://www.cleveland.com/court-justice/2020/03/cuyahoga-county-officials-will-hold-mass-plea-hearings-to-reduce-jail-population-over-coronavirus-concerns.html); Mahoning County (Ohio) jail is refusing all non-violent misdemeanor arrestees (https://www.wkbn.com/news/coronavirus/mahoning-county-jail-refusing-some-inmates-due-to-coronavirus-outbreak/); see also Collin County (TX) (https://www.dallasnews.com/news/public-health/2020/03/12/facing-coronavirus-concerns-collin-county-sheriff-says-police-not-to-bring-guilty-criminals-to-jail/).

is far greater if Ms. Williams-Void continues to be detained during this public health crisis.

Williams-Void is vulnerable because of her advanced age and compromised medical condition. Liberty is the norm and "detention prior to trial or without trials is the carefully limited exception." *United States v. Salerno*, 481 U.S. 739, 755 (1987). One charged with a crime is, after all, presumed innocent. *Stack v. Boyle*, 342 U.S. 1, 4 (1951). A single individual unnecessarily detained before trial is one individual too many, and the increasing use of the practice places tremendous wear on our constitutional system. *United States v. Montalvo-Murillo*, 495 U.S. 711, 723-24 (1990) (Stevens, J., dissenting, joined by Brennan and Marshall, JJ.). Due to the crucial interests involved, it follows that a "case-by-case" approach is required at any stage of the case in assessing the propriety of pretrial detention. *See United States v. Gonzales Claudio*, 806 F.2d 334, 340 (2d Cir. 1986) (discussing due process analysis for evaluating propriety of prolonged pretrial detention, and the interests at stake) (citations omitted), *cert. dismissed sub nom., Melendez-Carrion v. United States*, 479 U.S. 978 (1986).

The courts have long recognized that there is no greater necessity than keeping a defendant alive, no matter the charge. As Judge Weinstein held, "We do not punish those who have not been proven guilty. When we do punish, we do not act cruelly. Continued incarceration of this terminally ill defendant threatens both of these fundamental characteristics of our democracy." *United States v. Scarpa*, 815 F.Supp.88 (E.D.N.Y. 1993) (pretrial defendant with AIDS facing murder charges released on bail because of the "unacceptably high risk of infection and death on a daily basis inside the MCC").

This Court should consider the "total harm and benefits to prisoner and society" that continued pretrial imprisonment of Ms. Williams-Void will yield, relative to the heightened health risks posed to her during this rapidly encroaching pandemic. *See Davis v. Ayala*, 135 S.

Ct. 2187, 2209 (2015) (Kennedy, J., concurring) (calling for heightened judicial scrutiny of the projected impact of jail and prison conditions on a defendant); *United States v. Mateo*, 299 F. Supp. 2d 201, 212 (S.D.N.Y. 2004) (reducing sentence where defendant's pretrial conditions were "qualitatively more severe in kind and degree than the prospect of such experiences reasonably foreseeable in the ordinary case").

Conditions of Release Are Available That Allow Ms. Williams-Void To Be Treated Humanely While Also Ameliorating Any Danger To The Community

From Ms. William-Void's perspective her life—not only her liberty—is on the line, creating a powerful incentive to abide by any release conditions the Court may impose and changing the calculus that initially led to the denial of bail in this case. While the charges against Ms. Williams-Void are serious; they are not of a violent nature. Ms. Williams-Void has never failed to appear in court and her last criminal conviction was in 2002. She poses little to no risk in her compromised medical state to anyone. Non-financial conditions of release are more than sufficient to ensure her appearance in court. Releasing her on a conditional promise to appear with electronic monitoring and pre-trial supervision should be more than enough to assure her continued appearance in court; while not further compromising her medical condition.

The elderly and chronically ill, no matter what crime they are accused of, pose a lower risk of violating supervision, particularly during a global pandemic during which even leaving the house will endanger their lives.

Conclusion

Ms. Williams-Void is among the vulnerable population at heightened risk of getting very sick from this illness. For all of the above reasons, Williams-Void should be granted release on bond.

RESPECTFULLY SUBMITTED
Patrikate Williams-Void

BY: _____

Tiana Victoria Hercules
Public Defender Juris # 439790
Deputy Assistant Public Defender
Superior Court, G.A. #15
20 Franklin Square
New Britain, CT 06051
(860) 515-5372
tiana.hercule@jud.ct.gov

ORDER

The foregoing motion having been heard, it is hereby ordered GRANTED/DENIED

BY THE COURT

_____ _____
JUDGE

4/3/20

CERTIFICATION

It is hereby certified pursuant to Practice Book, that a copy of the foregoing was delivered to the office of the State's Attorney for the Judicial District of ~~Hartford~~ New Britain CJD this 24th day of, March, 2020.

_____ TVH
Tiana Victoria Hercules
Commissioner Superior

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT O

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT., et al, *Defendants,*	:	MAY 18, 2020

DECLARATION OF WARDEN MOLDEN

I, Derrick Molden DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for over 17 yrs.
3. Currently I hold the position of Warden of Manson Youth Institution ("MYI").
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility once a week for general population and twice a week for special population. I have been touring more frequently than that since the pandemic began. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. MYI is a correctional facility with a specialized population of inmates under the age of twenty-one (21). It consists of cells divided into seven units, with an eighth unit available for quarantine and isolation for medical reasons. There are 36 cells per unit. Each unit is divided

up into 3 wings. The population has declined significantly since the pandemic. On March 1, 2020, there were 284 inmates at MYI. On May 7, 2020, there were 237.

6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have ensured that we are not allowing more than six inmates out at a time. Meals are served in the unit, but we only let three cells (i.e. a maximum of six inmates) out at a time. As there are six tables in each common area, spaced at least six feet apart, eating can occur while maintaining social distancing. In any case, most inmates choose to eat in their cells.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. Guidance takes the form of posters with information from the CDC and we also developed an FAQ document. I am aware that the posters have been hung up because I have observed them and I stayed late one night to ensure they were all hung up. The guidance provided is attached here as **Exhibit A**.

8. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic, and the facility is the cleanest that I have ever seen it. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned when the lieutenant came out to clean typically once per shift or as needed. Due to the pandemic, we are not just cleaning at these points in time; rather, we are continuously cleaning whenever inmates are allowed out of their cells. Cleaning is performed using Lemon All. I know that this cleaning has been occurring because I have personally observed it.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Officers have access to hand sanitizer wall units.

14. Handcuffs are cleaned between use, and also cleaned by the armory officer.

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least two cloth masks, with plans to distribute two additional cloth masks in two weeks. Inmates have been required to wear a cloth mask every time they exit their cell. The inmate's masks are laundered at least once per week. They send two masks out to be laundered and retain two for use that week.

16. Staff have also all been issued at least a cloth mask. As of April 22, 2020, staff are required to wear at least a cloth mask at all when social distancing is not possible, and, to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by a supervisor. I know this because I have observed this.

17. In addition to cloth masks, staff could be required to don other PPE, depending on the situation at hand, including goggles, tyvex suits, N95 masks, and gloves.

18. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation.

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html. Attached hereto as Exhibit B.

I am also screened prior to entry to the facility. If staff are sick, they can stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. Areas the staff member was in for significant periods of time are cleaned thoroughly with disinfectant.

20. If an inmate displayed symptoms of COVID-19, he would be moved to a medical unit (if there was only one) or a quarantine unit if there was more than one, and tested. Their living areas would be locked down and cleaned.

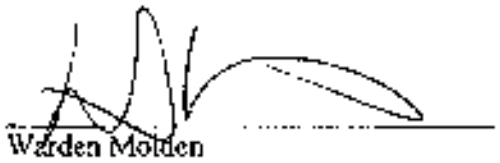
21. If an inmate tests positive for COVID-19 (and no inmate to date has tested positive), he would be moved to an isolation unit immediately and be cared for by medical staff. Due to the age of MYI's population being under 21, inmates will be cared for at MYI and not transported to Northern.

22. I have had my facility's records reviewed and as of May 8, 2020, MYI has not had any grievances filed regarding COVID-19. If there were any grievances related to COVID-19 we would expedite them to address the issue as quickly and efficiently as possible.

23. The grievance process is available to inmates in my facility. Although very few inmates at MYI ever file grievances, either before or during the pandemic, any grievance an inmate filed would be processed.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Detrick Molden declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.



Warden Molden

EXHIBIT A

Attention

All members of the population, if you're reading this sign you should be wearing a mask.

Thank you!

What Is Social Distancing?

Social distancing means keeping enough space between people to avoid the spread of germs. Experts say the right amount of space is 6 feet (2 meters). We all try not to get too close to people when they (or we) are sick with any contagious virus. But social distancing is more than staying away from people who are sick or coughing or who don't feel well. It means keeping a safe distance from everyone for now, even people who look and feel perfectly healthy. Even though we feel perfectly healthy.

Social distancing is a new idea for most of us. But it's not new to scientists who study the spread of diseases. They know it's something we all can do to make a big difference in the spread of coronavirus (COVID-19).

How Does Social Distancing Help?

When everyone in a community does it, social distancing slows the spread of the coronavirus. The result is that fewer people get sick at the same time.

When fewer people are sick, doctors and hospitals are better able to keep up with taking care of people. Scientists have time to work on vaccines that can help prevent people from getting sick.

Why Is Social Distancing so Important Now?

A few things about this new coronavirus make social distancing so important:

- The new coronavirus is very contagious. It spreads quickly and easily from person to person. It can spread when someone who has the virus coughs, sneezes, or just breathes too close to someone else.
- Coronavirus can cause some people to become seriously sick.
- People can have the virus and pass it on even before they know they have it, even if they don't show symptoms or become sick.
- This is a new virus for humans, and there's no vaccine yet to help us become immune to it.

What do I need to know about washing my hands effectively?

Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; after blowing your nose, coughing, or sneezing; and after handling anything that's come from outside your cell.

- Use soap and water, covering all surfaces of your hands and rubbing them together until they feel dry.

- Always wash hands with soap and water if hands are visibly dirty.

Atención

Todos los miembros de la población,
si está leyendo este letrero,
debería usar una máscara.
¡Gracias!

C VID 19 STO OF GERMS

Avoid close contact with people who are sick.

Clean and disinfect frequently touched objects and surfaces.

Avoid touching your eyes, nose, and mouth.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds

EXHIBIT B

CDC

Handwashing: Clean Hands Save Lives

Hand Sanitizer Use Out and About

Germs are everywhere! They can get onto hands and items we touch during daily activities and make us sick. Cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you.

There are important differences between washing hands with soap and water and using hand sanitizer. Soap and water work to remove all types of germs from hands, while sanitizer acts by killing certain germs on the skin. Although alcohol-based hand sanitizers can quickly reduce the number of germs in many situations, they should be used in the right situations. Soap and water are more effective than hand sanitizers at removing certain kinds of germs like norovirus, *Cryptosporidium*, and *Clostridioides difficile*, as well as chemicals.

Hand sanitizers also may not remove harmful chemicals, such as pesticides and heavy metals like lead.

Handwashing reduces the amounts of all types of germs, pesticides, and metals on hands. Knowing when to clean your hands and which method to use will give you the best chance of preventing illness.

When should I use?

Soap and Water

- **Before, during, and after** preparing food
- **Before** eating food
- **Before and after** caring for someone who is sick with vomiting or diarrhea
- **Before** and **after** treating a cut or wound
- **After** using the toilet
- **After** changing diapers, or cleaning up a child who has used the bathroom
- **After** touching an animal, animal feed, or animal waste
- **After** handling pet food or pet treats
- **After** touching garbage
- If your hands are visibly dirty or greasy

Alcohol-based Hand Sanitizer

- **Before and after** visiting a friend or loved one in a hospital or nursing home, unless the person is sick with *Clostridioides difficile* (if so, use soap and water to wash hands).
- If soap and water are not readily available, use an alcohol-based hand sanitizer that contains **at least 60%** alcohol and wash with soap and water as soon as you can.

DO NOT use hand sanitizer if your hands are visibly dirty or greasy—for example, after gardening, playing outdoors, fishing, or camping. If a handwashing station is available, wash your hands with soap and water instead.

After blowing your nose, coughing, or sneezing, you should clean your hands by immediately washing your hands with soap or using alcohol-based hand sanitizer to avoid spreading germs.

How should I use?

Soap and Water

- **Wet** your hands with clean running water (warm or cold), turn off the tap, and apply soap.
- **Lather** your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
- **Scrub** your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song twice.
- **Rinse** your hands under clean, running water.
- **Dry** your hands using a clean towel or air dry them.

Alcohol-based Hand Sanitizer

Use an alcohol-based hand sanitizer that contains **at least 60% alcohol**. Supervise young children when they use hand sanitizer to prevent swallowing alcohol, especially in schools and childcare facilities.

- Put enough sanitizer on your hands to cover all surfaces.
- Rub your hands together until they feel dry (this should take around 20 seconds).

Do NOT rinse or wipe off the hand sanitizer before it's dry; it may not work well against germs.

More Information

- Show Me the Science – When & How to Use Hand Sanitizer in Community Settings
- When and How to Wash Your Hands
- Publications, Data and Statistics

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT P

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
V.	:	
NED LAMONT, et al. *Defendants,*	:	MAY 18, 2020

DECLARATION OF WARDEN HANNAH

I, Amonda Hannah DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for twenty- six (26) yrs.
3. Currently I hold the position of Warden of Garner Correctional Institution.
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week. I physically tour the entire facility once per week, although I have been touring more often since the beginning of the pandemic. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. Garner Correctional Institution is a correctional facility that consists of cells divided into eleven (11) units with approximately 46-48 two person cells per unit. Garner is the state's primary facility for housing male inmates who have significant mental health needs. The

population in the mental health housing units was relatively low compared with other facilities, even before the pandemic.

6. Since the pandemic, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have canceled social visits, collective religious services, gym recreation, attendance at school, group programs. We have also begun feeding inmates in their cells so they are not eating together in day rooms, separated inmate kitchen workers into two different shifts so that we are not intermingling housing units, and passing out medications within the housing units. We have also eliminated any activities that would require different housing units to be in contact with each other.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided consists of CDC guidance. It has been provided in the form of posters and handouts. Additionally, I have explained the guidance while touring and when asked by the inmate population. I am aware that this guidance has been distributed because I have observed the posters while on tour. The guidance is attached hereto as **Exhibit A.**

8. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned once per shift. Due to the pandemic, this has been increased to twice on first and second shift, and once on third (on third shift, there is little human activity in the common areas) and general cleaning takes place with particular focus on common touch points such as door handles, light fixtures, table tops, etc. Cleaning is performed using bleach and lemon all. In addition, we have a work crew equipped with backpack cleaners containing bleach and water

that sprays rails, doors, walls in all areas of the facility. I know that this cleaning has been occurring because I have personally observed it.

9. My facility has communal showers that are used by inmates. There are approximately eight to fifteen inmates per shower. Communal showers are cleaned frequently, and at least once per shift. Due to the time it takes for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know this cleaning is occurring as I have been informed that it is by my unit managers.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. In all blocks, except for the restricted housing unit and the infirmary, the inmates who inhabit the cells are expected to clean their own cells. They are provided with spray bottles with lemon aid, mops, and brooms upon request, and we have increased the amount of cleaning supplies available on the units for inmate use. The cleaning products utilized are only diluted to the manufacturer's instructions. It would be dangerous to the inmates' health and safety to provide them with undiluted cleaning solutions. I know this is occurring I have personally observed it.

11. There is approximately one telephone per fifteen inmates at my facility. They are cleaned every recreation period, and inmates can request cleaning products to clean the telephone before they use it, although many choose not to and will hold the telephone with a sock rather than clean it or touch it directly. I know this is occurring because of personal observation.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap have been

distributed for free to inmates upon request. I know this soap distribution is occurring because I have been told that it is.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Officers were recently provided with hand sanitizer.

14. Handcuffs are not typically used on multiple inmates; however, they are re-used during escorts in the Restrictive Housing and Inpatient Units. We will ensure that the handcuffs are sanitized after each escort. If there is a biohazard potential, restraints are decontaminated before further use.

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least three cloth masks and we will distribute more as long as there are masks to supply. Inmates have been required to wear a cloth mask whenever they are out of their cell since April 22, 2020. They may send their masks to the laundry to clean them. Inmates have generally been compliant with wearing masks. I know this because I see them wearing the masks when I tour and I have only seen one disciplinary report for not wearing a mask.

16. Staff have also all been issued at least a cloth mask. As of April 22, 2020, staff are required to wear at least a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html.

a supervisor. I know this because of personal observation. Gloves are worn by staff during the escorts and or pat searches of inmates.

17. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. Staff have been given surgical masks once a week since April 13, 2020. N95 masks and other PPE would be available for staff in a quarantine unit; however, there have been no symptomatic or positive inmates at Garner to date.

18. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick or symptomatic, they must stay home; all staff have been given an additional two calendar weeks of leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. The area(s) in which the staff member spent any significant time are thoroughly cleaned and disinfected.

20. If an inmate displays symptoms of COVID-19, which has not occurred to date, he would be processed into the quarantine area along with his cellmate, if they had one. Their original cell and housing unit would be thoroughly cleaned and disinfected.

21. If an inmate tests positive for COVID-19 Garner would not send any inmate from its mental health units to the Northern COVID-19 ward; instead, it would care for these inmates at Garner itself. Garner would send its general population inmates to the Northern CI COVID-19 ward. Most of the facility consists of mental health inmates and not general population inmates.

22. I have had my facility's records reviewed and as of May 8, 2020, Frank Kelly #404548 and Tyrone Spence #367464 have not filed a grievance about the issues raised in their affidavits.

23. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. As of May 18, 2020, no inmate at Garner has filed a grievance about COVID-19. I have instructed my Administrative Remedies Coordinator to process COVID-19 related grievances in an expedited manner.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Amonda Hannah declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden Amonda Hannah

EXHIBIT A

3/10/20

NOTICE TO INMATE POPULATION

The Department of Correction is following all precautions related to the COVID-19 coronavirus as dictated by the Centers for Disease Control and Prevention (CDC). Please contact a staff member if you are experiencing any of the three common symptoms below:

Fever

Cough

Shortness of breath

The $3 co-pay has been temporarily suspended until further notice so that

anyone exhibiting signs of illness can seek medical attention and remain healthy.

Continue following these preventative practices:

- Frequent handwashing with soap and water
- Avoid touching your face, eyes, nose and mouth
- Avoid greeting others with a handshake

As a reminder the annual influenza shot, recommended by the CDC, is still available to the population. Please write to health services.

IMPORTANT NOTICE TO OUR INMATE POPULATION

As part of the Department of Correction's efforts to contain the spread of the coronavirus

All social visits have been suspended until further notice.
Meals will take place inside the unit

Only USD#1 classes will be held

Religious Services will be conducted by DOC Chaplains

Volunteers services have been suspended

Commissary and Laundry services will continue as usual

Securus is providing each offender two free phone calls per week for the next 30 days.

Your cooperation in helping to minimize the spread of the coronavirus is greatly appreciated.

Continue to follow these preventative practices:

- Frequent handwashing with soap and water
- Avoid touching your face, eyes, nose and mouth
- Avoid greeting others with a handshake

Please contact a staff member if you are experiencing any of these symptoms:
Fever, Cough, Shortness of breath

We are well aware of the impact these restrictions will have. However, these precautions are necessary at this time to ensure everyone's health and safety. We are continually reassessing the situation and will keep you updated on any new developments.

ATTENTION

Due to Public Health Concerns related to the coronavirus, and for the safety of the inmate population, public and staff

NO VISITS

UNTIL FURTHER NOTICE

Atención

Debido a preocupaciones de salud pública debido al coronavirus, y por la seguridad de la población de internos, público y personal:

Sin visitas Hasta más darse cuenta

IMPORTANT NOTICE TO OUR INMATE POPULATION

As part of their effort to minimize the spread of COVID-19

EFFECTIVE March 17, 2020

DUE TO THE PRESENT COVID-19 SITUATION ALL NON-EMERGENCY APPOINTMENTS OUTSIDE OF THE FACILITY FOR THE NEXT 30 DAYS WILL BE CANCELLED TO ALLOW HEALTH WORKERS TO FOCUS ON COVID-19 CARE.

These cancellations apply to everyone, including members of the public.

The DOC Health Services Staff will continue to provide you with the best care possible within our facilities.

Please contact a staff member if you are experiencing any of these symptoms:
Fever, Cough, Shortness of breath

AVISO IMPORTANTE AL CONFINADO

Como parte de nuestro esfuerzo para contener el virus de COVID-19

EFECTIVO 17 DE MARZO DEL 2020

**DEBIDO A LA SITUACIÓN ACTUAL DE COVID-19:
TODAS LAS CITAS MEDICAS QUE NO SON EMERGENCIAS AFUERA DE LA INSTITUCION
SERÁN CANCELADAS POR LOS PRÓXIMOS 30 DÍAS. ESTO ES PARA PERMITIR QUE LOS TRABAJADORES DE SALUD SE ENFOQUEN EN EL CUIDADO DE COVID-19.**

Estas cancelaciones se aplican a todos incluidos los miembros del público.

El personal de DOC Servicio de Salud continuara proveyendo la mejor atención posible dentro de nuestras instituciones .

**Comuníquese con un miembro del personal si tienes algunos de estos síntomas:
Fiebre, tos o dificultad para respirar.**

COVID 19 INFO SHEET

WHAT IS COVID 19?

- It's a new strain of the coronavirus, which causes a cold that can lead to pneumonia. It didn't exist before this winter. This means NO ONE is immune.
- It's very contagious. It spreads like the common cold or worse. It lives in (saliva) spit and (mucus) snot. It lives on metal or plastic surfaces (phones, tables, hand rails) for DAYS.
- Current estimates are that about half (50%) of all people in the world will get coronavirus this year. That's 1 in 2.
- Fortunately, most folks will be fine. If you catch it you might not even notice, because most people don't get super sick. In fact, some people, especially young people, get infected and don't feel a thing.
- Because it's so contagious, even if you don't feel sick when you catch it, it uses you to reproduce. The virus turns your nose into a virus making machine, so you'll spread it without even knowing it.

HOW DOES THIS AFFECT ME?

- If you're young and healthy- it might not affect you at all.
- If you are older and have asthma, high blood pressure or diabetes, you are at higher risk that the virus could turn into pneumonia (an infection goes to a person's lungs making it difficult to breathe).
- Because its so contagoius, social visits have been stopped (for now).
- Movement within facilities will be limited.
- Limited group programming
- Smaller number of people out for rec (if at all)
- If you have symptoms, you may be kept separate (quarantined) to be monitored more closely and cared for appropriately.
- Medications will be reviewed and renewed to reduce face to face contact, to prevent interruption in care.

HOW CAN I PROTECT MYSELF?

- As much as possible, stay away from people. Don't touch things. Don't touch people. Avoid being around others as much as possible.
- Cover your mouth with your elbow when you sneeze or cough.
- ***Wash your hands often*** – Soap actually works. If you need more, please alert staff.
- Clean your cell.
- Don't shake hands/ hug/ or fist bump.
- When possible, keep 6 feet from you and another person (social distancing).
- If you feel like you have a fever, tell someone immediately

COVID 19 INFO SHEET

WHAT YOU CAN DO TO HELP SLOW THE SPREAD

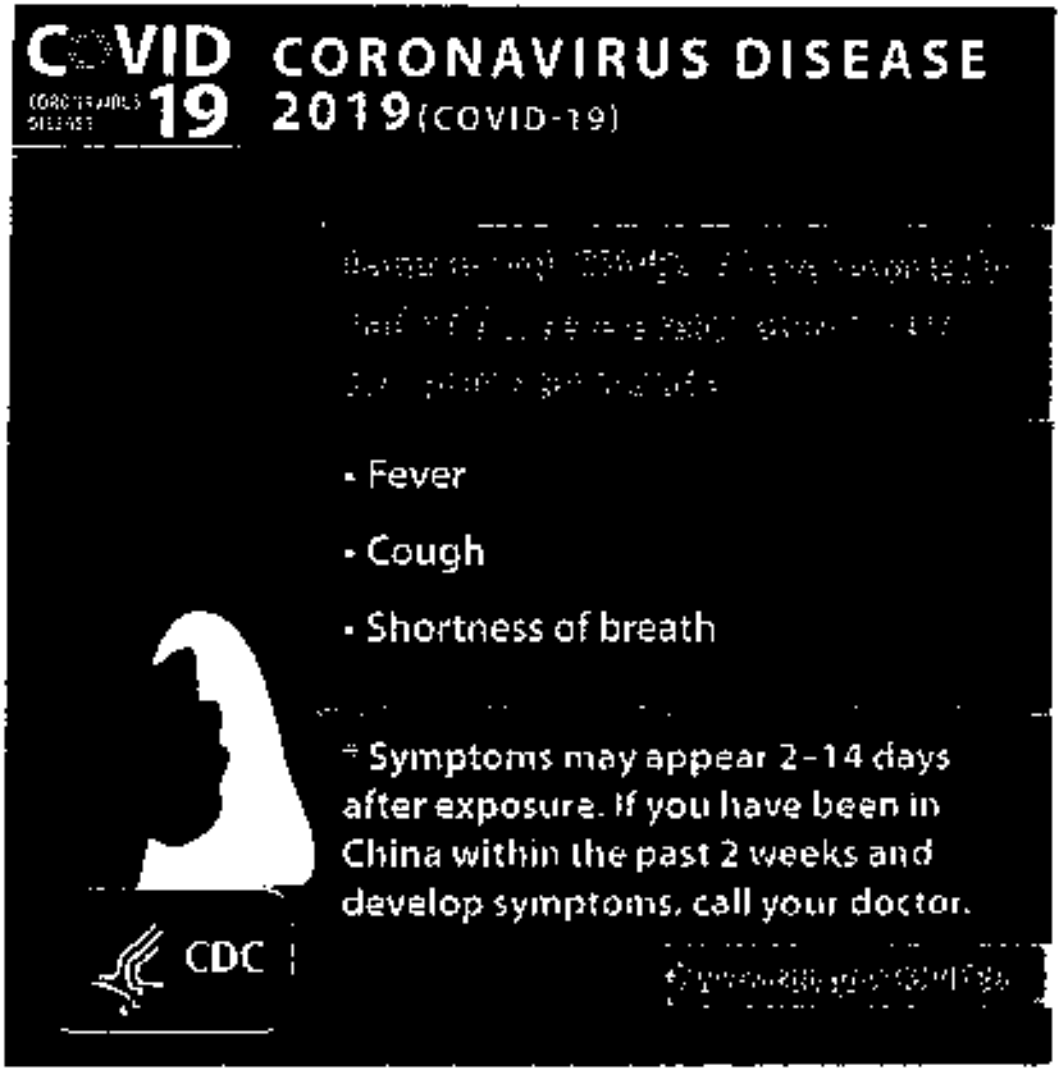
- Avoid unnecessary requests to be seen by medical. The fewer people in medical, the better.
- Let medical staff be available for those folks who do get sick and need their attention.
- If you are sick, or having problems with medications, please write to be seen.
  - We ask that you write specific requests; so, if possible, staff can triage the request and, if able, address your request in writing.
  - *As always*, tell staff if you are having a medical emergency
- Avoid close contact with others, avoid shaking hands, fists bumps and hugs
- Cover your mouth with your elbow if you sneeze or cough
- Wash your hands often

WHAT STAFF IS DOING

- We are taking temps of all employees before entering their facilities to reduce the possible spread to our population.
- We are taking temps of all inmates when they are leaving and returning into our facilities including a COVID 19 screening.
- Staff is practicing social distancing and good handwashing techniques
- Staff is going to work together to make sure you have what you need to get through this time.

WHAT WE CAN DO TOGETHER

- Stay patient and understand that this is a situation we have never been in before
- It takes EVERYONE's commitment to practice the above to slow the spread.
- We will need to be flexible and adapt to this situation as we learn more. What we do today may need to change tomorrow. We will make every effort to keep you all informed as soon as we can.
- We don't know how quickly things will change. Our goal is to keep **EVERYONE** safe and healthy. **ALL** decisions being made are for that goal.
- We understand this is going to be difficult. If at any time you are having difficulty dealing with this and have thoughts to hurt yourself, **PLEASE TELL STAFF IMMEDIATELY.**



Risk Assessment

Outbreaks of novel virus infections among people are always of public health concern. The risk from these outbreaks depends on characteristics of the virus, including how well it spreads between people, the severity of resulting illness, and the medical or other measures available to control the impact of the virus (for example, vaccine or treatment medications). The fact that this disease has

caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic. As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.

The potential public health threat posed by COVID-19 is high, both globally and to the United States.

But individual risk is dependent on exposure.

- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- Under current circumstances, certain people will have an increased risk of infection, for example healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.

However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, the risk assessment would be different.

If you are feeling ill and experience the above symptoms submit a request to medical to be seen.

COVID 19 CORONAVIRUS DISEASE

What to do if you are sick with coronavirus disease 2019 (COVID-19)

If you are sick with COVID-19 or suspect you are infected with the virus that causes COVID-19, follow the steps below to help prevent the disease from spreading to people in your home and community.

Stay home except to get medical care

You should restrict activities outside your home, except for getting medical care. Do not go to work, school, or public areas. Avoid using public transportation, ride-sharing, or taxis.

Separate yourself from other people and animals in your home

People: As much as possible, you should stay in a specific room and away from other people in your home. Also, you should use a separate bathroom, if available.

Animals: Do not handle pets or other animals while sick. See [redacted] for more information.

Call ahead before visiting your doctor

If you have a medical appointment, call the healthcare provider and tell them that you have or may have COVID-19. This will help the healthcare provider's office take steps to keep other people from getting infected or exposed.

Wear a facemask

You should wear a facemask when you are around other people (e.g., sharing a room or vehicle) or pets and before you enter a healthcare provider's office. If you are not able to wear a facemask (for example, because it causes trouble breathing), then people who live with you should not stay in the same room with you, or they should wear a facemask if they enter your room.

Cover your coughs and sneezes

Cover your mouth and nose with a tissue when you cough or sneeze. Throw used tissues in a lined trash can; immediately wash your hands with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60 to 95% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty.

Avoid sharing personal household items

You should not share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people or pets in your home. After using these items, they should be washed thoroughly with soap and water.

Clean your hands often

Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

Clean all "high-touch" surfaces every day

High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Also, clean any surfaces that may have blood, stool, or body fluids on them. Use a household cleaning spray or wipe, according to the label instructions. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves and making sure you have good ventilation during use of the product.

Monitor your symptoms

Seek prompt medical attention if your illness is worsening (e.g., difficulty breathing). Before seeking care, call your healthcare provider and tell them that you have, or are being evaluated for, COVID-19. Put on a facemask before you enter the facility. These steps will help the healthcare provider's office to keep other people in the office or waiting room from getting infected or exposed.

Ask your healthcare provider to call the local or state health department. Persons who are placed under active monitoring or facilitated self-monitoring should follow instructions provided by their local health department or occupational health professionals, as appropriate.

If you have a medical emergency and need to call 911, notify the dispatch personnel that you have, or are being evaluated for COVID-19. If possible, put on a facemask before emergency medical services arrive.

Discontinuing home isolation

Patients with confirmed COVID-19 should remain under home isolation precautions until the risk of secondary transmission to others is thought to be low. The decision to discontinue home isolation precautions should be made on a case-by-case basis, in consultation with healthcare providers and state and local health departments.

CDC

[redacted]

For more information: www.cdc.gov/COVID19

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT Q

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al. *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT., et al. *Defendants*,	:	MAY 1, 2020

DECLARATION OF WARDEN BRYAN VIGER

I, Bryan Viger DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 18 yrs.
3. Currently I hold the position of Warden of New Haven Correctional Center ("New Haven CC").
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility 2-3 times per week, and additionally, I am present in at least some housing units within the facility 2-3 times per week. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. As of May 7, 2020, the New Haven CC facility count was 605 inmates, reduced from the March 1, 2020 facility count of 679 inmates. EXHIBIT A.

6. New Haven CC is a correctional facility that consists of both cells and dorms divided into 12 units. Of the 12 units, there are 9 celled units and 3 dorm units. Celled units hold 51 inmates (Alpha – Hotel) and Sierra has 62 beds and the hospital has 10 beds; each dorm (East and West) have 128 beds and the Golf Unit has 74 beds.

7. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have reduced the number of offenders that exit their cell at any given time. Prior to implementing this, (17) seventeen inmates would go into a dayroom. Since the implementation, only 8-9 inmates are out at any given time, for use of the phone and / or shower. All units are fed back, either in their cell or on their bunk. All recreational activities have been suspended and all visits have been cancelled. Units are thoroughly cleaned at least 3-4 times a day, to include the population having the equal opportunity to clean their cells. Additional masks, soap, toilet paper, clean linens and cleaning agents have been provided to the inmate population.

8. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to practice proper social distancing, practice frequent handwashing, avoid touching face, eyes, nose and mouth, inform someone if they are not feeling well, and wear the provided masks. It has been provided in the form of CDC posters that are placed in all housing units and reinforced with constant oral reminders. I am aware that this guidance has been distributed because I view it while touring the facility.

9. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned once or twice daily. Due to the pandemic, this has been increased to minimum of 4 times / day. Cleaning is performed using mops, spray bottles, towels, sponges, brooms, bleach, gloves, masks, etc. I know that this cleaning has been occurring because I have personally observed it. I have reviewed log books, I have had camera footage reviewed, I have spoken to supervisors and staff, and I have spoken to inmate workers and the population. In early May, New Haven CC obtained two Field King Max Backpack Sprayers. Starting May 10, 2020, these sprayers are being used to disinfect and sanitize the entire facility.

10. My facility has communal showers that are used by inmates. There are approximately 8 inmates per shower. Communal showers are cleaned frequently, approximately 4-5 times a day. Due to the time it takes for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know this is occurring for the same reasons stated in #8.

11. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. All inmates are provided an opportunity to clean / sanitize their living quarters with LemonAll and bleach at least 4 times / daily, in addition to the 4 designated times for unit cleanup. I know this is occurring for the same reasons stated in #8 and #9.

12. There are approximately 2 telephones per tier (17 inmates) at my facility. They are cleaned frequently, a minimum of 4 times a day, and are able to be sanitized after each use with LemonAll, during out of cell time. I know this is occurring for the same reasons stated above.

13. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap were / are distributed, for free, to inmates on a weekly basis (typically Fridays) and will continue to be distributed on a weekly basis or as needed for the duration of the pandemic. I know this soap distribution is occurring for reasons stated above.

14. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] EXHIBIT B. The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Staff do have on person, personally owned / controlled hand sanitizer.

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least (4) cloth masks. Masks are provided weekly (typically Friday). Inmates have been required to wear a cloth mask when outside their cell or living cube (dorm). The population, as a whole, has been cooperative, with regards to the use of masks. Inmates have been provided several masks and as such, masks can and have been laundered with their uniforms. I know the mask distribution and compliance is happening for the same reasons as listed previously.

[1] See https://www.cdc.gov/handwashing/hand-sanitizer-use.html

16. Staff have also all been issued at least a cloth mask. As of Wednesday, April 22, 2020, staff are required to wear at least a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by a supervisor. I know this because of my continued presence inside of New Haven CC and I have personally observed this.

17. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. All staff assigned to NHCC have been provided at least (4) N95 masks, as of Thursday, April 30, 2020. Masks (surgical, cloth and N95) are provided weekly to staff (typically Mondays). In addition to masks, face shields have been provided to all medical staff and are available for all housing units (at least 2 per each unit), to include the Admitting and Processing room. Those with direct contact, in quarantine units (Sierra, Hospital and Foxtrot Left, all celled units) have available gowns and other PPE available, if needed.

18. Staff are screened prior to entry to and exiting the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick, they can stay home; all staff have been given an additional 14 calendar of paid leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. Cleaning of all areas happens at least (4) times / day. Staff clean all officers' station areas prior to and during their shift.

20. If an inmate displays symptoms of COVID-19, they are moved to Sierra Unit, where they are swabbed for COVID-19. Once the results are provided (typically 24-48 hours), they are either returned to their housing unit, if negative, or moved to Foxtrot Left, if positive. Once confirmed positive, they are scheduled for transfer to Northern Correctional Institution. Prior to their departure, they are provided medical treatment at the facility. The area where the inmate(s) came from are sanitized and taken offline for 24 hours. If there was a cellmate, he too is monitored / swabbed.

21. If an inmate tests positive for COVID-19 he is moved to Foxtrot left, provided farther medical attention and transferred to NCI within 24 hours.

22. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed.

DECLARATION UNDER PENALTY OF PERJURY PURSUANT TO 28 U.S.C. § 1746

I, Bryan Viger, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on _May_ _17_, 2020.

Warden Bryan Viger

EXHIBIT A

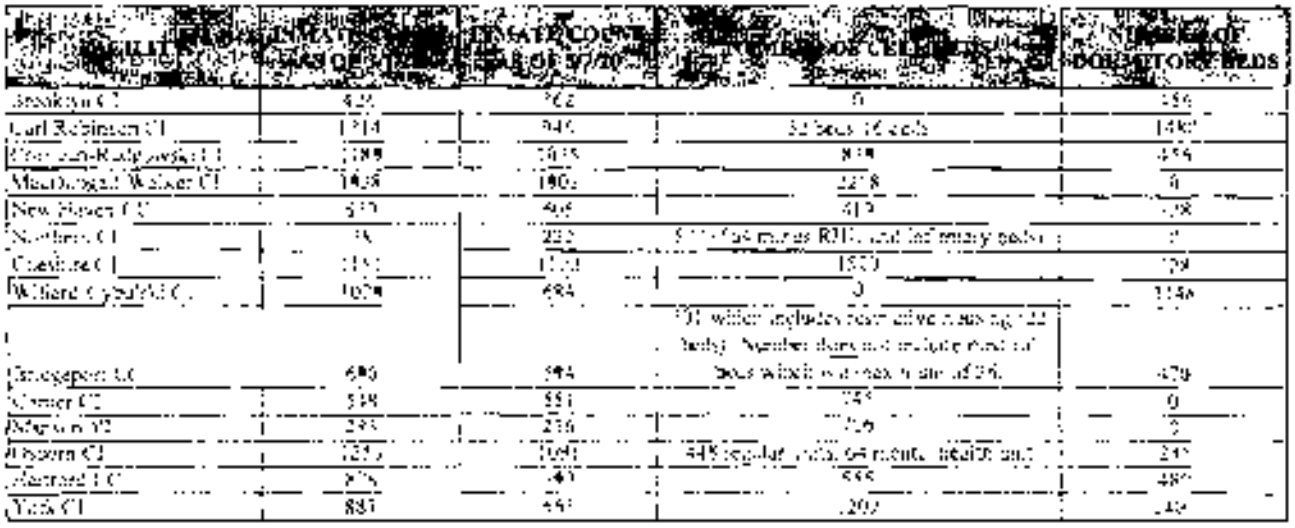


EXHIBIT B

CDC Centers for Disease Control and Prevention

Handwashing: Clean Hands Save Lives

Show Me the Science – When & How to Use Hand Sanitizer in Community Settings

Note: For hand hygiene guidance in healthcare settings, please visit the Clean Hands Count webpage.

CDC recommends washing hands with soap and water whenever possible because handwashing reduces the amounts of all types of germs and chemicals on hands. But if soap and water are not available, using a hand sanitizer with at least 60% alcohol can help you avoid getting sick and spreading germs to others. The guidance for effective handwashing and use of hand sanitizer in community settings was developed based on data from a number of studies.

Alcohol-based hand sanitizers can quickly reduce the number of microbes on hands in some situations, but sanitizers do *not* eliminate all types of germs.

Why? Soap and water are more effective than hand sanitizers at removing certain kinds of germs, like *Cryptosporidium*, norovirus, and *Clostridioides difficile*.[1] Although alcohol-based hand sanitizers can inactivate many types of microbes very effectively when used correctly,[2] people may not use a large enough volume of the sanitizer,[3] or may wipe it off before it has dried.[4]

Hand sanitizers may not be as effective when hands are visibly dirty or greasy.

Why? Many studies show that hand sanitizers work well in clinical settings like hospitals, where hands come into contact with germs but generally are not heavily soiled or greasy.[5] Some data also show that hand sanitizers may work well against certain types of germs on slightly soiled hands.[6,7] However, hands may become very greasy or soiled in community settings, such as after people handle food, play sports, work in the garden, or go camping or fishing. When hands are heavily soiled or greasy, hand sanitizers may not work well.[8,9] Handwashing with soap and water is recommended in such circumstances.

Hand sanitizers might not remove harmful chemicals, like pesticides and heavy metals, from hands.

Why? Although few studies have been conducted, hand sanitizers probably cannot remove or inactivate many types of harmful chemicals. In one study, people who reported using hand sanitizer to clean hands had increased levels of pesticides in their bodies.[10] If hands have touched harmful chemicals, wash carefully with soap and water (or as directed by a poison control center).

If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.

Why? Many studies have found that sanitizers with an alcohol concentration between 60-95% are more effective at killing germs than those with a lower alcohol concentration or non-alcohol-based hand sanitizers [1]. Hand sanitizers without 60-95% alcohol 1) may not work equally well for many types of germs, and 2) merely reduce the growth of germs rather than kill them outright.

When using hand sanitizer, apply the product to the palm of one hand (read the label to learn the correct amount) and rub the product all over the surfaces of your hands until your hands are dry.

Why? The steps for hand sanitizer use are based on a simplified procedure recommended by CDC [2]. Instructing people to cover all surfaces of both hands with hand sanitizer has been found to provide similar (or greater) effectiveness as providing detailed steps for rubbing-in hand sanitizer [3].

Swallowing alcohol-based hand sanitizers can cause alcohol poisoning.

Why? Ethyl alcohol (ethanol)-based hand sanitizers are safe when used as directed [4], but they can cause alcohol poisoning if a person swallows more than a couple of mouthfuls.

From 2011 – 2015, U.S. poison control centers received nearly 85,000 calls about hand sanitizer exposures among children [5]. Children may be particularly likely to swallow hand sanitizers that are scented, brightly colored, or attractively packaged. Hand sanitizers should be stored out of the reach of young children and should be used with adult supervision. Child-resistant caps could also help reduce hand sanitizer-related poisonings among young children [6]. Older children and adults might purposefully swallow hand sanitizers to become drunk [7].

References

[illegible]

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT R

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al, *Defendants*,	:	MAY 18, 2020

DECLARATION OF WARDEN MCCORMICK

I, NED MCCORMICK DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 22 years.
3. Currently I hold the position of Warden of Hartford Correctional Center.
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week. I physically tour the entire facility one or two times per week, and I am present in at least some housing units within the facility nearly daily. I also maintain regular communication with my deputy wardens and my unit supervisors.
5. Hartford Correctional Center is a correctional facility that consists of cells and dorms. As of May 6, 2020, Hartford Correctional Center has four dorms with 120 beds per unit, eight cell blocks with 60 cells per unit, a Restricted Housing Unit with 14 cells, and South Block with 30 cells for special management of inmates. We have not opened any overflow dorms. We designated a new intake block where newly admitted inmates are quarantined for 14 days.

6. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. Our inmate population has decreased from 876 inmates as of March 1, 2020 to 792 inmates as of May 7, 2020. See Exhibit A: Inmate population by facility. At the onset, we immediately cancelled social visits and limited outside contact by utilizing the non-contact visiting area to conduct legal visits, parole functions, and bail commissioner interviews. At my facility, we now feed all inmates in their housing unit/cell and utilize Styrofoam trays to protect the food. As of April 4, 2020, we entered phase three of the operational plan, which eliminated all programming. On April 30, 2020, we were downgraded to phase two of the operational plan which allows inmates to exit their cells for tier recreation and day room recreation.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to practice preventative measures such as frequent hand washing with soap and water, avoid touching the face, eyes, nose and mouth as well as avoiding greeting people with a handshake. The guidance has been provided in the form of CDC posters that have been placed in all housing units in the common areas and additional handouts have been provided to the inmate population regarding COVID-19. The deputy wardens and I have spent hours touring dorms talking to the inmate population about the pandemic.

8. All areas of the facility are regularly cleaned. Before the pandemic, common areas such as the dayrooms, and bathrooms were cleaned twice daily by the tier workers. The frequency of the cleaning has increased dramatically since the pandemic and the cleaning continues to occur on

each shift. We are now using bleach, diluted per the manufacturer's recommendation, to clean the facility. As of March 11, 2020, a cleaning crew disinfects the facility on both first and second shifts in conjunction with the inmate tier workers. The frequency of the cleaning depends upon the area that is being cleaned. If the area housed symptomatic inmates, it would be cleaned more frequently than an area that did not house symptomatic inmates. The quarantine unit is disinfected more frequently than an area that never housed symptomatic inmates. We have a hazmat cleaning crew with a backpack sprayer to clean the walls and the floors. The cells of presumptive positive inmates are cleaned with disinfectant as well. On April 28, 2020, my facility received and deployed mobile disinfectant dispersal units known as "Power Breezers." The Power Breezers can spray disinfectant as far as 25 feet away. The Power Breezers were used throughout the facility's common areas as of April 30, 2020. I know that this cleaning has been occurring because I have observed it and I have records of cleaning.

9. My facility has communal showers that are used by inmates. There are approximately 15 inmates per shower in the cell block and 15 inmates per shower in the dorms. A cleaning crew is responsible for cleaning the communal showers with diluted bleach. The showers are cleaned multiple times per day. Due to the time it takes for cleaning and the number of inmates who need to shower, it is not possible to clean the shower between each use. I know this is occurring because I have personally witnessed the showers being cleaned.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates who are housed in cells are responsible for cleaning their own cell unless the inmate is positive for COVID-19 or presumptively positive, in which case, a cleaning crew will disinfect the cell and destroy the linens. Inmates in the cells and cell block are provided an

ample amount of Lemon All to clean their cells and they have been provided increased amounts of cleaning supplies. The Lemon All is in spray bottles and inmates can obtain the cleaning supplies as needed or when requested. Cleaning solutions are diluted pursuant to the manufacturers' instructions in the supply warehouse prior to being issued to the inmate population. It would be dangerous to the inmates' health and safety to provide them with undiluted cleaning solutions. If there are inmates in the area where an inmate who is positive or presumptively positive for COVID-19, he can request that his area be cleaned as well. Tier men in the dorms are responsible for cleaning the common areas, dorms, benches, and showers at least daily. We now have a dedicated cleaning crew, whereas, prior to the pandemic, we only utilized hallway workers and the tier men. I know this cleaning is occurring because I have personally witnessed the cleaning occur in cell blocks and dorm areas.

11. There is approximately one phone per seven (7) inmates who are housed in the cells and one phone per twenty (20) inmates housed in the dorms. All telephones are presently operational as we had repairmen fix all the telephones. We have requested one additional telephone be installed per dorm. The telephones are cleaned regularly by the tier men. I know this cleaning is occurring because I see the tier men constantly cleaning and hear from staff that the telephones are being cleaned.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been provided to inmates (even those who are not indigent) at no cost. In my facility, we began to distribute free soap to inmates on March 2, 2020 and will continue to distribute soap on a

weekly basis for the duration of the pandemic. Soap deliveries were made on March 2, 2020, March 9, 2020, March 16, 2020, March 23, 2020, March 27, 2020, March 30, 2020, April 6, 2020, April 13, 2020, April 20, 2020, and April 27, 2020. Inmates can request additional soap as needed. On any given day, there are between 120 and 200 bars of soap per unit and cell blocks receive 60 bars of soap. We receive 1,200 bars of soap per week and the population uses an average of 800 bars of soap weekly. I know this soap distribution is occurring because I have confirmed as such with the warehouse supply officer who is responsible for the soap distribution.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer.[1] The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. There are numerous hand sanitizer stations around the facility and staff are constantly utilizing the hand sanitizer.

14. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, as of May 4, 2020, every inmate has received at least three (3) cloth masks. The masks are laundered once per week. The extra masks were delivered to the population in the event one was damaged or misplaced as well as to ensure that the inmates can have their masks cleaned. Inmates are required to wear the masks when they are unable to social distance. Initially, inmates were non-compliant with wearing the masks. They were sending the masks they received home to their families. On April 22,

[1] https://www.cdc.gov/handwashing/hand-sanitizer-use.html

2020, wearing a face covering was required per Governor Lamont's order, at which point, both staff and the inmate population were required to wear the mask when social distancing was not possible. The inmates who are housed in the dorms are not required to wear the mask while on their bunks. When officers see inmates not wearing the masks, they require the inmates to don their masks.

15. Staff have also all been issued multiple masks to include cloth masks, surgical masks, KN95 masks, and N95 masks. As of April 22, 2020, staff are required to wear at least a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. We have passed out N95 masks for all staff once per week on the following dates: April 13, 2020, April 20, 2020, April 27, 2020, and May 4, 2020. Fabric masks were issued to the staff on April 3, 2020 and as requested. I know staff are complying with the requirement to wear masks because I have personally witnessed staff wearing masks within the facility. Staff are reminded to don masks if they are seen not wearing one in a situation when social distancing is not possible.

16. In addition to cloth masks, staff may be required to don other PPE depending on the situation at hand. Staff have access to gloves if they need them. Inmates who require gloves to clean also have gloves available to them.

17. Staff are screened prior to entry and upon exiting the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry and upon exiting the facility. If staff are sick or

symptomatic, they must stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

18. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else could have been potentially infected. A staff member who has tested positive is asked where they worked, when they became symptomatic, and with whom they had extensive contact. A cleaning crew then disinfects identified areas including keys, handcuffs, and anything else the staff member had on his or her person.

19. If an inmate displays symptoms of COVID-19, medical staff will go to his unit and perform a temperature check. If the inmate has a fever or other symptoms of COVID-19, he is removed from his unit and placed in a presumptive positive unit with his property. The area where the symptomatic inmate came from is disinfected immediately and medical staff will check the temperatures of those inmates in the immediately surrounding area.

20. If an inmate tests positive for COVID-19, he is transferred to Northern Correctional Institution. Other symptomatic inmates are isolated, medically monitored, and, if they later test positive, are also transferred to Northern Correctional Institution.

21. I have had my facility's records reviewed and Marcus Champagne (#409669) has not filed a grievance about the issues raised in his affidavit.

22. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. My facility's grievance coordinator is flagging COVID-19 related grievances for immediate review. No such grievance has yet been filed at my facility.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Ned McCormick, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden McCormick

EXHIBIT A

FACILITY	INMATE POPULATION AS OF 5/7/20	DESIGNED CAPACITY AS OF 5/7/20	NUMBER OF CELLS/BEDS	NUMBER OF DOUBLE BEDS
Brooklyn CI	926	962	0	936
Carl Robinson CI	1314	946	32 beds/16 cells	1486
Corrigan-Radgowski CC	1268	1076	856	356
MacDougall-Walker CI	1914	1400	1078	0
New Haven CI	673	605	319	328
Northern CI	78	252	504 (504 mental health RHU and infirmary beds)	0
Cheshire CI	1251	1222	1026	226
Willard-Cybulski CI	1079	686	0	1348
Bridgeport CC	649	384	96 beds with a maximum of 24 hours. Number does not include medical beds which have a maximum stay of 24.	470
Garner CI	548	551	256	0
Manson YI	285	256	256	0
Osborn CI	1243	935	448 (regular cells, 64 mental health unit)	245
Stafford CI	806	793	256	680
York CI	885	661	1026	140

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT S

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

JRE MCPHERSON, et al. *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al. *Defendants,*	:	MAY 1, 2020

DECLARATION OF WARDEN NATHAN HEIN

I, NATHAN HEIN DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 19 yrs.
3. Currently I hold the position of Warden of Bridgeport Correctional Center ("Bridgeport CC").
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week. I physically tour the entire facility a minimum of two times per week, and I am present in at least some housing units within the facility two times per week. I also maintain regular communication with my deputy warden and my unit supervisors.
5. As of May 7, 2020, the Bridgeport CC facility count was 594 inmates, significantly reduced from the March 1, 2020 count of 699 inmates. EXHIBIT A.

6. Bridgeport CC is a correctional facility that consists of dormitories and cell blocks divided into thirteen units. 37A and 39A each have a total of 36 cells and are capable of holding 60 inmates. 37B and 39B each have a total of 48 cells which can hold 60 inmates. 38B has 24 cells and can hold 37 inmates. 38A has 12 cells and can hold 22 inmates. Memorial 1 and Memorial 2 are both dorms capable of housing 120 inmates each. North Wing A, B and C are also dorms which can hold 58 inmates each. North Wing D is also a dorm that can accommodate 56 inmates. Our Medical Unit has 16 cells with a maximum capacity of 26 inmates.

7. Since the pandemic, in addition to reducing population density at the facility, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have cancelled all visits, religious services, indoor recreation and outdoor recreation. In unit day room recreation has been limited to a maximum of 5 inmates to use phones, showers or the dayroom. All units have been isolated from each other and movement within the facility has been curtailed regarding transfers and medical appointments. Medical staff are required to assess inmates in confidential areas of each housing unit to further limit unnecessary movement.

8. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to practice social distance to the best of their ability, wash hands frequently, wear provided face masks, avoid unnecessary contact, report any signs or symptoms immediately and keep their living space clean. It has been provided in the form of memos/posters affixed in common areas as well as housing units, verbal instruction in orientation and verbally in housing unit Town hall style. I am aware that this guidance has been distributed because I have personally delivered many

verbal instructions, witnessed staff issuing verbal instruction and witnessed multiple memos affixed to walls and bulletin boards in housing units and common areas.

9. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms and bathrooms were cleaned once per shift. Due to the pandemic, this has been increased to an around the clock, continuous operation as time permits. Cleaning is performed using bleach, Quadd4, soap and water. Cleaning solutions are diluted pursuant to the manufacturers' instructions. It would be dangerous to the inmates' health and safety to provide them with undiluted cleaning solutions. I know that this cleaning has been occurring because I have personally observed it, I have reviewed log books, I have reviewed camera footage as well as speaking to supervisors, line staff and inmate workers. During the week of May 4, 2020, Bridgeport CC has also obtained Field King Max Backpack Sprayers. The entire facility is sanitized once a week with these sprayers.

10. My facility has communal showers that are used by inmates. There are approximately 1-4 inmates showers per area. Communal showers are cleaned frequently, a minimum of once per shift. Due to the time it takes for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know this is occurring because I have personally observed it, I have reviewed log books in addition to speaking to supervisors, line staff and inmate workers.

11. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates are responsible for cleaning their respective sleeping areas. Supplies are provided as needed. Cell cleanup is mandated once per week. I know this is occurring because I have

personally observed it. I have reviewed camera footage as well as speaking to supervisors, line staff and inmate workers.

12. There are approximately 2 – 5 telephones per tier of each housing unit at my facility. They are normally cleaned before each use and a minimum of once per shift. I know this is occurring because I have personally observed it, I have reviewed camera footage as well as speaking to supervisors, line staff and inmate workers.

13. Inmates have been provided with soap for hand washing. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent). In my facility, bars of soap have always been provided for free to inmates and will continue to be distributed upon request, verbal or written, for the duration of the pandemic. I know this soap distribution is occurring because I have personally observed it, I have reviewed log books, I have reviewed camera footage as well as speaking to supervisors, line staff and inmate workers.

14. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, per the Centers for Disease Control ("CDC") guidelines, soap is known to be more effective against COVID-19 than hand sanitizer[1]. The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer. Officers have been provided with hand sanitizer as a preventative measure as they typically have less frequent access to handwashing than inmates, who have sinks in their cells' dorms. I have personally observed officers using hand sanitizer on my tours.

[1] See https://www.cdc.gov/handwashing/hand-sanitizer-use.html

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the CDC guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least two cloth masks. More are distributed upon request to replace lost, stolen or damaged masks. Inmates have been required to wear a cloth mask any time they leave their sleeping quarters. Inmates are compliant as I have personally observed it, I have reviewed camera footage as well as speaking to supervisors and line staff. Inmates can have them cleaned in the laundry or use the sinks in the bathroom areas.

16. Staff have also all been issued at least a cloth mask, surgical masks and N95 mask. As of April 22, 2020 staff are required to wear at least a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by a supervisor. I know this because I have personally observed it, I have reviewed log books, I have reviewed camera footage as well as speaking to supervisors and line staff.

17. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. N95 masks, surgical masks, gloves, face shields and gowns have also been made available in limited numbers and used when situationally appropriate. They are utilized when interacting with an inmate and there is a chance for bodily fluid to become airborne or when working with inmates that are known or suspected to have COVID-19.

18. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick, they can stay home, all staff

have been given an additional 2 calendar weeks of paid leave if they are sick with symptoms of COVID-19

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. Staff work and break areas are cleaned a minimum of once per shift. Break areas and certain work areas are cleaned by inmate workers. Depending on the sensitivity of the work area (control posts versus dormitory work station), staff would be required to clean their own work areas. When an inmate tests positive, the housing unit is isolated and all inmates are assessed by medical for signs and/or symptoms. I have personally observed this and have spoken to supervisors and line staff about this.

20. If an inmate displays symptoms of COVID-19, they are immediately rehoused in our medical unit and tested. The housing unit is isolated and all inmates are assessed and monitored for signs and symptoms. The housing units are all cleaned in accordance to our cleaning protocol noted above.

21. If an inmate tests positive for COVID-19 they are transported and immediately transferred to Northern CI within 24 - 48 hours.

22. As of May 13, 2020, I have had my facility's records reviewed and Christopher Russell #401913, Tyquwene Gilchrist #593706 and Tre McPherson #391124 have not filed a grievance about the issues raised in their respective affidavits.

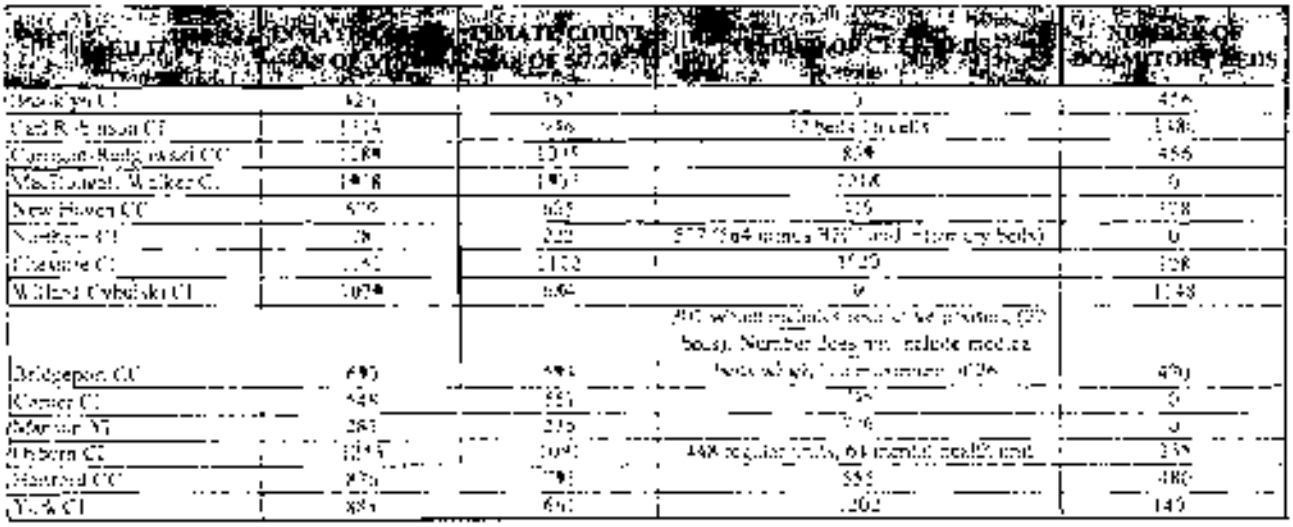
23. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, NATHAN HEIN, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden Nathan Hein

EXHIBIT A



CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT T

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al, *Defendants*,	:	MAY 15, 2020

DECLARATION OF WARDEN ROGER BOWLES

I, ROGER BOWLES, DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for 27 years.
3. Currently I hold the position of Warden of Northern Correctional Institution ("NCI").
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility at least twice per week, and I am present in at least some housing units within the facility three to five times per week. I also maintain regular communication with my Deputy Wardens and my Unit Supervisors.
5. NCI is a correctional facility that consists of cells divided into six housing units and one medical unit. There are 50 cells in each housing unit and four cells in the medical unit. As of April 7, 2020, three units have been designated as COVID-19 units. NCI has 27 total single cells; 277 total double cells. (The COVID-19 units have 3 single cells; 147 double cells.)

Today, NCI has 30 double cells that are occupied by 2 inmates. (The COVID units have 13 double cells that are occupied by 2 inmates.)

6. Since the pandemic, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have cancelled indoor gymnasium recreation, group programming, and visits, and inmates are required to eat their meals in their cells. We have reduced the number of inmates allowed out for outdoor recreation from ten at a time to eight at a time. Inmates are still taken out of their cells by Mental Health staff as needed. Based on my personal observation, close physical contact between inmates has drastically reduced due to these measures.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. The guidance we have provided tells the inmates to wash their hands for 20 seconds, maintain six feet of social distance whenever possible. It has been provided in the form of a poster that is displayed in every housing unit and a flyer that was distributed to each individual inmate. I am aware that this guidance has been distributed because it was reported to me by my Unit Managers, several inmates mentioned it to me on my tours, and I personally observed some. The guidance is provided is attached here as Exhibit A.

8. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms were cleaned every day. Due to the pandemic, this has been increased to every shift. Cleaning is performed using Quat64 or Lemonall, cleaning solutions approved and provided by the Department. The floors are mopped daily. I know that this cleaning has been occurring because I have personally observed it. I have spoken to Unit Managers, and I have spoken to inmates.

9. My facility has individual showers that are used by inmates. There are approximately six inmates per shower. Showers are cleaned after each use by spraying Lemonall or Qual64. I know this is occurring because I have personally observed it being done.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. After a deep cleaning performed over several days by a detail crew beginning on March 13, 2020, inmates have been responsible for cleaning their cells. The cells contain a toilet and a sink. They are provided a cup of Lemonall, paper towels, a mop, and a toilet brush. Cleaning solutions are diluted pursuant to the manufacturers' instructions. It would be dangerous to the inmates' health and safety to provide them undiluted cleaning solutions. Before the pandemic, these supplies were available on a weekly basis. Inmates now may obtain the supplies every day upon request and they have been instructed to clean frequently. I know this is occurring because I have personally observed it and inmates have spoken to me about it.

11. There are approximately 52 telephones at NCI. This breaks down to approximately five inmates per telephone. They are cleaned after each use. Cleaning spray and paper towels are kept next to each telephone. Inmates usually clean the telephone prior to use, as well. I know this is occurring because I have personally observed it and have received feedback from the inmates.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase, but it has also been given out to inmates (even those who are not indigent) free of charge. In my facility, bars of soap were distributed for free to inmates beginning on or about March 20, 2020, and will continue

to be distributed on a weekly basis for the duration of the pandemic. Inmates may also request soap at any time. I know this soap distribution is occurring because staff and inmates have informed me this is happening and I am apprised by the Supply Officer as to an increase in the amount of soap delivered.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, soap is known to be more effective against COVID-19 than hand sanitizer. See https://www.cdc.gov/handwashing/hand-sanitizer-use.html. The high alcohol content poses a danger because inmates could ingest the hand sanitizer.

14. Restraints are cleaned with Lemonall or Quat64 after each use and are disinfected every third shift.

15. Prior to the pandemic, I was aware of an inmate's complaint about the water at NCI. The water and water system were subsequently inspected, tested, and evaluated by DOC PFE Bob Bell. The agency periodically has facility water tested by outside entities. There are no current issues with the water at NCI.

16. One of the reasons NCI was selected as the facility to contain the COVID-19 units was that air in the housing units is not shared. The ventilation system allows the air to enter the cell and exit the same cell. It is not circulated throughout the unit or facility. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received at least one cloth mask. They can exchange the mask for another as needed. Inmates are required to wear a cloth mask whenever out of their cell. They can launder the mask in the sink in their cell.

17. Staff were all issued a cloth mask by April 3, 2020. Staff have been required to wear at least a cloth mask at all times while inside the facility since April 22, 2020, per direction by Commissioner Cook. To the best of my knowledge, they have been doing so. I know this because I have personally observed staff wearing them. If staff are not wearing a mask, the issue is addressed by a supervisor.

18. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. The facility has a supply of N95 masks for staff use. When inmates housed in one of the three COVID-19 units has to be moved out of the COVID-19 unit, staff conducting the escort wear an N95 mask, eye shield, booties, a surgical gown, and gloves.

19. Staff are screened prior to entry to the facility. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. They are also checked again approximately midway through their shift. They may choose to be screened again upon exit from the facility. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick, they can stay home; all staff have been given an additional 14 days of paid leave if they are sick with symptoms of COVID-19.

20. If staff tests positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. Potentially infected areas are thoroughly cleaned with bleach, Lemonall and/or Quat64. Inmates are not quarantined.

21. If an inmate displays symptoms of COVID-19, he is placed in the medical infirmary and tested. There has only been one inmate in my facility who has exhibited symptoms; he was moved to

the infirmary and tested negative. However, his cell was thoroughly cleaned with bleach, Lemonall and Quat64. The common areas were all cleaned with Lemonall and Quat64.

22. Other than those inmates housed in the COVID-19 units, no inmate at NCI has tested positive for COVID-19. The unit we had set aside to be a quarantine unit has become one of the three COVID-19 units. If an inmate exhibits symptoms, he is moved to the infirmary and, if he tests positive for the virus, he will be assigned to one of the COVID-19 units.

23. NCI has increased its cleaning regimen. We have a Zamboni machine that we use for the floors. We also have backpacks with disinfectant and will be receiving an industrial sprayer. We have increased our stock of the various cleaning products.

24. I have had my facility's records reviewed and, as of May 6, 2020, neither Alex Flemming nor Luis Pagan have filed any grievances about the issues raised in their affidavits. Alex Flemming has not spoken to me about the issues raised in his affidavit; however, he has apparently communicated with his family on various topics. I have spoken to his grandfather prior to the pandemic. I have spoken to his aunt during the pandemic, as she is trying to get him an early release. Contrary to his allegations in his affidavit, he is housed in a single cell. There are ten individual showers in his housing unit, which as of May 4, 2020, housed 49 inmates. This means that each shower is used by five inmates. Inmates who are not housed in a unit do not use that unit's showers. Similarly, the housing unit has five telephones for the 49 inmates to share. Inmates from other housing units do not use these showers or telephones. Luis Pagan has not spoken to me about any of the concerns alleged in his affidavit. However, he is incorrect in that there are ten showers – not one -- for the approximately 43 inmates in his housing unit. The showers are sprayed with cleanser after each use. Similarly, there are ten

telephones in his housing unit for those 43 inmates. As for staff not changing their gloves between touching restraints and serving food trays, this has not been a reported issue. Inmates are not restrained when in their cells, which is where they eat their meals. Staff deliver the meals directly to the cells. When delivering meal trays, staff are not wearing the same gloves they wore when touching restraints.

25. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. One of the affiants, Kyle Lamar Paschal-Barros, submitted a grievance on April 17, 2020, requesting early release. Because he does not meet the eligibility criteria for early release, his grievance was denied.

DECLARATION UNDER PENALTY OF PERJURY
PURSUANT TO 28 U.S.C. § 1746

I, Roger Bowles, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 15, 2020.

Warden Roger Bowles

EXHIBIT A

Notice to Inmate Population

Effective Wednesday, April 22, 2020

inmates must wear protective masks when they are:

- **exiting their cells**
- **exiting their cubicle**
- **in a common area**

To be in compliance, the masks need to cover both your nose and your mouth completely.

Failure to comply will result in progressive discipline, up to a Class B Disciplinary Report for Disobeying a Direct Order.

The wearing of masks is being required for your personal safety.

NOTICE TO INMATE POPULATION

The Department of Correction is following all precautions related to the COVID-19 coronavirus as dictated by the Centers for Disease Control and Prevention (CDC). Please contact a staff member if you are experiencing any of the three common symptoms below:

Fever

Cough

Shortness of breath

The $3 co-pay has been temporarily suspended until further notice so that

anyone exhibiting signs of illness can seek medical attention and remain healthy.

Continue following these preventative practices:

- Frequent handwashing with soap and water
- Avoid touching your face, eyes, nose and mouth
- Avoid greeting others with a handshake

As a reminder the annual influenza shot, recommended by the CDC, is still available to the population. Please write to health services.

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT U

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al, *Plaintiffs*,	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al, *Defendants*,	:	MAY 18, 2020

DECLARATION OF WARDEN KRISTINE BARONE

I, KRISTINE BARONE, DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.
2. I have been employed by the Connecticut Department of Correction ("DOC") for over 21 years.
3. Currently I hold the position of Warden of MacDougall-Walker Correctional Institution ("MWCI").
4. My position entails overseeing operations within my correctional facility. I am typically physically in the facility five days a week, I physically tour the entire facility two times per week, and I am present in at least some housing units within the facility 4 times per week. I also maintain regular communication with my Deputy Wardens and my Unit Supervisors.
5. MWCI is a correctional facility that consists of cells divided into 22 units. Currently, we have 34 inmates on single cell status. On May 8, 2020, our total inmate population was 1,903.

6. Since the pandemic, we have taken many steps to increase social distancing and reduce the number of people with whom each inmate has contact. At my facility, we have suspended social visits, school, gym recreation, vocational education, religious services (e.g., masses and prayer groups), and basketball games. All volunteer services have been suspended. As of April 23, 2020, all meals have been eaten inside of cells. Prior to that date, inmates had the option of eating their meals inside of their cells. Approximately three cells are out of their cells at a time in order to get their meal trays. Recreation periods are usually of two-and-a-half-hour duration. Half a tier are out on recreation at one time and may either remain in the housing unit or go outside.

7. We have provided inmates with guidance about how to keep themselves and others from contracting COVID-19. See Exhibit A. The guidance we have provided advises the inmates to wash hands with soap and water for at least 20 seconds, to wear a protective mask at all times when out of their cell, to keep a distance of 6 feet apart from others when at all possible, to wipe down telephones before and after use, and to keep housing units and cells clean. This guidance has been provided in the form of posters and memos distributed in each housing unit (including the Restrictive Housing units, Medical, the In-Patient Medical ward, and Protective Custody). I am aware that this guidance has been distributed because each memo and poster was assigned to a supervisor who was responsible for posting them in the housing units, and I have personally seen the memos and posters displayed in the units throughout the facility. Furthermore, when touring the facility and the housing units, the Deputy Wardens and I speak with both staff and the offender population about social distancing and cleaning procedures.

8. All areas of the facility are regularly cleaned, and cleaned at a rate higher than before the pandemic. Before the pandemic, common areas such as the dayrooms and bathrooms were cleaned at least three times per day. Due to the pandemic, this has been increased to a level of continuous cleaning throughout all shifts. As requested, an increased amount of cleaning supplies has been brought to each housing unit. Cleaning is performed using departmental-approved cleaning products that are diluted per the manufacturer's directions. The dilution directions are provided on the back of each container of cleanser. I know that this cleaning has been occurring because I personally have observed it, I have spoken to Unit Managers, and I have spoken to inmate workers.

9. My facility has communal showers that are used by inmates. There are approximately 11 inmates per shower. Communal showers are cleaned more than three times per day. Due to the time it takes for cleaning and the number of inmates who need to shower, it would not be possible to clean the shower between each inmate using the shower. I know the cleaning is occurring because I personally have observed the workers cleaning the showers and have had no complaints from the population as to the cleanliness of the showers.

10. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Unit staff provide cleaning supplies to any offender upon request. The offender population is told that cleaning supplies are available upon request. These supplies include a spray bottle of Quat64 and Lemonall, napkins, and paper towels. Mops are available upon request. Prior to the pandemic, it was mandated that offenders clean their cells every Saturday. Since the pandemic, they can obtain the supplies and clean their cells whenever they want. They have

been informed that they should be cleaning more often. I know this is occurring because I have received feedback from unit management staff.

11. There are approximately 158 telephones throughout the facility, or twelve inmates per telephone. The telephones are cleaned at least four times per day by the unit tier workers, after each recreation period. Spray bottles filled with cleaning solution are available for each inmate to clean the telephones before and after each use. I know this is occurring because I have personally observed inmates and the inmate tier man cleaning the telephones before and after use, as well as at the end of each recreation period.

12. Inmates have been provided with soap for hand washing. Before the pandemic, inmates received soap for free if they were indigent, and soap was available at the commissary for purchase. Soap continues to be available for commissary purchase. In my facility, bars of soap are distributed for free for the sinks in the common areas of the housing units and will continue to be supplied weekly for the duration of the pandemic. I know this soap distribution is occurring because I have been informed of same by the warehouse officer.

13. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, per CDC Guidelines, soap is known to be more effective against COVID-19 than hand sanitizer. See https://www.cdc.gov/handwashing/hand-sanitizer-use.html. The high alcohol content of the hand sanitizer poses a danger because inmates may ingest the hand sanitizer.

14. Staff have been provided with state-issued hand sanitizer as a preventative measure as they typically have less frequent access to handwashing than inmates, who have sinks in their cells. I have personally observed officers using hand sanitizer on my tours.

15. All inmates and staff have been issued some level of Personal Protective Equipment ("PPE"). Following guidance from the Centers for Disease Control and Prevention ("CDC") guidelines, the level of PPE issued depends on the situation. At my facility, every inmate has received two cloth masks and can exchange one mask for another in the event a mask gets torn or otherwise damaged. They are provided two masks so that they will have one while the other is being laundered. Inmates are required to wear a cloth mask whenever they are out of their cell. The offender population has been compliant in this regard. I know this is true because I personally have not seen an inmate outside of his cell without a mask.

16. Staff have also all been issued at least a cloth mask. As of April 22, 2020, staff have been required to wear a cloth mask at all times while inside the facility, and, to the best of my knowledge, they have been doing so. If staff are not wearing a mask, the issue is addressed with them by a supervisor. Prior to April 22 and as early as the first week of March, staff were issued masks produced by inmates.

17. In addition to cloth masks, staff may be required to don other PPE, depending on the situation at hand. N95 masks, gloves, gowns, and eye protection are available to all staff to be worn when working in a COVID-19 positive or quarantined area.

18. Staff are screened prior to entry to the facility and upon exit. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry. This occurs on all three shifts. I am aware of this through personal observation. I am also screened prior to entry to the facility. If staff are sick, they are instructed to see a medical professional, get tested, and to stay home. To return to work, staff must provide documentation from a medical professional, approving their return. All staff have

been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

19. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. The entire area in which the staff member worked is thoroughly cleaned by either staff or an inmate worker. Cleanser and bleach are utilized, as well as a disinfectant sprayer.

20. If an inmate displays symptoms of COVID-19, he is removed from the housing unit and brought to the monitoring/quarantined area to be assessed by medical. The cell is cleaned. Staff attempts to keep the inmate's cell "reserved" for him upon his return to the housing unit. If this is not possible, the inmate's property is removed and the cell is thoroughly cleaned.

21. If an inmate tests positive for COVID-19, Population Management is notified and the inmate is picked up for transport to Northern Correctional Institution by staff from the Correctional Transportation Unit and Special Operations Group. The inmate is always informed of the results of the test when they become available. If an inmate tests positive and is on dialysis, the inmate stays at MWCI in isolation in the medical unit in order to maintain his dialysis schedule.

22. I have increased the administrative presence throughout the facility in order to respond directly to questions and concerns raised by both staff and the offender population regarding the COVID-19 pandemic. I am committed to being as transparent as possible.

23. I have had my facility's records reviewed and Kezlyn Mendez, an inmate at MWCI, has not filed a grievance about the issues raised in his affidavit.

24. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed.

DECLARATION UNDER PENALTY OF PERJURY PURSUANT TO 28 U.S.C. § 1746

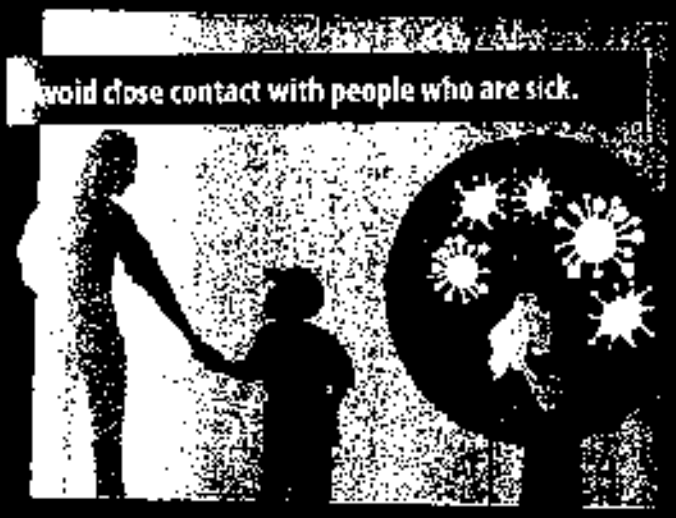
I, Kristine Barone, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 18, 2020.

Warden Kristine Barone

EXHIBIT A

COVID 19 CORONAVIRUS DISEASE

STOP THE SPREAD OF GERMS



Avoid close contact with people who are sick.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

Clean and disinfect frequently touched objects and surfaces.

Avoid touching your eyes, nose, and mouth.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

CDC

MACDOUGALL-WALKER CORRECTIONAL INSTITUTION

TO: All Supervisors

FROM: Deputy Warden Joseph Roach

DATE: April 17, 2020

SUBJECT: **INMATE WORKERS**

As a reminder, it is imperative that after recreation is completed that inmate workers are released to perform their necessary cleaning duties, on all three shifts in an appropriate allotted time. Sector Lieutenants please ensure compliance.

Thank you for your attention to this important matter.

Cc: Warden Barone
File

COVID 19 INFO SHEET

WHAT IS COVID 19?

- It's a new strain of the coronavirus, which causes a cold that can lead to pneumonia. It didn't exist before this winter. This means NO ONE is immune.
- It's very contagious. It spreads like the common cold or worse. It lives in (saliva) spit and (mucus) snot. It lives on metal or plastic surfaces (phones, tables, hand rails) for DAYS.
- Current estimates are that about half (50%) of all people in the world will get coronavirus this year. That's 1 in 2.
- Fortunately, most folks will be fine. If you catch, it you might not even notice, because most people don't get super sick. In fact, some people, especially young people, get infected and don't feel a thing.
- Because it's so contagious, even if you don't feel sick when you catch it, it uses you to reproduce. The virus turns your nose into a virus making machine, so you'll spread it without even knowing it.

HOW DOES THIS AFFECT ME?

- If you're young and healthy- it might not affect you at all.
- If you are older and have asthma, high blood pressure or diabetes, you are at higher risk that the virus could turn into pneumonia (an infection goes to a person's lungs making it difficult to breathe).
- Because its so contagious, social visits have been stopped (for now).
- Movement within facilities will be limited.
- Limited group programming
- Smaller number of people out for rec (if at all)
- If you have symptoms, you may be kept separate (quarantined) to be monitored more closely and cared for appropriately.
- Medications will be reviewed and renewed to reduce face to face contact, to prevent interruption in care.

HOW CAN I PROTECT MYSELF?

- As much as possible, stay away from people. Don't touch things. Don't touch people. Avoid being around others as much as possible.
- Cover your mouth with your elbow when you sneeze or cough.
- ***Wash your hands often –*** Soap actually works. If you need more, please alert staff.
- Clean your cell.
- Don't shake hands/ hug/ or fist bump.
- When possible, keep 6 feet from you and another person (social distancing).
- If you feel like you have a fever, tell someone immediately

COVID 19 INFO SHEET

WHAT YOU CAN DO TO HELP SLOW THE SPREAD

- Avoid unnecessary requests to be seen by medical. The fewer people in medical, the better.
- Let medical staff be available for those folks who do get sick and need their attention.
- If you are sick, or having problems with medications, please write to be seen.
    - We ask that you write specific requests; so, if possible, staff can triage the request and, if able, address your request in writing.
    - *As always*, tell staff if you are having a medical emergency
- Avoid close contact with others, avoid shaking hands, fists bumps and hugs
- Cover your mouth with your elbow if you sneeze or cough
- Wash your hands often

WHAT STAFF IS DOING

- We are taking temps of all employees before entering their facilities to reduce the possible spread to our population.
- We are taking temps of all inmates when they are leaving and returning into our facilities including a COVID 19 screening.
- Staff is practicing social distancing and good handwashing techniques
- Staff is going to work together to make sure you have what you need to get through this time.

WHAT WE CAN DO TOGETHER

- Stay patient and understand that this is a situation we have never been in before
- It takes EVERYONE's commitment to practice the above to slow the spread.
- We will need to be flexible and adapt to this situation as we learn more- What we do today may need to change tomorrow. We will make every effort to keep you all informed as soon as we can.
- We don't know how quickly things will change. Our goal is to keep **EVERYONE** safe and healthy. **ALL** decisions being made are for that goal.
- We understand this is going to be difficult. If at any time you are having difficulty dealing with this and have thoughts to hurt yourself, **PLEASE TELL STAFF IMMEDIATELY.**

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT V

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, et al., *Plaintiffs,*	:	CIVIL NO. 3:20-CV-534 (JBA)
v.	:	
NED LAMONT, et al. *Defendants.*	:	MAY 17, 2020

DECLARATION OF DIRECTOR RONALD COTTA

I, RONALD COTTA, DO DECLARE UNDER PENALTY OF PERJURY THAT THE FOLLOWING IS TRUE AND CORRECT AND IS BASED UPON MY PERSONAL KNOWLEDGE:

1. I am over the age of eighteen years old and believe in the obligations of an oath.

2. I have been employed by the Connecticut Department of Correction ("DOC") for 20 years.

3. Currently I hold the position of Director of Tactical Operations. In this capacity, I oversee, inter alia, the Corrections Emergency Response Team ("CERT"), which has been assigned the oversight of the three COVID-19 units which were established at Northern Correctional Institution ("NCI") on April 07, 2020. All staff assigned to the COVID-19 units have volunteered for this duty.

4. My position entails overseeing the entire operation of the three COVID-19 Units, including housing, staffing, inmate movement, transport, and collaboration with Health Services. I am typically physically in the facility five days a week and I physically tour the three units once per week. I receive reports from staff at the end of each shift and am on call 24 hours a day, 7 days a week.

5. NCI is a correctional facility that consists of cells, divided into six units. There are three designated COVID-19 units of four tiers each, with a total capacity of 97 inmates per unit. On April 20, 2020, there were 182 inmates housed in the COVID-19 units, the largest number of inmates as of May 11, 2020. On May 11, 2020, there were 79 inmates in the COVID-19 units.

6. In the COVID-19 units, movement is strictly limited. Inmates are assigned to either a single cell or, when necessary due to housing capacity, to a double cell as authorized by medical. Those assigned to a double cell have reported the onset of symptoms of COVID-19 on the same day, so both individuals are on the same timeline as to the disease. As of April 20, 2020, there were 132 inmates housed in the three COVID-19 units, with 24 inmates double-celled. As of May 11, 2020, there were 79 inmates housed in the COVID-19 units, with 12 inmates double-celled. Each unit is made up of four self-contained tiers. One inmate per tier is out of his cell at a time, for an hour a day. They may use the telephone during that time. They do not shower. Medical staff tours the units twice daily, for four hours at a time. Inmates eat their meals in their cell.

7. Each inmate who enters a COVID-19 unit is provided an Orientation Notice upon arrival. This Notice spells out everything the inmate will experience: why they are there, what is going to happen, and when they can expect to be removed from the COVID-19 unit. It also advises inmates that they may request cleaning supplies at any time. The Notice is also posted on the Connecticut Department of Correction website for families to access. The Orientation Notice is attached here as Exhibit A.

8. The common areas of the three COVID-19 units are cleaned daily with bleach and Lemonol. I know this is happening because staff documents the cleaning in both the log book and the

end of shift report, which is submitted to me twice daily. Note that staff operate on a two shift schedule: Shift A is from 7:00 a.m. to 7:00 p.m.; Shift B is from 7:00 p.m. to 7:00 a.m. Cleaning solutions are diluted pursuant to the manufacturers' instructions. It would be dangerous to the health and safety of inmates to provide inmates with undiluted cleaning solutions.

9. In addition to common areas, inmates' sleeping areas are cleaned in the following manner. Inmates are provided cleaning supplies on a weekly basis and upon request. Lemonall, brushes, paper towels, a dust pan, and a toilet brush. An inmate usually is in the COVID-19 unit for no more than two weeks. If his condition is such that he requires more than 14 days in such a restrictive environment, he usually requires a higher level of care than we can provide and is admitted to a hospital. As of May 11, 2020, 36 inmates have been sent to outside hospitals from the COVID-19 units. When an inmate discharges from the unit, staff thoroughly disinfects the cell with bleach and Lemonall and leaves the cell empty for 24-hours for decontamination. I know this is occurring because staff document this in both the log book and the end of shift report.

10. There are four telephones in each of the three COVID-19 units. We added additional telephones in order to increase the population's ability to make calls. The telephones are cleaned by staff with Lemonall at the end of each inmate's time out of his cell.

11. Upon entry into one of the COVID-19 units, each inmate is provided a bag from Commissary free of charge. This bag contains personal hygiene products, including soap, shampoo, and toothpaste, as well as snacks. The inmate is also given clean clothes, linens, and a towel. These

items are replaced upon request. There is no laundry service. Inmates in the COVID-19 units do not have access to Commissary.

12. Inmates are not permitted hand sanitizer because of the high alcohol content of the product and, in any case, per CDC Guidelines, soap is known to be more effective against COVID-19 than hand sanitizer. See https://www.cdc.gov/handwashing/hand-sanitizer-use.html. Furthermore, the high alcohol content of hand sanitizer poses a threat to inmates because there exists the possibility that inmates would ingest the hand sanitizer. Inmates are provided soap free of charge.

13. Staff have been provided hand sanitizer and use it regularly. I have personally observed staff using the hand sanitizer when I have toured the units.

14. Restraints are cleaned and disinfected after every use utilizing Lemonall. Note that the only time an inmate is restrained is when he is being taken to Medical. I know this is occurring because it is documented in the end of shift report.

15. I have never heard a complaint about either the water, the temperature, or the lack of cleanliness of a cell. I have personal knowledge that the housing units and cells are maintained at a comfortable temperature.

16. When we opened the COVID-19 units, not all intercoms were functioning properly, but were all fixed by maintenance staff shortly after opening the units.

17. All inmates and staff have been issued Personal Protective Equipment ("PPE"). Following guidance from the CDC guidelines, the level of PPE issued depends on the situation. An inmate being transferred to a COVID-19 unit is given a surgical mask when they are picked up at their originating facility. They may either retain the cloth mask they were provided at the

originating facility or they are given an additional new cloth mask upon arrival at NCI. They may have two masks in their possession. Inmates are provided gloves if they are being escorted to Medical. Otherwise, they do not have gloves in their cell. While they do not send items out of the unit to be laundered, they are provided new clothing, linens, a towel, and a mask upon request.

18. Staff have worn PPE at all times since the COVID-19 units were established. Staff adhere to the CDC guidelines in terms of what PPE they wear at what time. Specifically, the PPE worn varies depending on the type of contact staff has with COVID-19 positive inmates. All staff are issued an N95 mask, goggles, a face shield, a Tyvek or Hazmat suit or surgical gown, and gloves. The Tyvek suit or surgical gown are only required when staff is in direct contact with an inmate, but staff may wear them at all times if they choose. PPE is cleaned per CDC guidelines.

19. Staff are screened prior to entry to the facility and twice during their shift. They have their temperatures taken and are asked about possible symptoms. If they are symptomatic, or if they have a fever, they are denied entry or sent home. I am also screened prior to entry to the facility. If staff are sick, they can stay home; all staff have been given an additional two calendar weeks of paid leave if they are sick with symptoms of COVID-19.

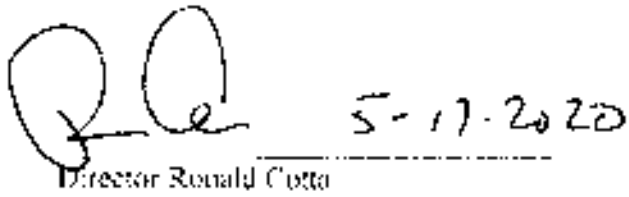
20. If staff test positive for COVID-19, the facility engages in contact tracing to determine who else (staff or inmates) could have been potentially infected. As all inmates in the units are COVID-19 positive, the focus is on other staff. All staff areas are thoroughly cleaned, using bleach and Lemonall, on a daily basis.

21. I have had my facility's records reviewed and, as of May 11, 20202, Christopher Russell, an inmate in one of the COVID-19 units, had not filed a grievance about the issues raised in his affidavit.

22. The grievance process is available to inmates in my facility. Inmates continue to file grievances and they continue to be processed. Inmates are provided envelopes in which to place their grievances. I have received one Inmate Request Form (the first step in the grievance procedure) regarding a property issue; that issue has been resolved.

DECLARATION UNDER PENALTY OF PERJURY PURSUANT TO 28 U.S.C. § 1746

I, Ronald Cotta, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge regarding the events alleged. Executed on May 17, 2020.



Director Ronald Cotta

EXHIBIT A

ORIENTATION NOTICE

NORTHERN CORRECTIONAL INSTITUTION - COVID UNITS

All inmates that are admitted to the COVID units have tested positive for the COVID 19 Virus. Once admitted to a COVID unit, you should expect the following procedures:

1. Medical is onsite 24 hours a day, 7 days a week. Expect to receive your medications as prescribed. Methadone maintenance will be distributed on a daily basis by the methadone clinic. If any medical issues arise or you experience any changes in your medical condition, please immediately notify staff. Medical will be notified. Vital signs are taken twice a day. Any questions for medical should be addressed during this time, unless there is an emergency, notify unit staff. There is an intercom button in every cell for immediate emergency assistance.
2. Discharge from the COVID-19 unit will be considered after 14 days from the onset of symptoms (not testing date). In addition, you must be 72 hours fever free without the use of fever reducing medication and have a noted improvement in symptoms. The official determination will be made by the health care provider.
3. Property will be distributed as we receive it from your sending facility. Please keep in mind, there is a limit of 2 boxes/bags of property that will be sent. The remaining property will be stored at your sending facility.
4. Mail will be delivered upon receipt. If you have outgoing mail, notify staff and they will place it in the outgoing mailbox. Legal mail will be distributed as received in accordance with the legal mail policy.
5. Phone calls will be given on a daily basis. To ensure that everyone is afforded an opportunity to a daily phone call please be mindful of the duration of your calls.
6. Due to the limited amount of time that you will be in the COVID unit, commissary orders will not be addressed or filled. Free Commissary items, when available will be distributed accordingly.
7. There will be no outside of cell recreation and no showers. You will be provided all hygiene products and a towel to wash in the cell. If you need additional hygiene products, please notify staff. We are leaning on the guidance provided by the Centers for Disease Control and Prevention (CDC) and the CT Department of Health (DPH).
8. Notary services are available upon request. Routine requests will be collected daily and disseminated properly. Envelopes are available by request for confidentiality.
9. Mental Health services are available by request. Please inform a staff member immediately if you are having any emotional problems you need to talk with someone about.
10. Please ensure that you are wearing your masks at all times when exiting the cell.
11. If you wish to clean your cell, notify staff and supplies will be provided. Also if there are any maintenance issues with your cell, please notify staff and a work order will be generated to fix the issue(s).
12. Religious Services is available every Tuesday and Thursday via Intercom please inform unit staff if you would like to be contacted by religious services.
13. Special diets, Ramadan will be accommodated. Please address staff with any issues.
14. Any additional questions or concerns, please address unit staff.

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT W

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL.	:	CIVIL NO. 3:20-CV-0534 (JBA)
V.	:	
NED LAMONT, ET AL.	:	MAY 15, 2020

DECLARATION OF ASSOCIATE RESEARCH ANALYST, VILMARIS DIAZ

Vilmaris Diaz, pursuant to 28 U.S.C. § 1746 hereby declares as follows:

1. I am over 18 years of age, of sound mind, and otherwise competent to make this declaration.

2. I am employed by the State of Connecticut Board of Pardons and Paroles ("Board") as an Associate Research Analyst. I have been employed by the Board in this capacity for approximately 6 years.

3. As an Associate Research Analyst, my current assignments include developing and conducting formal research methodologies and procedures, analyzing and evaluating data; performing complex statistical analysis; preparing comprehensive narrative and statistical reports; and preparing reports for agency officials in response to inquiries from the legislature or the public.

4. I independently gather and compile data on parole, special parole, medical parole, and compassionate parole release decision-making on a monthly and annual basis.

5. I have reviewed the data referenced in paragraph 4 for the period of time starting on January 1, 2020 until April 30, 2020, and confirm the following information based on my personal knowledge.

6. In January 2020, the Board conducted 119 parole release hearings. The Board paroled 63 inmates and denied 56 inmates, a 53% grant rate.

7. In January 2020, 19 inmates were discharged to special parole supervision.

8. In January 2020, the Board conducted 17 transfer parole reviews, 8 of which the Chairperson authorized for immediate transfer pursuant to Conn. Gen. Stat. § 54-125b.

9. In January 2020, The Board granted one inmate compassionate parole release. The Board denied one inmate medical parole release.

10. In February 2020, the Board conducted 126 parole release hearings. The Board paroled 56 inmates and denied 70 inmates, a 44% grant rate.

11. In February 2020, 26 inmates were discharged to special parole supervision.

12. In February 2020, the Board conducted19 transfer parole reviews, 11 of which the Chairperson authorized for immediate transfer.

13. In February 2020, the Board granted early termination of supervision to 19 offenders under supervision.

14. In March 2020, the Board conducted 132 parole release hearings. The Board paroled 71 inmates and denied 61 inmates, a 54% grant rate.

15. In March 2020, 16 inmates were discharged to special parole supervision.

16. In March 2020, the Board conducted 27 transfer parole reviews, 20 of which the Chairperson authorized for immediate transfer.

17. In March 2020, the Board granted early termination of supervisions to 40 offenders under supervision.

18. In March 2020, the Board granted one inmate compassionate parole release.

19. In April 2020, the Board conducted 118 parole release hearings. They paroled 77 inmates and denied 41 inmates, a 65% grant rate.

20. In April 2020, 14 inmates were discharged to special parole supervision.

21. In April 2020, the Board conducted 103 transfer paroled were reviewed, 103 of which the Chairperson authorized for immediate transfer, in accordance with Chairperson's order dated April 14, 2020 (attached hereto as Exhibit A).

22. In April 2020, the Board granted early termination of supervision to 42 offenders under supervision.

23. In April 2020, the Board granted one medical parole release.

24. In April 2020, the Board granted two compassionate paroles releases and denied two compassionate parole releases.

25. I could not accurately provide data for the month of May as I am not yet able to validate the data at this time.

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

5/15/2020
Date

Vilmaris Diaz

STATE DEFENDANTS

WILLIAM TONG
ATTORNEY GENERAL

BY: /s/

Steven R. Strom
Assistant Attorney General
110 Sherman Street
Hartford, CT 06105
Federal Bar #ct01211
E-Mail: steven.strom@ct.gov
Tel.: (860) 808-5450
Fax: (860) 808-5591

EXHIBIT

A

Ned Lamont
Governor

Carleton J. Giles
Chairperson

STATE OF CONNECTICUT

Telephone
(203) 805-6605

Fax
(203) 805-6652

BOARD OF PARDONS AND PAROLES
55 West Main Street - Waterbury, CT 06702

ORDER

WHEREAS, on March 10, 2020, Governor Ned Lamont (the Governor), in response to the global pandemic of 2019 Coronavirus disease (COVID-19), declared a public health and civil preparedness emergency throughout the State of Connecticut pursuant to Sections 19a-131a and 28-9 of the Connecticut General Statutes, to remain in effect through September 9, 2020, unless sooner terminated by the Governor;

WHEREAS, the Board of Pardons and Paroles is committed to carrying out its mission in a manner which minimizes the risk of COVID-19 to those in state custody while also mitigating the spread of COVID-19 infections throughout the state and region;

WHEREAS, the transfer of some inmates pursuant to § 54-125h of the Connecticut General Statutes may be beneficial to their health, community health and welfare, and the health and welfare of the prison population as a whole;

WHEREAS, the Board of Pardons and Paroles, in coordination with the Department of Correction, is dedicated to the successful reentry of such persons when it is compatible with the welfare of society, and when there are appropriate community supports in place; and

WHEREAS, pursuant to statute and the clear intent of the Legislature, the release of an inmate to the community before the end of their maximum lawful sentence of confinement is a decision left to the discretion of certain officials and experts because it requires an individualized balancing of multiple factors, including but not limited to; the likelihood of reoffending, the seriousness of the crime, the ability to properly adjust to life within the community, the availability of a suitable residence, halfway house, group home, or mental health facility, access to suitable medical and mental health care within the community, and under the present circumstances, whether an offender is exhibiting any symptoms of COVID-19, has been exposed to COVID-19, or is likely to be put at risk of being exposed to COVID-19 or expose others to COVID-19 upon release;

NOW, THEREFORE, based on concerns relative to COVID-19, and pursuant to the authority vested in me by § 54-125h of the Connecticut General Statutes, unless sooner terminated by me or unless the Governor sooner repeals the declared public health and civil preparedness emergencies, I hereby **ORDER** the transfer, effective April 20, 2020, of all persons confined in a correctional institution or facility to any public or private nonprofit halfway house, group home or mental health facility or to an approved community or private residence, provided that:

1. said person has been granted parole pursuant to subsections (a), (d), or (f) of section 54-125a of the Connecticut General Statutes by a panel of board members,

2. said person is within eighteen months of the parole release date ("voted to parole date")("VTP") established by said panel,
3. said person has an acceptable community release plan and if needed, appropriate medications or other community support, which has been approved by the Department of Correction, and
4. said person's transfer poses no health risk to the public as determined by the Department of Correction.
5. No person voted paroled again pursuant to subsection (a) of section 54-128 of the Connecticut General Statutes may be transferred pursuant to this order.

Ordered this 14th day of April, 2020

Carleton J. Giles
Chairperson

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT X

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL., *Petitioners,*	:	CIVIL NO. 3:20-CV-0534 (JBA)
v.	:	
NED LAMONT, ET AL., *Respondents.*	:	MAY 15, 2020

DECLARATION OF MICHELLE DEVEAU

The undersigned declarant, Michelle DeVeau, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I work for the Department of Correction ("DOC"), in the Central Records Office at the Sentence Calculation and Interstate Management Unit in Suffield, Connecticut, as a Records Specialist II. I have been with the DOC for over 29 years and at the Central Records Office for approximately 24 years.

2. As a Records Specialist II, I audit the records of inmates kept in the various correctional facilities throughout the State. I am responsible for reviewing the accuracy of computerized inmate records. I also assist the Office of the Attorney General in state and federal court matters involving lawsuits filed by inmates with respect to the inmate's personal history and disciplinary history as contained in their inmate master file. I have been qualified as an expert in inmate records and sentence calculations on numerous occasions. My duties at times include training and answering questions for the Public Defender's office, defense attorneys, as well as Judicial Branch staff, including training at judges' conferences when asked to do so.

3. I provided a previous declaration in this case which I incorporate by reference herein, (ECF Doc. #26-4, Filed 5/1/2020).

4. At the request of the Office of the Attorney General to me and to the DOC Research Division, a report was generated comparing the daily population of the DOC facilities, based on May 1, 2019, as compared to May 1, 2020. See Exhibit A, attached hereto.

5. In addition, a second report was generated detailing the number of discretionary releases from January 1, 2020, to May 14, 2020, month by month, and for each month from January 1, to May 1, 2020, and from May 1, 2020 to May 14, 2020. See Exhibit B, attached hereto.

6. The numbers set forth in these reports are based on the day-to-day computerized business records of the DOC's computer systems and are true and accurate records of the DOC as reflected in these computerized systems which tack inmate population as well as inmate movements, including discretionary releases to the community.

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 15th day of May, 2020.

Michelle DeVeau

Exhibit A

Population by Facility

5/1/2020

Facility	Female	Male	Total
BRIDGEPORT CC	0	581	581
BROOKLYN CI	0	376	376
CHESHIRE CI	0	1128	1128
CORRIGAN CI	0	642	642
GARNER	0	550	550
HARTFORD CC	0	812	812
MACDOUGALL	0	1450	1450
MANSON YI	0	239	239
NEW HAVEN CC	0	604	604
NORTHERN CI	0	270	270
OSBORN CI	0	1114	1114
RADGOWSKI	0	377	377
ROBINSON CI	0	971	971
WALKER RC	0	459	459
WILLARD-CYBULSKI	0	726	726
YORK CI	675	0	675
Total	675	10299	10974

5/1/2019

Facility	Female	Male	Total
BRIDGEPORT CC	0	685	685
BROOKLYN CI	0	450	450
CHESHIRE CI	0	1303	1303
CORRIGAN CI	0	772	772
GARNER	0	560	560
HARTFORD CC	0	916	916
MACDOUGALL	0	1530	1530
MANSON YI	0	325	325
NEW HAVEN CC	0	706	706
NORTHERN CI	0	282	282
OSBORN CI	0	1327	1327
RADGOWSKI	0	341	341
ROBINSON CI	0	1469	1469
WALKER RC	0	426	426
WILLARD-CYBULSKI	0	1338	1338
YORK CI	849	0	849
Total	849	12188	13037

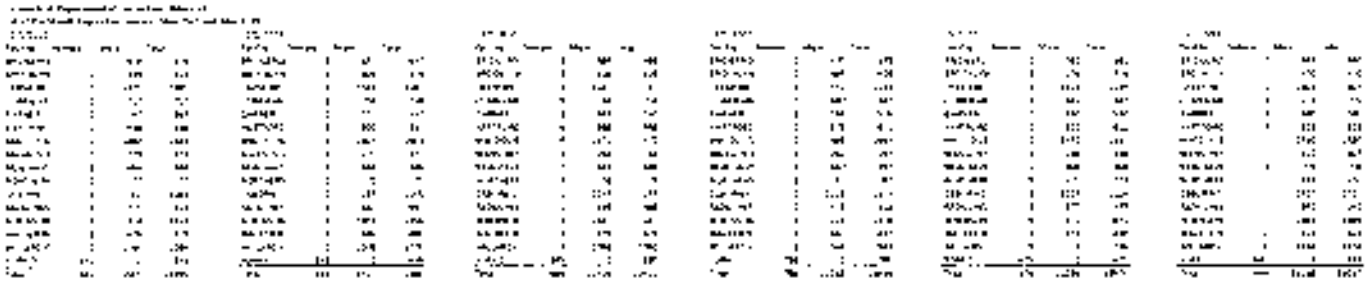


Exhibit B

Discretionary Release

Connecticut Department of Correction - Research
Discretionary Releases by Month January-May 14, 2020

	Jan-20	Feb-20	Mar-20	Apr-20	May 1-14, 2020
DUI/DRUG SUPRVSN	25	19	44	46	7
HALFWAY HOUSE	101	77	177	39	152
PAROLE	67	70	92	64	44
REENTRY FURLOUGH	5	3	15	119	33
TRANS PLACEMENT	14	12	31	58	11
TRANSFER PAROLE	7	10	20	54	20
TRANSITIONAL SUPERVISION	124	112	183	172	62

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General

EXHIBIT Y

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

TRE MCPHERSON, ET AL., *Petitioner*,	:	CIVIL NO. 3:20-CV-0534 (JBA)
v.	:	
NED LAMONT, ET AL., *Respondent.*	:	MAY 18, 2020

DECLARATION OF KATHRYN STACKPOLE

The undersigned declarant, Kathryn Leger Stackpole, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I work for the State of Connecticut, Judicial Branch, and I am presently an Assistant Clerk - Habeas Matters, in the Rockville Superior Court GA #19, 20 Park Street, Rockville, CT 06066.

2. On March 26, 2020, the Judicial Branch posted notice on its website that in response to the COVID-19 emergency, effective, Monday, March 30, 2020, the Rockville Courthouse GA #19, would be temporarily closed and matters from Rockville would be transferred to the Hartford Courthouse GA #14.

3. On March 30, 2020, both the Tolland JD and Rockville GA #19 Priority 1 business was absorbed by Hartford JD at GA #14.

4. From March 26, 2020 through May 13, 2020, all of the habeas mail was forwarded to GA #14.

5. On April 3, 2020, I contacted the Hartford JD Chief Clerk and arranged for GA 14 staff in Hartford to open all of the habeas mail in order to identify any emergency motions or petitions.

6. All matters deemed emergencies were sent to a habeas judge who reviewed the matter and determined how it should be handled. The judge directed that new matters be opened with a Hartford docket number. The Hon. Tejas Bhatt was assigned to handle these tasks.

7. On April 13, 2020, an emergency motion for bail filed in the matter of *Robert Day v. Commissioner of Correction*, TSR-CV17-4008971 was received in Hartford and forwarded to Judge Bhatt; a memorandum of decision was subsequently issued by Judge Bhatt.

8. The next day, an Emergency Motion for Temporary Injunction was filed in the matter of *Jeffrey Grimes v. Commissioner of Correction*, TSR-CV20-5000478, in which the petitioner sought immediate release. The respondent filed an Objection. On May 4, 2020, the Court (Bhatt, J.) promptly ruled upon the motion.

9. New habeas petitions were being scanned and forwarded to Judge Bhatt for review in furtherance of the procedure outlined in Con. Prac. Bk. § 23-24 Preliminary Consideration of Judicial Authority.

10. On April 15, 2020, I was given systems access, which allowed me to remotely process orders and code pleadings in an effort to expedite our internal procedure.

11. Mary Clark, Assistant Clerk at GA #19 was authorized, on April 24, 2020, to retrieve all of the Rockville mail held at GA #14. The habeas mail was then delivered to me. I promptly opened and reviewed all the mail to look for any emergency petitions/motions. I coded a motion for emergency release that was forwarded to Judge Bhatt who issued an order denying the motion.

12. On April 29, 2020, Judge Bhatt instructed that 3 new habeas petitions, which raised issues regarding COVID be docketed, with a Hartford docket number, and emailed to the

Office of the Attorney General to expedite the filing of appearances. Orders were issued in each of the three cases for the respondents to file a response by May 13, 2020.

13. Those three petitions are: *Solomon Boyd v. Commissioner of Correction*, HHD-CV20-5063875; *Douglas Murphy v. Commissioner of Correction*, HHD-CV20-5063876 and *Malik Nunn v. Commissioner of Correction*, HHD-CV20-5063877.

14. On April 29, 2020, it was agreed that twice a week habeas staff from GA #19 would operate out of the GA #14. On Wednesday afternoons, I opened habeas mail and coded and scanned pleadings into the Judicial Branch's e-filing system. Attention was given to emergency matters. On Friday afternoons, another habeas clerk performed the same tasks. This continued until May 13, 2020.

15. On May 4, 2020, the civil courts permitted non-arguable matters to go forward on the short calendar. I sent motions that did not require hearings to Judge Bhatt and Judge Chaplin for review. Habeas staff has been working with the judges to enter orders on the motions that can be ruled on.

16. An emergency motion for bond was filed, on May 6, 2020, in the matter of *Madeline Griffin v. Commissioner of Correction*, TSR-CV17-4009012. Judge Bhatt issued an order for a response to be filed by respondent by May 11, 2020. Representatives from the Office of the Attorney General and the State's Attorney's Office timely filed an Objection and Exhibits. A pretrial was scheduled, and conducted using Microsoft Teams, on May 11, 2020 at 2:00 p.m.

17. Since the COVID pandemic began, and up through May 8, 2020, 68 new Habeas Petitions have been filed. Eight petitions were returned for noncompliance with the requirements

of Conn. Prac. Bk. §23-22. Ten petitions are currently under review by a judge to determine if the court should decline to issue the writ pursuant to Conn. Prac. Bk. Sec. 23-24.

18. The remaining 50 petitions were docketed. Of these 50, 16 are considered conditions of confinement cases and 11 raised medical issues. The remaining 34 petitions challenge the petitioner's underlying conviction and are not COVID related. These petitions, not urgent in nature, were processed to maintain habeas operations.

19. Only four of the new petitions, reviewed since March, have been COVID related, which we consider an emergency.

20. In addition to the three petitions that were docketed in Hartford, on May 11, 2020, a fourth petition making emergency claims related to COVID was filed. This matter was reviewed by Judge Vernon Oliver, and was opened and docketed on May 12, 2020. That case is *Jose Rivera v. Commissioner of Correction*, TSR-CV20-5000056l. The respondent was notified of the new petition by email, and Judge Oliver entered a scheduling order with a responsive pleading due date of May 19, 2020.

21. The Hon. Vernon Oliver sitting in Middletown, on May 13, 2020, held the first conditions hearing that had been previously continued due to the shutdown. It was conducted remotely and utilized the Cisco Meeting video-conferencing platform. Only Judge Oliver, the court monitor, and the courtroom clerk appeared from the courthouse. The AG, the Petitioner and witnesses participated via videoconferencing. The hearing was successfully completed, and the matter was withdrawn.

22. The Habeas Caseflow Coordinator compiled a list, on May 13, 2020, of pending medical cases that had been continued due to the shutdown for review and triage for the Habeas docket.

23. On May 13, 2020, the Rockville Courthouse, GA #19, was opened for limited staff only to prepare for the imminent opening of the courthouse to the public.

24. On May 14, 2020, the three petitions originally docketed in Hartford, specifically *Solomon Boyd v. Commissioner of Correction*, TSR-CV20-5000611, *Douglas Murphy v. Commissioner of Correction*, TSR-CV20-5000610 and *Malik Nunn v. Commissioner of Correction*, TSR-CV20-5000609, were transferred back to GA #19 and assigned Rockville docket numbers.

25. On May 14, 2020, GA #19 mail, including habeas mail, started being delivered to the Rockville Courthouse. Habeas mail is currently being opened and reviewed by habeas staff.

26. On May 15, 2020, the Hon. Judge Hunchu Kwak conducted a hearing in the matter of *Malik Nunn v. Commissioner of Correction*, TSR-CV20-5000609. The parties were afforded an opportunity to be heard, present witnesses, and submit documentation to the court. The hearing concluded with the Petitioner being provided additional time to respond to the Respondent's Objection.

27. Hearings are scheduled for May 18, 2020 in the matters of *Solomon Boyd v. Commissioner of Correction*, TSR-CV20-5000611 and *Douglas Murphy v. Commissioner of Correction*, TSR-CV20-5000610.

28. Emergency matters that involve COVID claims will be addressed expeditiously in Middletown, before Judge Oliver and Judge Hunchu Kwak. Habeas staff will be present along with a Temporary Assistant Clerk (TAC) from Middletown.

29. Going forward habeas judges and staff have triaged the docket to continuously review and prioritize petitions that were scheduled for hearing or trial but continued as a result of the COVID crisis.

30. Of the cases scheduled and continued, conditions of confinement cases where the Petitioner asserted underlying medical claims as the basis for the petition, are culled out and prioritized for scheduling.

31. The habeas court staff will continue to identify and prioritize petitions with underlying conditions of confinement claims.

32. A review of judicial records reveals that Pattikate Williams-Void #297642, Thomas Cavey #387020, and Tre McPherson have not filed state court habeas petitions challenging conditions of confinement based on COVID.

DECLARATION

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 18th day of May, 2020.

Kathryn Leger Stackpole, Esq.
Assistant Clerk - Habeas Matters
Rockville Superior Court

CERTIFICATION

I hereby certify that on May 18, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

James M. Belforti
Assistant Attorney General