

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

KEITH SETH, et al.,
Individually and on behalf of a class of similarly
situated persons
Plaintiffs-Petitioners,

v.

MARY LOU McDONOUGH,
In her official capacity as Director of the Prince
George's County Department of Corrections
Defendant-Respondent.

Civil Action No. 8:20-cv-01028-PX

DEFENDANT'S OPPOSED EMERGENCY MOTION TO STAY PENDING APPEAL

Defendant Mary Lou McDonough, by and through the Prince George's County Office of Law, pursuant to Federal Rule of Civil Procedure 62(d), moves to stay the Injunction entered on May 21, 2020 [ECF 84 and 85], pending its appeal of the Court's entry of Temporary Restraining Order and Preliminary Injunction, and in support states the following:

I. INTRODUCTION

On May 21, 2020, at approximately 5:01 p.m. [ECF 84 and 85], this Court entered a temporary restraining order and preliminary injunction directing the Defendant to take certain enumerated actions concerning the Prince George's County Department of Corrections' ("PGCDOC") response to COVID-19 as it pertains to "high risk" detainees, facility testing, cleaning, and education. The Defendant filed a notice of appeal of that order to the U.S. Court of Appeals for the Fourth Circuit [ECF No. 86.] Pursuant to Federal Rule of Civil Procedure 62(d) and Federal Rules of Appellate Procedure 8, the Defendant moves the Court stay its order

pending appeal and respectfully requests a ruling on this emergency motion to stay by May 29, 2020 at 3:00 p.m.

II. LEGAL STANDARD

Federal Rule of Civil Procedure 62(d) provides that “while an appeal is pending from an interlocutory order or final judgment that grants, continues, modifies, refuses, dissolves, or dissolve or modify an injunction, the court may suspend, modify, restore, or grant an injunction on terms for bond or other terms that secure the opposing party’s rights.”

Courts consider four factors in deciding whether to grant a stay pending appeal: (1) whether the stay applicant has made a strong showing that it is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) whether the public interest lies. *Nkwn v. Holder*, 556 U.S. 418, 434 (2009).

III. ARGUMENT

A. The Defendant is Likely to Succeed on the Merits Because the Record Does Not Establish That the Director of PGCDOC Acted With Deliberate Indifference

A stay in the above captioned matter is warranted because Defendant is likely to prevail on the merits of her appeal for the reasons stated in Defendant’s Response in Opposition to Plaintiff’s Emergency Motion for Temporary Restraining Order [ECF 29], Supplemental to Response in Opposition to Plaintiff’s Emergency Motion for Temporary Restraining Oder [ECF 36], Defendant’s Response to [ECF 24] Court Order Attachment A [ECF 37], Supplemental to ECF 29 Response in Opposition to Emergency Motion for Temporary Restraining Order [ECF 38], Supplemental to ECF 29 Response in Opposition to Emergency Motion for Temporary

Restraining Order [ECF 39], Court's Exhibit List [ECF 65], Letter correspondence addressing substantive legal issues [ECF 72], and Second Motion for Other Relief to Supplement Record [ECF 78].

Defendant is likely to prevail on the merits of its appeal for four reasons. First, as this Court acknowledged during the Status Conference held on May 20, 2020 and stated in its Memorandum Opinion, the Prison Litigation Reform Act ("PLRA"), 42 U.S.C. §1997e, applies to Plaintiffs' claims, specifically Counts I and III. [ECF 84 at 18]. Thus, the PLRA precludes Plaintiffs' request for relief pursuant to 42 U.S.C. §1983 because they failed to exhaust administrative remedies. *Jones v. Bock*, 549 U.S. 199, 211 (2007) ("there is no question that exhaustion is mandatory under the PLRA and that unexhausted claims cannot be brought in court.").

Second, Plaintiff's claims pursuant to the Eighth and Fourteenth Amendments have no merit, are not supported by the undisputed evidence, or by the court-appointed jail inspector's report [ECF 65.] The record is replete with evidence that Defendant has not been deliberately indifferent to risk posed by the COVID-19 pandemic and its potential impact on the inmates ("high risk" or otherwise) at the Prince George's County Correctional Center and court appointed jail inspector's report supports that conclusion.

An official "who actually [knows] of a substantial risk to inmate health or safety may be found free from liability if [she] responded reasonably to the risk, even if the harm was not ultimately averted." *Brown v. Harris*, 240 F.3d, 383, 389 (4th Cir. 2001), *quoting Farmer v. Brennan*, 511 U.S. 825, 844 (1994). "[W]hether one puts it in terms of duty or deliberate indifference, prison officials who act reasonably cannot be found liable under the Cruel and

Unusual Punishments Clause.” *Id.*

Here, Dr. Franco-Paredes found that PGCDOC was in compliance with CDC Guidelines. [ECF 64, 26:19-24.] Dr. Franco-Paredes acknowledge that “there’s challenges, like social distancing, when even the CDC says things have to be applied according to, you know, each institution...” *Id.* Dr. Franco-Paredes found that Director McDonough employed different tactics to help promote social distancing in many ways – eliminating inmate work details, locking down the housing units so that only the same ten (10) individuals shared the common area and recreation area during breaks (thus reducing exposure to additional people), asking inmates to sleep in opposite directions in their bunks, and when inmates used phones in the housing unit. [ECF 64, 27:15-19.] Inmates from each housing unit were addressed en masse by correctional officers and nurses who advised about the contagiousness of the virus, symptoms, covering a cough, washing hands, cleaning cells, and social distancing. [ECF 29-3.] Educational posters were erected throughout the jail in multiple languages. [ECF 29-3.] The Director has worked extensively with the state courts, State’s Attorney’s Office and Office of the Public Defender to reduce the jail’s population, from an average daily population of 720 on March 1, 2020 to the current population of 540. [ECF 29-3, 78-5.] The record also reflects that none of the detainees/inmates have been transported from PGCDOC to any area hospital for medical treatment or death attributable to COVID-19. [ECF 29-1.] Of the 18 detainees/inmates diagnosed with COVID-19 and found symptomatic, all were placed in proper isolation units, suffered only minor symptoms and fully recovered. [ECF 29-1.] The last date a symptomatic inmate/detainee tested positive for COVID-19 was April 20, 2020. [ECF 29-1.]

The Court's concern that an outbreak occurred in the jail in April, which was traced to an introduction by a correctional employee, is not reflective of deliberate indifference – the entire country experienced a spike in cases in April. Even plaintiffs' experts, by affidavit, have said that controlling the spread of COVID-19 in a correctional facility is impossible. [ECF 1, Ex. 30, Meyers Decl. ¶ 30.] Yet, at time of the inspection, Dr. Franco-Paredes did not observe any inmate exhibiting symptoms indicative of COVID-19. [ECF 64, 31:14-18.]¹ That other inmates may have become infected did not result in any harm as, according to Dr. Franco-Paredes, 93% of the inmate population is at low risk of developing complications (COVID-19) due to corona virus infection. [ECF 65.] As noted in the record, the Director, through PGCDOC's medical contractor, was only recently able to secure additional testing kits. [ECF 88 at 17.] The court pointing to the lack of testing kits in PGCDOC's inventory fails to recognize that not too long ago, there was a nationwide shortage of testing capabilities.

Further, there is no evidence that a failure to have a specific plan to address a segment of the inmate/detainee population at PGCDOC caused or will cause any unnecessary and wanton infliction of pain on any member of that segment or that the medical treatment provided would be any different with or without a plan. *See Estelle v. Gamble*, 429 U.S. 97, 104 (1976)(quoting *Gregg v. Georgia*, 428 U.S. 153, 169-173 (1976)). The record reflects that all inmates/detainees were treated as "high risk" due to the closed, confined space of the facility, inmate/detainee population, the location of the facility, and experience with other highly contagious

¹ It is simply implausible that the inmates' declarations, obtained by assistant public defenders to whom they look to get out of jail, have any credibility at all given Dr. Franco-Paredes' findings. That a massive outbreak occurred just three weeks prior to his arrival is simply belied by the fact that he did not observe a single inmate exhibiting COVID 19 symptoms.

communicable viruses. After consultation with Meskerem Asresahegn, M.D., PGCDoc's Site Medical Director, Director McDonough decided that "high-risk" inmates/detainees would remain in their current housing units to avoid movement through the jail exposing them to new people and increasing the risk of an infection. [ECF 78-4.] Additionally, if all "high risk" inmates/detainees were housed in the same housing unit and one became symptomatic, there would be an increased risk that all "high risk" inmates/detainees would become symptomatic, which could potential overwhelm medical staff. [ECF 78-4.] Yet, any failure to have a plan specifically for "high risk" inmates/detainees constitutes, at most, mere negligence and fails to meet the high standard of deliberate indifference. *See Estelle v. Gamble*, 429 U.S. 97, 105–06 (1976). As noted, the record reflects that the Director relied on the medical advice of those professionals at her disposal. [ECF 78-4.] Any disagreement with advice provided pursuant to the medical judgment of the Medical Director cannot be imputed to the Director for purposes of the deliberate indifference analysis.

Dr. Franco-Paredes found no problems with the facility's sanitation efforts or provision of cleaning supplies and hygiene supplies to the inmates. [ECF 65.] There is no indication that the facility will not continue to provide proper sanitation or supplies. Yet, the Court has ordered a detailed report to be submitted addressing these matters.

The sustainability of repeated or periodic widespread testing or targeted, periodic testing is dependent on factors beyond the authority and ability of the Director. [ECF 78-1.] Testing supplies, as elsewhere throughout the country, have been in short supply. [ECF 78-1.] Thus, any shortfall in executing the plan cannot be construed as deliberate indifference when the County's jail is only one of many in need during this pandemic where many citizens in Prince

George's County and State have suffered the ultimate injury.

B. The Director and County Will Suffer Irreparable Injury in the Absence of a Stay and Plaintiffs will not.

Next, a stay is also warranted and appropriate in this instance because the Court's Order threatens irreparable injury to the Defendant by obstructing Director McDonough's exercise of her judgment as a correctional administrator in discharging her fundamental duty to ensure the safety and security of PGCDOC.² The Prince George's County Code of Ordinances, Sec. 18-108(a) provides that "the County is authorized and directed to provide for the board and feeding of prisoners confined in the County jail" and "the administration of the County jail shall be under the direction of the Director of the Department of Corrections appointed by the County Executive and confirmed by the County Council pursuant to Section 322 of the Prince George's County Charter." "It is 'difficult to imagine an activity in which a State has a stronger interest, or one that is more intricately bound up with state laws, regulations, and procedures, than the administration of its prisons.'" *Woodford v. Ngo*, 548 U.S. 81, 94 (2006)(quoting *Preiser v. Rodriguez*, 411 U.S. 475, 491–492 (1973)). The Defendant has had to expend extensive resources and staff time simply responding to this lawsuit and the Court's orders. The Court's Order for TRO and preliminary injunction will require even more time and resources needed to run the institution and implement plans to respond to the ever-evolving nature of this global pandemic. More importantly, the Court's order dictates to the Director what must be done to

² See generally *Overton v. Bazzetta*, 539 U.S. 126, 132 (2003) (recognizing that courts must accord "substantial deference to the professional judgment of prison administrators, who bear a significant responsibility for defining the legitimate goals of a corrections system and for determining the most appropriate means to accomplish them."); *Lovelace v. Lee*, 472 F.3d 174, 199 (4th Cir. 2006) ("courts must accord deference to the officials who run a prison, overseeing and coordinating its many aspects, including security, discipline, and general administration.").

satisfy the Court, rather than to leave that prerogative to the Director, when the evidence on the record simply does not require judicial oversight.

Plaintiffs will not suffer irreparably injury if the matter is stayed. The health and safety policies and procedures implemented by Defendant pursuant to the CDC Guidelines reveal that such policies and procedures are reasonable to protect inmates/detainees at the PGCCC as evidenced by low number of symptomatic, COVID-19 positive inmates/detainees compared to the community of Prince George's County. No detainee – “high risk” or otherwise – has required hospitalization. Plaintiffs only offer speculation, and no evidence (other than claims of symptoms that, if believed, could be attributed to a number of illnesses) of any inmate/detainee needlessly suffering for lack of a plan. There is no evidence of any inmate/detainee regardless of “high risk” or not being in any immediate threat of harm. On the contrary, the evidence reveals that Director McDonough acted proactively in implementing a pandemic policy modeled after the CDC Guidelines while weighing their impact on the inmates/detainees versus preventing the COVID-19 to spread in the jail. The number of COVID-19 symptomatic inmates, or lack thereof, speaks to the effectiveness of Director McDonough's policies and procedures in controlling and preventing the spread of COVID-19 in PGCCC. [ECF 29-1.] Thus, any omission of Director McDonough to implement a plan for “high risk” inmates/detainees when no evidence of any member of this segment of the inmate/detainee population suffered any serious injury during the pandemic cannot be found to meet the high standard of a violation of the Eighth or Fourteenth Amendments to the Constitution. More importantly, the Director's entire response demonstrates that the high-risk population remains unlikely, in the future as well, to suffer from serious risk of harm. In this regard, it should be noted that any inmate who incurs serious

COVID-19 disease, high-risk or otherwise, will receive hospitalization paid for by the County, thus providing inmates the same medical resources they would have if not incarcerated.

C. Plaintiffs fail to properly plead a *Monell* claim against the County.

It is well-established that “an official capacity claim against a government employee is, in effect, a claim against the governmental unit.” *Lowery v. Prince George's County*, 960 F. Supp. 952, 953 (D.Md. 1997). To state a claim under § 1983, Plaintiffs must allege: “(1) a deprivation of a constitutional right or some right secured by the laws of the United States, and (2) that the deprivation was caused by a state actor.” *West v. Atkins*, 487 U.S. 42, 48 (1988). A municipality may not be held liable under § 1983 unless a municipal policy or custom caused the plaintiffs' injury. *Monell v. Dep't of Soc. Servs. of City of New York*, 436 U.S. 658, 694, (1978). The policy or custom requirement of *Monell* applies to § 1983 claims for declaratory or injunctive relief no less than claims for damages. *Los Angeles Cty. v. Humphries*, 562 U.S. 29, 31 (2010). A district court may not award prospective relief against a municipality unless the requirements of *Monell* are satisfied. *Id.* Thus, plaintiffs must establish that they are likely to satisfy the requirements of *Monell* to obtain a preliminary injunction against a municipality. *Id.*

Here, Plaintiffs' §1983 claim asserted against Mary Lou McDonough in her official capacity as Director of PGCDOC is a claim against the County. In Plaintiffs' Emergency Motion for Temporary Restraining Order and Preliminary Injunction, Plaintiffs claimed that Director McDonough failed to adopt measures to prevent the spread of COVID-19 and ignored the guidance from the CDC. [ECF 3-1, p. 4.] The record clearly does not support Plaintiffs' assertions. The record reflects that Director McDonough prepared and implemented a pandemic

policy modeled after the CDC Guidelines dated March 23, 2020. [ECF 29-5.] Along those lines, Dr. Franco-Paredes found that Defendant's policy was in compliance with the CDC Guidelines. [ECF 65.] The policy's effectiveness is evidenced by the low number of COVID-19 inmates/detainees, reduced inmate/detainee population, no transports to area hospitals, and no deaths, which contradicts the claims in the Plaintiffs' motion and affidavits. [ECF 29-1.]

More importantly, the record is devoid of any evidence that the lack of a policy caused any harm to any inmate/detainee. The record shows that Defendant did have a policy and practice of identifying "high risk" inmates through its Chronic Care Clinic, which monitors and treats inmates/detainees medical conditions. [ECF 29-1.] The County's reliance on its Chronic Care Clinic as a reasonable means of identifying those inmates that may meet the definition of "high risk" as defined by the CDC, but may fail to capture all "high risk" inmates, does not rise to the level of conduct indicative of deliberate indifference. The Court must appreciate and take into consideration that knowledge of COVID-19 changes sometimes daily, weekly, or monthly. The constitutional standard for a violation of the Eighth and the Fourteenth Amendments is not best practices, but *reasonable* practices. Based on all of the policies and safeguards employed by the Defendant, those incarcerated at PGDOC are safer than those in the community.

IV. CONCLUSION

Based on all of the above, Defendant Mary Lou McDonough respectfully requests that this Honorable Court grant Defendant's Motion to Stay pending the appeal of this matter.

V. CERTIFICATE OF CONFERRAL

The parties conferred by electronic mail on May 27, 2020 and Plaintiffs oppose this motion.

VI. EMERGENCY CERTIFICATION

After reviewing the facts and researching applicable legal principles, we certify that this motion in fact presents a true emergency (as opposed to a matter that may need only expedited treatment) and requires an immediate ruling because the Court would not be able to provide meaningful relief to a critical, non-routine issue after the expiration of seven days.

Respectfully submitted,

RHONDA L. WEAVER
COUNTY ATTORNEY

ANDREW J. MURRAY
DEPUTY COUNTY ATTORNEY

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Filed: 05/27/20

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
SOUTHERN DIVISION

KEITH SETH, et al.,)
)
 Plaintiffs,)
) Case Number: 8:20-cv-1028-PX
 vs.)
) Videoconference
 MARY LOU McDONOUGH,)
)
 Defendant.)
)

TRANSCRIPT OF PROCEEDINGS - TRO HEARING
BEFORE THE HONORABLE PAULA XINIS
UNITED STATES DISTRICT JUDGE
MONDAY, MAY 11, 2020; 3:00 P.M.
GREENBELT, MARYLAND

A P P E A R A N C E S

FOR THE PLAINTIFFS:

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ALSO PRESENT: Mary Lou McDonough - Defendant

Proceedings Recorded by Audio Recording
Transcript Produced By Computer-Aided Transcription

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A P P E A R A N C E S
(continued)

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1 THE DEPUTY CLERK: The United States District Court
2 for the District of Maryland is now in session, the Honorable
3 Paula Xinis presiding.

4 THE COURT: All right. Good afternoon, everyone.
5 I'm so glad that we're able to do this, if not in person, by
6 Zoom. It's wonderful to see faces and put them to voices and
7 hopefully it will help with regard to this hearing today.

8 This is Seth versus McDonough, 20-1028. This is a hearing
9 on the pending motion for temporary restraining order filed by
10 the plaintiffs, and it is to follow up, as we discussed last
11 time, on Dr. Franco-Paredes' independent inspection and report
12 that he has offered.

13 So just briefly for the record, I do have Plaintiffs'
14 counsel. There are many of you on the line, but those who are
15 intending to speak are Ms. Chamblee Ryan and Mr. Williams. I
16 also have for the Defense Ms. Koshy, Ms. Johnson, Mr. Murray.
17 And the doctor, Dr. Franco, has joined us. Thank you so much.

18 For all of you who are on the line listening as if you
19 were in the audience of my court, I'll remind you this is a
20 public proceeding. We welcome one and all, but we do have to
21 follow some important guidelines. First: Keep your phones on
22 mute if you're not speaking so that we cut down on background
23 noise, barking dogs, crying babies. It's just par for the
24 course these days and I understand it but we want to minimize
25 it.

1 Second: There is absolutely no recording of this
2 proceeding whatsoever. You would be in violation of a court
3 order if you do independently record this proceeding. There is
4 only one official recording and that is taken by our official
5 court reporter, Ms. Kerr, who is with us today, and she will be
6 permitted to interrupt any time to let us know if she cannot
7 hear us.

8 So thank you, Ms. Kerr.

9 THE COURT REPORTER: You're welcome.

10 THE COURT: Finally, if there's any interruptions of
11 any kind, there won't be a second warning for anyone on the
12 line. You will be what's called electronically ejected. And I
13 don't anticipate that's going to happen, but I do need to give
14 you forewarning on that. We have a lot to do today so I'm
15 going to try to keep it moving.

16 First off, before we -- I do want to get an update from
17 counsel on any meet and confer you may have had after
18 Dr. Franco sent us this morning his report, but for the sake of
19 completeness of the record and for those of you who are
20 listening, last time we were all together I did appoint
21 Dr. Franco-Paredes, an expert in infectious diseases and public
22 health, to conduct an independent inspection of the facility;
23 and he was appointed pursuant to Federal Rule of Evidence 706,
24 which allows me as the Court to appoint an expert, an expert
25 who does not work for the plaintiffs nor the defense.

1 And I want to thank Dr. Franco because you, sir, are the
2 definition of humanitarian in that you jumped on a plane from
3 Colorado, conducted a two full-day inspection. You, by virtue
4 -- I've learned this from your report -- interviewed a number
5 of corrections officers, 41 detainees. You inspected every one
6 of the housing units and spoke with all the important people,
7 including the Defendant, Director McDonough.

8 And I likewise want to thank both the Plaintiffs and
9 Defense for making yourselves available and fully so, and I
10 think the report reflects that, that the Defendant and her
11 staff were cooperative, they were forthcoming, and I would
12 expect that's going to continue.

13 So and finally, I would be remiss, Dr. Franco, if I didn't
14 pay you a special hat tip to doing this all pro bono, free of
15 charge. In these times where we are -- we're facing serious
16 economic difficulties, everyone is in crisis, you have really
17 stepped up, and I so appreciate it. And I wanted, on behalf of
18 I'm sure the parties who are equally appreciative to extend my
19 personal thanks.

20 So with that, what I would like to do today is first hear
21 as to whether there has been any movement toward agreement of
22 any kind and, if so, you know, what are those areas of
23 agreement and what would you like me to do next. That's the
24 meet and confer. I do want to give both sides the opportunity
25 to follow up with Dr. Franco on any questions that you may have

1 stemming from the report, and I may have some follow-up as
2 well. And then finally, I do have some questions about
3 applicable legal principles as to the three counts in the
4 Complaint, as well as some of the more recent filings at ECF 61
5 and I believe it's 63. We'll talk about those before we
6 conclude today.

7 So with that, who wishes to update me on the meet and
8 confer?

9 MS. CHAMBLEE RYAN: Your Honor, this is Katie
10 Chamblee Ryan for the Plaintiffs. I'll turn to my colleague Ed
11 Williams for additional details, but just as an initial matter,
12 we did have some movement towards agreement on some areas with
13 Defendant's counsel. There's also some disagreement including
14 areas where we agree in principle but disagree about
15 implementation and whether monitoring is appropriate.

16 What we think would make sense now is we think that based
17 on the evidence on the record, this Court should enter a TR0
18 and then the parties should continue to meet and confer during
19 that 14-day period, and by the end of that, hopefully we can
20 bring something to the Court that will significantly narrow the
21 issues by the time the TR0 expires.

22 THE COURT: Do you have agreement on the TR0 that you
23 wish for me to enter or is this a --

24 MS. CHAMBLEE RYAN: No. No, Your Honor.

25 THE COURT: Okay.

1 MS. CHAMBLEE RYAN: No, Your Honor. Plaintiffs --
2 let me -- let me clarify. So we did meet and confer with
3 opposing counsel. There were areas of substantive change that
4 we think we may be able to move on. There is even some
5 disagreement around implementation. We think we'd benefit from
6 further conversations and both parties seem willing to do that.

7 Plaintiffs' position -- this isn't an agreement but, of
8 course, Defendant disagrees, but Plaintiffs' position is that
9 it would be appropriate, particularly given the urgency here
10 and the ongoing outbreak that Dr. Franco confirmed is in the
11 jail, combined with the inadequacies in screening, delays in
12 medical care, we think that it would make sense for the Court
13 to issue a TR0 on the current record; but we think that because
14 the parties are both, I'm sure, willing to negotiate, we think
15 that we would be able to narrow the issues by the end of that
16 14-day TR0 period. But that's just plaintiffs' perspective on
17 those next steps.

18 I think the place where we have agreement is that both
19 parties are willing to continue negotiating.

20 THE COURT: Okay. Yeah, because, I mean, I'm not
21 prepared today to enter a TR0. As I've already alluded, I have
22 a number of questions regarding, frankly, the law and the
23 facts. So I think you all do benefit from putting your heads
24 together to see if you can come up with a formal Consent
25 Decree, if you will, because if nothing else, it appears to me

1 that both sides have benefited greatly from Dr. Franco's
2 inspection; and he has a number of, you know, recommendations
3 that seem, you know, not terribly burdensome and onerous. Some
4 others are a little more involved, and we can talk about them
5 in a moment, but I think bottom line is that you all would
6 benefit from additional discussion.

7 And I'm heartened to hear that you're making progress. It
8 doesn't sound like you're at any point though -- you're not at
9 the point today to put any agreements on the record. Am I
10 getting that right?

11 MS. CHAMBLEE RYAN: I believe that's right, Your
12 Honor. I'll let Defendant's counsel or my colleague correct me
13 if I'm wrong on that I think.

14 And the point -- our point about the TRO is just that it's
15 not to say that we wouldn't benefit from further negotiation.
16 We certainly agree that we would. We just think that it's
17 appropriate to have something -- some protections in place
18 while we do, particularly since the remedy is a short-term
19 measure.

20 THE COURT: All right.

21 Okay. Ms. Johnson, Mr. Murray, do you wish to add --
22 Ms. Koshy, do you wish to add to that?

23 MS. KOSHY: Just very briefly, Your Honor. We would
24 not agree with Plaintiffs' counsel that a TRO is required at
25 this juncture. There has been no continued outbreak with

1 regard to the cases at the detention center.

2 With the -- discussing the meet and confer, discussing the
3 issues raised in Dr. Franco's report, I think it was a good
4 discussion overall. I think really what it comes down to is
5 the implementation and the feasibility of some of these
6 suggestions that were raised.

7 And so actually I would, you know, provided that a Consent
8 Decree didn't, you know, acknowledge any type of violation on
9 the part of the County, we would be interested in continuing to
10 meet and confer to see if we can come to some type of an
11 agreement because a lot of the items noted in this report have
12 been addressed, are being addressed, and there is no need for
13 any severe emergency relief that a TRO would otherwise be
14 imposing.

15 THE COURT: Okay. So maybe what we'll do is let's
16 see how the rest of this hearing goes, and at the conclusion of
17 the hearing, I may be asking you, Counsel, for a follow-up
18 status report, and provisionally I'm thinking seven days from
19 today, maybe sooner, maybe later. We'll see how the rest of
20 the hearing goes. But continue those talks and let's see how
21 much progress you all can make, and we'll set an interim
22 reporting deadline on ongoing discussions.

23 Okay. With regard to Dr. Franco's report, as I've
24 mentioned, I'm going to give both sides an opportunity to ask
25 the doctor any follow-up questions on the report. As I think

1 the order had noted or, perhaps, it was in communication that I
2 had with Counsel, I'm going to give each side up to 20 minutes.
3 You don't need to take it all. The report -- oh, and the other
4 thing. I want to make sure that Dr. Franco's report is
5 appended as a hearing exhibit of today. Any objection to it
6 being filed as a hearing exhibit in unredacted form? I didn't
7 see any personal identifiers or anything of concern, but I just
8 want to get both sides to weigh in on that.

9 Any problem with that, Plaintiffs?

10 MS. CHAMBLEE RYAN: No, Your Honor.

11 THE COURT: Okay. Defense?

12 MS. KOSHY: No, Your Honor.

13 THE COURT: Okay. So the report will be made Hearing
14 Exhibit 1.

15 Let's turn to Plaintiffs. Do you have any follow-up
16 questions for the doctor?

17 MS. CHAMBLEE RYAN: We do, Your Honor. Okay. And if
18 you could just give me one moment.

19 (Brief pause.)

20 MS. CHAMBLEE RYAN: Hello?

21 THE COURT: Yeah, you froze for a moment. I think
22 you're back with us.

23 MS. CHAMBLEE RYAN: I hope so. Can you hear me now?

24 THE COURT: Yes.

25 MS. CHAMBLEE RYAN: Okay. And, Dr. Franco, are you

1 able to hear me?

2 DR. FRANCO: Yes. Can you hear me?

3 MS. CHAMBLEE RYAN: Yes, I can.

4 And may I proceed, Your Honor, with questions?

5 THE COURT: Yes, you may.

6 MS. CHAMBLEE RYAN: Okay, great.

7 Dr. Franco, thanks for the report. I have a few
8 questions. I'm actually just going to focus on some areas
9 where there was some confusion on our part and hoping you can
10 maybe clarify.

11 So there's three or four areas that we were hoping to ask
12 you about. So the first is with respect to medically
13 vulnerable prisoners. So you noted that you had identified
14 additional cases of medically vulnerable people, but it didn't
15 look like in the report that you had a chance to review any
16 medical records. How did you identify those people?

17 DR. FRANCO: I identified them during the interviews.

18 MS. CHAMBLEE RYAN: Okay.

19 THE COURT: And Ms. Kerr -- before you go on,
20 Ms. Chamblee Ryan --

21 MS. CHAMBLEE RYAN: Yes.

22 THE COURT: Dr. Franco --

23 DR. FRANCO: Yes?

24 THE COURT: -- I think we're having a little bit of
25 difficulty hearing you.

1 DR. FRANCO: Okay.

2 THE COURT: You may want to move closer to the
3 microphone and, if possible, slow down a little bit.

4 DR. FRANCO: Sure.

5 THE COURT: Okay, thank you.

6 MS. CHAMBLEE RYAN: Okay, great.

7 And so, Dr. Franco, our understanding and from the
8 declaration from the lead doctor at the jail, it appears that
9 there is no -- the jail has not already created any kind of
10 list of people who are medically vulnerable. Is that your
11 understanding as well, or were you able to review any evidence
12 that disputes that?

13 DR. FRANCO: During my interview with Dr. Asresahegn,
14 the physician in the Prince George's County jail, she mentioned
15 that they have, for example, a knowledge of the -- for example,
16 individual detainees who may have, for example, diabetes
17 management because they provide them with their medications or
18 their insulin, or people that have issues with asthma or COPD.
19 So she does have some knowledge of the detainees throughout the
20 units.

21 My point -- and if it's okay to add -- is what I was
22 referring to is that during my interviews, as I mentioned, with
23 the detainees in different units, I, for example, encountered
24 one detainee who had a history of a cardiac surgery last year
25 who was in the same unit as -- you know, there were other cases

1 or there was another individual who had a history of -- or not
2 history but he had stage -- advanced stage pancreatic
3 carcinoma.

4 So this is an example of some of the patients -- not
5 patients but detainees who are in the -- in some of the units.
6 And I was referring specifically to that, Ms. Chamblee.

7 MS. CHAMBLEE RYAN: Great. Thank you.

8 And just to be totally clear, the doctor did not represent
9 that the jail had actually compiled a list of people who fell
10 within the CDC high risk categories?

11 DR. FRANCO: I would say not per se it's a list like
12 with the categories, but they knew, as I mentioned, that -- the
13 distinction of patients in the different units that have
14 potentially, you know, some of these conditions, like diabetes
15 or asthma, because of their medication.

16 MS. CHAMBLEE RYAN: Okay. And you didn't see any
17 medical records that substantiated that; is that right?

18 DR. FRANCO: I did not see any records nor did I ask
19 for them because I, as I mentioned, I was interviewing mostly
20 the detainees.

21 MS. CHAMBLEE RYAN: Oh, of course. You had very
22 little time. I just want to -- what I'm trying to understand
23 is just the basis of knowledge because it helps us understand
24 the evidence.

25 So and this doctor, did you notice in her declaration she

1 had also made a statement that she didn't know what Plaintiffs
2 meant by the term "medically vulnerable" and listed only 23
3 people within the jail who had conditions? And then the doctor
4 also referred -- claimed that the jail was keeping up-to-date
5 temperature logs, but those temperature logs had a number of
6 serious errors. Did you notice that?

7 DR. FRANCO: I noticed that also in the declaration.

8 MS. CHAMBLEE RYAN: Okay.

9 Okay, and are you aware of any evidence or even
10 representations from the doctor that the jail has any plan to
11 protect the medically vulnerable that's similar to what you
12 recommended in your report?

13 DR. FRANCO: Not from the medical doctor. We did
14 discuss this with Director McDonough and asked her
15 specifically, and she was aware of some detainees who were in
16 the medically vulnerable group.

17 And to answer your question also, when I asked Dr. Meske
18 about the CDC guidelines on correctional facilities, which
19 includes those called medically vulnerable, she was familiar
20 with the list.

21 MS. CHAMBLEE RYAN: Is it fair to say that, you know,
22 from your interviews with both of them, both of them had
23 knowledge that it was important to protect the medically
24 vulnerable but none of them told you anything about any kind of
25 plan to protect those people?

1 DR. FRANCO: I would say from Dr. Meske, not
2 specifically. With Director McDonough, she mentioned, for
3 example, that there is a -- just to give you an example -- a
4 detainee, Ms. O, in the female unit, which is medical -- excuse
5 me, Unit 1; that she is actually one of the cases that she
6 tried to because of her age, she's 73 or 74, she tried to I
7 would say favor her release or early release because of her age
8 factor; and she was actually one person that had the
9 confirmation of the diagnosis, and she followed her closely
10 with Dr. Meske to ensure that she was okay.

11 So she did touch on the concern about some of the people,
12 some of the detainees in the high risk groups.

13 MS. CHAMBLEE RYAN: So she gave some anecdotal
14 examples of individual people she might have been worried about
15 but still not a plan like the plan you recommended?

16 DR. FRANCO: I guess she was not that specific or I
17 asked, you know, for specific names or the specific conditions;
18 however, she did talk about -- we talked about the number
19 that -- like a census, right, the number of detainees that have
20 reduced from previous month. So the issue here is that she did
21 talk about that most of the reduction in the number of
22 detainees in the -- currently in the jail were mostly due to
23 decrease from -- you know, the reduce arrests in the community
24 but that there were a few that were released recently or their
25 release was accelerated because of their risk factors.

1 MS. CHAMBLEE RYAN: Okay. And did you -- did you
2 review any evidence that shows what the jail's process is for
3 tracking people's chronic conditions or that would suggest to
4 you that that was a good process beyond just the bare
5 representations of Ms. McDonough or the doctor?

6 DR. FRANCO: No, I did not see that.

7 MS. CHAMBLEE RYAN: Okay. And then you made a note
8 in your report. You said all cases other than one person with
9 documented COVID-19 were detainees at low risk of severe
10 COVID-19 without underlying conditions. What was your basis
11 for that statement?

12 DR. FRANCO: I requested to Major Dixon and Captain
13 Matthews, who were very supportive during this inspection, for
14 data on the age groups or the distribution of the population at
15 this point in time in the Prince George's County jail. So I
16 have a list of the different age groups.

17 So, for example, let me -- for example, I have the
18 proportion and the number and the percentage of population in
19 the different units -- not in the different units but in the
20 age groups. So I looked at the overall percentage of
21 individuals under the age of 55 is about approximately
22 93 percent.

23 MS. CHAMBLEE RYAN: Right.

24 DR. FRANCO: And then from the reports that I learned
25 and from the interviews that I conducted during the inspection,

1 all individuals I interviewed were below age 55, and except for
2 one who had mild to moderate asthma, I didn't find any other
3 predisposing conditions.

4 MS. CHAMBLEE RYAN: So we know -- it seems like we
5 can be pretty confident about age but as for -- you know, as we
6 just talked about, we don't actually know how they identify who
7 has conditions. We don't know that they have a plan to track
8 it. We don't know that they have a plan to manage it.

9 And then Plaintiffs have submitted evidence of people who
10 were COVID positive and did have chronic conditions. So is
11 it -- I just -- I'm just wondering if anything that you saw
12 would suggest that that couldn't be true as opposed to you just
13 didn't run into it. Do you see what I'm asking?

14 DR. FRANCO: Yes, it could possibly be true because
15 some of the patients with -- that were diagnosed or confirmed
16 with COVID-19, some of them have been released, so I don't have
17 that information about them. So maybe some of them may have
18 actually had some medical conditions or comorbidities which
19 placed them at that risk.

20 But the ones that I interviewed, I -- except for that one
21 with asthma, I didn't find anyone.

22 MS. CHAMBLEE RYAN: Okay, thank you.

23 I have just a few more questions. So you had noted there
24 was likely a much higher rate of infection at the jail than
25 what's represented by their testing. Could you explain that a

1 little bit?

2 DR. FRANCO: Yes. So during the interviews that I
3 conducted -- and, again, I would like to emphasize that Captain
4 Matthews was extremely helpful and Corporal Alfaro, who was
5 also with us -- with me particularly during that two days.

6 We interviewed some of the individuals that provided
7 affidavits or were declined, but we also sometimes followed the
8 -- in a way, if I may use the word like contract tracing. So
9 we were asking for information about roommates or cellmates or
10 cellies to figure out exactly how was the -- so like the
11 outbreak happened, and in that way we were able to, you know,
12 for example, understand that there were many, many more
13 individuals who suffered some of the -- or experienced symptoms
14 that were consistent with COVID-19 during those days, and that
15 was also corroborated by some of the sick call forms, slips
16 that they showed me. Many of them keep records or track by
17 writing down their symptoms and the dates. So I do have, for
18 example, copies or pictures of their narratives from the
19 events.

20 So during these interviews, what I learned is that some of
21 them placed sick calls at the same time as those cases that
22 were confirmed were occurring or, you know, soon thereafter
23 during those particular days at the end of March, beginning of
24 April.

25 So when one ask -- when asking different symptoms, you

1 know, many of them talk about having -- these are different
2 examples but, you know, some of them that like to play
3 basketball, they say, you know, during those days, I have
4 really difficulty playing basketball because I felt my muscles
5 were not responding that well. You know, they were achy. I
6 was having sweats, you know, and my linens were wet, fever.

7 You know, it was fevers that was sometimes detected during
8 the screens performed by the medical staff, but sometimes, you
9 know, as you know, with this infection or others, fever may
10 come not throughout the day but, you know, at different times;
11 or some of them may have headaches or, you know, frequently
12 some of them noted the presence of smell or taste changes,
13 which is consistent with the condition. It's not unique but
14 it's consistent along with other symptoms.

15 So I think it's the fact that this is the -- the clinical
16 syndrome of COVID-19 or the spectrum of symptoms were present
17 in many of the interviewees and that were not necessarily, you
18 know, corroborated with fever at the time that they were
19 screened.

20 And one important thing that I would like to add, too, is
21 when -- you know, I learned this from one of the units and then
22 I applied the same question to the other units is that one of
23 the detainees for maybe the person who is assigned to each
24 unit, the meals to the different cells told us that he noticed
25 that during those days, many, many of the detainees were

1 returning their food almost without touch. So I started asking
2 that question, and that was corroborated, you know, in Unit 9,
3 Unit 10, and similar things happened in Unit 17.

4 As well as the other thing that corroborates this is some
5 of them may not be as, I would say, specific with their
6 symptoms, but they talked about the fact that they, you know --
7 you know, they felt that they couldn't do many activities, not
8 that they were able to because of the lockdown, which, you
9 know, they're in the cell, but their issue is that they felt
10 that they were losing weight because their appetite was
11 severely affected.

12 So I think it was a constellation of symptoms that was
13 consistent with COVID-19 among them. And I think what matters
14 in this case is the enclosed or the conglomerate environment,
15 as well as the findings. So it coincides to the date where
16 there were other cases so, you know, it indicates that that
17 cluster was larger.

18 And then finally, I'll add just one more thing is that,
19 you know, that's exactly what is found in other correctional
20 facilities throughout the country, different places like in
21 Ohio, here in Colorado, that isn't specific to one, at a point
22 where they had only eight cases, you know, it's two, then it's
23 four, then it's eight, they did extended testing and they found
24 that there were many more infected.

25 So like what we're seeing is the tip of the iceberg. So

1 those positive cases were some of the cases that were, you
2 know, confirmed, but there is evidence that there more cases
3 and this is also extrapolated from the experience in other
4 correctional facilities.

5 MS. CHAMBLEE RYAN: I have two follow-up questions
6 about that, just brief ones before I move on to just a couple
7 more topics, and then -- I'm trying to keep it brief.

8 So it sounds like you actually saw a lot of evidence of
9 COVID-19 spreading throughout the jail, throughout the units,
10 you know, in general population. These are not people who have
11 been isolated or quarantined or something from what you're
12 saying. And -- but you noted in your report, you made a
13 comment that said at the time of the inspection, there was no
14 evidence of any further active cases. I was curious what you
15 meant by that, because I also noticed in your report you said
16 that another -- there was another confirmed case of an officer
17 on the day of the inspection. So I wanted to just understand
18 that comment.

19 DR. FRANCO: Sure. So I think, you know, although I
20 made I think a note of this, Ms. Chamblee, in the -- so they
21 didn't call it quarantine, per se, but I do believe it
22 qualifies as quarantine what they did, which is that, for
23 example, Unit 9 or Unit 10, if you take them individually,
24 they -- once they identified that there were some cases of
25 COVID-19 and then those cases were transferred to the medical

1 unit for isolation. What they started doing is that they did
2 not accept any new detainees at that point, which is one of the
3 criteria for quarantine.

4 Secondly, you know, they were in a way monitoring -- not
5 in a way. They were monitoring them with temperature screens,
6 maybe not perfect but they were doing some monitoring to
7 identify if there were, you know, detainees with fever. And
8 then they were able to in that way identify a few other cases
9 in these units.

10 So first, you know, in a way by not accepting new
11 processed -- or not moving, I would say, detainees from that
12 unit to other units I think reduced the spread of the
13 infection. So in a way I believe, you know, whether it's
14 called quarantine, it qualifies as quarantine.

15 MS. CHAMBLEE RYAN: I'm sorry. I think -- I'm so
16 sorry. I didn't mean to cut you off.

17 I was asking something a little different, which is
18 just -- you made a statement in your report that said there
19 wasn't evidence of further active cases, but you just described
20 a lot of active cases in general population. Would you say
21 there is an ongoing outbreak at the jail? Sorry if I wasn't
22 clear before.

23 DR. FRANCO: Sure. So I think the peak of this
24 outbreak occurred at some point maybe, you know, around early
25 April, maybe April 5th to April the 10th, so there is no --

1 when I -- I apologize for that confusion. It may have been
2 active in the sense of symptomatic cases, because one of the
3 things that I did -- and I think every single detainee during
4 the interview was very clear is they would point out about like
5 cellmates or people in the other rooms who may have had
6 symptoms during this period. And so, you know, I think what I
7 meant is that the outbreak was really much larger at some
8 point, like around mid April, let's just say that.

9 So but then recently there has not been anymore
10 individuals with any symptoms that are consistent with -- among
11 detainees in the different units with COVID-19.

12 MS. CHAMBLEE RYAN: Sorry, Dr. Franco. I'm confused
13 because I thought that you had just said that a lot of people
14 that you spoke to on the units did have symptoms of COVID-19.

15 DR. FRANCO: No. They had symptoms during the period
16 of the -- I would say the earlier period of the outbreak. I
17 think what I meant to say is the -- there is no, no one with
18 active symptoms at that time of the inspection in terms of like
19 there's nobody with alteration of -- you know, there's nobody
20 with fevers that we knew, nobody that was coughing, nobody that
21 was having any, you know, other like alteration in the sense of
22 taste or smell, but that they were before and they were
23 recovering from it.

24 MS. CHAMBLEE RYAN: And was that -- so sorry. Was
25 that based on your personal observations of all of the inmates,

1 like you took their temperature or reviewed temperature logs,
2 or was that based on what staff told you?

3 THE COURT: And Ms. Chamblee Ryan -- before you
4 answer, Dr. Franco --

5 MS. CHAMBLEE RYAN: Yes, Your Honor.

6 THE COURT: I just want to let you know you're coming
7 real close to being to your 20-minute allotment. I've got to
8 move on.

9 MS. CHAMBLEE RYAN: Oh, sure. Yes, I'll move on to a
10 few other things then.

11 THE COURT: Thanks.

12 MS. CHAMBLEE RYAN: Once we're done with this, yes.

13 DR. FRANCO: If I may answer that briefly so then you
14 have more time, that's based on the interview. So the
15 detainees were very forthcoming with that information about who
16 was sick and who was -- you know, there was nobody else. The
17 question was, when I asked them, do you know of anybody else
18 who is sick at this time? And they would say, no, there is
19 nobody else who is sick at this point.

20 And then they would go into details about the other
21 cellmates or other detainees in the unit who had the symptoms
22 at that point earlier, excuse me, during the outbreak.

23 MS. CHAMBLEE RYAN: Okay. So I'll just -- since I'm
24 running close to my time, I'll just ask two other questions.
25 So one, you've made the statement that the doctor --

1 Dr. Asresahegn is providing appropriate medical care. Is that
2 based on your conversation with her, or is that based on review
3 of any records or any other evidence?

4 DR. FRANCO: That's based on my conversation with
5 her.

6 MS. CHAMBLEE RYAN: Okay.

7 And then you had said -- so I just want to review some of
8 the points that you made. So I just want to make sure that I
9 got this correct. I mean, it sounds like what you found was
10 that there is -- there has been a broad outbreak. There is
11 under testing. There is no contact tracing. There is poor
12 temperature screening --

13 THE COURT: Ms. Chamblee Ryan, I'm going to stop you
14 because your summary is not necessarily his report,
15 Dr. Paredes' report, and what I need for you to do is ask a
16 question --

17 MS. CHAMBLEE RYAN: Sure.

18 THE COURT: -- if you need additional information.
19 I've allowed you to go on with summaries, but we can't -- I
20 can't do that anymore because we've got to get to some other
21 issues. So --

22 MS. CHAMBLEE RYAN: Absolutely, Your Honor.

23 THE COURT: Okay.

24 MS. CHAMBLEE RYAN: Let me just make sure that I
25 don't have any other questions. I was just making sure I

1 understood the situation.

2 Okay. I guess one thing that I don't think was answered
3 was just a staff member tested positive for COVID the day of
4 the inspection?

5 DR. FRANCO: Yes.

6 MS. CHAMBLEE RYAN: Okay.

7 And then -- okay. I think that's it. Thank you very
8 much.

9 And thank you, Your Honor, for allowing me to go over my
10 time. I apologize.

11 THE COURT: Thank you.

12 Okay, Defense, do you have any follow-up for the doctor?

13 MS. KOSHY: Yes, just briefly, Your Honor.

14 Good afternoon, Dr. Franco. How are you?

15 DR. FRANCO: Good. Thank you.

16 MS. KOSHY: And so in your report, I just wanted to
17 make sure that I understood. You determined that Prince
18 George's County was following the CDC guidelines?

19 DR. FRANCO: At the time of the inspection, I think
20 for the most part, yes. You know, I think there's challenges,
21 like social distancing, which even the CDC says things have to
22 be applied according to, you know, each institution; but I
23 think for the most part they were in compliance with CDC
24 guidelines at the time of the inspection.

25 MS. KOSHY: And so with regard to social distancing,

1 did you see any failures on the part of Prince George's County
2 to implement social distancing protocol?

3 DR. FRANCO: Yes. You know, the general -- the
4 lockdown, as I mentioned to Ms. Chamblee, is in place and it
5 has been in place since the cases were identified earlier in
6 April.

7 The second thing is that, you know, they allow a group of
8 detainees, usually no more than 10, would come out for
9 recreation for one hour; and it is -- you know, I understand
10 it's a challenge, but there is not fully social distancing
11 because it's the hour where they can make their phone calls,
12 and, you know, the telephones are close to each other and, you
13 know, they're basically shoulder to shoulder, as one I think --
14 so many mentioned that I add it as Annex 1.

15 So I understand from my conversation with Director
16 McDonough that they have tried different things, for example,
17 like putting casings on the phone, every other telephone to
18 avoid this but usually the case is removed and then the
19 telephones are used.

20 THE COURT: Doctor, could I -- I'm sorry to interrupt
21 you. Is it possible to move your camera slightly down so that
22 we could -- perfect -- so we can see your face. It will help
23 with your answers.

24 DR. FRANCO: Sure. Thank you.

25 THE COURT: Great. Thank you.

1 DR. FRANCO: Sorry about that, Your Honor.

2 THE COURT: Not a problem.

3 DR. FRANCO: If I may add one more, you know, I think
4 it is a challenge, but we spoke with one officer in the
5 courtroom who was very concerned because in the courtroom, some
6 of the images that I provided in the inspection shows some
7 degree of social distancing, but sometimes the number of
8 detainees attending a hearing in the courtroom, you know,
9 there's many of them together at the same time. So complying
10 with social distancing definitely is somewhat of a challenge.

11 MS. KOSHY: Okay. And so Director McDonough, she --
12 when she spoke with you, did she ask your opinion on the
13 different ways of implementing social distancing?

14 DR. FRANCO: Yes. You know, I think one of -- I
15 mean, she did talk about the telephones, for example, and then,
16 you know, the lockdown.

17 One thing that was mentioned also is the -- you know, the
18 head-to-toe type of foot position in the bunk beds, but when I
19 asked the different detainees if they were told, I was told
20 that not a single one of them was actually informed of the
21 importance of, you know -- because the rooms, there's two bunk
22 beds, one below, one on top of the other. Ideally the
23 recommendation is to put them opposite of head to head in those
24 bunk beds, but they were not informed.

25 Although, more recently some of the -- some of this

1 information has been provided to detainees in the form of
2 posters or signs close to the telephones in the different
3 units.

4 MS. KOSHY: Okay. So you saw that there was signs
5 put up in the cell and near the phones about social distancing?

6 DR. FRANCO: Yes. Yes, I was told that they were
7 placed recently.

8 MS. KOSHY: I see. And it was the inmates that told
9 you that?

10 DR. FRANCO: Yes.

11 MS. KOSHY: Okay.

12 And the -- I wanted to go back to discussing the medically
13 vulnerable inmates. When you were interviewing them and they
14 were talking about their conditions, during your interviews,
15 did you ask anything about their pending charges?

16 DR. FRANCO: Their pending charges?

17 MS. KOSHY: Their pending criminal charges.

18 DR. FRANCO: No, I -- maybe something had come up in
19 a couple of interviews, but not per se like asking why are you
20 here or -- because I am unfamiliar with most of the
21 terminology, I'm not -- I didn't get into those questions.

22 MS. KOSHY: Okay. So then you don't know anything
23 about their criminal history or why they would be in the
24 facility versus being released, any of those facts?

25 DR. FRANCO: I mean, except for a few. You know, for

1 example, Ms. O that I mentioned, the female in Unit 1, I hear
2 from Director McDonough the reason why she's there. And then
3 maybe a couple of detainees offered that information to me in
4 terms of, you know -- I cannot remember them at this point, but
5 yes, I did not approach that specifically.

6 MS. KOSHY: Okay.

7 And are you aware that when inmates first come into the
8 facility, they go through a medical screening process before
9 they are assigned to a housing unit?

10 DR. FRANCO: Yes.

11 MS. KOSHY: Okay. And so you're aware that during
12 that medical screening process is when inmates would have the
13 opportunity to report any of the conditions that they have to
14 medical staff?

15 DR. FRANCO: Yes.

16 MS. KOSHY: Okay. And so -- and I recall you stating
17 earlier you didn't have the opportunity to review medical
18 records during your inspection, correct?

19 DR. FRANCO: Correct.

20 MS. KOSHY: So all the information that you received
21 regarding any conditions that the inmates had, that was based
22 on them reporting those to you, correct?

23 DR. FRANCO: Correct. And I did have the opportunity
24 to interview the nurse in the processing area where they
25 conduct the -- that assessment, and I would say that -- to

1 answer what I believe is part of your question is that most of
2 these questions, specifically the screening for COVID-19
3 symptoms, you know, they're doing that, in my opinion, in my
4 personal opinion in an incomplete way. And we've seen some of
5 the questions are like the initial questions recommended by
6 CDC, which have not been updated, at least at the time when I
7 performed the inspection in the processing unit.

8 So, again, one of the concerns that I have was that some
9 of these individuals who are detainees, who are new intakes
10 maybe either may have the symptoms and not being asked
11 appropriate questions or adequate questions or that the
12 temperature screening I noticed that there is some based on
13 that.

14 MS. KOSHY: Okay. But you stated that during your
15 interviews of inmates that you did not observe anybody with
16 active symptoms of COVID-19; is that right?

17 DR. FRANCO: At the time of the inspection, that is
18 correct.

19 MS. KOSHY: Okay.

20 And during the course of your inspection -- well, you
21 mentioned talking to the medical staff, so I wanted to ask you
22 a question about something in your report. You mentioned about
23 the sick call response. Is it that -- were the sick calls
24 being ignored by staff, or was it a concern about the speed of
25 response?

1 DR. FRANCO: I think there were multiple -- I think
2 the answer is -- has different aspects. One is that sometimes
3 it may take, you know, according to the interviews with
4 detainees, you know, three, four times, five times,
5 particularly with the Spanish-speaking interviewees that I
6 conducted, that it's difficult for them to communicate to --
7 correctly or using the language to express their symptoms.

8 But in general I think the consensus in all the units is
9 that the response to the sick calls, at least during these
10 periods, has been either delayed or the attention paid by the
11 medical staff conducting these -- responding to these sick
12 calls has been insufficient.

13 And, you know, I think one of the things that seemed to be
14 very consistent is that sometimes, you know, if the detainee
15 have other symptoms that they report but they have no fever at
16 the time of the sick call response, that, you know, they were
17 not really taken seriously regarding the possibility of having
18 COVID-19.

19 And, you know, also consistently was the fact that many of
20 them reported exactly the same, even though they were in
21 different units, that the answer was that they were told that
22 if they were able to walk, they would be fine, by just checking
23 their temperature without any further medical evaluation.

24 MS. KOSHY: Okay.

25 And during the course of your inspection, you determined

1 that there was no uncontrolled outbreak of COVID-19 at the
2 jail, correct?

3 DR. FRANCO: You know, it's difficult to answer that
4 question because, you know, this infection, these viral
5 pathogens, the way it spreads is, you know, in different
6 mixture in different settings, correctional settings or --
7 excuse me, or -- what I meant to say is in conglomerate
8 settings such as nursing homes, long-term care facilities, the
9 percentage show individuals who could be infected without
10 symptoms is up to 50 percent or higher.

11 So one of the things -- and, you know, also regarding the
12 question that Ms. Chamblee asked me is that, you know, there is
13 nobody with symptoms that we could see, but because of these
14 earlier outbreaks, there could be some individuals who may
15 still be infected and we would not know because, again, they
16 have been on lockdown and because there is no new intake of
17 detainees coming to the unit to spread further infection; but
18 there is a chance that they could be -- if we do further
19 testing, that we may identify further individuals, individual
20 detainees who may be infected with the virus.

21 So technically, yes, we don't see the symptoms, but at
22 least, as I mentioned, using different scientific sources is
23 that at least 50 percent of individuals may have no symptoms
24 and could be infected and could be vectors of transmission.

25 MS. KOSHY: During the course of your inspection, did

1 you observe that there were adequate supplies for hygiene and
2 for personal protection for the inmates?

3 DR. FRANCO: During the inspection, yes. And I asked
4 that question specifically to the detainees, and they said that
5 recently -- and I put some of the dates for, for example, the
6 masks, for the supplies, soaps that's been given, but that
7 lately or more recently they have.

8 Received all the supplies.

9 One thing that came up was that the Spray Nine, which is
10 the disinfectant used in the units, sometimes -- you know, it
11 is provided at this point for them, but that sometimes they run
12 out early, you know, or soon. So, you know, having more
13 available may be potentially helpful.

14 MS. KOSHY: Okay.

15 And when you were speaking with the detention center with
16 their command staff and with Ms. McDonough, I believe you noted
17 in your report that they seemed open to suggestions about
18 improving their measures to reduce the risk to staff and
19 inmates. Is that right?

20 DR. FRANCO: That is correct.

21 MS. KOSHY: Okay.

22 And there have been no deaths that are COVID-19 related
23 that have occurred at the detention center, right?

24 DR. FRANCO: That's correct.

25 MS. KOSHY: Okay.

1 And during the course of your inspection, did the jail
2 ever refuse to provide you with any information that you
3 requested?

4 DR. FRANCO: No.

5 MS. KOSHY: Okay. And so if there is any information
6 today that you said that you don't have, it's because you
7 didn't request it, right?

8 DR. FRANCO: Yes.

9 MS. KOSHY: Okay.

10 To your knowledge, have any inmates been transported for
11 treatment of COVID-19 to the hospital?

12 DR. FRANCO: No. I asked that question and I was
13 told no.

14 MS. KOSHY: Okay.

15 You noted in your report that there was no existing
16 protocol for inmates to report grievances and negative events.
17 You, in preparing for this inspection, you had an opportunity
18 to review all the documentation that counsel submitted to the
19 Court, correct?

20 DR. FRANCO: Yes.

21 MS. KOSHY: Okay. Did you happen to see that there
22 was an inmate handbook with a grievance process in it?

23 DR. FRANCO: Yes. You know, when I mentioned -- I
24 think I have it in my note. It's not that it's not an existing
25 protocol but it's not functioning because what routinely was

1 mentioned to me by different detainees is that when they want
2 to report a grievance, there are different -- there is a
3 process but it's not functional in the sense that it takes --
4 it takes an effort to -- for them to be able to do -- report
5 their grievance and then get a resolution about that grievance.

6 And what I mean with that is that sometimes the
7 correctional officers do not on -- on the particular shift may
8 say, you know, you have to go back to the shift that this
9 happened. And then in that process, it may take a long time
10 for them to be able to speak up and be able to do the report,
11 these grievance. So that's what I mean. It's not that there
12 is no protocol, but there is not functional protocol that
13 allows them to communicate effectively or receive a response to
14 their complaint.

15 MS. KOSHY: Okay.

16 Let me just go through and see if I have any -- with
17 regard to increasing the testing done at the agency, you stated
18 that you believed it's necessary to test newly admitted inmates
19 for COVID-19, correct, even if they're asymptomatic?

20 DR. FRANCO: Yes, that would be one strategy and
21 that's based on some recent evidence, and I believe that would
22 be something that may be helpful for the jail to conduct.

23 MS. KOSHY: Okay. Now, if -- when new inmates are
24 first admitted to the jail, if they are kept in a 14-day
25 quarantine before being assigned a housing unit or into general

1 population -- and actually, let me back up.

2 That's currently the jail's protocol, right, is
3 quarantining newly admitted inmates?

4 DR. FRANCO: Yes, you know, which I learned by
5 discussing over the weekend with Dr. Greifinger. The right
6 word, you know, which again was something I learned recently,
7 is sequestered.

8 MS. KOSHY: Sequestered, yes. Correct.

9 DR. FRANCO: For 14 days, yes.

10 MS. KOSHY: Okay. So if they are currently being
11 sequestered for 14 days when they're first admitted to the
12 jail, is there really a need to immediately test them for
13 COVID-19? If they're sequestered for the first 14 days,
14 wouldn't they become asymptomatic if they were infected at that
15 point?

16 DR. FRANCO: Thank you for asking that question. I
17 think that, yes, there is a rule and the reason is, number one,
18 because they could be in the incubation period and, again, you
19 know, you're sequestering them and then doing these temperature
20 screens; but as I alluded in the report a couple of times,
21 these temperature screens are insufficient to detect the cases.

22 In sequester, in quarantine, you know, they help. You
23 know, they help you identify one case, but it seems to me that
24 in particular, you know, based on the jail medical staff is
25 over relying on those temperature screens as the only --

1 basically the only screening method, and it may be, just to
2 give you an example, maybe somebody who's admitted could have
3 -- may be incubating the infection or maybe asymptotically
4 infected and then because you're not really able at this point
5 to say somebody with uncontrolled diabetes management was
6 admitted to one of these units or maybe a cardiac history or
7 something that do not require them to be admitted directly to
8 the medical unit, per se, to potentially be housed or celled
9 with somebody that may be potentially infectious, and then you
10 may have a new introduction of a new outbreak into the jail.

11 So you may be able to rectify this outbreak at some point,
12 but I think you would be preventing -- you would be closing the
13 door to identify some potentially asymptomatic infections.

14 And we have to take into account what's happening out
15 there in the community at Prince George's County, and there is
16 evidence that, you know, that county is with the highest number
17 of cases as well as evidence of sustained community
18 transmission.

19 So there is a chance shown also by the deputy officer --
20 or the correctional officer positive on May 6th that either a
21 new intake or an officer can present a risk of new
22 introductions and may lead to further outbreaks.

23 And my opinion -- sorry for the long answer -- is to -- I
24 think the key part is that because the population in the jail
25 are mostly young individuals, there are still some of them that

1 are medically vulnerable, and at the end of the day, the
2 overall goal should be to protect them by all means.

3 MS. KOSHY: And so during your inspection, did you
4 have the opportunity to determine the feasibility of testing
5 every new detainee?

6 DR. FRANCO: You know, I think at the time of the
7 screening in the processing, it may be something that is
8 feasible. You know, at this point in time I would say
9 scientifically or the community is starting to do prevalence
10 testing with blood testing too, but even if we just focus on
11 what is accepted as the standard of care at this point, which
12 is the nasopharyngeal swab, that could be done easily regarding
13 the number of -- because the number of intakes has decreased,
14 you know, or the admissions, per se, to the jail, I think it's
15 something that could be feasible.

16 And in speaking with Dr. Carter from the health
17 department, he was very positive about that, you know,
18 supporting Director McDonough's efforts to potentially test all
19 the people. We didn't specifically talk about there strategy,
20 but he was willing to support further testing to support
21 detainees in the jail.

22 MS. KOSHY: Did you have an opportunity to learn --
23 yes? Sorry, Your Honor.

24 THE COURT: This is -- yeah, we're going to need to
25 wrap yours up because then I've got some follow-up and then

1 we're going to move on. Thanks.

2 MS. KOSHY: Sure.

3 Dr. Franco, did you have an opportunity to find out how
4 many tests, COVID-19 tests are currently available at D.O.C. at
5 the time of your inspection?

6 DR. FRANCO: No. No, Ms. Koshy.

7 MS. KOSHY: Okay. So you didn't ask?

8 DR. FRANCO: We asked about the specific test, and
9 Dr. Meske showed me that -- the test but not the available
10 number of tests that are currently available.

11 MS. KOSHY: Okay.

12 DR. FRANCO: If I may say, I was told by Dr. Carter
13 that they have increased possibility. He didn't specifically
14 say the number, but he was, again, supportive of testing
15 efforts in the jail.

16 MS. KOSHY: Okay.

17 And in your report where you noted in your recommendations
18 that the County should continue to adhere to strict hygiene and
19 provide soap and provide disinfectant, that means that the
20 County is already doing it and you just want them to continue
21 doing that, correct?

22 DR. FRANCO: Yes, and if I may say, there is a voice
23 of the detainees that I would like to portray here is that they
24 -- you know, they feel like at this point, you know, they are
25 getting the supplies, and they would like to be able to receive

1 them in the near future for their protection. Because I think
2 one of the things is fear, you know, I think the fear of, you
3 know, getting infected or potentially developing severe
4 symptoms or dying from infection. So, yes, they would like
5 very much to continue to have that support from the jail.

6 MS. KOSHY: Okay.

7 And I believe that's all I have, Your Honor. Thank you.

8 THE COURT: All right. Thank you, Ms. Koshy.

9 Doctor, I just have a couple of follow-up questions.

10 DR. FRANCO: Yes, Your Honor.

11 THE COURT: You have discussed speaking with
12 Dr. Carter about increased capability for testing. Given that
13 there was a historic outbreak, combined with currently no
14 detainees are reporting symptoms but there is this asymptomatic
15 piece of the virus, what would be your recommendation for, if
16 additional tests are available, testing the current population
17 in the housing units? How would you suggest going about that?

18 DR. FRANCO: I would suggest testing at least Unit 9,
19 Unit 10, and Unit 17 to detect any potential asymptomatic
20 infection. I believe that would be helpful because, Your
21 Honor, in that way we make sure that there is no asymptomatic
22 infections and that way we may be able to provide a line of
23 safety to be able to move detainees; however, you know, the
24 test is not perfect and it's about 70 percent sensitive, which
25 means it could still mean somebody could be infected and the

1 test may not be positive.

2 So that's where I think hopefully in the near future, and
3 I mean in the next few weeks -- and there are some places that
4 are already conducting these, Your Honor. These blood testings
5 may provide specific measurements of what is called the IgG.
6 The IgG is an immunoglobulin which indicates recent exposure.
7 It's not also perfect but if you combine that with the PCR
8 testing, it may give you specifically who has been exposed and
9 infected and has recovered from the infection.

10 So it gets a little technical there, but it may be the
11 best way to proceed, but at least identifying those that could
12 be potentially asymptomatic carriers with a nasopharyngeal swab
13 is feasible and the susceptibility I think would be helpful.

14 And the second place, you know, which is in the new
15 inmates that would be admitted maybe also another important
16 strategy which is not perfect but it may add another line of
17 safety for the introduction -- of preventing the introduction
18 of any new infections.

19 THE COURT: Okay, great.

20 Did you and the Director have any conversations to that
21 detail about implementing additional testing?

22 DR. FRANCO: No, Your Honor.

23 THE COURT: Okay.

24 All right. I noted that you interviewed the facility's
25 psychologist. I don't remember his name, but I noted that you

1 had an opportunity to talk with that person --

2 DR. FRANCO: Yes, Your Honor.

3 THE COURT: -- but did not reference whether there
4 are, especially given the 23-hour a day lockdown, whether there
5 is provision of psychological services which seems to be
6 important to the plaintiffs and has come up along the way in
7 this case.

8 Can you summarize your discussion with the psychologist
9 and if you have any findings or recommendations for provision
10 of mental health services going forward?

11 DR. FRANCO: Yes, Your Honor. I apologize for not
12 including that. And you're absolutely right, I did have the
13 opportunity to speak with Dr. Hernandez in the medical unit,
14 and she was extremely helpful.

15 She described that during the lockdown it seems, you know,
16 they basically cancelled all the group activities that involve
17 her field. Obviously, everyone who is on any medications,
18 psychiatric medications continue to receive so and that there
19 is a clinical psychologist that goes around every day to the
20 different units to provide visitation to some of those that may
21 be requesting it and some of them that they feel that need to
22 be observed on a continuous basis; and she showed me some of
23 the records that they have.

24 When I asked her specifically about if there's been an
25 increase in the number of people or detainees having worsening

1 episodes of anxiety or agitation, she did describe that there
2 were a few that she in a way expected that may have, you know,
3 because the lockdown has exacerbated some of their symptoms but
4 that they were watching them carefully.

5 If I may add one more comment here is that it seems to me,
6 as I mentioned in the report, that at least on Unit 9 where we
7 spent many hours, that at least one time the emergency response
8 team had to come in to control the situation inside that unit;
9 and when asking specifically the inmates about that, they
10 reported that they've been happening more frequently. And that
11 I believe that's the result of not -- you know, I'm not a
12 psychologist and I'm not trying to give my opinion, but it's
13 basically the result of the, you know, lockdown maybe causing,
14 you know, a little bit more agitation or more activity.

15 But when I asked the psychologist, Dr. Hernandez, about
16 this, she's concerned, obviously, about the lockdown but that
17 she understands also that this is important policy to prevent
18 the spread of infection.

19 THE COURT: Okay, thank you.

20 Did you have any discussions with either Dr. Asresahegn
21 -- and I'm saying his name or her name incorrectly, and I'm
22 sorry about that, but any of the other medical personnel about
23 provision of non-COVID-related medical services?

24 DR. FRANCO: Not specifically, no. No, Your Honor.

25 THE COURT: All right.

1 And then with regard to what has been termed the medically
2 vulnerable population, I'm currently thinking about that more
3 akin to the CDC, and the CDC, as you referenced in your report,
4 identified higher risk individuals for significant adverse
5 outcomes if they were to contract COVID.

6 Based on your discussions with the detainees, do you have
7 any estimate -- and your review of the records, any estimate
8 for the number of detainees who would fall into that high risk
9 category? And if not, that's fine, because I think there's
10 other ways to skin the cat, if you will, to get that
11 information, but I was curious about your observations.

12 DR. FRANCO: So I don't have a, I would say, a
13 systematic way to answer that question, but I would tell you
14 that in the -- in Unit 8, which is the admission unit or the
15 intake unit, I identified two individuals who have risk factors
16 that would put them in the category; as well as in Unit 9 and
17 10 there were two -- there were two in Unit 9, one in Unit 10,
18 and then one in Unit 17. So these are conditions listed by
19 CDC, Your Honor, that I identified. So there may be some of
20 them distributed in the different units.

21 And to answer your question specifically also, I did
22 discuss with Dr. Meske about those medically vulnerable and
23 she -- you know, she was familiar with the guidelines and with
24 the presence of some of the detainees having some of these
25 conditions. However, when I asked specifically if housing of

1 placed inmates, that they were placed on their vulnerability,
2 she said no. So there's not any effort to -- specific effort
3 to house them in a specific way.

4 THE COURT: So -- and you're reading my mind because
5 the next question I had was I noted that in your report, you
6 did visit at least one unit that was empty and that in looking
7 at the defendant's responses, there are some units that are
8 very -- the population is very much reduced. Did you have any
9 conversations with the Director or other leadership about
10 repurposing some of those empty units to house higher risk
11 detainees so that there is a way going forward to implement
12 some of the recommendations you made, such as single cell for
13 the higher risk individuals?

14 DR. FRANCO: Not specifically, Your Honor, that I
15 recall. I remember that Director McDonough did mention, for
16 example, that for Ms. O in the female unit, she was in a single
17 cell because of her age and trying to protect her; but other
18 than that, we didn't talk about any other specific housing
19 arrangements for these purposes.

20 THE COURT: Okay.

21 And Doctor, just finally, is there anything that we didn't
22 ask you but in the questions that you have been asked it
23 sparked additional information, findings or opinions you wish
24 to share before we conclude with you?

25 DR. FRANCO: Well, thank you, Your Honor, for the

1 opportunity. I feel that my answer to Ms. Chamblee regarding
2 the word "active cases" probably is not fully -- I feel like
3 it's not fully -- or I didn't answer it fully. If I may just
4 clarify again is that the outbreak, these large outbreaks that
5 we talk about, so like the people that we addressed by those
6 18 cases that maybe based on my assessment that there were many
7 other cases that were not confirmed, it seems that it's -- it's
8 definitely weighing down to the point where there may be only
9 some that may be asymptotically infected that it's hard to
10 give an opinion.

11 But at the time of my inspection, there was not anyone
12 based on my observations as well as during that interview
13 that -- you know, the detainees were very forthcoming with that
14 information if there were anyone with any symptoms, recent
15 infections in those areas.

16 There is, as I mentioned -- the last comment is that, you
17 know, I think the risk -- because there is community
18 transmission in Prince George's County at-large, there is a
19 risk for future introductions, and that's why we need to be
20 observant; and in that case of the officer on May 6th, which is
21 the first day of inspection, do confirm that concern that we're
22 still at risk for further introduction of the infection.

23 THE COURT: Okay. Thank you so much. And, again,
24 thank you so much, Doctor, for doing this out of your own --
25 your own time, your own dime. We really do appreciate having

1 your boots-on-the-ground review of the situation, and it's been
2 extremely helpful to me. I'm sure the parties would say the
3 same.

4 You're welcome to stay and listen to the legal argument or
5 not; it's up to you. You've devoted so much time to this case
6 as it is. I don't want to be an imposition. So with that, I
7 thank you, and I'm going to turn now to some of the legal
8 questions I have for the parties. Okay?

9 DR. FRANCO: Thank you, Your Honor, for the
10 opportunity. And I hope that it, as you say, was helpful, and
11 I appreciate the opportunity to be part of the process.

12 THE COURT: Thank you. And we may be calling you as
13 a, you know, phone-a-friend for additional help as we go
14 forward, but thank you for your time and your report. It was
15 well done.

16 DR. FRANCO: Thank you very much.

17 THE COURT: All right, thank you.

18 Okay. Counsel, so I wanted to discuss with you all now to
19 sort of shift to the legal framework in this case, because, you
20 know, I don't act as a super director. I don't second guess
21 Director McDonough. I'm not here to walk her shoes. She's got
22 a tough job, and I've got to make, if I'm going to grant any
23 form of TRO, I've got to do it within a legal framework,
24 because these are tough times but the law still applies, and I
25 have some questions in that regard.

1 So let's just start with what the plaintiffs have brought.
2 There are three counts, Count One alleging Eighth and
3 Fourteenth Amendment violations based on whether you frame it
4 as a deliberate indifference failure to address a serious
5 medical need or a substantial health and safety violation,
6 they're really kissing cousins to one another and that's
7 brought pursuant to 42 U.S.C. 1983. There's Count Two, which
8 I'm going to short-term as -- or shorthand as over-detention
9 claims, also brought pursuant to 1983. And then finally Count
10 Three, which is the 28 U.S.C. 2241 Writ of Habeas Corpus
11 brought for the medically vulnerable subclass.

12 And not to oversimplify a very complex area of the law,
13 but it appears as if Plaintiffs have brought that particular
14 count in recognition that if I were to ever grant the ultimate
15 remedy that the Plaintiffs seek, which is ordering release or
16 transfer, that I could only do that pursuant to Writ of Habeas
17 Corpus under 2241. It's not an available remedy under 1983,
18 that's how I read the cases, and so that's part of the reason
19 why this was brought.

20 This is a very complicated area of the law, but I'm going
21 to start -- and I see, Ms. Chamblee Ryan, you want to jump in,
22 but we've got a larger issue here -- okay? -- which is, unlike
23 the Sixth Circuit and Judge Gwin, I'm finding the PLRA, the
24 Prison Litigation Reform Act squarely applicable in this case.
25 I can't, based on the way in which the claims are framed and

1 the relief that you're requesting and the reason why you're
2 requesting it -- and I've got the statute up right now,
3 18-3626 -- I am having a hard time figuring out how I'm not
4 bound by the PLRA for most all of the claims, especially if I
5 am construing even the request for release is one about
6 condition with confinement and not a fact of confinement. So
7 that's the global question I have.

8 The more specific question I have is -- well, anyway,
9 let's start there. Ms. Chamblee Ryan, tell me, if you
10 disagree, why.

11 MS. CHAMBLEE RYAN: Yes, Your Honor. So there's a
12 few different -- just to frame, there's a few different ways
13 that the PLRA might apply to this case, and I think we agree
14 with some and disagree with others, and so I just want to walk
15 through the different options and make sure I'm not missing
16 anything if that's okay.

17 THE COURT: Sure.

18 MS. CHAMBLEE RYAN: Okay. The options that I'm aware
19 of are exhaustion, which is an affirmative defense. We
20 addressed it anyway because we thought that Your Honor might be
21 concerned about it.

22 THE COURT: I'm less concerned about that.

23 MS. CHAMBLEE RYAN: Okay, great. We won't worry
24 about exhaustion.

25 The next is the PLRA's limitations on types of injunctive

1 relief. We didn't address that because defendants didn't raise
2 it given the timeline, but we're happy to -- if it's helpful,
3 we're happy to submit briefing on that by midnight. We have
4 prepared on that issue.

5 We do think that, you know, injunctive relief under 1983
6 is governed by that provision of the PLRA, and we think that
7 what we requested is compliant with those provisions, and we're
8 happy to explain how. I mean, essentially it's just saying
9 that you're not ordering things beyond what's necessary to
10 remedy to Eighth Amendment violation.

11 THE COURT: Right, and I'm with you because I see --
12 even if I were to say PLRA applies, it applies to all claims,
13 and the injunctive relief that you're asking for I would
14 narrowly draw. It will extend no further than necessary to
15 address -- if I find an outstanding likelihood of success on
16 the merits for a constitutional violation, I see the PLRA and
17 the injunctive -- the *Winter's* factors likelihood of success on
18 the merits and irreparable harm to kind of be harmonized.

19 THE COURT: But my question is -- you know, you are
20 seeking this remedy of release and not only in Count Three but,
21 frankly, in Count One, which is now its own --

22 MS. CHAMBLEE RYAN: Yes.

23 THE COURT: So let's just start with Count One.
24 You've only alleged a 1983 claim for Count One. You haven't
25 alleged 2241. So even if I were at all, which I'm not -- I've

1 got to tell you, I've got a lot of questions about Count One --
2 but as a matter of law, I couldn't order the release because
3 it's a 1983 claim; but secondarily, I couldn't order it until I
4 first attempt to give the Defense an opportunity to remedy
5 short of injunction and then I've got to get a three-judge
6 panel.

7 So none of this has really been teed up for me.

8 MS. CHAMBLEE RYAN: No, Your Honor. I disagree with
9 that a bit if you wouldn't mind allowing me to explain.

10 THE COURT: Sure.

11 MS. CHAMBLEE RYAN: Since it hasn't been fully
12 briefed, we're happy to provide more on that. I'm just pulling
13 up a few things on this issue.

14 So first of all, on Count One, just to be clear, what
15 we've asked for is that the Court remedy the Eighth and
16 Fourteenth Amendment violation.

17 THE COURT: I'm talking about Count Two. My bad.

18 MS. CHAMBLEE RYAN: No, no. For Count One, the 1983,
19 there is an element that could be characterized as release, so
20 I think that you're right. What we said is we want to remedy
21 the conditions, but we recognize -- we don't know whether this
22 is the case yet, but we recognize that it may be impossible to
23 remedy the conditions without transfer of some individuals to
24 less restrictive custody, like home confinement.

25 And we gave you in the TR0 brief a whole series of cases

1 saying that that kind of transfer, particularly to restrictive
2 custody like home detention does not constitute release under
3 the PLRA.

4 THE COURT: But you pled it to me prison -- I mean,
5 the one case that obviously is front and center is Judge Gwin's
6 in *Wilson*, and that is a post sentencing prison case where
7 Judge Gwin found on grounds that I don't quite know yet if I
8 wholly agree with but that's why we have an independent
9 judiciary, because we can disagree. But it is also less
10 problematic in my view because it is post sentencing, federal
11 Bureau of Prisons where the authority of a federal judge to
12 change the kind of imprisonment is a lot more well-settled.

13 Here I've got pretrial detainees for the most part who
14 enlargement isn't making a whole lot of sense. And in any
15 event, if I find that the PLRA controls, there's interim steps,
16 you would agree, before I could ever, you know, consider that
17 kind of relief.

18 MS. CHAMBLEE RYAN: No, Your Honor. If I may, I
19 would like to tease out some of these threads because I think
20 that some things are getting conflated a bit that it might be
21 helpful for me to just separate out some things.

22 THE COURT: Okay.

23 MS. CHAMBLEE RYAN: So just to give you the overview
24 of the universe and then I'll explain -- and I apologize. I'm
25 going to try to do this as expeditiously and clearly as

1 possible but it can be difficult, especially because I can hear
2 my son crying upstairs.

3 So there's a few different remedies that I would -- let's
4 call them release related where you might be concerned about
5 the PLRA. For some of them I think PLRA makes sense and
6 applies and some of them I think it doesn't, and so I just want
7 to walk through them, and they are different.

8 So on Count One for 1983, we said in order to effectuate
9 the remedies under Eighth and Fourteenth Amendments, it may be
10 necessary to transfer some people to other less restrictive
11 custody, custody outside the jail. We've given you -- and it's
12 in Footnote 55 of the TRO brief -- a number of cases that say
13 that when you transfer someone, that is not a release under the
14 PLRA, so the PLRA does not apply, even when you're transferring
15 them to less restrictive custody.

16 And so in addition to those three cases, you know, courts
17 may be confronted with this all the time. For example, a few
18 years ago the Alabama Department of Corrections was segregating
19 HIV positive prisoners. Well, the effect of that order was to
20 transfer those prisoners to prisons across the state instead of
21 segregating them. Some of them were less restrictive. No one
22 argued it was a prisoner release order, and this is really
23 tantamount to that, so I would make that point.

24 I'll also say that I think that, you know, even if you
25 don't choose to make the transfers under 1983, and I assume

1 we're going to get into the weeds on this later so I'll be
2 brief, I think the fact that the Department of Corrections have
3 the ability right now and actually the obligation to transfer
4 127 people out of the jail and has not done so is relevant on
5 the subjective prong two.

6 *(Simultaneous Speakers.)*

7 THE COURT: ECF 61 which, frankly, is clear as mud.
8 We're going to need some more clarification on that.

9 MS. CHAMBLEE RYAN: Yes, I'm happy to.

10 THE COURT: Because that's not -- and I also received
11 ECF 63 in very, very short notice, and so I will allow further,
12 you know, further factual development on that but we'll get to
13 that in a minute.

14 MS. CHAMBLEE RYAN: That makes total sense.

15 THE COURT: But I'm not sure how that's really
16 responsive to this question about transferring at this point.

17 MS. CHAMBLEE RYAN: Yes. So, okay, but in answer to
18 your transfer question, we welcome the opportunity to provide
19 you more cases. We've provided three in Footnote 55 of our
20 brief.

21 THE COURT: I'm looking for Footnote 55. And this is
22 in ECF -- you said in the reply?

23 MS. CHAMBLEE RYAN: 3-1.

24 THE COURT: 3-1.

25 MS. CHAMBLEE RYAN: And it's on page -- it's on ECF

1 34 and our numbering 33.

2 THE COURT: Okay. Well, let me tell you this, we've
3 burned a lot of midnight oil looking at cases and the ones that
4 help a judge like me are the ones that are factually similar to
5 the situation. I'll let you know we've had in our district
6 consent decrees involving detention facilities that have lasted
7 for decades. There is one right now, if I'm looking at the
8 docket right, it started in 1973; and in 2002, when the most
9 recent Consent Decree was issued, it was done pursuant to the
10 PLRA. It involves health and safety of the detainees. It
11 involves imminent health risks.

12 The difference between that case and COVID is that COVID
13 is affecting us globally and is in a way that is perhaps
14 magnified in the detention facility and of great concern. But
15 it's not as if we've never had an imminent health risk to a
16 detained population that need immediate attention, and they're
17 done pursuant to the PLRA.

18 A number of the cases that you've given me are not really
19 lining up factually with this one.

20 MS. CHAMBLEE RYAN: The points you make are
21 absolutely true, Your Honor. Just to continue teasing out the
22 issues --

23 THE COURT: Okay.

24 MS. CHAMBLEE RYAN: -- those cases are just to make
25 the point that when you make a transfer, it does not

1 necessarily under the PLRA, meaning the transfer to more
2 restrictive custody. And, again, we're happy to provide more
3 on that. However --

4 *(Simultaneous Speakers.)*

5 THE COURT: How do I that? I'm telling a state
6 detention facility to transfer with detention facilities in
7 this state and prisons all operating under the same very
8 difficult --

9 MS. CHAMBLEE RYAN: Uh-huh.

10 THE COURT: What exactly does this order look like,
11 to tell Director McDonough to find another detention facility
12 to take some of her detainees? Is that -- what do I do?

13 MS. CHAMBLEE RYAN: Your Honor, I think what we think
14 would be appropriate -- and this does have to do with those new
15 documents but it doesn't necessarily have to. We think what
16 would be appropriate is a transfer to home detention in the
17 cases where it's appropriate, and you could individually review
18 those cases. She could select the cases that would be
19 appropriate. It could also just be that the Court asks her to
20 review cases --

21 *(Simultaneous speakers.)*

22 THE COURT: So you're calling sending detainees home
23 a transfer?

24 MS. CHAMBLEE RYAN: Yes.

25 THE COURT: That's a release. That's what I call

1 artful pleading. I mean, it's not a transfer to another
2 detention facility; it's --

3 MS. CHAMBLEE RYAN: Uh-huh.

4 THE COURT: It's release to home.

5 And, you know, we'll talk about the most recent filings
6 and the fact that the practical reality is that there is still
7 working district court who's holding bail reviews by order of
8 the Chief Judge.

9 And so there are many, many steps that Plaintiffs would
10 have to go through before you convince me I'm to step on the
11 toes of an active working court by releasing 120 detainees.
12 Like, that's just -- and that's certainly not contemplated in
13 the PLRA, which just goes back to my, you know, original
14 question.

15 MS. CHAMBLEE RYAN: Yes, Your Honor. I think -- and
16 I also notice Footnote 56 is relevant to that.

17 I'll just leave my argument at this: It's totally
18 understandable if you don't agree with the argument, but I just
19 ask that you review the arguments in those two footnotes, and
20 if you have more questions, we would like to brief it.

21 There is another release related issue, though, that I
22 would like to flag --

23 THE COURT: Sure.

24 MS. CHAMBLEE RYAN: -- or actually two more.

25 So with respect to 2254, the Sixth Circuit, you know, the

1 case that we sent the notice of when they found that and the
2 underlying case noted that when you ask for release under
3 2241 --

4 THE COURT: Yeah.

5 MS. CHAMBLEE RYAN: Bail review doesn't apply in that
6 situation and that's actually statutory. The PLRA --

7 THE COURT: But I have to find that your claim is
8 challenging the fact of detention. But by the plain language
9 of your own TRO motion, you're asking for release because of
10 the jail's conditions. I mean, I can pull up the quotes.

11 MS. CHAMBLEE RYAN: Yes.

12 THE COURT: I'm having a hard time. How do I fit
13 your claim -- and let's just stick with Count Three for which
14 you clearly brought a 2241 and you're now invoking the
15 exception of 3626. How do I fit your claims as ones for
16 challenging the fact of detention as opposed to the conditions?

17 MS. CHAMBLEE RYAN: Yes, Your Honor.

18 Judge Chuang in this district confronted this precise
19 question recently.

20 THE COURT: Judge Chuang?

21 MS. CHAMBLEE RYAN: Yes, Your Honor.

22 THE COURT: That was an immigration case, though. I
23 mean, PLRA doesn't apply.

24 MS. CHAMBLEE RYAN: Yes, but I don't think it's the
25 -- so I guess two things -- well, actually, I think I see what

1 you're asking. So I guess just to tease it out, you're saying
2 there are two questions. So one is, is the challenge to the
3 fact of confinement based on the conditions of confinement?
4 Maybe it's true that's properly brought under 2241. That's the
5 argument Defendants made, and we responded to that in our
6 reply.

7 What you're saying is, but if that's the reason you're
8 challenging the fact of confinement, doesn't PLRA apply? Is
9 that your question?

10 THE COURT: Kind of. Well, you know, I guess
11 basically what I'm saying is to cite me *Coreas* --

12 MS. CHAMBLEE RYAN: Yes.

13 THE COURT: -- doesn't really provide an analysis
14 under the PLRA.

15 MS. CHAMBLEE RYAN: I understand that.

16 THE COURT: It's immigration, civil detention --

17 MS. CHAMBLEE RYAN: Yep.

18 THE COURT: -- and the doctrine that's emerged from
19 those cases has been one of -- it's just a completely different
20 concern, and so I'm not quite sure I can use that body of case
21 law.

22 MS. CHAMBLEE RYAN: I apologize, Your Honor. I was
23 confused. I thought -- Defendants had raised an argument that
24 2241 was an inappropriate vehicle and the Court didn't have
25 jurisdiction to use it to consider the claim, and so I thought

1 you were raising that issue.

2 THE COURT: No, I'm not.

3 *(Simultaneous speakers.)*

4 THE COURT: I see I have jurisdiction.

5 MS. CHAMBLEE RYAN: Right. I'm so sorry. I was
6 confused. My apologies.

7 On the PLRA issue, I do think the Sixth Circuit case is
8 probably the best explanation of that issue, an analogous
9 conduct. I understand, you know, your point about it being
10 distinguishable. This issue hasn't been briefed, so I think
11 what we would hope for is, you know, even if this wasn't part
12 of the TRO relief, we'd like the opportunity to provide
13 supplemental briefing on it as we move toward the PI, you know,
14 so that we could -- I hate referencing on an authority issue,
15 pointing you to a footnote. I just didn't quite know what
16 would come up or what Defendants would raise, and so we tried
17 to respond to their arguments in the reply; but we're happy to
18 provide more argument on it --

19 *(Simultaneous speakers.)*

20 THE COURT: And that's -- that's kind of where I'm
21 moving to --

22 MS. CHAMBLEE RYAN: Yes.

23 THE COURT: -- because, frankly, to the extent, you
24 know, that you all do not come to some agreement in whole or in
25 part and I need to rule, if I am moving toward any TRO, I'll

1 tell you right now I'm guided by the PLRA unless told
2 otherwise.

3 MS. CHAMBLEE RYAN: Yes, absolutely. That makes
4 sense.

5 MS. CHAMBLEE RYAN: And Your Honor, I think there's a
6 lot of --

7 THE COURT: I'm going to allow you to --

8 MS. CHAMBLEE RYAN: I'm so sorry.

9 THE COURT: I'll certainly allow you briefing on
10 that. When you do brief it, too, because I'm not prepared to
11 rule on this either, but this is the corollary question is
12 Count Two, the over detention claim as brought under 1983, my
13 understanding of binding Fourth Circuit law is that -- and
14 maybe even Supreme Court law. It's all swirling in my head.
15 You cannot request the ultimate relief of release, and that's
16 how I see it pursuant to 1983. So as a matter of law, you
17 haven't brought the claim.

18 MS. CHAMBLEE RYAN: Now, that one I think I can
19 answer here now, Your Honor, without additional briefing.

20 So we actually don't request release as relief on our over
21 detention claim.

22 THE COURT: Okay.

23 MS. CHAMBLEE RYAN: That may be -- what we actually
24 request is that the jail cease its policy of over detaining
25 people because of COVID.

1 Now, I understand that that could have the effect of
2 release, and if you are concerned about that, we're happy to
3 look at it under the PLRA, but there have been a large number
4 of over detention cases in other jurisdictions where this
5 didn't seem to be an issue. It didn't go to the three-judge
6 panel. So I wouldn't think on that particular claim that would
7 be a barrier to release.

8 THE COURT: Okay.

9 MS. CHAMBLEE RYAN: I also -- I also just want to
10 note -- and, again, we can brief any of this tonight if you
11 want it now, but what we're really asking for is to end the
12 policy, which we have evidence that's ongoing.

13 And then just two other quick points. I think, you know,
14 the PLRA question aside, and I certainly recognize that's a
15 growing issue, if we agree the PLRA applies to everything, we
16 think there is a lot of meaningful relief that is perfectly
17 justifiable here. We do think that this might end up in a
18 three-judge panel, you know, if Your Honor decides that that's
19 appropriate. I mean, it's an unprecedented situation, so
20 determining how the law applies to this is complicated.

21 I think, you know, it's not clearcut whether the PLRA
22 applies to these things. We presented what we think are very
23 strong arguments that doesn't apply to a lot of it, but we
24 think what may be appropriate now is relief on the conditions
25 and then moving to these release issues later.

1 I will note, though, there is pretty clear authority for
2 this Court to release people on non-monetary bond pending
3 habeas review, and we provided a lot of cases on that. It's
4 also in the attached declaration from Judith Resnik.

5 THE COURT: Which are individual cases challenging
6 individual claims. Do you have one for me where the Court
7 ordered it for 100 detainees in a class action?

8 MS. CHAMBLEE RYAN: Your Honor, the closest analogy
9 is -- I actually believe there might be another analogous, but
10 *Savino*, which we talk about in our TRO brief, you can see that
11 at -- I'm just pulling that for you. It's at 34 and 35 of our
12 TRO brief. In that case -- that's *Savino v. Souza*. And we
13 also attach the order as Exhibit H.

14 THE COURT: Okay.

15 MS. CHAMBLEE RYAN: Now, in that case here's what
16 happened. They asked for immediate release of basically
17 everyone in the detention facility, and the Court has been
18 conducting individualized bond hearings in groups of 10 to
19 consider the individualized circumstances; and here there
20 really is -- the circuits are in agreement that a federal court
21 does have authority to release on non-monetary bond while
22 habeas is pending. The Fourth Circuit has said it.

23 And so we think that, you know, to the extent -- I think
24 there is undisputed problems with the care of medically
25 vulnerable people in this jail, and I think it may be useful

1 while the evidence has developed to exercise that option, and
2 we think this Court can and Defendants haven't disputed that.

3 I think, you know, I've never seen anything suggesting
4 that that is release under the PLRA. It's bond. None of the
5 courts that talk about it have suggested that it's release.

6 THE COURT: But the plain language of the statute
7 defines release order as anything that reduces -- any order
8 that reduces the population of the facility, essentially. I
9 mean, it's a very broad -- it's broadly worded all the way
10 around.

11 MS. CHAMBLEE RYAN: Yes.

12 *(Simultaneous speakers.)*

13 THE COURT: So --

14 MS. CHAMBLEE RYAN: I think -- you know, obviously, I
15 think we would say the language has to be read in context. I
16 think it doesn't make sense to say that, you know, bond is
17 release, but we could brief that as well.

18 That said, you know, even putting all the PLRA issues
19 aside, we think there's meaningful relief that -- even assuming
20 the PLRA applies -- that this Court could order now.

21 And I'm happy to also answer all of your substantive
22 questions. I think it sounds like you have substantive Eighth
23 and Fourteenth Amendment questions, and I'd love to answer
24 those, too.

25 THE COURT: Well, I mean, I have questions for both

1 sides regarding whether there's room for the high risk
2 detainees, for the Defendants to produce, if you haven't
3 already, a list based on the screenings of who falls into that
4 category and if there's any meaningful discussion about
5 rehousing those detainees so that they are separated from --
6 well, so that they're housed consistent with what Dr. Franco
7 recommends, which is single cells separated from the non-high
8 risk population and can be monitored perhaps in a more -- in a
9 closer way.

10 And I recognize that that's going to need some
11 conversation between the parties because there's lots of other
12 concerns, whether it be security, mental health. Like that's
13 where you all get in the weeds, but, frankly, I see the need
14 perhaps for some consideration in that regard; and I'll ask the
15 Defendants some questions about that in a moment.

16 But the reason why I'm pressing on this with Plaintiffs is
17 because I am living right now in the sweet spot of if I'm
18 ordering any relief, it's narrow.

19 MS. CHAMBLEE RYAN: Yes.

20 THE COURT: And you do have the benefit of an
21 independent expert report that suggests several areas of
22 relatively narrow relief. It seems like you might not need me.
23 It seems like a good opportunity to focus in on those and see
24 if you can get them buttoned down before I have to rule.

25 I do have some questions about the most recent filings,

1 but those are more factual. So if we could, I'd like to turn
2 to the Defendants and ask some questions of you all and then
3 maybe we'll end with the two pleadings that I just received and
4 what next steps in that regard.

5 What is the Defendant's position on Dr. Franco's
6 recommendations? I'm going to go broad on this one. I want to
7 hear your views on it.

8 MS. JOHNSON: Initial -- with our review from
9 Dr. Franco and the answers to the questions we have, a lot of
10 his recommendations I am happy to report that Director
11 McDonough had already -- is already implementing, thought they
12 were good suggestions, saw where improvements could be made,
13 especially with the -- what we believe is the checklist of
14 symptoms, and has already started implementing those changes.
15 So some of those things are -- are already on -- are already
16 working on being implemented.

17 With regards to the test kits and testing every inmate
18 coming in, which I know -- from the numbers that we have in the
19 jail and the number of COVID patients that were positive when
20 we first started this, this case, and what's going on now,
21 which we are down to zero, and the number of -- and looking at
22 that in conjunction with the number of positive cases in the
23 county and those numbers, which are not zero, I think that it
24 shows and I think Dr. Franco's report shows that Director
25 McDonough did take appropriate steps, did not bury her head in

1 the sand here but -- and continues to do that and continues to
2 --

3 THE COURT: Well, here's my question, Ms. Johnson.
4 My question is not to relitigate whether the Director took
5 appropriate steps, because, frankly, this is a movie; it's not
6 a photograph, and if I roll that movie back to the first
7 positives and in advance of the first positives, I have a
8 healthy disagreement with you, and that's not in every area.

9 I think in fairness to the Director and to the detention
10 facility, they were responding in my view based on the record
11 to certain aspects of it, but as we talked about last time,
12 there was an obvious, in my view, under testing; and so that's
13 why we had that high positivity ratio between tests and
14 positives. Right? And the doctor has even confirmed that by
15 talking to the detainees from the affected units.

16 So one, I'm not sure it's zero right now; but two, the
17 more direct question is what is the -- what is your client's
18 position on testing going forward? Do you have them? Can you
19 implement them? And if so, how?

20 MS. JOHNSON: Okay. Currently, right now, we do not
21 have enough test kits to use for everybody that's coming into
22 the facility. We could probably test everybody that came in
23 today but then that would leave us with a shortage of tests
24 tomorrow. We are in the process and continually we're always
25 in the process of getting more test kits. If we have -- and

1 that really comes down to feasibility.

2 If we have those test kits, then Director McDonough has no
3 problem with testing every inmate coming into the facility.

4 THE COURT: How do you get the test kits? Do you get
5 them from the county health department? Does Corizon purchase
6 them? What's the process?

7 MS. JOHNSON: We deal with a combination of both. We
8 go it both ways trying to get as many as we can. Corizon is
9 constantly asking for more supplies, and the county health
10 department also has been asked to provide more kits. Again,
11 the county health department is also responding to the -- also,
12 all of them are first responders who -- in their agencies who
13 want test kits and need to have those test kits just as much as
14 the detainees.

15 Again, we have a very large demand and a limited supply,
16 and so what we are all trying to do through -- Director
17 McDonough is doing, Corizon is doing, the county health
18 department is doing, is trying to get more kits into -- testing
19 kits into the county, and that's an ongoing process.

20 THE COURT: How many detainees do you have, new -- on
21 average, new detainees a day?

22 MS. JOHNSON: Twenty.

23 THE COURT: Okay.

24 MS. JOHNSON: And so like currently, right now, we
25 have 24 test kits. And so, as you can see, that is just not

1 enough. If we did test those -- like today we have 20 new
2 detainees, and we use 20 test kits. And as I think Dr. Franco
3 pointed out in his discussion here in answering questions, they
4 may test negative when we first test them but then they would
5 have to be retested later before we move them to a housing unit
6 to make sure that they really are negative, because there is
7 some type of incubation period.

8 And I think that's one of the things that's a problem with
9 this virus is that we are still learning everything about it.
10 We don't know. And so what we have now is a very limited
11 supply, which we are trying -- just like I think probably
12 everybody is -- to get more test kits; and if so, we will test
13 because, again, that protects not only the detainees but the
14 correctional officers as well.

15 So we would like -- you know, I believe and Dr. Franco
16 pointed out that it was contact tracing found in -- found
17 origin in the correctional officer's dining hall. So it's
18 reasonable that that is how COVID got into some of these
19 housing units is through correctional officers.

20 THE COURT: So I hear you and what I would say is
21 that as you continue your talks, there is room between zero and
22 perfect.

23 MS. JOHNSON: Oh, yes.

24 THE COURT: And there's got to be -- and I hear that
25 you're working on it. I hope that the agencies that support

1 the detention facility appreciate that the risk of transmission
2 in a detention facility is orders of magnitude greater than in
3 the community. So tests, while they are not perfect as the
4 doctor said, go a lot further in a detained population than one
5 might think if you're just looking at a one to one.

6 So it's my way of saying as testing becomes increasingly
7 available, we've got to put the effort toward making them
8 available to the detention facility.

9 MS. JOHNSON: And I don't think that Director
10 McDonough would argue with that, and she would be happy to --

11 THE COURT: Well, I need to know from you all going
12 forward what roadblocks you're encountering.

13 MS. JOHNSON: No problem.

14 THE COURT: Who are you asking and who's telling you
15 no so that I have some assurance that everyone is watching and,
16 you know, we're really making best efforts to get some
17 additional tests, because I do see the record, and the expert
18 in infectious diseases had some very practical recommendations
19 in that regard.

20 Ms. Johnson, do you have any commentary about the high
21 risk population at this point and perhaps resurfacing the
22 facility to accommodate them?

23 MS. JOHNSON: Yes, and that has been debated,
24 evaluated, and discussed periodically. It's just not one time
25 but throughout with Director McDonough about that, the pros and

1 cons of doing that; and so one of the things that we had -- or
2 she had discussed was that -- you know, what concerned her was
3 placing all the vulnerable inmates in one housing unit and, God
4 forbid, COVID gets into that housing unit. That could have
5 devastating effects on everybody in there who is in a
6 vulnerable position.

7 So -- and then in trying to balance that with, you know,
8 you don't want to have too much movement because, again, that's
9 how COVID is spread, through introducing new people into
10 housing units. So they had gone back and forth with that in
11 that -- and they are continuing to explore that.

12 I think that what is -- what I don't know and I would love
13 to be able to tell you is whether or not any of those 18 that
14 we've had or the people that Dr. Franco has said is medically
15 vulnerable, had any of them experienced any COVID symptoms and
16 were not tested or not treated. I don't know that. So I think
17 that we have explored that. We did not -- you know, it's not
18 something we totally disregarded. We did weigh the pros and
19 cons, and at the time --

20 THE COURT: So what's the plan? Do you have a plan?
21 Is there -- I mean, currently on the record I'm not seeing much
22 of a plan for the high risk population, and I'm, you know, at
23 this point, if I had to make a finding, that may be one of
24 them. So what can you tell me about the plan?

25 MS. JOHNSON: Okay. Well, the plan is, and it's been

1 in practice, is that those medically vulnerable patients,
2 specifically those like who are making medication, asthma
3 medication, diabetes -- I'm not sure about the individual who
4 Dr. Franco referred to as having heart surgery over a year ago
5 and whether or not that was disclosed to our medical staff, but
6 those individuals are monitored and checked in every time they
7 get -- like diabetes patients get medication daily. They go
8 ahead and they check those individuals when they are giving
9 them medication.

10 THE COURT: What do you mean they check them?

11 MS. JOHNSON: Asking about how they're feeling. Are
12 you experiencing any symptoms of COVID? You know, checking
13 temperature, checking cough, if you have a fever, if you're
14 feeling nauseated. Again, they are putting -- looking at those
15 individuals every day.

16 THE COURT: Is this current? Because the historic --

17 MS. JOHNSON: Current.

18 THE COURT: Okay, because when I asked for -- you
19 know, we had those areas. You responded very quickly. I
20 appreciate it. I saw no evidence of that. So is this --

21 MS. JOHNSON: Yes.

22 THE COURT: -- now a new protocol?

23 MS. JOHNSON: No, Your Honor. I think it's -- sorry
24 to interrupt.

25 THE COURT: That's okay.

1 MS. JOHNSON: I think it was an omission on my part
2 in trying to get you a response in a timely manner that I may
3 have omitted that, but from my understanding from talking with
4 my client and Dr. Meske is that they have always been
5 monitoring those vulnerable patients.

6 THE COURT: Are vulnerable patients -- are you making
7 any efforts to single cell them? That seems like an easy one.

8 MS. JOHNSON: When it's practical -- when they can do
9 that, they are single celled. So again, you know, because they
10 had put these individuals -- put the inmates on lockdown, they
11 were not moving them from housing unit to housing unit. So
12 some housing units have a population and I believe the records
13 reflect a very low population. If a medically vulnerable
14 inmate is in a low populated housing unit, they get their own
15 cell.

16 THE COURT: There is no -- let me be clear, though,
17 because I'm asking a really specific question, which is of
18 those identified in the high risk category, is there any
19 affirmative plan or steps taken to give them single cells? Not
20 because of happenstance, because they happen to be in a unit
21 that the population is reduced but a plan to single cell high
22 risk detainees. And if not, maybe that's another line item.

23 MS. JOHNSON: I guess -- no, it depends on -- it
24 depends on that. It depends on a couple of things, but right
25 now as in if they have no -- if they're just in the category of

1 medically vulnerable in a housing unit, no, there is no plan to
2 put them in single cells. If they are in isolation or -- in
3 isolation because of COVID or because of something, they are in
4 single cells.

5 THE COURT: Okay.

6 MS. JOHNSON: And the problem also -- and that issue
7 is, again, feasibility. As Dr. Franco pointed out and
8 Dr. McDonough had stated in her affidavit, we have a number of
9 housing units that are in the midst of renovation and currently
10 cannot have any inmates in them. So that is another issue that
11 we're dealing with.

12 THE COURT: Well, right. And I know about the two
13 units that are offline, but just, you know, looking at the
14 units, I understand that they have 48 cells off of a common
15 housing unit. You've got a reduced population. It seems to
16 me -- again, I am not interested in being a super director of a
17 detention facility, but I do ask that you take that to the
18 drawing board and try to figure out whether there is -- you've
19 got to implement a plan --

20 MS. JOHNSON: Right.

21 THE COURT: -- for the high risk.

22 MS. JOHNSON: Okay.

23 THE COURT: That that be part of the plan.

24 MS. JOHNSON: We will look at that, but I just want
25 to clarify the record that there are four units that are closed

1 for renovation. One is vacant for COVID-19 positive inmates in
2 case of an outbreak and that's if the medical unit is full. So
3 there is a contingency housing unit if the medical unit is full
4 that is left empty for that purpose and just in case we have an
5 outbreak. So luckily, we haven't had one to have -- where that
6 has been a necessity.

7 But in response to one of the things that (AUDIO GAP) had
8 said and one of the comments that you made is that what helps
9 you in cases that are factually similar to this case, and I
10 wanted to draw the Court's attention to one particular case
11 that I think may provide the Court with some -- if I can find
12 it -- some more guidance, and that's *Swain vs. Junior*, 2020
13 Westlaw 2161317. And that is a jail in Florida that had an
14 outbreak of COVID cases. I believe it was 163 positive cases
15 in that jail.

16 They were dealing with similar issues that we are dealing
17 with. They had -- asking for a TRO injunction, habeas corpus
18 relief, same issues that we are -- that you are confronted
19 with; and questions you have, that court had. And that, I
20 believe, in the lower district court level, a TRO was issued,
21 but the appellate court stayed it and went through all the
22 analysis that you were discussing with Ms. Chamblee Ryan. So I
23 believe that case will provide you with some guidance
24 hopefully.

25 THE COURT: It already has. We've read it. It's --

1 yeah. I hear you. Thank you for pointing that out. I
2 appreciate that. Okay.

3 MS. CHAMBLEE RYAN: Your Honor.

4 THE COURT: Anything else, Ms. Johnson, on that?

5 MS. JOHNSON: Well, I think that, you know, the
6 arguments or the questions that you had for Ms. Chamblee Ryan
7 about whether or not you are bound by the PLRA, especially with
8 the 1983 claim, I think that that is true. I think you're
9 correct in that, and I think that the -- that case also dealt
10 with that.

11 As to the over detention and specifically -- and that kind
12 of goes into the latest filings, and I'm going to ask my
13 deputy, Andy Murray, to address that issue because he's the one
14 that filed it and knows the contents of it better than I do.

15 THE COURT: Okay. Yeah, I'm planning to move on to
16 that shortly. Is there anything on the other claims that --

17 MS. JOHNSON: Well, with the habeas corpus relief
18 that they're asking for, again, I agree with what she said in
19 response to Plaintiff's assertions that this is about a
20 condition of a confinement. I think that the -- what we are
21 seeing here is that -- and what the record reflects is that the
22 Circuit Court for Prince George's County is having -- is
23 conducting bond review hearings every day, every day.

24 THE COURT: Is the district court as well? Maybe,
25 Mr. Murray, when we get to this, I need to be walked through

1 what's happening, boots on the ground, because I do have, from
2 a just fundamental principles of comedy say don't step on my
3 state judge's toes unless I have to. Right? Unless I find
4 that there is a constitutional -- overriding constitutional
5 violation that's, in my view, extraordinary -- and I don't have
6 all the nomenclature right but I do know that much.

7 And so I want to understand what's happening right now
8 because the affidavit I got from the public defender was
9 confusing to some degree and concerning. So with that -- we'll
10 get into the weeds on that in a minute.

11 Ms. Johnson, let me ask it this way. The things that
12 we've discussed is it fair to say are still on the drawing
13 board for you to take back to the Plaintiffs and continue your
14 conversation on the Eighth and Fourth Amendment questions?

15 MS. JOHNSON: Yes. When it comes to testing, social
16 distancing, you know, I believe with the -- you know,
17 definitely still on the drawing board. We are always, as
18 Director McDonough was with Dr. Franco, we're always open to
19 discussions on how we can combat this virus, because I think,
20 having a safe jail is beneficial not only to the inmate but the
21 correctional officers and staff that work there as well.

22 So yes, we do want to make a safe environment for
23 everyone.

24 THE COURT: Well, I do encourage the parties to keep
25 talking about this case from the perspective of Dr. Franco's

1 report. I am strongly inclined to say he's moved you all in
2 the right direction, and we'll talk about timing going forward.

3 Okay. With regard to the over detention question, which,
4 frankly, in my view, given ECF 61 and 63, is morphed into
5 something that's different than it was in the beginning. And
6 now there has been evidence offered with respect to the
7 mechanism by which detainees seek release in the state system,
8 and there's been, according to ECF 61, a difference that's been
9 drawn between an order of release and an authorization of
10 release.

11 I have some very basic questions about a couple of things.
12 One: Does the Pretrial Services office fall under the auspices
13 of the Director?

14 MS. CHAMBLEE RYAN: Your Honor, I'm sorry. Are you
15 asking the Plaintiffs?

16 THE COURT: I'm asking the Defendant because I
17 want -- the Defendant is the defendant, so I think the
18 Defendant is probably in the best position to tell me whether
19 she's responsible for pretrial or not.

20 MS. CHAMBLEE RYAN: No problem.

21 MR. MURRAY: Yes, Your Honor.

22 THE COURT: And the answer is yes?

23 MR. MURRAY: Yes. Yes, Your Honor.

24 THE COURT: Okay. So we have the proper party has
25 been sued in that respect.

1 MR. MURRAY: Right.

2 THE COURT: Great. Okay.

3 Second question: Are detention -- this is my word,
4 detention hearings. Are bond hearings being conducted
5 currently where -- not at the commissioner's stage but at the
6 district court stage?

7 MR. MURRAY: Yes.

8 THE COURT: Okay. And can you explain to me the
9 difference between a court authorization and a court order for
10 release just so I understand it?

11 MR. MURRAY: Certainly, Your Honor.

12 So the Court can order the release of an individual via a
13 bond review hearing, via a Writ of Habeas Corpus, and the jail
14 is bound by that court order.

15 Through criteria that has been established in
16 collaboration with the district court and circuit court, when
17 the Court authorizes, that is, provides the option for pretrial
18 release rather than ordering pretrial release, the Department
19 of Corrections has to go and assess various criteria to
20 determine whether the person can, in fact, be put on pretrial
21 release.

22 THE COURT: Okay.

23 MR. MURRAY: And the affidavit that I have -- that
24 requested leave to file for the Court explains the various
25 considerations that the jail must take into account before it

1 can put someone on pretrial release, and it depends on the
2 level of release. There's four different levels.

3 THE COURT: Right.

4 MR. MURRAY: So when the Department of Corrections,
5 for example, if it cannot verify an address for someone or the
6 victim of the crime does not consent to or approve of the
7 release or various other -- the criminal history background of
8 the particular person that the Court has offered the option of
9 pretrial release, if after investigation the pretrial release
10 unit of the department cannot authorize the release, it then
11 notifies the Court of that and the Court, in turn, can notify
12 the parties. And the public defender's office is completely
13 free to challenge that finding and request another bond review.
14 At least that's my understanding.

15 So the affidavit that, frankly, that was submitted by
16 Ms. Glenn is misleading to a large degree in the sense that the
17 inference is that the Department of Corrections pretrial
18 release is not releasing people who are, in fact, eligible for
19 release, but what she doesn't indicate are the factors that
20 must be evaluated, whether those factors were evaluated, what
21 conclusions the department reached, and the fact that the Court
22 is always notified of the department's decision not to release.

23 So I hope I've answered your question, Judge.

24 THE COURT: Well, you have but let me ask one very
25 specific factual question. The affidavit does identify six

1 people who the Court has ordered release and they have not been
2 released. So putting the authorization, the option ones to the
3 side, and I understand there is this give and take in those
4 cases and the Defendant's position is the give and take is
5 still happening, defense counsel can go back to pretrial or the
6 Court and try to work out the difficulties in satisfying
7 pretrial's conditions.

8 What about the ones where there's a court order?

9 MR. MURRAY: Judge, if there are any with court
10 order -- and again, there is no specificity in the affidavit.
11 The individuals have not been identified. But the policy of
12 the department is that if it's Court ordered, it's really not a
13 policy of the department. It has to abide by the Court order.
14 If there is anybody detained in contravention of the Court's
15 order, the department is going to release them, but without the
16 names, without the specifics, we can't investigate the veracity
17 of that claim.

18 THE COURT: Okay, and I'm moving in that direction.
19 I'm moving to a list, exchanging of lists. So I hear you on
20 that, and your response on behalf of the Defendant is give us
21 the names, we'll look into it. If someone is being held in
22 violation of a court order, we will release them.

23 MR. MURRAY: One hundred percent, Your Honor, yes.

24 THE COURT: All right. Okay.

25 All right, so then that -- Ms. Chamblee Ryan, what can you

1 tell me about this authorization question because, frankly, I
2 see it differently as the ones -- if there are individuals who
3 are still being detained in violation of a release order where
4 the judge says I order you released, that's an easy one. These
5 authorizations, I'm thinking about them as almost conditional
6 releases. Judge -- if pretrial comes up with conditions and
7 Defendant can meet it, then that person is released. Those are
8 a bit trickier. What do you want to tell me about them?

9 MS. CHAMBLEE RYAN: Yes, Your Honor. So as an
10 initial matter, during our meet and confer with defense counsel
11 today, we said that we would promptly send them the names of
12 those people who have been authorized and the names of the
13 people who have been ordered release. The only reason we
14 didn't include it with the evidence was just because of the
15 timeline. We needed to get counsel's permission on each case
16 and, you know, just file it publicly, and so we were -- there
17 were those kinds of consideration.

18 THE COURT: And when you do file it, if you do file
19 it with the Court, do file it under seal.

20 MS. CHAMBLEE RYAN: Yes. Yes, Your Honor, we will.
21 We can also just provide it to them. Whatever is your
22 preference. We can also file it under sealed, and we're also
23 happy to provide more evidence on the issue and put on
24 witnesses about it because it's been thoroughly investigated.

25 THE COURT: Well, see, that's the problem that we're

1 having.

2 MS. CHAMBLEE RYAN: Yes.

3 THE COURT: We are in a COVID environment.

4 MS. CHAMBLEE RYAN: I know.

5 THE COURT: And I'm putting everybody through the
6 paces when you give me an affidavit that is nonspecific that
7 raises great concerns about whether these detainees are getting
8 procedural due process. Because, frankly, if they go to a
9 district judge, if they go to a commissioner and then they have
10 the district judge and then they could petition by Habeas
11 Corpus for circuit court review and they can go back and
12 negotiate further conditions and pretrial rejects them, that's
13 a different kettle of fish --

14 MS. CHAMBLEE RYAN: Yes.

15 THE COURT: -- than the substantive due process claim
16 you brought.

17 MS. CHAMBLEE RYAN: Your Honor, yes. Let me tease
18 that out, please --

19 THE COURT: Okay.

20 MS. CHAMBLEE RYAN: -- just on those issues. No
21 problem.

22 MS. CHAMBLEE RYAN: So we're happy to file that with
23 the Court tonight if you would like, the names of the
24 individuals.

25 Now, I want to start with a few things that I want to hit

1 here that were important. One was the idea that the affidavit
2 overlaps with the over detention claim. I think in some ways
3 it does; in others it doesn't, but I want to address that.

4 Second, I want to address some of the representations that
5 have been made in Defendant's counsel's filings and here today,
6 and then I also want to address kind of the authorization
7 issue. It sounds like you're most concerned about the
8 authorization issue or have questions about that, so maybe I'll
9 start there --

10 *(Simultaneous speakers.)*

11 THE COURT: Well, I guess -- is I really want you and
12 the Defense --

13 MS. CHAMBLEE RYAN: Yes.

14 THE COURT: -- to do your level best to hammer this
15 out before you give it to me.

16 MS. CHAMBLEE RYAN: Yes.

17 THE COURT: And the question of sending me a list
18 before midnight tonight for me to look at when you all haven't
19 had the opportunity to go through them, is, frankly, you know,
20 putting the cart before the horse. If we're all about getting
21 to the right result as quickly and fairly as possible,
22 actually, frankly, the parties are in the best position to do
23 that.

24 So before you send me a list, send it to the Defense.
25 Negotiate this. Give a good-faith read on that, Defense. To

1 the extent you have areas of disagreement, those are the people
2 I want to see. And what information do you have that those
3 individuals are being denied due process, that's what I want to
4 know.

5 MS. CHAMBLEE RYAN: Absolutely, Your Honor.

6 Just to quickly untangle an issue, we did not mean that
7 all of that evidence was relevant to just the over detention
8 claim. I think the only individuals that are actually relevant
9 to the over detention claim are the ones who have been ordered
10 released. The rest I think are not. And even the ones that
11 are ordered released may not all be relevant because our over
12 detention claim is just that they are not releasing people
13 because they are COVID positive.

14 So there are people outside of the people who the Court
15 has ordered release, like people who've paid their bond, who
16 ultimately are entitled to release that we've alleged Defendant
17 is not releasing. And they admitted that they did that and
18 Director McDonough was involved. So that's the policy we want
19 to enjoin. This speaks to a separate issue.

20 So, first of all, in describing their policies and the
21 ways in which they've tried to make an effort to remedy the
22 problems in the jail, Defendant insisted and multiple times and
23 in our motion with the declaration we noted each of those.
24 They insisted that they did not have the authority to release
25 further people in the jail, that the only people there are

1 people convicted of violent offenses. And we, based on this
2 evidence, we've learned that that is not true.

3 And the evidence that Defendant's counsel has submitted,
4 you know, I have to review it quickly, but my understanding
5 there is that Defendant is only bound by its own policies. No
6 one is saying that they must do this or that. They have the
7 power to adjust their policies, and, in fact, they've made
8 representations in their evidence that they have, in fact,
9 adjusted their policies themselves, that they have the power.

10 And what this goes to is the subjective part of the Eighth
11 Amendment test because Defendant has acknowledged that careful
12 review of people for release is appropriate, and this shows
13 that even though they do have the power to make additional
14 releases, they haven't done it. And that's separate from the
15 question of whether this Court orders release --

16 THE COURT: But there's a whole lot of gray --
17 there's a whole lot of gray in between that you leave out.

18 MS. CHAMBLEE RYAN: Sure.

19 THE COURT: Give me 121 authorized release cases and
20 the four levels of supervision and then we jump to this is
21 somehow evidence that the Director is not doing what she said
22 she was doing. There is a whole lot of back and forth between
23 pretrial, defense counsel, the Court, the prosecutor that is
24 not the director's bailiwick.

25 MS. CHAMBLEE RYAN: Your Honor, that's not my

1 understanding of the factual situation here in Prince George's
2 County. My understanding is that there's a unique situation
3 and it's -- as described in the declaration, it's -- I've never
4 seen it in any other jurisdiction where I've worked where the
5 court actually essentially kicks it to the Department of
6 Corrections to make the decision for release. And so I think
7 what's not gray is do they have the authority.

8 Now, what may be gray is, you know, was it appropriate in
9 each and every case, but they represented that they didn't have
10 the authority and they do. We're happy to --

11 THE COURT: When did they represent they didn't have
12 the authority? What specific factual representation is this
13 affidavit designed to rebut or underline?

14 MS. CHAMBLEE RYAN: They made the representation in
15 their brief, Your Honor, and we cited each of those in our
16 motion to supplement the record.

17 They also made the representation that the only people in
18 the jail are there for serious crimes against other
19 individuals, but there is someone in the jail for two trespass
20 charges. There is someone in the jail for a single count of
21 driving without a license.

22 So there's representations made in the brief, and it's
23 true there are various sources of counsel that aren't true, and
24 I think -- the reason I think that's so critical, Your Honor,
25 is because given the fast pace, there's a lot of

1 representations being made. There were representations made,
2 you know, by counsel to Dr. Franco, and we found that a lot of
3 times Defendant's own evidence and our evidence contradicts
4 that. And so, you know, that's something that's very, very
5 concerning to us.

6 And so we are very grateful that Defendant wants to work
7 to improve the conditions in the jail, but we're also very
8 concerned that even where Defendant has said it's implementing
9 certain policies, the evidence shows that those policies really
10 weren't properly implemented. Some of them the facts don't
11 quite match what was described and that's very concerning to
12 us. I think, you know, the issue isn't is it the jail's
13 obligation to release every single one of the 121 people.
14 That's not what we're saying.

15 THE COURT: Okay.

16 MS. CHAMBLEE RYAN: We're saying the jail has the
17 authority to release 121 people and they said they don't, and
18 there are people in the jail who are not violent offenders and
19 the jail said there are none. And importantly, there are
20 people in the jail that the Court has ordered to be released
21 and the jail hasn't released them.

22 THE COURT: Well, those are -- right. Those are a
23 different category.

24 MS. CHAMBLEE RYAN: Yeah, those are different;
25 agreed.

1 THE COURT: Okay. Now, with regard to the
2 authorization cases --

3 MS. CHAMBLEE RYAN: Yes.

4 THE COURT: -- your point is the Director said she
5 doesn't have the authority and she does.

6 MS. CHAMBLEE RYAN: Yes, Your Honor.

7 THE COURT: Okay. But she does consistent with
8 pretrial coming up with conditions and determining whether the
9 Defendant has met those conditions.

10 MS. CHAMBLEE RYAN: No, Your Honor. Our
11 understanding is that -- well --

12 THE COURT: That's what the affidavit lays out.

13 MS. CHAMBLEE RYAN: Well, yes and no, Your Honor.
14 That's -- actually, maybe yes, but let me just restate it to
15 make sure that we're understanding it. So what the affidavit
16 lays out is that Pretrial Services is under the authority of
17 the Director.

18 THE COURT: Okay.

19 MS. CHAMBLEE RYAN: The Department of Corrections
20 runs that department. That department sets its own policies
21 about who to release and who not to release, maybe in
22 consultation with others but the buck stops with them. They
23 have the authority to do it. That's our understanding of the
24 evidence at this time. No one at the Public Defender's Office
25 seems to be aware of anyone else with the authority to release

1 people who are authorized for release by the Court.

2 THE COURT: It's Pretrial Services who sets this four
3 level -- this four-tiered supervision structure?

4 MS. CHAMBLEE RYAN: No, Your Honor. My understanding
5 is that the Court sets the four-tier supervision structure, and
6 the Court can say, okay, defendant one, I authorize you release
7 on level four.

8 THE COURT: Right.

9 MS. CHAMBLEE RYAN: Now it's up to Pretrial Services
10 to decide whether to release him on level four. Then Pretrial
11 Services has its own criteria --

12 THE COURT: Okay.

13 MS. CHAMBLEE RYAN: -- and makes that decision.

14 And that's why I'm saying it's within the authority of the
15 department because after the Court authorizes it, it's Pretrial
16 Services' decision and its own policy that it's applying.

17 Does that make sense?

18 THE COURT: It does.

19 MS. CHAMBLEE RYAN: I was really concerned with
20 confusing it and it is. I apologize.

21 THE COURT: Right. I'm still struggling with
22 basically, you know, this is being offered in a sense to
23 impeach a representation that was made, and what I'm trying to
24 determine is whether it's true impeachment, because it's really
25 a long road to a small house on that point. Like, I'm having a

1 hard time matching up the representation with the affidavit and
2 what -- while I sort of work through that, I think what makes
3 sense is for you all to exchange those lists.

4 MS. CHAMBLEE RYAN: Yes, Your Honor.

5 THE COURT: Because if for nothing else, it gives the
6 Defendant additional information about whether you can continue
7 to reduce the population.

8 MS. CHAMBLEE RYAN: Of course, Your Honor. We're
9 happy to work with them on that. And to the extent they want
10 to adjust their policies, we're happy to make recommendations
11 on that.

12 THE COURT: But, see, that's another question I have
13 for you. What policy is there of over detention?

14 MS. CHAMBLEE RYAN: Two things. This is separate
15 from the affidavit issue. This is about the only people --
16 this is just over detaining people who are court ordered to be
17 over detained. So first of all, we've submitted -- we've now
18 submitted evidence that at least three people in the jail who
19 had a legal right to release were over detained just because
20 they tested positive for COVID-19.

21 And, now, we've also alleged that Department of
22 Corrections staff told a public defender that it was their
23 policy not to release people who are COVID positive until they
24 are no longer contagious. So that is in evidence and
25 Defendants have not presented anything to dispute it, not from

1 the moment we made the claim; and, in fact, they actually
2 presented evidence that shows that they did, in fact, over
3 detain someone for 14 days after that person paid their bond,
4 and they've added new information that Plaintiffs did not have
5 before which was that Director McDonough was directly involved
6 in that over detention position.

7 That means that this is a policy under *Mone* in two
8 different ways. Number one, we've shown that there is an
9 official policy. It appears to be a classic bread and butter
10 written policy that they have communicated as --

11 THE COURT: Written policy? Where?

12 MS. CHAMBLEE RYAN: I misspoke. I misspoke, Your
13 Honor. What I mean is -- sorry. It's a little distracting
14 from the images that I'm seeing on the screen. I apologize,
15 Your Honor. I misspoke.

16 What I mean is --

17 THE COURT: It's just like court.

18 MS. CHAMBLEE RYAN: I apologize. I know. I'm so
19 sorry. I apologize.

20 What I mean is so *Mone* you can prove policies a few
21 different ways. One is there's an official top-line policy,
22 the Director or somebody high up says this is how it's going to
23 be. Sometimes it's written down, sometimes it's not.
24 Sometimes it's proven by custom. They just do it so much that
25 it might as well be a policy.

1 Here I think we're looking at an official policy. I
2 misspoke when I said "written." I don't have evidence of that,
3 but we do have evidence that it was official. However, there's
4 actually an easier way to get to the policy in this case and we
5 outlined this for you in the reply. Because Defendant's
6 counsel stated that Ms. McDonough was personally involved in
7 the over detention decision, under *Pembaur*, the U.S. Supreme
8 Court decision, even a single decision sanctioned by --

9 THE COURT: Okay, I'm going to stop you right there
10 because we're at the TRO stage.

11 MS. CHAMBLEE RYAN: Yes.

12 THE COURT: And there's evidence that points in both
13 directions, and I'm going to make it very easy. Defendants are
14 open to the list. If there is anybody currently over detained
15 and it's clear, the Defendants are saying our bad, let's get
16 them released. We will sort the rest of it out after that.

17 MS. CHAMBLEE RYAN: Yes, Your Honor.

18 THE COURT: Because if it's 60 detainees, far greater
19 circumstantial evidence of a policy.

20 MS. CHAMBLEE RYAN: Yes, Your Honor.

21 THE COURT: If it's one, at least at this stage it's
22 weaker. Right? And bottom line is we want those folks out.

23 MS. CHAMBLEE RYAN: Yes, Your Honor, absolutely; and
24 we're happy to work with them on that, and if they allege they
25 will never do this again, we would like to work with them on

1 implementation in making sure that that's the case.

2 THE COURT: How about we get the people out who
3 deserve to be out because the Court said so? Let's we'll start
4 there.

5 MS. CHAMBLEE RYAN: A hundred percent.

6 THE COURT: All right. So, yeah, go ahead.

7 MS. CHAMBLEE RYAN: Oh, sorry, Your Honor.

8 I would like the opportunity to respond to a few of the
9 points on the merits that Defendant's counsel made earlier if
10 that's all right with you.

11 THE COURT: Okay.

12 MS. CHAMBLEE RYAN: So and as part of that, I would
13 like to address the Eleventh Circuit decision in Swain because
14 that case has actually made a few -- several legal errors. It
15 was a split decision. Judge Wilson dissented from the opinion
16 by Judge Pryor, and we think that there are some legal errors
17 and we also think that even if that opinion were binding law,
18 it don't actually affect this case. So I'll talk about that.
19 I just want to put a pin in that.

20 In terms of the points that they raise, I think that, you
21 know, the appropriateness of a TRO -- Dr. Franco's report
22 presents undisputed evidence of a serious problem. There
23 appears to be no plan for medically vulnerable detainees. The
24 only evidence we've heard of any kind of plan was the bare
25 assertion of counsel today and it still didn't sound like an

1 actual plan.

2 There's genuine concern that they don't even know who the
3 medically vulnerable detainees are. The doctor said he didn't
4 know what the term meant -- or she didn't know what it meant
5 initially. We don't know how they process people at intake
6 other than just the representations we heard today that they
7 asked them questions. That was during Defendant's --

8 THE COURT: Well, there is a screening form. There's
9 a screening.

10 MS. CHAMBLEE RYAN: Oh, we don't know anything about
11 how that's given, how that's implemented, whether that's
12 effective medical practice. We just don't know.

13 THE COURT: We don't have any evidence that it isn't.
14 I mean, I'm with you. I'm with you on the plan. I'm with you
15 on the testing. We need testing. We need a plan.

16 MS. CHAMBLEE RYAN: Yes.

17 THE COURT: Those are the two areas of historic
18 discreet possible likelihood of success on the merits with some
19 irreparable harm.

20 MS. CHAMBLEE RYAN: Yes.

21 THE COURT: But, you know -- but with that in mind --

22 MS. CHAMBLEE RYAN: Yes.

23 THE COURT: -- where else do you see the --

24 MS. CHAMBLEE RYAN: Yes. I'll add -- so, I mean, the
25 only point I wanted to make about the identification was that

1 identification of those individuals beyond just I know them
2 because I give them medication sometimes is not -- is part of a
3 plan. You know, so that's the only point I was trying to make
4 there.

5 THE COURT: Okay.

6 MS. CHAMBLEE RYAN: In terms of additional things,
7 one thing that Dr. Franco repeatedly said that appears
8 especially concerning to us is just that there are major
9 inadequacies of screening, inability to get access to medical
10 care both in general population and for people who are in
11 isolation. People in isolation call out. They can't get
12 someone to respond. People in general population, even people
13 who are, you know, cellmates of people who were sick or in
14 close proximity made sick calls at the same time and did not
15 get a response or got a very delayed response.

16 There is inadequate symptom screening. Even the
17 inadequate screening, the temperature checks, are done in an
18 inadequate manner; and he said that the nurses do not seem
19 well-educated. So I do think, you know, bringing the screening
20 guidelines up to CDC standards would be a good area for
21 immediate relief here because I think that's a major danger.

22 THE COURT: But that's an area where the Defendants
23 have -- you've been pretty quiet, Defense, on that, so you
24 might get some areas of agreement. I mean, I don't want to
25 sound like settlement judge here, but it just sounds as if

1 maybe -- maybe this is my fault in setting in this hearing so
2 soon after Dr. Franco issued his recommendations but many of
3 those seem quite implementable and reasonable, and it doesn't
4 sound like we were getting a whole lot of pushback from the
5 Defense yet so --

6 MS. CHAMBLEE RYAN: We agree, Your Honor. We do
7 think that -- I think, you know, one area that might emerge but
8 we're going to talk with Defendants about that is, you know,
9 even if there's an agreement in principal, the implementation
10 and monitoring of that implementation might be really
11 important.

12 So I just want to quickly -- I'm just reviewing what I
13 have here. Oh, one thing that I just want to flag is we do
14 think that it might be appropriate to do some expedited
15 discovery on some of these issues. Like, for example, the
16 provision of adequate medical care. Dr. Franco said today, you
17 know, his assessment was just based on a conversation with the
18 doctor at the jail, but, of course, we've seen
19 misrepresentations or problematic representations in the
20 doctor's declaration, you know, about the temperature logs.

21 The doctor made the statement that people are safer from
22 COVID-19 in the jail than they are in the general public. So
23 it seems like there are some discrete places where it would be
24 useful to test the evidence, you know, and so it might be that
25 at the same time that we're negotiating, we could be developing

1 that record, and we're happy to --

2 THE COURT: You all can discuss -- you can discuss
3 informal exchange of discovery.

4 MS. CHAMBLEE RYAN: Right. Okay.

5 THE COURT: I don't know whether the Defense is
6 planning to answer or move on the complaint, but certainly if
7 you all are talking about implementing some of the remedial
8 measures of Dr. Franco, then I would expect that there may be
9 some exchange of informal discovery; but, you know, on both
10 sides let's get to the solution in a short-term and then we'll
11 --

12 MS. CHAMBLEE RYAN: Sure.

13 THE COURT: -- roll out the rest of it.

14 MS. CHAMBLEE RYAN: Absolutely. I just wanted to
15 flag that that would be helpful.

16 THE COURT: Okay.

17 MS. CHAMBLEE RYAN: So I also just want to note that,
18 you know, a number of courts both in and out of the COVID-19
19 context have found the inadequacies here on their own even with
20 many more measures and undisputed compliance with CDC
21 guidelines, which is not the record that we have today, and
22 have issued TRO's and preliminary injunctions based on those
23 insufficiencies alone, and those include the *Wilson v. Williams*
24 that said that the testing inadequacies --

25 (Simultaneous speakers.)

1 MS. CHAMBLEE RYAN: -- and medically vulnerable
2 inmates. I mean, there is just a state of cases on that issue.
3 And then, you know, so on the legal matter, I just want to
4 note that, you know, it's a totality of the circumstances test,
5 and I think a problem we have reinforcing problems, you know,
6 where you have inadequate screening, you also have inadequate
7 contact tracing, you also have inadequate care, and so all of
8 these things together make it more dangerous. So if you do
9 half measures on ten things, you still might have a really --
10 that might be still an unreasonable response to the --

11 THE COURT: But that's precisely why Dr. Franco went
12 in --

13 MS. CHAMBLEE RYAN: Yes.

14 THE COURT: -- and was an independent assessor with
15 regard to things that -- frankly, I can tell you I was
16 concerned about quarantining. I'm less concerned now because
17 Dr. Franco went in and identified what precisely was the
18 quarantine measures. Do I have concerns going forward? I'm
19 sure both parties do. With regard to lockdown, indefinite
20 lockdown may not be the answer for lots of reasons.

21 But, again, we're in a fluid situation. I hear you. I
22 think you make great points. I guess I am just of the mind
23 right now that while I'm working on the opinion, and believe
24 me, we are, you all can be working on the solution.

25 MS. CHAMBLEE RYAN: Absolutely. We don't disagree

1 with that at all, Your Honor. I was just trying to flag some
2 of the cases that might be useful for the opinion and what we
3 think the law justifies. I think there's a little bit of -- we
4 sense that maybe there were some questions about the subjective
5 test, and since the Defendant didn't really address kind of the
6 Defendant's knowledge or dispute certain aspects of the
7 subjective test, we didn't address it in our briefs, and so I
8 just wanted to highlight some of those; but if it's not helpful
9 to the Court, I'll just --

10 THE COURT: Well, yes, you seem to in your briefs
11 sort of adopt *Coreas* and the -- you know, for sake of -- for a
12 quick analytical structure, assumed deliberate indifference,
13 adopts both the objective and subjective prong and sort of
14 table whether *Kingsley* changes that.

15 MS. CHAMBLEE RYAN: Yeah.

16 THE COURT: I'll tell you, I'm provisionally of the
17 mind that *Kingsley* does change it, but I'm adopting that rather
18 -- I'm adopting the more stringent standard because if
19 Plaintiffs ring the bell on the more stringent standard, why am
20 I wading into this -- it becomes an academic exercise. That's
21 how I'm doing it.

22 MS. CHAMBLEE RYAN: Agreed. We agree with that.

23 THE COURT: Okay.

24 MS. CHAMBLEE RYAN: What I thought would be useful,
25 and if it's not, I apologize, but nothing I'm saying is to

1 suggest in any way that we're not entirely committed to working
2 out every single thing that we can with opposing counsel. We
3 agree that the PLRA applies the injunctive relief on 1983, and
4 because of that, the narrower it can be the better and it's
5 better for everyone. So we more than agree with that.

6 There were just -- you know, there were a few things on
7 the suggestive test, given some of the arguments that got made
8 kind of by implication, we thought it might be useful to
9 highlight, but if the Court isn't interested in that, I can
10 move on.

11 THE COURT: So, yeah, so this is how I'm seeing some
12 of the rhetoric, like we're in CDC compliance. That may be
13 today, not necessarily historically, and that matters.

14 MS. CHAMBLEE RYAN: Yes.

15 THE COURT: So I'm sensitive to that --

16 MS. CHAMBLEE RYAN: Yes.

17 THE COURT: -- that there is a movement toward
18 compliance but that's not the whole record. So if that's kind
19 of where you're going with it --

20 MS. CHAMBLEE RYAN: In part, yes, Your Honor.

21 THE COURT: Okay.

22 MS. CHAMBLEE RYAN: Yes, I mean, that's definitely
23 part of it so I'll leave that out. I mean, I think, you know,
24 we did want to highlight that the point of the subjective test
25 is not did you try anything good, or are you a good person.

1 It's, you know, based on the -- in light of the risk, is
2 your -- is your response on the whole, when you put it
3 together, is it reasonable in light of the risk. And I think
4 we've given you lots of cases on that, but there were some
5 other questions I thought might be useful and the one was just,
6 you know, sort of how do we know that Defendant's counsel knew
7 that it should have been doing those things.

8 And so in addition to direct knowledge, I just want to
9 flag we've got a lot of evidence of direct knowledge, not only
10 of the risk of COVID-19 but also the specific risk of the
11 problem identified in Defendant's evidence and we're happy to
12 put those forward.

13 But, you know, the Fourth Circuit has also said that the
14 subjective test is met when the risk is obvious, and so, you
15 know, we think that plays a role, too.

16 And then, you know, I think I've addressed everything
17 else. I mean, one thing I would note, though, just in light of
18 Ms. Johnson's comment about testing is that there is law that I
19 think is pretty persuasive that suggests there's a difference
20 between damages relief and injunctive relief when you talk
21 about the role that inadequate resources plays in determining
22 whether the subjective test is met. And there is case law --
23 you know, this wasn't specifically raised, but I thought Your
24 Honor might be wondering about it when Ms. Johnson was making
25 those points.

1 And so the Ninth and Eleventh Circuit have both said
2 things like this as has the U.S. Supreme Court, and I'm just
3 pulling up that case.

4 THE COURT: But while you do that, what I'm more
5 interested in is how many, frankly, trees have been shaken to
6 get more tests.

7 MS. CHAMBLEE RYAN: Yes, we find that certainly
8 relevant, too.

9 THE COURT: Right. I mean, because the facts drive
10 the analysis and that's why I asked Ms. Johnson in the -- in
11 the coming days, really drill down on who has been asked for
12 what and what are the answers that you're getting, because I
13 don't want to -- if I find that there has been some historic
14 deliberate indifference in the area of under testing and we're
15 talking about how to make sure that doesn't happen again, it's
16 a very narrow area but if I find it, then I want to understand
17 going forward how are you going to get adequate tests and how
18 are you going to use them.

19 MS. CHAMBLEE RYAN: Yes.

20 THE COURT: So, again, I don't mean to sound as if
21 the cases don't matter, but at this stage they don't matter
22 unless they are really factually very close to this one.

23 MS. CHAMBLEE RYAN: That makes complete sense. I
24 think -- yes. And I think we agree. As a factual matter, I
25 think we would say that there's been an adequate effort to get

1 more tests, but even if there had been and there weren't
2 enough, we think the case law supports that's not a defense for
3 injunctive Eighth Amendment claim. The case is *Horrell v.*
4 *Dillard*, and we're happy to send it to the Court. It sounds
5 like the Court is familiar.

6 So the last thing, I just want to address *Swain* and then
7 I'll end. So --

8 THE COURT: Uh-oh. I think we have a frozen screen.
9 Will someone let me Ms. Chamblee Ryan know she's frozen.

10 MS. CHAMBLEE RYAN: I can hear you. Am I back?

11 THE COURT: You're not frozen anymore.

12 MS. CHAMBLEE RYAN: Oh, no. I'm sorry.

13 THE COURT: You're good now.

14 MS. CHAMBLEE RYAN: Okay. I apologize.

15 So just a few things in that *Swain* opinion that I thought
16 were problematic. So one is the court says that the district
17 court improperly collapsed the objective and subjective
18 requirement because the court considered the severity of the
19 outbreak and the number of cases. In our view that's not quite
20 right because, of course, the subjective element is considered
21 in light of the severity of the risk. So you assess the
22 reasonableness in terms of how dangerous the situation is.
23 Something that's reasonable one way isn't in another.

24 So we just thought that that wasn't, you know, a proper
25 conclusion under the law, but more importantly, most of the

1 court's opinion that with the facts of the jail is physically
2 incapable of carrying out a lot of these measures, and even if
3 that were true, we just don't have evidence that that's the
4 case here.

5 I also think it's disputed by (AUDIO GAP) so you would
6 have basically a circuit split on that question. It's also
7 disputed by another Eleventh Circuit case that we're aware of.
8 And, of course, you know, without much reasoning, given the
9 timeline, Judge Wilson dissented on that.

10 So, I mean, I would just note that I think we have a
11 problem with the reasoning but also, you know, it's a different
12 situation because the decision mainly hinged on impossibility
13 and that's really not what we have here.

14 THE COURT: Right. No, I see your point and I think
15 I largely agree with it, but I need to read *Swain* because I
16 haven't.

17 MS. CHAMBLEE RYAN: Yes, of course.

18 THE COURT: My wonderful law clerks have, and they
19 told me you must read it but -- and I will. I promise.

20 Okay. Anything else before I tell you where I think I
21 want to go with this?

22 (No response.)

23 THE COURT: All right. So since you all are
24 continuing to talk, I would like some interim exchanges to be
25 made. We'll put this in a letter order, but the Defendants are

1 welcoming that list responsive to ECF 66-1 to identify the
2 individuals who are still detained despite a court order for
3 release. Also, I do think it's relevant and should be given
4 those who are detained for very minor charges, traffic charges.
5 Those do seem to be easily resolvable, and the Defendant would
6 benefit from those individuals; and then finally, the 121
7 people who are authorized for release but who have not been
8 released, and the list should include the identifiers, the
9 name, the case number, any other identifiers that would make it
10 easier for the Defense to get you all a response. So maybe you
11 can work together to weed that list down, and that would reduce
12 the population and help with some of the other issues.

13 So I was going to order -- how quickly, Ms. Chamblee Ryan,
14 could you get that to the Defense?

15 MS. CHAMBLEE RYAN: I think, you know, just to allow
16 time to double check it, I mean, 24 hours --

17 THE COURT: Okay.

18 MS. CHAMBLEE RYAN: -- from now. Tomorrow maybe. Or
19 certainly 48, and then we could really double check, but
20 24 hours I think certainly.

21 THE COURT: All right. So no later than 48 hours but
22 if you get it sooner, great.

23 And then within -- from seven days from today I do want a
24 status report from the parties on the outcome of that exchange.
25 If you've identified individuals, they have been released, or

1 if there is a process now that's being put in place to reduce
2 the population further and/or make sure that we don't have any
3 over detained defendants, let's -- let me hear you on that.

4 I also want the Defendant to prepare a list using the CDC
5 guidelines of high risk detainees, again, identifying them --
6 and this is all for attorneys' eyes only, pursuant to the
7 protective order. If I need to see them, you do it under
8 seal -- but identifying them by name if you need to or initials
9 at best and where they're housed right now, what are the high
10 risk factors, because there's often more than one, so we know
11 who they are and how many we have and where are they currently
12 and any efforts that you all have made to identify a
13 prospective plan going forward to keep the high risk population
14 -- not only to identify them but to adequately, you know,
15 screen and treat them in light of COVID.

16 And then finally, in the same period I want a status from
17 you all seven days from now as to the outcome of your
18 discussions regarding a potential Consent Decree. If you get
19 it to me sooner, great. In the meanwhile I'm going to be
20 working on an opinion. My view, though, is that in the end of
21 the day my opinion and your ultimate conclusions, if we all are
22 serious about getting this right, are probably going to be
23 largely one in the same, and so let's work in parallel on that.

24 After you get me that information, I want to have a
25 follow-up hearing with you all. So we can do it even -- you

1 know, what we can do, just because I know time is of the
2 essence, is I can make the due date for a number of these
3 things five days out and then we can convene a week from now to
4 see where you are with progress. Does that make sense?

5 So it's Monday --

6 MS. CHAMBLEE RYAN: Yes, Your Honor.

7 THE COURT: Make everything due to me by Friday and
8 then we talk again next Monday.

9 MS. KOSHY: Your Honor, I'm sorry. Just briefly, the
10 only concern I have with that is if it's going to be 48 hours
11 before we get the list of all the identified inmates, we won't
12 really have enough time to determine, you know, kind of where
13 we stand with those because we need time to be able to review
14 it. So if we could possibly keep it at the seven days, I think
15 it might give us a little bit of time that we need to review
16 that list.

17 THE COURT: So why don't we do this, why don't we
18 do -- we'll keep the 48 hours. We'll keep the seven days and
19 we'll talk the next day. So you make the report to me. I'm
20 the quick turnaround. So we talk -- you get it to me on Monday
21 and we talk on Tuesday.

22 MS. KOSHY: Thank you.

23 THE COURT: Yes?

24 MS. JOHNSON: Yes, Your Honor. Thank you.

25 THE COURT: So then while we're all together -- how

1 is Zoom? We all like Zoom? Shall I see if we can do this
2 again by Zoom?

3 MS. JOHNSON: That's fine.

4 MS. KOSHY: Yes, Your Honor.

5 THE COURT: Okay. The 19th, can we do 9 a.m.? I
6 know that's a quick turnaround for me, but I'm otherwise pretty
7 booked during the day, and I'd rather get you all moving if,
8 you know -- I'd rather get the information and discuss it. We
9 can do it 9 a.m. or we could do it -- oh, Tuesday is a bad day.
10 How about Wednesday? Can we do Wednesday at 9 a.m., which is
11 the 20th?

12 MS. KOSHY: Yes, Your Honor.

13 MS. JOHNSON: Yes, Your Honor.

14 THE COURT: Okay, let's do that. So follow-up Zoom
15 with us 5-20-2020. I will issue -- now, let me ask you this.
16 Given that we have arrived at the exchange of the list and you
17 all will be working on identifying the list, is there any need
18 for any further response to 61?

19 MS. CHAMBLEE RYAN: Your Honor, I think that it would
20 probably be useful -- we got it about 12 minutes before this
21 hearing started, so I think it would probably be useful to
22 review it closely, you know, talk with, you know, some people
23 with firsthand information of it and see whether that's the
24 case.

25 THE COURT: Well, I guess my question was I was

1 talking about ECF 61 because the Defendants said they need time
2 to respond and their response was "and we also want to
3 supplement." And my question at this point is until you all
4 exchange the list and figure out what's going on with these
5 individuals, there may not be any need for crossfire.

6 MS. CHAMBLEE RYAN: Oh, sure, Your Honor. That
7 sounds fine.

8 THE COURT: All right, then why don't you get the
9 list exchanged, and we figure out what's really going on with
10 these detainees and then in the status report you can update
11 me.

12 MS. JOHNSON: That's what I was going to suggest,
13 Your Honor.

14 THE COURT: Perfect. Okay.

15 All right, and that status report will be due on Monday
16 the 18th.

17 Okay, so to recap, because I know we're -- I'm not as
18 linear as I think you would like, especially at almost
19 6 o'clock. Plaintiff will provide Defendant the list of
20 individuals we've discussed from ECF 66-1. Defendant will
21 provide Plaintiff the list of detainees screened and identified
22 as high risk detainees not only by, you know, individual
23 identifiers but the housing units which they are currently
24 housed.

25 And then you all will continue your negotiations, and you

1 will submit a status report to me by Monday the 18th, and we
2 will convene again on the 20th at 9 a.m. for next steps.

3 MS. CHAMBLEE RYAN: Yes, Your Honor. One quick
4 question.

5 MS. JOHNSON: Yes, Your Honor.

6 THE COURT: Yes.

7 MS. CHAMBLEE RYAN: We discussed some additional --
8 whether it might be helpful to the Court to submit additional
9 briefing on the PLRA issue and then there's also been some
10 discussion about the adequacy of the state court. I know we
11 referenced that exhaustion was an affirmative defense. It
12 wasn't raised and so we submitted some evidence on it and
13 pointed you to it but we're happy to provide more if you think
14 that would be useful.

15 THE COURT: Oh the PLRA exhaustion? PLRA exhaustion
16 of 2241?

17 MS. CHAMBLEE RYAN: No, you said you weren't worried
18 about that so I was referring to 2241 exhaustion just because
19 there was some conversation about the state court and kind of
20 what is going on there. We're happy to, you know, provide more
21 argument and point you to --

22 THE COURT: Well, frankly, there's three kinds of
23 exhaustion going on here. There is PLRA exhaustion, which
24 implicates the grievance process. I think the grievance
25 process at this stage has been called into question and I'm not

1 going to -- and it is an affirmative defense that hasn't been
2 raised. I'm not hanging my hat on that.

3 There is exhaustion in the detention review of release
4 conditions, you know, whether there is an adequate process
5 there before claiming that you've got to bring it to me and
6 then there is the 2241 exhaustion, which is judge-made and,
7 again, an affirmative defense. There is -- I guess my issue on
8 that is there's bigger fish to fry on exhaustion. So I'm
9 thinking -- I'm thinking that for now what's most important is
10 the PLRA.

11 MS. CHAMBLEE RYAN: Sure.

12 THE COURT: Okay? And so by the same time, which is
13 Monday, let's do simultaneous letter pleadings on any
14 additional information you wish for me to consider with respect
15 to the PLRA.

16 MS. CHAMBLEE RYAN: Yes, Your Honor.

17 THE COURT: Okay? So that it gives you all seven
18 days to consider the PLRA and its implications. And not on
19 exhaustion but on if I am to order any injunctive relief, I
20 have to comply with the PLRA.

21 MS. CHAMBLEE RYAN: Yes.

22 THE COURT: Okay. All right, that would be great.

23 MS. CHAMBLEE RYAN: Thank you.

24 THE COURT: Anything else that we talked about
25 including in this that I seem to have dropped off?

1 (No response.)

2 THE COURT: All right. We're going to get a letter
3 order out. Keep working. Really appreciate it. You all have
4 been great. I think judicial good sparring among lawyers with
5 Zoom has gone tremendously well and this gives me great hope
6 for our future oral arguments on these important issues, so
7 thank you so much.

8 And this will conclude our session until we talk again on
9 the 20th. Everybody be safe. Thank you so much.

10 THE DEPUTY CLERK: This Honorable Court now stands
11 adjourned.

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13 (The proceedings were adjourned at 5:55 P.M.)

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1 I, Marlene Martin-Kerr, certify that the foregoing is a
2 true, correct, and complete transcript of the video-recorded
3 proceedings in the above-entitled matter and transcribed from
4 the video recording to the best of my ability.

5
6 Dated this 16th day of May, 2020.

7
8 /s/
Marlene Martin-Kerr, RPR, RMR, CRR, FCRR
9 Federal Official Court Reporter
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Affidavit of Mary Lou McDonough

My name is Mary Lou McDonough. I am over 18 years of age and am competent to testify. The following statements are made based upon my personal knowledge and my knowledge as Director of the Prince George's County, Maryland Department of Corrections (DOC).

I am the Director of the Prince George's County Department of Corrections. I have held this position since June 4, 2008. Prior to becoming Director of the County's Department of Corrections, I held the position of the Deputy Director, Bureau of Administration at the Prince George's County Department of Corrections for three years. Prior to working at the Department of Corrections, I served as Deputy Director for the Prince George's County Department of Housing and Community Development (DHCD). Totally, I spent 25 years working in subsidized and public housing; particularly with the elderly and Section 8 Rental Assistance recipients. My education and training consist of a Bachelor of Science, with Majors in Sociology and Political Science from the University of Maryland, College Park, Maryland and a Master of Public Policy from the School of Public Policy at the University of Maryland, College Park, with a concentration in Public Finance. I have had extensive training in Corrections Administration through many classes, trainings and workshops sponsored by Correctional Professional organizations including the American Correctional Association (ACA), the National Institute of Corrections (NIC), the American Jail Association (AJA) and the Maryland Correctional Administrators Association (MCAA). I participate in the Correctional Chiefs Committee of the Metropolitan Washington Council of Government (MWCOC). I have served as Chair and Vice Chair of this Committee.

Under normal circumstances, and prior to the onset of COVID 19, the County's Correctional Center contagious disease policy was in place and is attached to this Affidavit as **affidavit exhibit number 1**. The policy has been constantly updated this year to reflect the COVID-19 pandemic and health experts' recommendations.

I first became aware of the possible spread of a Coronavirus to the United States in December 2019 and in January 2020 by watching, listening and reading reports in the press and on-line. Knowing that a spread of any contagious disease in a Correctional Center could be dangerous to both inmates and staff, I immediately began preparations to assist in our readiness for potential introduction, spread and mitigation of COVID-19 in the County's Correctional Facility. As a result, I took the following actions:

On February 6, 2020, the medical staff began a new and additional screening process for all committed persons upon their arrival in Upper Marlboro Processing, which included the completion of a check list asking about possible "flu-like" symptoms and checking the temperatures. The questions included asking about recent travel outside of the Country. A Copy of the check list used is included Dr. Asresahegn Declaration. Information about this new process was brought to the attention of the Office of the County Executive during my monthly briefing of Deputy Chief Administrative Officer for Public Safety (DCAO) Mark Magaw.

At our regular February 2020 Monthly Medical Advisory Committee (MAC) meeting with our Medical Administrator and Physician and Chiefs of DOC Divisions, additional planning steps were taken to include reviewing, revising and updating our Infectious Control Policy. At that time our current infectious disease policy had more to do with contamination from blood and body fluids than it did with airborne illnesses, like COVID-19. The policy was reviewed and changed to add more specifics in dealing with an airborne disease and has been continuously

changed regarding social distancing and crowd size and other recommendation by the Health Department, the US Centers for Disease Control and Prevention (CDC) and the County Office Emergency Management (OEM). Also, flu vaccine was only offered and available to staff in October -December, but, since we wanted to be able to better distinguish flu from the coronavirus, flu vaccine was offered free to staff in February and March. Health compromised inmates were already receiving flu vaccine in our Medical Unit. Since COVID-19 testing was not available in February and early March in the US, being able to rule out flu could possibly be a help in diagnosis of COVID-19 cases. I also asked that our Airborne Infection Isolation Rooms (AIIR) rooms be tested to make sure the negative pressure system was working in them. I also asked Maintenance to finish any outstanding repairs, plumbing, electrical, etc. that may have been needed in the Medical Unit. I asked about the cleaning that was being done by an outside Contractor in the Medical unit and was it enough and being performed properly. I was assured by our Medical Contractor that they were satisfied with cleaning protocol. I confirmed that Physicals were being performed on time on all new inmates, within 14 days of arrival. The Medical Administrator spoke highly of the Officers who were assigned to Sick Call and to the Medical Unit and asked if Management could try to use the same Officers in Medical as much as possible on the regular Officers days off. Management agreed to do that as much as possible depending on schedules and leave usage.

On March 3, 2020, I sent a memo to DOC Staff advising them of preliminary actions being taken at the jail and reminding them to wash their hands regularly and often. We also posted a Health Department flyer through the correctional facility describing how to best avoid infectious disease by hand washing often, hand washing etiquette, coughing into the crook of

your elbow and using tissues, which are then disposed of for any sneezes. We also reminded staff to stay home if they felt sick and inmates to report and symptoms to staff.

During early March, I attended many meetings, 3/3/20, Meeting with Prince George's County Full Cabinet, led by Chief Administrative Officer Major Riddick, 3/4/20, Meeting with County Executive Angela Alsobrooks, Health Officer Dr. Ernest Carter and Heads of agencies that could be strongly affected by the virus, i.e., Public Safety, Housing, Health and Public Works, 3/5/20 participated in a community roundtable held by Congressman Steny H. Hoyer (D-5th MD) and Congressman Anthony Brown (D-4th MD) representatives for Prince George's County and 3/9/20 Met with Corrections Physician, Medical Director, Chief of Nursing and Corizon Corporate Officials to discuss plans and operations moving forward.,

On March 12, 2020, I stopped our normal group Roll calls, usually held during the 15-minute period prior to an 8-hour Shift start. Post assignments and information is now shared individually with Officers by Command staff and through electronic measures.

During this same time period, early March 2020, increased sanitation efforts began on all Shifts; particularly in common areas. Sanitation in the facility is normally done by inmate work crews supervised by Correctional Officers. These efforts are supplemented by a Contractual Cleaning Company in the Medical Unit and in staff offices. We provided additional disinfectant cleaners and wipes and paper towels to all inmates and staff. Copies of inventories, orders, and invoices for additional cleaning supplies are attached. These additional supplies of disinfectant wipes and diluted bleach and paper towels were made available in Housing Units for Officers and inmates for use on surfaces and equipment, including telephones, doors, door handles and knobs, electronic equipment, tables, seating areas and all other frequently touched surfaces. On March 18, 2020, additional personal bars of soap were provided to detainees at arrival in

Processing for their individual use. Soap was and is distributed FREE OF CHARGE to all detainees in accordance with the later published recommendation of the Centers for Disease Control (CDC) which states that Correctional Agencies stock “liquid soap when possible, if bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing”. Our agency finds that “bar” soap is more convenient for detainees to use because it is readily available, can be easily kept with a detainee and does not create the environmental waste and potential for abuse as contraband that liquid soap containers (pumps) may contribute. On April 9, 2020, Officers were reminded to distribute soap freely within the Housing Units to anyone needing or requesting it, and Zone Commanders were instructed to continually monitor and ensure that there were bars of soap available in the Housing Units for consistent distribution.

We have chosen not to use alcohol-based hand sanitizer within proximity of detainees because of the potential for abuse. We have previously had inmates abuse alcohol-based hand sanitizer by drinking it for the alcohol content, which previously caused the admittance of two inmates to the hospital, one who remained in the ICU in critical condition and resulted in the possibility of permanent organ damage. This option is in accordance with CDC guidance which recommends the use of alcohol-based hand sanitizer *if soap and water are not available*, (emphasis added).

Our Housing units are not dormitory style, which may require up to 12 individuals to share bathrooms and sinks as may be seen in other jurisdictions. In our facility, detainees are housed in cells, which are situated around a common day room area. Each cell has its own toilet and sink and holds no more than two occupants, many detainees are single celled and have a private sink and toilet. The common area also contains a Kitchenette area with a sink and running water.

In early March, we met with our food and medical contractors to make sure that their inventories of food and medical supplies were enough for a longer than usual time period in case there were future delays in deliveries.

In mid-March, I met with our Administrative Judges from both Circuit Court and District Court to review both their and our Continuity of Operations Plans (COOP) and test our capacity to hold hearings remotely. We also set up and reviewed existing procedures to provide remote access to detainees by Attorneys, particularly Public Defenders. The Office of Public Defender (ODP) was involved in the development of these procedures. At this time our Average Daily Population (ADP) was over 700 so we began additional daily reviews of our current detainees to explore the possible release to Home Detention or on pre-trial release of additional individuals. We have worked closely with both the OPD and the States Attorney's Office (SAO) to reduce our ADP. During this time period, I had often and regular telephone conversations with Keith Lotridge, Public Defender for Prince George's County, about the possibility of getting inmates released from jail. I asked him about any inmates that he may know of that had serious health issues and asked them to please work on getting these released. I brought to his attention Inmate Chun Oh, who is a 74-year-old female, who I was concerned about. I knew that although she is charged with Murder, I didn't believe her to be a danger to herself or others nor a flight risk. He replied that he didn't believe that she had anywhere else to go. She is still in our custody. Our ADP was routinely in the high 1400's or over in 2008, when I became Director and instituted many programs and processes to release pre-trial individuals. I am a strong believer in criminal justice reform in Maryland and have worked on it with the Governor's Office and the State legislature. Since early March 2020, these efforts have lowered our ADP by more than 20%. Our population on March 1, 2020 was 706 and our population on April 24, 2020 was 560. On

many days in the past two months, our number of releases is substantially more than our intakes.
(ADP Reports for March and April 2020)

During the rest of March, these additional steps were taken to prepare for the potential/possible introduction of COVID-19 in the correctional facility.

- I held a Town Hall style meeting for staff with our Physician to discuss COVID-19 preparation and policies and to respond to questions. Session was videotaped and shared with all staff to include staff on all three Shifts. 3/12/20
- Reviewed minimum staffing needs in all Divisions; including Security 3/13/20
- Remind Security Staff temporarily assigned outside of Security that they may be needed to work Security Post and to be prepared to have their Post changed 3/13/20
- Ready Cots and Linens for Staff sleep-overs if necessary 3/13/20
- Push Office of Central Services (OCS) to open all closed cells in Housing Units identified as Consolidation Units - to stay open in case of outbreak, particularly HU 14, 15, 16 & 17, throughout February & March, continuing into April
- Identified Units as “infirmary Units” if sick population is too large to be contained in Medical Unit (HU 6 Males & HU 2 Females)
- Make sure all 12 Airborne Infection Isolation Room (AIIR), or negative pressure cells, are working and ready. 1 remains out of service because of major plumbing issue and back-ordered parts.
- Identify Civilian Staff who may be able to work from Home – week of March 16th
- Ensure Staff who may work from home have access to County network from their homes via County laptops Week of March 16th
- Identify minimum Sworn Staff needed to run the Jail – Week of March 16th
- Identify Civilian Staff who could be excused from Work., Administrative Leave – 3/20/20

- All civilian staff eligible for Teleworking were assigned to Telework- 3/25
- Talk to Office of the Sheriff and the Prince George's Police Department (PGPD) about possible need for staffing following posts, in the case that a high percentage of our Security Staff are ill or quarantined at home – Gate, Reception, Transportation and Perimeter Done Mid-March
 - Met with Sheriff Deputy to walk through action Post Duties of Perimeter (K-9) and Gate – April 7
- Talk to Prince George's Fire/EMT about inmate transport requirements for staff (follow along if arrestee/inmate is restrained) Policy in place for COVID-19 patients - Done Mid-March
- Command staff, along with Medical Staff visited every Housing Unit to inform inmates on COVID-19 preparedness and to explain to inmates how to social distance and the importance of cleaning area and washing hands 3/06/20
- Additional Soap was purchased, stocked and distributed as needed (4,500 bars) for inmate use, so that inmates may have enough soap to use for showering and washing hands. 3/18/20

On March 23, 2020, the CDC *finally* issued its Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. Keep in mind that all the above had already been done in the Prince George's County DOC. I reviewed the Guidance to see what, if anything I/we, could be doing to prevent and prepare for the potential introduction of COVID-19 in the facility.

Under the topic of Communication and Coordination, the guidance recommends identifying points of contact with our public health department. Beginning Monday, March 16 and almost every day since, I have personally been in contact with Dr. Ernest Carter, Health Officer for Prince George's County and/or Angela Crankfield-Edmond, Chief, Infectious Diseases at the County Health Department for advice and recommendations on COVID-19 and its affect on the

Jail, our inmates and our staff as well as the County community at-large. Together, our Health Provider our Public Information Officer and I created and tested our plan to disseminate critical information to detained/incarcerated persons, staff, contractors, vendors and visitors as the pandemic has progressed. Through my participation in the Maryland Correctional Administrator Association (MCAA) (I am a Former President, Vice-President and current Executive Board Member.) I have communicated regularly with other Maryland local Correctional facilities to share information, including disease surveillance and staff absenteeism patterns. With the Assistance of Judge Barbera, Chief Judge on the Maryland Court of Appeals and Judge Morrissey, Chief Judge District Court of Maryland, the local jails in the State of Maryland working with the State prison system have put a plan in place to prevent inmates from being transferred between facilities in Maryland during the COVID-19 outbreak by allowing local judges to hold hearings on cases outside of their normal geographic locations.

We had already reviewed our existing infectious disease policy, all hazard and disaster plans and have been continuously revising them for COVID-19. Because we are fortunate enough to have a full medical unit within our facility; including 12 Airborne Infection Isolation Rooms (AIIR), a Female ward (6 bed) and a Male Ward (10 bed), plus examination space, a dental room, a pharmacy and full time 24/7 staffing by medical professionals we were able to plan for how suspected and COVID-19 cases are isolated, evaluated and tested and provided all necessary medical care. Our Medical Director and Physician are providing information on the care and treatment of inmates under separate affidavits.

We are one of only three local jails in the state with a full Medical Unit of this size and capacity. We have the equivalency of forty full time positions staffing our Medical Unit, including a full time Physician, a full time Psychologist, 4 Licensed Clinical Social Workers

(LCSW), a 30 hour per week Psychiatrist and a part time Mental Health practitioner and over 20 full time nurses.

As previously stated, we had already coordinated with local law enforcement and Court Officials and are using alternatives to in-court appearances and have worked with the SAO and OPD to reduce our inmate population. Our rated capacity is 1524, but we have two full housing units (96 cells, 48 in each HU) and two half units (48 cells, 24 in each HU) off-line for renovation, reducing our capacity by almost 300 occupants. Our inmate population as of April 23 was 570.

We posted Health Department signage concerning COVID-19 symptoms and hand hygiene throughout the facility, including areas frequented by inmates in English, Spanish and pictograms (for the illiterate). We have updated the signage continuously as new information about the virus has emerged, always using CDC or Health Department signage in English, Spanish and pictograms. (Copies attached)

We reviewed our sick leave policies and worked with the County's Office of Human Resources (OHR) on Sick, Health and Safety Leave, a new type of leave developed for COVID-19 related absences. We have encouraged and commanded sick employees to stay at home. We have planned for staff absences and allowed many more staff to telework. Since we were able to return many sworn staff members to Security positions from temporarily closed programs, we have maintained the staff necessary to staff the jail, even with staff absences.

We have ensured stock of hygiene supplies, cleaning supplies, PPE and medical supplies are available and restocked as necessary. (Invoices attached.) We exceeded the CDC recommendations by issuing N-95 masks to all staff starting on March 30, 2020. We replace the

masks as needed and will have replaced all of them at least two additional times as of April 27, 2020. We also distributed a video and written instructions on how to use the masks and how to care for them, going as far as giving every staff member a paper bag to store their masks in when not in use. We mandated the use of masks in the facility on April 7, 2020. We issued surgical masks to all inmates on April 5th & 6th, 2020 and require them to wear them when outside of their cells. We also issued paper bags to inmates to store their masks while in their cells and explained how to don and doff the masks safely.

We are performing all prevention practices as outlined in the CDC Guidance; including performing pre-intake screening and temperature checks, which began on January 29, 2020. In early April 2020, we began masking ALL arrestees upon arrival to the facility, if they were not masked by Law Enforcement already. We began taking temperatures and asking about other symptoms on March 17th of all individuals, including arrestees, detainees, staff, police officers, attorneys and arrestees entering the facility.

We have implemented social distancing strategies to increase the physical space between inmates in a variety of ways and changed them to reflect the changes in guidance from the CDC and the Governor and the County Executive. We have also limited group sizes, starting with no larger than 50, then 30 and finally to groups of no more than 10. This has not been easy within the confines of our facility.

We stopped all visiting, except for legal visits, and stopped volunteers from entering the building on March 13, 2020. Detainees were informed that because we were stopping visiting for their protection and for the protection of our staff and that we made arrangements with our inmate phone provider to allow each inmate to make three free 10-minute phone calls to their family and friends each day. This is more free calls than any other jail or prison in Maryland,

where two free calls per week is the average being offered. Inmate calls to Attorneys were free prior to the COVID-19 crisis and remain free today. Since the “normal” phone numbers of many law firms are not currently not being answered because the Attorneys are working from home, we have made special arrangements to enable free calls to alternate numbers provided by Attorneys. This is especially true of the Office of Public Defender (OPD), who represents most of our inmates. The OPD has provided us with a complete listing of additional phone numbers to add to the free Attorney call listings. Attorneys may still visit their clients, but for the protection of our inmates we ask them to use a non-contact visiting booth. If the Attorney needs to pass paper to the client or collect signatures from their client, they may give the paperwork to a Correctional Officer who will take the paperwork to the inmate and allow them to read it or sign it in front of the Attorney and return it to the Attorney as needed. We are still providing notary services to our inmates.

On April 6, 2020, after consultation with Dr. Ernest Carter, Prince George’s County Health Officer, and Angela Crankfield-Edmond, Prince George’s County Chief, Infectious Diseases, Dr. Meskerem, Physician at the Correctional Center and my Command Staff, I decided to change the number of inmates allowed out of their cells at one time to ensure social distancing.

We are a Direct Supervision Facility. Direct Supervision combines two key elements—the physical design of a jail and an inmate management strategy—to significantly reduce the problem inmate behavior commonly seen in jails.

Direct Supervision jails focus on actively managing inmate behavior to produce a jail that is safe

and secure for inmates, staff, and visitors. Correctional Officers and Civilian staff interact and communicate continuously with inmates in housing units, actively supervising them to identify problems in their early stages. They use basic management techniques to prevent negative behavior and encourage positive behavior. Staff assume control of the jail and establish a professional supervisory relationship with inmates. There are no physical barriers separating staff and inmates in the housing units. The design of the jail supports the management of inmate behavior by reducing physical barriers that impede staff/inmate interaction, by insuring there are clear sight lines into all areas of the housing units, and by incorporating design elements, fixtures, and furnishings that promote positive inmate behavior.

All services, including medicine, meals, spiritual and educational services, library etc. are normally brought to the inmate in their housing unit. All but our smallest housing units have their own recreation yards available only to the inmates in that housing unit. Our two open smaller size units share a recreation yard with another small size unit. These units take turns using the recreation yard..

Usually, Pre-COVID-19, inmates spent most of their day not locked down. They were only locked down during Shift Change which happens 3 times every 24 hours, and Count, which takes place immediately after Shift Change and overnight, starting at 2200 hours through 700 hours and half the unit, either upstairs or downstairs were locked in while the other half ate and cleaned up following their meals. They also spent many hours going to Court, participating in Programs and Groups and working throughout the facility. All of these activities are now stopped.

Since the common room is not big enough for all the inmates to share the space and remain 6 feet apart from others, we have changed our practice to ensure proper social distancing to only allowing 10 inmates out of their cells at a time. This means that 140 inmates throughout the 14 currently occupied housing units are out of their cells most hours of the day, in groups of 10. Currently Housing Unit 1, which is our Female Unit has 18 occupants. These inmates are out their cells every other hour of the day. In more crowded Units, like HU 17, which had 69 inmates on April 24th; inmates may be only out of their cells for approximately 3 hours per day. When inmates are out of their cells, they are sharing the common space with the same 10 inmates as much as possible. They can shower, make phone calls, watch television, read the newspaper or go outside in the unit's recreation yard. Televisions can be tuned to any station that is provided, including news stations and copies of The Washington Post newspaper is provided to every Housing Unit every day for inmate use. Extra reading materials and work packets were added to the units for use since so many other activities are not taking place.

We encourage inmates to maintain spacing of at least 6 feet apart and are only allowing usage to every other telephone to help ensure this spacing. There are 10 to 12 inmate phones in every large housing unit, but they are fastened to the walls 2 – 2 ½ feet apart. Housing Units 11 A and 11B which are half the size of the other Units have 8 phones and much smaller populations. 11A is our Juvenile Unit and has only 9 occupants as of April 24, 2020 and HU11B which is our Special Needs Unit had 18 occupants on April 24, 2020.

By only allowing usage of every other phone, we have done our best to keep the callers 6 feet away from the next caller and because only 10 inmates are out at a time do a variety of things, social distancing is maintained as much as physically possible. Initially, we tried taping

off every other phone, but found that the inmates would tear the tape away and use the phone anyway.

Meals are served to the inmates in their cells. Units with smaller populations have more space to single cell inmates. A cell that is single celled means that only one occupant is assigned to a cell that can be used for two occupants, using bunk beds. In cells with two occupants, we encourage inmates to sleep on their bunk beds head to foot to assist with the 6-foot distancing.

We have provided up-to-date information on COVID-19 to inmates in both written, see flyers and oral form. Inmates also have access to daily newspapers and television news. They have been encouraged to report COVID-19 symptoms to staff as the first sign of illness. As recommended by our Health Department, Nurses visit all inmates and staff in housing units who may have shared space with a positive COVID-19 patient twice every day and talk about possible symptoms and check temperatures.

To promote family unification and mental health, when we discontinued family and friend visitation in the facility, we negotiated with our inmate phone provider to allow every inmate to make three “free” 10-minute phone calls per day. Additional phone calls may also be made at regular cost.

On March 30, 2020 at approximately 1500 hours inmate work details outside of Housing Units were suspended. Staff immediately began performing all work normally done by inmates. This includes meal preparation, distribution and clean-up, sanitation in all common areas trash collection, laundry collections, washing and drying and folding all inmate clothes and linens, distribution of clean laundry, commissary receiving and delivery, landscaping maintenance including outside trash removal and general grounds sanitation duties.

On April 1, 2020, all inmate movement outside of their Housing Units, except for medical purposes, was stopped from within the facility. This has helped with contact tracing and preventing inmate exposure to additional asymptomatic individuals. Inmates are only allowed to move from their assigned housing unit for medical purposes. If an inmate is escorted to the Medical Unit they are masked and kept 6-feet away from staff and other inmates. Unlike in many penal facilities in the Country, in Prince George's County, inmates are never allowed to travel anywhere in the facility outside of their housing unit unless they are escorted by staff.

Unfortunately, we do not have the means to do electronic visiting as of now. It is cost prohibitive, unless the inmate's family pay the fees associated with it and that is a burden we have not wanted to place on families.

We have implemented alternative work arrangements, usually tele-working from home, for all non-essential employees.

We have suspended transfers of inmates to and from other jurisdictions as much as possible. If the transfer is absolutely required, we have a transfer alert package that is sent from our Medical Services to the Medical Services of the receiving agency prior to the transfer to allow the receiving agency to prepare for any possible medical conditions that the detained person may have. We also ask for a transfer Alert including all medical information from any agency transporting inmates to the County.

On March 19, 2020 we set up new procedures for our Initial Housing Units for new intakes. These include keeping inmates in Initial Housing for a minimum of 14 days. A full Physical is completed on every inmate within the first 14 days of their incarceration as required by Maryland Correctional Standards Commission. This physical must be completed prior to any

inmates leaving initial housing. While in the Initial Housing Units the Medical staff monitors the inmate's health twice daily for COVID-19 symptoms and by taking temperatures. Inmates are fed within their cells. Inmate Sanitation Crew cleans and disinfects all hard surfaces twice daily. Inmates are provided with cleaning supplies and encouraged to clean their cells. (See **Housekeeping Policy**) Inmates are encouraged to sleep head to foot on the bunkbeds in the cells. If standing in line for medication, health monitoring and feeding they must stand at least 6 feet apart. If a detainee complains of symptoms or seems sick to the Officer, Medical is contacted immediately. When out of their cells, inmates must wear their masks. Inmates are encouraged to change their clothes and shower regularly. Inmates are encouraged to send their dirty clothes to the laundry and exchanged for clean clothes on a regular basis.

Twice in April 2020, an outside cleaning company has been brought into the jail to deep clean the common areas in all housing units, the medical unit, lobby areas and Officers Dining Room. This process will continue throughout the pandemic and is being done to supplement the regular housekeeping activities and increased cleaning that is encouraged and being done by staff in the kitchen and offices. Diluted bleach spray, Spray 9 and paper towels, as well as the normal mops, and brooms are provided in the housing units for use by inmates and staff. Inmates are provided with cleaning supplies and strongly encouraged to clean their cells daily if not more often. Disinfecting wipes and or diluted bleach in a spray bottle and paper towels are available for inmates to use to clean the telephones between usage. The Medical Unit always uses an outside cleaning company to clean and disinfect the AIIR rooms between usage and provides inmates with cleaning supplies to augment the professional services.

Each inmate receives a medical screening examination, which includes blood pressure, temperature and tuberculosis test upon initial entry to the facility. Within fourteen days they

receive a full physical with either a Physician or a Physician's Assistant. If inmates are diagnosed with a chronic disease, like hypertension, diabetes or heart disease, they are enrolled in a chronic care clinic in which they will see medical professions regularly during their stay in the jail.

Normally, pre-COVID-19, if an inmate was feeling unwell, they may request to see a medical professional by completing a sick call request slip. It is our normal process to charge four dollars for a sick call visit for the initial visit. If the inmate needs to see a doctor for a follow-up visit for the same issue, or if the doctor requests to see the inmate there is no charge for the visit. Indigent inmates are always treated without charge. Part of the reason that there is a charge to the inmate is to attempt to eliminate unnecessary visits that strain the system and could possibly allow contact with other inmates that the Court has ordered to keep separate. Unfortunately, some inmates try to "work the system" in this way.

We have not charged inmates for visits relating to COVID-19. This information may not have been shared with our entire inmate population but will be shared with them on April 27, 2020. Inmates are never charged when a medical professional or staff member make the referral, for example after a fight, accident, emergency or when a staff member thinks that the inmate may be unwell because of actions or symptoms. The inmate handbook clearly states that there is no fee for emergency medical services, and my interpretation of that includes all COVID-19 related visits and care.

As of April 24, 2020, we have had 18 inmates who have tested positive for COVID-19 since the first case on March 30, 2020. Currently no test results are pending. All 18 have relatively minor cases of the virus. Nine of them have completely recovered and have returned to their Housing Units after spending at least 14 days without symptoms in medical isolation. No

cases have been acute or required hospitalization. We have not seen a surge in cases or an exponential increase in numbers. I believe that this is true partly because of the care and attention we have given to preparation and mitigation of the virus.

Twenty-eight (28) staff members have tested positive for COVID-19, 25 Officers and 3 Civilians. Nine of the staff members have fully recovered and returned to work. Several more staff are expected to be cleared by their doctors to return to work in the next week. In consultation with the Health Department we have asked staff to be symptom free for a minimum of fourteen days, prior to returning to work. The CDC guideline recommends symptom free for seven days. No one has been acutely ill. After the first case of COVID-19 was identified in the Jail on March 30, 2020, I sent a memo to all staff explaining what had happened and how our actions would now turn from preparation to mitigation. I also videotaped a message to staff on the same topic, urging them to take additional precautions. Communications staff in the Office of the County Executive issued a press release when the first case was diagnosed and has been completely transparent with the press about the virus and the jail.

I believe that under my leadership the Prince George's County Department of Corrections prepared for the potential introduction, spread and mitigation of COVID-19 in our facility to the best of its ability. The health and safety of the inmates under my custody and the staff under my responsibility is of great importance to me. I believe that we have done everything that we were capable of to prepare and respond to this unprecedented health event.

.....

I SOLEMNLY SWEAR AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND BASED UPON MY PERSONAL KNOWLEDGE AND THE KNOWLEDGE OF THE COUNTY CORRECTIONAL FACILITY.

A handwritten signature in blue ink, reading "Mary Lou McDonough", is enclosed within a rectangular box. The signature is written in a cursive, flowing style.

Mary Lou McDonough

April 25, 2020

Date

**PRINCE GEORGE'S COUNTY
DEPARTMENT OF CORRECTIONS
BUREAU OF OPERATIONS
POPULATION MANAGEMENT DIVISION**

May 18, 2020

AFFIDAVIT BY JEFF LOGAN, CHIEF OF POPULATION MANAGEMENT

Referencing Civil Action No. 8:20-cv-01028-PHX

As the Division Chief of the Population Management Division for the Prince George's County Department of Corrections (PGCDC) and having functioned in that capacity and position for over 10 years, I am responding with and from an abundance of knowledge regarding how the PGCDC's Pretrial Release program intricately works.

Plaintiffs make several allegations and assumptions in their "Motion to Supplement the Record" and accompanying affidavit by Assistant Public Defender Claire Glenn. Subsequent to that filing, Plaintiffs provided a "List of Detainees Approved or Ordered Released" dated May 13, 2020 ("May 13th List") which my division has reviewed and researched. I will respond to how the Population Management Division researched and compiled responses to the May 13th List, which is attached herein as **Attachment A**.

How Respondent Compiled its Responses to Plaintiffs' May 13th List:

1. All criminal defendants listed by the Plaintiff ("Listed Defendants") were identified utilizing the PGCDC's computer database known as the Offender Management System (OMS). Each defendant's name was checked to determine the following:
 - a) Name
 - b) Case Number(s)
 - c) Charge(s)
 - d) Bond Amount(s), if any
 - e) Warrant(s)-open, pending, and or served
 - f) "Comments" Field for status updates to include judge's comments, bond hearing or other court docket entries input by PGCDC Records Paralegals, and Population Management supervisors' coded comments
 - g) Mental Health and/or Medical Health information
 - h) Pretrial release status (for all Prince George's County cases for which the defendant is currently committed to PGCDC)
 - i) Whether pretrial release was ordered or authorized by the presiding judge.
2. PGCDC requires specific information that must be collected in a prescreening interview with a defendant and verified prior to any defendant's release on Pretrial Release Level IV:
 - a. Non-violent offense (unless otherwise ordered or approved by PGCDC)

- b. Inmate's identity, address and telephone number;
- c. Full criminal history check to ensure no open warrants, detainers or pending charges (other than the intake case, and that all pending cases allow pretrial release);
- d. Residence in Prince George's County, MD;
- e. Employment/school address and schedule;
- f. Have and maintain an operable telephone;
- g. Ability to reside with a cooperative family member willing to accept program rules;
- h. Be employed or willing to participate in full-time employment, education and/or training;
- i. References to establish community ties;
- j. Employment history;
- k. Past and present substance usage and abuse;
- l. Medical information (for any medication compliance requirements);
- m. Any other conditions ordered by the court, such as victim contacts, social media information, internet access, .etc.)

This process is outlined in PGCDOC Policy and Procedure 20.3 Pre-Trial Investigation Services. **See Attachment B.** Once PGCDOC determines that a defendant who has been ordered to pretrial release cannot satisfy one or more of these criteria, PGCDOC informs the court that issued the order for pretrial release ("the issuing court") and awaits further instructions. This information is required in order to determine the proper parameters of electronic monitoring for each individual defendant. Without proper home address verification, for example, GPS monitoring of a defendant's location would be meaningless, especially if there are stay-away orders or restrictions on activity. The time it takes to obtain this information can vary for each defendant, as it is based on the amount of time responses are received from external sources and involved individuals, such as employers and alleged victims.

- 3. All Listed Defendants were checked for all possible issues that needed to be investigated, mitigated, or reviewed prior to any status being recorded or defendant being released or coded that s/he can't be released at current time. Some of the issues that may affect a defendant's release are:
 - a. Contacting the victim(s);
 - b. Verifying an address;
 - c. Verifying a Prince George's County address of residency. This is important because we have field investigators that check on clients (defendants) released on Level 4 Supervision, either on Electronic Monitoring ("EM") or Home Detention for County-sentenced defendants ("HD"). A home address is essential for both EM and HD.

The courts have entrusted the PGCDOC's alternative to incarceration programs, as far as EM and HD are concerned, to check on these defendants at least three (3) times per week at their respective Prince George's County residence, school, and/or place of employment.

4. Criminal defense attorneys have often contacted PGCDOC in order to ask about the status of his/her client's pretrial release. **See Attachment C - Typical Email Communication with Defense Attorney.** Generally, in cases where there is confusion or disagreement with a defendant's criminal defense attorney about a defendant's pretrial release conditions, the attorney would contact the court for clarification or intervention.
5. As of the date of this Affidavit, PGCDOC has 151 defendants on EM and HD and 120 defendants being monitored on Levels II and III. Currently, the aggregate is 271.
6. All Listed Defendants were also cross-referenced with the population list being maintained in the Monitoring Service Unit which records statuses for defendants being considered for either EM or HD. It is important to note that the court status of any of these defendants can change from day to day or week to week, month-to-month. The Unit attempts to verify all information to work towards releasing a defendant, but there are circumstances the Unit cannot control, such as a victim's reactions to potential release, family members/friends who are hesitant or reluctant to allow a defendant to live with them, stipulations that can't be successfully implemented or monitored (for instance-"Release Defendant but s/he is to have no contact with anyone in the community under the age of 18" or "no access to any Internet device or the Internet," etc.). While PGCDOC continuously works to obtain and verify information, screening any defendant for pretrial release can take anywhere from a few days to a few weeks, even with assistance from defense attorneys to find new friends or family to approach or alternate contact information when initial information is not successfully verified.
7. All Listed Defendants who had court statuses that needed updates were cross-referenced with information from OMS, the courts, CAPS (Court Applications Portal), and Maryland Case Search.
8. Only Listed Defendants who had open warrants had their Records Base File reviewed to determine if the warrant is valid, extraditable, and if the jurisdiction wants to have custody of the defendant once s/he finishes all pending Prince George's County charges.
9. No Listed Defendants were released due to the Plaintiff's lawsuit or May 13th list. Any defendants that were released or held in custody were effectuated as a part of the PGCDOC's adherence to court orders, its routine operational policy and procedures governing custody, alternatives to incarceration, and release to either maintain custodial care of all defendants committed to the PCCDOC based on a court officer or other public safety agency, or conversely, a court officer or other public safety agency submitting a "Release" to the PGCDOC, resulting in the PGCDOC relinquishing custody of said defendant.

Professional Observations about the Plaintiff's Complaint and May 13th List

The Plaintiffs, by Ms. Claire Glenn's representations throughout her Affidavit (ECF 61-1), and the May 13^e List, continues to use **misleading** phrases, such as "...approved for release...". The PGCDOC receives court status updates on defendants from each court hearing, where the judge has determined:

- the defendant will not be granted the "option" (or "authorization") of pretrial release;
- the defendant is granted the "option" of pretrial release (Supervision Level is sometimes established by the judge, but otherwise left to the discretion of the PGCDOC); or
- the judge has ordered the defendant released on [a pre-determined level of] pretrial supervision.

Even if a defendant is court-ordered for pretrial release, PGCDOC must ensure that its Electronic Monitoring criteria, as well as any additional criteria set by the court, are met prior to release in order to properly effectuate electronic monitoring. Pretrial release is conditional on meeting those criteria. This has been the practice for decades. The Courts are aware of this, as are criminal defense counsel. If defense counsel disagrees with the Unit's application of release criteria or contests its findings, they will seek court intervention. If an inmate ordered to pre-trial release does not qualify for it, the Court is notified and may then order the release anyway or revisit the inmate's bond status.

The PGCDOC Community Supervision staff work exhaustively, attempting to find reasonable ways to effectuate releasing defendants, not the opposite.

Countless human-resource allocation has gone into researching each of these defendants on the May 13th List. In most cases, it has impeded our staff's ability to actually work on cases to facilitate pretrial release (i.e. analysis, review, follow-up with other public safety agencies, defendant's victim(s), family members, trying to obtain a viable address, working with Mental Health Court and other external psychological services providers attempting to get these defendants critical care and assistance etc.).

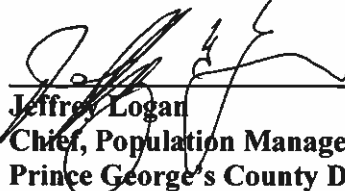
Warrants-Warrant Service Etc.

The PGCDOC has not changed its procedures for serving and or servicing of warrants for defendants held in its custodial care. Ms. Glenn states that the PGCDOC's serving and or servicing of warrants has impeded defendants being released through pretrial services. There are times that open warrants and detainers do hold up a defendant's release because case managers have to ensure whether the warrant is still valid, and if the public safety agency that filed the warrant is willing to extradite the defendant to their jurisdiction, etc.

Conclusion

On its face, as stated in my first and current Affidavits, the Ms. Glenn's affidavit paints a picture that the PGCDOC is going out of its way not to release defendants, regardless of whether they have been granted the option of pretrial release and/or Home Detention, court-ordered or not. However, I can unequivocally state the PGCDOC's entire community supervision program is accomplishing the antithesis of what the Plaintiffs are alleging. PGCDOC follows all court orders and instructions in effectuating the pretrial release of inmates.

I SOLEMNLY AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE CONTENTS OF THE FOREGOING AFFIDAVIT ARE TRUE AND BASED UPON PERSONAL KNOWLEDGE.

 5/18/20 @ 8 28 PM

Jeffrey Logan
Chief, Population Management Division
Prince George's County Department of Corrections

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**

KEITH SETH, et al.,)
Individually and on behalf of a class of))
similarly situated persons,))
))
Plaintiffs,))
) **Case No. 8:20-cv-01028-PX**
v.))
))
MARY LOU MCDONOUGH,))
In her official capacity as Director of))
the Prince George's County Department))
of Corrections,))
))
Defendant.))

DECLARATION OF MESKEREM ASRESAHEGN, M.D.

I, MESKEREM ARESAHEGN, M.D., pursuant to 28 U.S.C. § 1746, hereby make the following Declaration under penalty of perjury, declare that the statements made below are true, and state:

1. My name is Meskerem Asresahegn, M.D. I am over the age of nineteen (19) years and have personal knowledge of the information contained in this Declaration.

2. I have been licensed to practice medicine in the State of Maryland since 1998. I am board certified in internal medicine. Since approximately February 2000, I have served as the Site Medical Director on the medical staff for the Prince George's County (Maryland) Jail (the "Jail"). Corizon, LLC ("Corizon") contracts

with Prince George's County, Maryland to provide medical services to patients housed at the Jail.

3. As the Jail's Medical Director, I fulfill a variety of roles and responsibilities. My duties include providing care to my patients within the Jail; supervising the care provided by other members of the medical staff; and implementing the clinical guidelines issued by Corizon's corporate office tailored to the specific characteristics and needs of the Jail's patient population. Although I am not responsible for supervising the Jail's medical staff from an administrative standpoint, I provide clinical input on administrative procedures at the Jail which touch upon the delivery of medical services.

4. I reviewed a copy of the Plaintiffs' Complaint in this matter. It appears to me from my review of the Complaint that the Plaintiffs claim that they and other inmates are exposed to an unnecessary health risk from COVID-19. Plaintiffs assert that this alleged risk results from improper screening and isolation procedures, as well as inadequate medical care for the inmates, including those patients with COVID-19. Plaintiffs also contend that the members of the Jail's medical staff failed to implement the recommendations in the Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("CDC's Guidance") issued by the United States Centers for Disease Control and Prevention ("CDC") on March 23, 2020. Based upon my personal observations, my

professional knowledge, training, and experience, and currently accepted information from medical scholarship, Plaintiffs' allegations fail to acknowledge the current circumstances within the Jail and the comprehensive efforts made by both Jail security and medical staff to implement necessary measures for the protection of our patients and the inmate population in general.

5. Contrary to Plaintiffs' representations, our patients (pretrial and post-trial detainees) at the Jail continue to receive appropriate medical care and do not face the same threat posed to the public by COVID-19. The Jail's security and medical staffs continue to work tirelessly to prevent the spread of COVID-19 within the Jail and to provide appropriate care to those who need medical attention. Thanks to these efforts, none of our patients within the Jail have required hospitalization, respiratory assistance, or suffered any fatal condition as a result of COVID-19. In fact, as of April 24, 2020, only eighteen (18) patients at the Jail had tested positive for COVID-19 (over a four (4) week period) out of a total potential patient population of approximately 565 inmates. Currently, each patient with COVID-19 is medically isolated from the inmate population.

6. This Declaration is intended to enumerate, to the best of my ability, the efforts of the medical staff at the Jail, to address the on-going COVID-19 pandemic. Since the pandemic began, I have been employed on a full-time basis, providing medical care to my patients at the Jail and instructing our medical staff on the best

practices to protect themselves, our patients, and the other Jail staff and persons in the prevailing strategies in the prevention and management of COVID-19 infections. I have personally witnessed all of these efforts described in this Declaration. Our staff has devoted hours on this Court's emergency request to identify documents reflecting our efforts in this crisis. Despite these efforts at identifying documents evidencing all of the measures implemented inside the Jail, the documents submitted by our medical staff to the Court only constitute the small portion of the total universe of relevant evidence that we could gather in the brief time permitted.

7. While this Declaration records the collective efforts of the medical staff within the Jail, I believe it is also important to understand that I have seen members of our staff providing compassionate care and changing the behavior and activities of the inmate population to prevent and manage the spread of COVID-19. For example, I personally witnessed our administration ensuring the availability of soap and disinfectant (which has not run short or otherwise been unavailable during the past three (3) months) and providing it. I personally witnessed medical staff increasing the frequency of handwashing, increasing the frequency of sanitation of common work areas and examination space, reducing personal interactions, and properly using gloves and other personal protective equipment ("PPE"). Our staffs' preventative and management efforts within the Jail, coupled with their precautionary efforts outside of the facility, are allowing the Jail to "flatten the

curve” associated with COVID-19 and protect those persons within the Jail. I personally remained in near quarantine conditions throughout this pandemic to ensure the safety of our staff and my patients. It would be impossible for me to enumerate in this Declaration all of the individual measures undertaken by each Corizon staff member to provide the best environment possible for our patients.

8. Mary Lou McDonough (“Director McDonough”), who supervises the Jail as Director of the Prince George’s County Department of Corrections, and Corizon’s clinical leaders initiated proactive measures to limit the spread of COVID-19 into the Jail well before the first positive case was reported in Maryland. On January 28, 2020, Dr. James Powell, Corizon’s Chief Medical Officer, issued a memorandum to Corizon’s regional medical directors regarding the emergence of COVID-19 in the United States. (See Jan. 28, 2020 Memo., attached hereto as Exhibit A). I received a copy of Dr. Powell’s January 28, 2020, Memorandum from my supervisor – Corizon’s regional medical director. Dr. Powell encouraged clinicians to work with the security staff at their facilities to develop and implement appropriate screening and preventive measures to combat COVID-19 at their facilities. (Id.). He specifically advised the medical staffs to implement a newly developed screening tool to assess patients during the intake process for symptoms of COVID-19. (Id.).

9. In early February 2020 (i.e. weeks before pandemic measures began in the general public), members of our medical staff began collaborating with Jail security leadership to develop a plan to combat COVID-19 at the Jail. On February 3, 2020, members of the medical staff shared with Director McDonough an update from Corizon's regional medical director regarding COVID-19. (See Coronavirus Update 2020, attached hereto as Exhibit B). The update summarized key measures for preventing the spread of the COVID-19. (Id.). Furthermore, with the support of Director McDonough, the Jail's medical staff began utilizing the COVID-19 intake screening form on February 5, 2020. (See Feb. 5, 2020 Email, attached hereto as Exhibit C). The COVID-19 intake screening tool supplemented the existing screening tools utilized by members of the medical staff during the intake process. (See Intake Forms, attached hereto as Exhibit D).

10. Members of the leadership teams for the Jail's medical and security staff met on February 27, 2020, to further discuss preparations for potential COVID-19 infections within the potential patient population. (See Feb. 27, 2020 MAC Mtg. Minutes, attached hereto as Exhibit E). I led the February 27, 2020, meeting and can attest that Director McDonough attended the meeting. (Id.). Although no confirmed cases of COVID-19 had appeared in Maryland at that time, the leaders of the medical and security staffs recognized the need to continue and broaden measures to reduce the risk of the virus entering the Jail. (Id.). The measures

discussed during the February 27 meeting included social distancing measures within the Jail, use of PPE, screening measures, and medical isolation of patients presenting with symptoms consistent with COVID-19. (Id.). Members of the medical staff related that they would begin conducting twice-daily temperature checks of the inmates in Housing Unit 1 (at that time, the housing unit for females) and Housing Unit 8 (the intake) at the Jail. (Id.). The February 27 meeting included a discussion of informational sheets for posting in prominent locations in the Jail, including in the health care unit and the housing units. (Id.).

11. Director McDonough also issued a memorandum on February 27, 2020, to all employees of the Prince George's County Department of Corrections. (See Feb. 27, 2020 Memo., attached hereto as Exhibit F). As the Jail's Medical Director, I received and reviewed a copy of the February 27 memorandum. Director McDonough warned that the CDC had declared COVID-19 to be a pandemic. (Id.). She urged the members of the Jail's staff to maintain good practices to prevent the spread of the virus, including following the CDC's recommendations. (Id.).

12. On February 27, 2020, Director McDonough also ordered that informational posters regarding COVID-19 provided by Prince George's County Public Health Department be posted throughout the Jail, including in all housing units. (Id.; see also Poster, attached hereto as Exhibit G). As I can attest from having seen copies of the poster in the facility, the Jail's staff placed this poster every

housing unit within the Jail, (id.), as well as a variety of similar informational posters in the health care unit. (See collection of informational posters, attached hereto as Exhibit H). The posters provide information to the persons living and working within the Jail regarding signs of COVID-19 to look for and how to seek medical care. (Id.). Other informational sheets provide guidance to our patients and members of the security and medical staffs regarding procedures for preventing the spread of COVID-19 within the Jail and providing care for the inmates. (Id.). The CDC recommends using such posters to keep persons living and working within the Jail informed about COVID-19 and appropriate preventive practices.

13. Other preventive measures instituted by Director McDonough included medical screening for all staff and visitors entering the Jail. Anyone entering the Jail must undergo a temperature check before proceeding past the lobby. I have undergone these temperature checks on a daily basis upon my arrival at the Jail. If anyone attempting to enter the Jail displays a temperature above 100.4 degrees, the Jail's staff instructs them to leave the facility until they obtain a medical clearance. Such daily temperature checks for anyone entering the facility are consistent with the CDC's Guidance.

14. To date, no member of Corizon's staff has been sent home due to an elevated temperature. One member of the nursing staff imposed a self-quarantine after reporting possible exposure to COVID-19, but, upon completion of the CDC-

hereto as Exhibit K). In memoranda reviewed by me dated March 24 and March 27, 2020, Dr. Powell urged Corizon's clinicians to closely review the CDC's Guidance. (See Mar. 24, 2020 Memo., attached hereto as Exhibit L; Mar. 27, 2020 Memo., attached hereto as Exhibit M). Upon receipt and review of Dr. Powell's recommendations, the Jail medical staff immediately began evaluating our internal processes and procedures to ensure compliance with these recommendations. We tailored the implementation to the particular characteristics of the Jail and its population, specifically following the CDC's Guidance that its recommendations **"may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions."** (Ex. K at 1).

19. The Jail's medical and security staffs implemented additional measures to bring the facility into further compliance with the CDC's Guidance. Director McDonough led the way in revising the Jail's intake practices to more fully comply with the Guidance. For example, Director McDonough revised how long inmates must remain in the intake housing unit upon their arrival at the Jail. Previously, they would remain in the intake housing unit for only three (3) days. However, new intakes now must remain in the housing unit for fourteen (14) days following intake to verify whether they have COVID-19. This change reflects the recommendations provided by the CDC.

20. Furthermore, members of the Jail's nursing staff continued complying with the instruction of Director McDonough and other members of the executive team for the Jail's medical and security staffs with respect to temperature checks in the intake housing unit. Members of the nursing staff continued conducting twice-daily temperature checks in the housing unit where new members of the population reside after intake. The intake housing unit contains approximately sixty (60) beds. As I can attest from personal observation, the temperature checks continue to occur, beginning at approximately 9 a.m. and 5 p.m. each day.

21. Director McDonough also revised how long inmates must remain in the intake housing unit upon their arrival at the Jail. Previously, they remained in the intake housing unit for only three (3) days. However, new intakes now must remain in the housing unit for fourteen (14) days following intake to verify whether they have COVID-19. This change reflects the recommendations provided by the CDC.

22. Consistent with the CDC's recommendations and a March 31, 2020, guideline provided by Dr. Powell, the Jail's medical staff disseminated patient information sheets regarding COVID-19 throughout the Jail. (See Mar. 31, 2020 Memo., attached hereto as Exhibit N). Copies of the patient information sheets are attached hereto as Exhibit O. Initially, the Jail's medical staff printed hundreds of copies of the information sheets and placed them in key locations in the Jail, including the health care unit. The medical staff also instituted a practice of

providing the information sheets during the intake process, and patients must sign a statement acknowledging their receipt of the information sheets. (See acknowledgement statement, attached hereto as Exhibit P). The practice of providing information sheets during the intake process continues to this day.

23. Despite the precautions implemented at the Jail, the Jail's medical staff confirmed the first patient testing positive for COVID-19 on March 28, 2020. (The patient underwent testing on March 27.) After members of the medical staff detected symptoms indicating this patient might be positive for COVID-19, the staff tested her for COVID-19 and isolated her in a negative air flow cell. The Jail contains twelve (12) negative air flow cells used for medical isolation. These cells are located in the health care unit's infirmary. The infirmary also includes sixteen (16) infirmary beds in addition to the negative air flow cells.

24. Consistent with the CDC's Guidance for medical personnel to collaborate with state and local public health officials, I initiated communication with officials in Prince George's County Public Health Department following the first patient testing positive for COVID-19 at the Jail. These communications continued since that time. Nearly every day I speak by telephone with the infection control coordinator in the Public Health Department seeking input and collaborating regarding the Jail's procedures related to medical isolation, screening, treatment, prevention, and other issues related to COVID-19.

25. Relying on guidelines provided by Corizon's clinical leaders in the corporate office and the CDC's Guidance, the medical staff implemented criteria for determining when to test patients for COVID-19. If a patient's temperature measures above 100.4 degrees, the medical staff will request for the patient to be brought to the health care unit. Once the patient arrives in the unit, the medical staff will check the patient's temperature a second time and assess the patient's symptoms. If the patient exhibits symptoms consistent with COVID-19, such as fever, coughing, and shortness of breath, the medical staff will administer a test and isolate the inmate. When members of the Jail's medical staff first began testing patients for COVID-19, it took approximately three (3) to four (4) days to receive the test results. However, with improvements in the testing, the medical staff now will typically get the results within forty-eight (48) hours.

26. The procedures implemented by the Jail's medical staff require the patient to remain in medical isolation pending the test results. If the test results are negative, the patient returns to his or her housing unit. If the test results are positive, the patient will remain isolated for fourteen (14) days to ensure the patient does not remain contagious, even though he or she might be asymptomatic. Consistent with the CDC's Guidance, all patients in medical isolation are required to wear masks.

27. Patients receive access to medical care throughout their time in medical isolation. Members of the Jail's nursing staff round on the patients in medical

isolation multiple times a day to check on their status. Nurses will also check the inmates' vital signs multiple times a day to assess for any changes in their condition. Medical providers also provide care for the patients in medical isolation as necessary. Furthermore, the patients in the negative air flow cells are located in the health care unit, and therefore have ready access to the members of the medical staff. Significantly, no patient at the Jail with COVID-19 has required transportation to an off-site facility for medical care related to COVID-19.

28. I and other leaders on the Jail's medical and security staff recognized that the twelve (12) negative air flow cells be inadequate for the number of patients who required isolation if we identified a large number of patients with COVID-19. Notably, the CDC's Guidance recognized that cohorting (or grouping) of positive patients or those awaiting test results might provide an appropriate measure at facilities which cannot provide separate isolation cells for every patient requiring isolation. Cohorting is the practice of housing small groups of individuals in isolation in a common area. I worked with other leaders on the Jail's medical and security staffs, as well as officials with Prince George's County Public Health Department, to develop a cohorting plan as a contingency if we encountered a scenario where we assigned a patient to every negative air flow cells and required additional quarantine space. We identified an empty housing unit with single-bed cells, previously used for restrictive housing, as an overflow medical isolation unit

for the Jail. However, the medical staff will only assign patients to this overflow isolation unit if they remain asymptomatic and reached approximately the seventh day of their isolation. To be clear, members of the Jail's security staff bring meals to the patients in medical isolation, regardless of whether they are in the negative air flow cells or in the overflow unit. In light of the restrictions on internal patient movement instituted by Director McDonough, I do not currently anticipate that it will be necessary to use the overflow isolation unit.

29. If a patient tests positive for COVID-19, members of the nursing staff will institute twice-daily temperature checks for the other patients in the unit where the positive patient had been housed. I have personally observed the nurses conducting these temperature checks in the housing units. The Jail's medical staff instituted this procedure of twice-daily temperature checks without undue delay after the first patient tested positive for COVID-19. The selection of temperature-check logs attached to my Declaration as Exhibit Q reflects the thoroughness of the temperature checks in the housing units. Contrary to Plaintiffs' allegations, I am not aware of any instances of nurses failing to clean the thermometers between checks. The nurses utilize infrared thermometers for the checks, and thus cleaning the instrument between checks is not necessary because the nurses are wearing PPE and the patients do not touch the thermometers.

30. In short, I dispute and deny Plaintiffs' allegations that the members of the Jail's medical staff are indifferent to the condition of the inmates, including any indifference to the possibility that a patient might contract COVID-19. Under the leadership provided by Director McDonough and the clinical leadership in Corizon's corporate and regional offices,¹ the members of the Jail's medical and security staff took an aggressive approach in implementing measures to combat the spread of COVID-19 within the Jail. In a variety of aspects, the staff working at the Jail implemented preventive measures which *anticipated* the recommendations in the CDC's Guidance. Furthermore, as outlined in this Declaration, the members of the Jail's medical and security staffs appropriately implemented the CDC's Guidance, tailored to the characteristics of the Jail and the patient population. In my professional judgment, any allegation that the patients housed at the Jail, including those who have tested positive for COVID-19, are not receiving access to appropriate monitoring, medical treatment, and care is false.

31. **Patients with Significant Medical Conditions.** I understand that Plaintiffs requested information regarding patients who are "medically vulnerable." It remains unclear to me how Plaintiffs define that term. However, I identify below

¹ For the sake of brevity, this Declaration does not detail every single guideline or memoranda issued by Dr. Powell reviewed by me for appropriate implementation at the Jail. Suffice to say, I reviewed the Declaration submitted by Dr. Powell in this matter, including the exhibits attached to his Declaration. The exhibits attached to Dr. Powell's Declaration accurately reflect the clinical guidelines provided by him and implemented by me with respect to the procedures in place at the Jail.

certain patients with chronic medical conditions. (For privacy considerations, I only identify the patients by their initials. It is my understanding that the attorneys for Director McDonough will be able to provide a key for their names once adequate protections are in place.) In doing so, I am not suggesting in any manner whatsoever that these patients are exposed to a dangerous, elevated, or unnecessary risk to their health by remaining housed at the Jail.

Patient Name	Medical Condition(s)
C.O.	Hypertension
M.E.	Pregnant
J.L.	Emphysema, chronic kidney disease
A.T.	Diabetes
K.B.	Hypertension, diabetes
K.B.	Hypertension, enlarged prostate
W.G.	Hypertension, asthma, enlarged prostate
C.M.	Hypertension, congestive heart failure
A.S.	Hypertension, asthma
R.R.	Asthma
F.A.	HIV
M.V.	HIV
C.W.	Hypertension, diabetes
SN.	Hypertension, deep vein thrombosis
J.N.	Hypertension
C.C.	Hypertension, enlarged prostate
J.M.	Hypertension
J.R.	Hypertension
Q.P.	Hypertension, gout, sleep apnea
M.W.	Hypertension
M.R.	Diabetes, hyperlipidemia
M.S.	Hypertension, GERD
J.W.	Asthma, seizure

32. It is my understanding that the Court directed Director McDonough to provide certain categories of information relating to the care provided to the Jail's patients regarding COVID-19. To the extent that my Declaration did not provide this information above, I outline below additional information responsive to the Court's directive:

33. **Testing.** I understand that the Court requested certain information related to testing for COVID-19 conducted at the Jail. As of April 24, 2020, the members of the Jail's medical staff had tested twenty (20) patients for COVID-19. Eighteen (18) of those patients tested positive, and two (2) patients were negative for COVID-19. The Jail's medical staff had retained a supply of twenty (20) testing kits as of April 24, 2020. Information regarding the number of tests administered per day since March 1, 2020, is set forth below:

Date	Number of Tests	Results
March 27	1	Positive
March 30	2	Both positive
March 31	1	Positive
April 2	2	Both positive
April 3	3	2 positive, 1 negative
April 4	2	Both positive
April 6	2	Both positive
April 7	1	Positive
April 8	1	Negative
April 9	1	Positive
April 13	2	Both positive
April 14	1	Positive

April 20	1	Positive
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34. **Sick Call.** A patient initiates the sick call process by placing a sick call request slip in one of the various sick call boxes located at the Jail or by handing a slip to a member of the medical or security staff. To the extent that a patient requires medical care on an urgent basis, a patient may make an oral request to a member of the medical or security staff at any point in time. The members of the Jail's medical staff will respond to an urgent need for medical care without undue delay upon learning of the need for care and provide appropriate attention. As a general matter, a registered nurse (RN) on the nursing staff will triage written sick call requests within twenty-four (24) hours. A member of the nursing staff will inform the relevant members of the security staff who needs to be seen for sick call, and the security staff will bring those patients to the health care unit. As a general matter, a member of the Jail's medical staff will see and, as necessary, begin treating a patient within forty-eight (48) hours after the nurse triaged the sick call request slip, or more quickly for urgent needs. Similar to what the medical industry experienced in society at large, the number of routine requests for medical care unrelated to COVID-19 dropped precipitously in the last several weeks. However, the members of the Jail's medical staff continue to provide care to patients unrelated to COVID-19, including referring patients off site to see specialists or for care on an emergency basis, as necessary.

35. **Medical Copays.** As a general matter, a patient seeking non-urgent medical care must pay a \$4.00 copay to the extent the patient is able to provide this payment. However, the Jail's medical staff will provide necessary care to a patient regardless of whether the patient can afford to pay the copay. The RN conducting sick call determines whether a copay applies with respect to particular requests for medical care. The members of the Jail's security staff oversee the administrative process of charging an inmate's account at the Jail for a copay. Furthermore, on Monday, April 20, 2020, Director McDonough directed that patients suspected of being positive with COVID-19 would not be charged a copay for any medical care related to COVID-19.

36. **Medical Records.** The Jail's medical staff maintains the inmates' medical records in electronic format through the support of an outside vendor. I understand that any third party seeking access to the inmates' medical records would need to provide a release pursuant to the Health Insurance Portability and Accountability Act of 1996, i.e. a HIPAA release.

I declare under penalty of perjury that the foregoing is true and correct. I understand that a false statement in this Declaration will subject me to penalties for perjury.

Date: 4/25/20


Meskerem Asresahegn, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

KEITH SETH, *et al*

Plaintiffs

v.

MARY LOU MCDONOUGH

Defendant

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Case No. 8:20-cv-01028-PX

**DIRECTOR MARY LOU MCDONOUGH'S
FIVE DAY RESPONSE TO THE COURT'S MAY 21, 2020 ORDER**

Defendant Mary Lou McDonough, in her official capacity as Director of the Prince George's County Department of Corrections ("Director McDonough"), submits this Response to the Court's May 21, 2020 Order (ECF 85, the "Order") granting in part and denying in part Plaintiff's Motion for a Temporary Restraining Order and Preliminary Injunction (ECF 3-1).¹ This Response is meant to provide the submission of information required by the Order's five day deadline.

¹ Director McDonough expressly preserves any and all objections to the Court's Order and Memorandum Opinion (ECF 84, 85), and nothing in this Response shall be construed as an admission by or a waiver of any objection Director McDonough may have to the Order and Memorandum Opinion. Nothing in this Response shall be construed as an admission of any kind by Director McDonough that the provision of medical care or any other condition of confinement relating to detainees at the Jail is unconstitutional or deficient in any way. Furthermore, nothing in this Response shall be construed as an admission of any kind by Director McDonough that the measures, processes, procedures, and/or policies described and/or referenced in this Response reflect the constitutionally minimum standards of care for detainees at the Jail. In fact, the measures, processes, procedures, and/or policies described and/or referenced in this Response far exceed the minimum standards of care and conditions of confinement required by the United States Constitution.

INTRODUCTION

Director McDonough continues to work diligently to combat the spread of the novel Coronavirus Disease 2019 (“COVID-19”) in the Prince George’s County Department of Corrections (“the Jail” or “PGCDOC”). Director McDonough, her correctional officers, and medical services staff, remain committed to the effort to protect the detainees housed at the Jail from COVID-19 and provide appropriate medical care to the detainees, including those detainees at “‘high risk’ for suffering adverse outcomes if infected with COVID-19.”² (ECF 85 at 1). Director McDonough’s efforts continue to evolve as the United States Centers for Disease Control and Prevention (“CDC”) continues to provide additional information and guidance on prevention and control of the disease. Nevertheless, Director McDonough and the Jail’s medical services contractor, Corizon, LLC (“Corizon”), have invested and will continue to dedicate enormous resources and invest thoughtful analysis in the Jail’s ongoing strategy for protecting detainees at the Jail from the COVID-19 pandemic.

Director McDonough worked diligently with her staff and the members of the leadership on the Jail’s medical staff to draft a response to the Court’s directive in the Order for a “plan or protocol” addressing various aspects of the Jail’s efforts to combat the COVID-19 pandemic. This Response reflects Director McDonough’s best effort to understand and respond to the Court’s directive. However, the Order remains ambiguous, confusing, and seemingly inconsistent with current circumstances at the Jail in a variety of respects. For example, and as discussed in more detail below, certain criteria in the Order’s definition of “high risk detainees” remains confusing

² For the sake of consistency with the Court’s terminology, the term “high risk detainee” in this Response refers to the Order’s definition of this term. (ECF 85 at 1). For the reasons set forth below, the definition of “high risk” set forth in the Order remains ambiguous and confusing for a variety of reasons.

and ambiguous. As another example, the directive to submit a plan “address[ing] training, education, and supervision of [the Jail’s medical and security staff] on ... rendering timely medical care to such detainees ... [and] improving Sick Call response time for COVID-19 symptomatic detainees” remains unclear to Director McDonough. *Id* at 2. Director McDonough responds to the Court’s Order based on her understanding of the Order but reserves the right to revise her response in light of further clarification.

This Response provides a comprehensive picture of the ongoing efforts by the Jail’s medical and security staffs to respond to the COVID-19 pandemic in light of the evolving understanding the disease. As set forth more fully below, the Response outlines the following areas with respect to Director McDonough’s plan for continuing to combat COVID-19 at the Jail:

- (1) Director McDonough and her medical services leadership team will continue to ensure the appropriate identification, monitoring, treatment, and housing of “high risk detainees”;
- (2) Director McDonough and her medical services leadership team will ensure the continued “training, education, and supervision” related to the identification of detainees with symptoms of COVID-19 and medical care for symptoms of COVID-19; and
- (3) Director McDonough, with the assistance of Corizon, will continue testing for COVID-19 and isolating COVID-19 positive detainees and symptomatic detainees as necessary.

As confirmed in this Response, Director McDonough and the members of the Jail’s security and medical staffs continue to employ aggressive, comprehensive measures to combat the COVID-19 pandemic.

DIRECTOR McDONOUGH’S RESPONSE

I. DIRECTOR McDONOUGH WILL CONTINUE TO ENSURE THE APPROPRIATE IDENTIFICATION, MONITORING, TREATMENT, AND HOUSING OF “HIGH RISK DETAINEES.”

As directed by the Court, Director McDonough’s Response outlines a “comprehensive written plan ... regarding identification, monitoring, treatment, and housing of detainees who are ‘high risk’ for suffering adverse outcomes if infected with COVID-19.” (ECF 85 at 1).

A. The Court’s Definition of “High Risk Detainees.”

The Order defined “high risk” detainees as:

Detainees who are aged 65 or over and/or who have any of the following conditions specifically identified by the [CDC]: (a) chronic lung disease including moderate to severe asthma, COPD, emphysema, chronic bronchitis, idiopathic pulmonary fibrosis and/or cystic fibrosis; (b) immunocompromised status, including status as a transplant recipient, on chemotherapy, HIV positive, prolonged use of corticosteroids, using immunosuppressive medication, and/or having an immune deficiency; (c) severe obesity (BMI of 40 or higher); (d) diabetes mellitus Type I or Type II; (e) gestational diabetes mellitus; (f) chronic kidney disease on dialysis; (g) chronic liver diseases, cirrhosis; and/or (g) serious heart conditions including congestive heart failure, coronary artery disease, congenital heart disease, cardiomyopathy, and/or pulmonary hypertension.

Id. Director McDonough understands that the Court derived this definition of a “high risk detainee” from the current information provided by the CDC concerning “Groups at Higher Risk for Severe Illness” from COVID-19.³

Director McDonough remains concerned with the Order’s definition of “high risk detainees” for a variety of reasons. First, the Order’s definition omits a critical phrase in the CDC’s guidance for identifying possibly high-risk individuals which permitted the exercise of medical

³ See <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html> (last accessed on May 24, 2020).

judgment. In identifying certain medical conditions which “might [place someone] at higher risk for severe illness from COVID-19,” the CDC qualified the list of medical conditions by noting a potential risk “*particularly if [the condition was] not well controlled.*” *Id.* (emphasis added). Stated differently, the CDC expressly acknowledged that the listed medical conditions might not place someone at higher risk from COVID-19 if the condition were well controlled. By omitting this key qualifier, the Order’s definition of “high risk detainees” prevents the members of the Jail’s medical staff from exercising their medical judgment and determining that a detainee might not be at high risk from COVID-19 because his or her medical condition is well controlled.

The Order’s definition of “high risk detainees” also contains ambiguity which creates uncertainty and confusion for Director McDonough and the members of the Jail’s medical staff in seeking to comply with the Order. For example, the Order defines as “high risk” any detainee with a “chronic lung disease,” “immunocompromised status,” “prolonged use of corticosteroids,” “chronic liver disease[],” or “serious heart condition[].” (ECF 85 at 1). Although the Order provides some examples of these conditions, it does not define these conditions or provide Director McDonough with any guidance in how to define these terms. This lack of certainty with respect to these terms will create challenges for identifying and, therefore, the monitoring, treating, and housing of detainees who might have such conditions. For example, without conducting a liver biopsy of every detainee, Director McDonough could not know whether a detainee has fatty liver disease. Similarly, the members of the Jail’s medical staff could not conclusively determine whether a detainee had a “prolonged use of corticosteroids,” particularly when the Order does not define what constitutes “prolonged” use. In short, the ambiguity in the Order’s definition of “high risk detainees” places Director McDonough at risk of becoming non-compliant with the Court’s Order by not knowing whether a detainee should be designated as “high risk.”

B. Identifying “High Risk Detainees.”

Notwithstanding Director McDonough’s concerns regarding the Order’s definition of “high risk detainees,” the members of the Jail’s medical staff will employ a multi-faceted approach to identify detainees potentially qualifying as “high risk detainees.” This approach builds on the Chronic Care Clinic process utilized by the Jail’s medical staff to provide a system for identifying “high risk detainees” to the greatest extent reasonably possible. As described below, the members of the Jail’s medical staff will cross reference medication administration records with the list of patients currently enrolled in the Chronic Care Clinic process to identify any detainees who might qualify as “high risk” but are not in the Chronic Care Clinic. The Jail’s medical staff will enroll these individuals in the Chronic Care Clinic process for close monitoring of their medical conditions. Furthermore, the members of the medical staff will continue to rely on the medical assessments and evaluations conducted as part of the Intake and Sick Call processes for identifying detainees who may begin exhibiting symptoms of a medical condition qualifying them as “high risk.”

i. Chronic Care Clinic.

The Chronic Care Clinic process serves as the foundation for the process of identifying “high risk detainees.” Patients at the Jail with chronic medical conditions are automatically enrolled in the Chronic Care Clinic. The members of the Jail’s medical staff evaluate and treat certain pre-defined chronic medical conditions through the Chronic Care Clinic such as, for example, asthma, chronic lung diseases, severe obesity, hypertension, any serious heart condition, diabetes, gastroesophageal reflux disease, kidney diseases (including diseases requiring a patient to undergo dialysis), chronic obstructive pulmonary disease, liver diseases, hyperlipidemia, as well as others. In addition, as a general matter, the medical staff will enroll a patient in the Chronic

Care Clinic if the patient is elderly (65 years or older) or immunocompromised. Thus, the Jail's Chronic Care Clinic process includes, but is not limited to, those patients at the Jail who fall within the criteria issued by the CDC for identifying individuals "who might face a higher risk of severe illness from COVID-19." The Jail's medical staff maintains a log of the patients enrolled in the Chronic Care Clinic.

As a short-term measure, the members of the Jail's medical staff will cross reference the list of patients reflected in the chronic care log with the medication administration records for the Jail. If the medical staff identifies any detainee who is currently prescribed with a medication for treating one of the medical conditions qualifying the detainee as "high risk," the medical staff will enroll the detainee in the Chronic Care Clinic. Thus, the Chronic Care Clinic log will provide the long-term basis for tracking "high risk" detainees at the Jail.

The Intake and Sick Call processes provide the routine procedures for identifying "high risk detainees" and for enrolling in the Chronic Care Clinic process. A detainee is enrolled in the Chronic Care Clinic following an evaluation by a provider who then diagnoses, or verifies a pre-existing diagnosis, a chronic medical condition. The provider's decision to place a detainee on the chronic care list may occur during the Intake process or at any subsequent point during the patient's time at the Jail.

ii. Intake Process.

Every detainee undergoes a nursing assessment, medical history screening, and an evaluation by a medical provider during the Intake process. A nurse conducts a screening and assessment of each detainee within a few hours of his or her commitment into the Jail. **[See Exhibit One - Intake and Receiving Screening Form]**. During the Intake assessment, the nurse will take the detainee's vital signs, including temperature, respiration, blood pressure, and will also

calculate the detainee's body mass index. Additionally, the nursing assessment includes a screening for symptoms of COVID-19 which has been updated to include all symptoms listed by the CDC. [See **Exhibit Two – COVID-19 Screening Form, updated 5/1/2020**]. The Intake nurse will also ask the detainee about his or her medical history and prescribed medications, documenting the responses on the Intake Screening Form.

If the nursing assessment or medical history screening indicates a detainee may have a medical condition qualifying him or her as a “high risk detainee,” the Intake nurse will refer the detainee to a medical provider for an evaluation without undue delay. [See **Exhibit Three - Health Assessment - History**]. If the nursing assessment or medical history screening does not indicate a detainee has a medical condition qualifying him or her as a “high risk detainee,” the detainee's medical history and physical by a provider must occur within fourteen (14) days of the detainee's arrival at the Jail. In any event, if the Intake evaluation by the provider leads to diagnosing a detainee with a medical condition qualifying the detainee as “high risk” or confirming such a pre-existing diagnosis reported by the detainee, the provider will enroll the detainee in the Chronic Care Clinic.

iii. Sick Call Process.

The members of the Jail's medical staff will also continue utilizing the Sick Call process for identifying “high risk detainees” who begin exhibiting signs of a “high risk” condition after their commitment to the Jail. The Sick Call process is initiated when a detainee places a Sick Call request slip in one of the various Sick Call boxes located at the Jail or by handing a slip to a member of the medical or correctional staff. To the extent that a detainee requires urgent medical care, he or she may make an oral request to a member of the medical or security staff at any point

in time. The members of the Jail's medical staff will respond to an urgent need for medical attention without undue delay upon learning of the need for care and provide appropriate attention.

As a general matter, a registered nurse (RN) on the nursing staff will triage written Sick Call requests within twenty-four (24) hours. A member of the nursing staff will inform the relevant members of the correctional staff of who needs to be seen for Sick Call, and the correctional staff will bring those patients to the Medical Unit. Typically, a member of the Jail's medical staff will see and, as necessary, begin treating a patient within forty-eight (48) hours after the nurse triaged the Sick Call request slip, or more quickly for urgent needs. If the nurse conducting the Sick Call screenings determines that a detainee exhibits symptoms of a "high risk" medical condition or otherwise requires a higher-level of treatment, the nurse will refer the detainee to a medical provider. A provider on the Jail's medical staff will evaluate the detainee without undue delay and enroll him or her in the Chronic Care Clinic if the provider diagnoses a "high risk" condition. In handling Sick Calls, medical staff try to process one housing unit per day (depending on the number of requests) in order to avoid mixing inmates from different housing units. Although it may take longer for medical staff to get to a unit, these are for triaged, routine requests only. For emergent issues that are reported to staff or indicated on a Sick Call request form, immediate attention will be provided. A nurse will either go the housing unit to see the patient, or have the inmate come to the Medical Unit.

Thus, the Chronic Care Clinic process, the review of the medication administration records, the Intake and Sick Call processes, and the health history assessment will provide a comprehensive system for identifying "high risk detainees."

C. **Monitoring and Treatment of “High Risk Detainees.”**

The Chronic Care Clinic process will ensure the known “high risk” detainees receive close monitoring and treatment of their medical conditions. The Chronic Care Clinic is designed to monitor and evaluate detainees with specific conditions that persist for more than six (6) months, including “high risk” conditions. As such, the Chronic Care Clinic process provides the members of the Jail’s medical staff with the tools for monitoring and treating the “high risk” detainees’ medical needs. Once a detainee is enrolled in a Chronic Care Clinic, providers on the medical staff determine, based upon the condition of the detainee, whether a detainee is seen at intervals of thirty (30), sixty (60), or ninety (90) days.

During a chronic care visit, a detainee will undergo an evaluation by a provider on the Jail’s medical staff. A detainee will also undergo a nurse screening during the chronic care visit to assess the detainee’s vital signs. If either the evaluation or screening detects indications that the detainee may have COVID-19, the medical staff will test the detainee and place him or her in medical isolation pending the test’s results. Medical staff also remind the detainees during the Chronic Care Clinic visits to alert the medical staff to any changes in the detainees’ symptoms and expressly instruct them regarding symptoms of COVID-19. This is in addition to the posted information and general announcements made in the housing units to all inmates regarding COVID-19.

Furthermore, the members of the Jail’s medical staff will continue to monitor the “high risk detainees” through other medical processes in addition to the Chronic Care Clinic. The Chronic Care Clinic’s log assists the medical staff, including the nurses, in tracking and monitoring “high risk detainees.” The members of the Jail’s medical staff will respond without undue delay in the event that any “high risk detainee” reports or exhibits a symptom of COVID-19. For example, the Sick Call nurses will assess and triage without undue delay any “high risk detainee”

submitting a Sick Call request indicating that the patient is experiencing a possible symptom of COVID-19. Additionally, every detainee in every housing unit will receive a daily temperature check and will be screened for symptoms including cough, chills, sore throat, headache, muscle pain, nausea and vomiting, and new loss of taste or smell. **[See Exhibit Four - COVID Daily Screening Form].**

Furthermore, members of the Jail's nursing staff enter each housing unit at the Jail twice a day for purposes of administering medications. Most, if not all, of the "high risk detainees" take medications on at least a daily basis. During the twice-daily medication administration in the housing units, the nurses will ask the "high risk detainees" about, and otherwise look for, any symptoms indicating those patients might have COVID-19.

Additionally, the Jail's medical staff updated its guidance relating any detainee, including "high risk detainees," seeking medical attention for symptoms of COVID-19. This updated guidance calls for the medical staff to notify members of the correctional staff to provide any detainee reporting a symptom of COVID-19 with a surgical mask, and to escort the detainee to the medical unit as soon as possible.⁴ Upon arrival in the Medical Unit, a member of the nursing staff will assess the detainee prior to other detainees. While in the Medical Unit, the correctional staff will keep the detainee away from other detainees. A member of the Jail's medical staff will assess any detainee reporting a symptom of COVID-19 utilizing the update COVID-19 assessment form.

If the medical assessment of a "high risk detainee" detects symptoms of COVID-19, the members of the Jail's medical staff will administer a test to the detainee and place him or her in medical isolation. The medical staff will require any detainee who has been tested to remain in

⁴ Currently, every detainee has been provided a mask, and receives a new one every five days. If a detainee to be transported to Medical is missing his or her mask, correctional officers are to ensure that the detainees have a mask prior to transport.

medical isolation pending the test results. If the test results are negative, the detainee returns to his or her housing unit. If the test results are positive, the detainee will remain isolated for fourteen (14) days to ensure the detainee does not remain contagious, even though he or she might be asymptomatic.

Detainees in medical isolation receive ready access to the members of the medical staff. The medical isolation cells are located in the Medical Unit. Members of the Jail's nursing staff make rounds on the patients in medical isolation multiple times a day to check on their status, take vital signs, and assess any changes in their condition. Medical staff will remain acutely alert to any indications that a "high risk detainee" in medical isolation may be experiencing severe illness as a result of COVID-19. Furthermore, in the event that a "high risk detainee", or any other patient, develops a severe illness due to COVID-19 which requires specialized or emergency care which the Jail's medical staff could not provide, the medical staff will initiate the process of transporting the detainee to a hospital to receive the necessary care without undue delay.

D. Housing of "High Risk Detainees."

In consultation with Dr. Meskerem Asresahegn, the Jail's Medical Director, Director McDonough previously decided against housing all of the "high risk detainees" together in a common housing unit or units. Spreading the "high risk detainees" throughout the Jail into various housing units reduced the likelihood of an increased infection rate among the "high risk detainees" from the introduction of a single infected detainee into a housing unit. As discussed above, Director McDonough will house any "high risk detainee" who tests positive for COVID-19 or is awaiting testing results in a medical isolation cell.

At this point in time, almost all previously identified "high risk detainees" are each housed in his or her own cell within their housing units. Director McDonough is taking all the necessary

steps to relocate all “high risk detainees” to single cells whenever possible. Each “high risk” detainee has a note placed on their tracking file indicating he/she is to be housed alone whenever possible. Housing Unit Officers will single cell such inmates, provided that there is available space and there are no classification issues such as co-defendants, or “keep separates,”⁵ preventing a single cell assignment. The State is accepting 25 inmates from PGCDoc on May 26, 2020, which should help with creating additional space to house high risk inmates in their own cells.

II. DIRECTOR McDONOUGH WILL ENSURE THE CONTINUED “TRAINING, EDUCATION, AND SUPERVISION” RELATED TO THE IDENTIFICATION OF DETAINEES WITH SYMPTOMS OF COVID-19 AND MEDICAL CARE FOR DETAINEES WITH SYMPTOMS OF COVID-19.

Director McDonough’s Response will ensure that members of the Jail’s medical and security staff receive “training, education, and supervision ... on (a) identifying symptoms of COVID-19 in detainees; (b) rendering timely medical care to such detainees; (c) improving sick call response time for COVID-19 symptomatic detainees; and (d) ensuring regularity and accuracy of temperature checks.” (ECF 85 at 2).

A. Training, Education and Supervision of Medical Staff.

Corizon provides comprehensive training for all members of the Jail’s medical staff on issues related to identifying symptoms of COVID-19 and providing appropriate care for patients with or suspected of having COVID-19. Corizon continues to update its training and educational materials as the medical community’s understanding of the virus evolves. At the beginning of each week, the Health Services Administrator on the Jail’s medical staff, Abu Kalokoh,

⁵ A designation of “keep separate” indicates that an inmate has a conflict with another inmate that warrants a housing assignment that keeps those inmates apart, such as being co-defendants, a “victim” or “enemy” designation, a threat based on gang affiliation, court stay-away orders, or similar conflicts. If such a designation is made for one or more inmates to kept separate from a particular inmate, it limits the ability to classify certain detainees into certain housing units. A detainee cannot be moved into a housing unit if he/she has a “keep separate” there.

disseminates updated training information on COVID-19 to the members of the medical staff. Each member of the medical staff must sign a form acknowledging they received and reviewed the updated training and informational material. Additionally, while large in-person staff meetings remain unadvisable, members of the Jail's medical staff continue to meet in groups of three (3) to four (4) people to review and discuss updated training and educational materials.

Corizon will ensure the Jail's medical staff receive training and education on identifying symptoms of COVID-19, providing timely, appropriate medical care for symptomatic detainees, responding to Sick Call requests reporting symptoms of COVID-19 as quickly as possible, and ensuring the regularity and accuracy of temperature checks. The weekly training will include these training topics as necessary to ensure the members of the Jail's medical staff undergo appropriate training. For example, Corizon will ensure the members of the medical staff continue receiving training and guidance on utilization of the updated COVID-19 screening form and the updated process for triaging requests for care by patients exhibiting or reporting symptoms of COVID-19.

The supervisors on the Jail's medical staff will continue providing oversight as the members of the medical staff work to identify and provide care to detainees exhibiting symptoms of COVID-19. The Health Services Administrator will direct the quality assurance process to conduct a weekly review of documentation related to the care sought by and provided to patients reporting symptoms of COVID-19 to address the appropriateness and timeliness of care. For example, the supervisors on the Jail's medical staff will review selections of completed COVID-19 screening forms to assess the thoroughness of the screenings and measures taken in response to the information gleaned from the screenings. The supervisors will take any corrective action as necessary to provide additional instruction for members of the nursing staff who fail to correctly screen for the virus. Similarly, the Health Services Administrator and the Director of Nursing will

review a sample of the Sick Call requests and the Sick Call log to determine the timeliness and appropriateness of responses to requests for care.

They will also review the logs for temperature checks to ensure the members of the nursing staff complete timely, accurate checks. Thermometers will be inspected daily for accuracy and proper calibration. Twelve additional thermometers have been ordered by PGCDOC as a backup to the current infrared thermometers.

In addition to reviewing documentation, supervisors will observe members of the medical staff as they engage in the various functions related to identifying and treating symptomatic patients. The supervisors will take appropriate follow-up action, including providing additional training and education, as necessary.

B. Training, Education and Supervision of Correctional Officers.

Each correctional officer will undergo a two-hour training module through e-Learning that will provide information about COVID-19 symptoms, transmission, and safety measures to employ personally and in the work place. This training will include instruction on the use of personal protective equipment, identifying signs and symptoms of COVID, cohorting and protocols to follow if he/she believes someone has been exposed to COVID-19. Upon completing the training, a test will be administered, and officers must obtain an 80% or better as a passing score. Correctional supervisors will ensure that officers under their command take the training in a timely fashion. Similar training modules will be administered on a quarterly basis specific to COVID-19 until the pandemic has abated. In addition, officers will receive bulletins by email with any updated CDC guidance or information, for which he/she must indicate receipt electronically or manually provide a signature to a staff member.

A supervisor (a sergeant or higher) will visit each housing unit a minimum of three (3) times per shift. During the visit, he/she will inspect all log entries, ensure that proper observations and symptom checks are occurring and are documented in the Offender Management System (“OMS”), that cohort integrity is being upheld on each break, and that proper social distancing protocols are being observed. If there are any issues noted in the log book regarding the provision of PPE, hygiene or cleaning supplies, or other safety protocols related to COVID-19, the supervisor will make personal contact with the inmate to ensure the inmate has all appropriate supplies or follow up as appropriate. The supervisor will also ensure there is an ample supply of Sick Call, Inmate Request and Grievance Forms in each housing unit.

III. DIRECTOR McDONOUGH WILL CONTINUE TESTING FOR COVID-19 AND ISOLATING COVID-19 POSITIVE DETAINEES AND SYMPTOMATIC DETAINEES AS NECESSARY.

A. Testing Current and New Detainees for COVID-19.

The recent nationwide expansion in testing capability and increased supply of COVID-19 tests provided additional testing capability at the Jail that was previously unavailable. On Monday May 18, 2020, 300 COVID-19 viral test kits⁶ were received through the assistance of Corizon. These test kits allowed for PGCDOC to begin testing asymptomatic inmates assigned to the four housing Units, as recommended by Dr. Carlo Franco-Paredes. On Friday, May 26, 2020, another 300 test kits were delivered to the Jail.

As a voluntary measure far exceeding constitutional requirements, Director McDonough recently decided to take advantage of the increased supply of testing kits to greatly expand testing at the Jail, authorizing the testing of all detainees currently at the Jail. As of the filing of this Response, the Jail had obtained sufficient testing kits to test all of the detainees at the Jail. The

⁶ A viral test is used to determine whether a current COVID-19 infection is present.

Jail's medical staff currently anticipates completing this testing before June 1, 2020. Additionally, Director McDonough directed that all incoming detainees undergo testing in Processing, prior to placement in a permanent housing unit. It takes 48-72 hours for test results to come back. The recent increase in testing availability in the State may slow result times, as do weekends. All test results are reported to the Prince George's County Health Department.

Once testing in the two Initial Housing units (H2 and H8) was completed, PGCDOC began the ongoing process of testing all newly committed inmates in Processing before being moved to an Initial Housing Unit. Any inmates with positive results will be moved to the Medical Unit for isolation and treatment. As of May 21, 2020, all current inmates in these two Housing Units were tested. Any new inmates arriving in the Unit are now tested in Processing.

While awaiting test results, detainees are separated and housed individually in cells in the downstairs area of the Housing Unit.⁷ Until results are returned, detainees remain on 23-hour lockdown, with the exception of being allowed access to phones and showering daily. All inmates in these Initial Housing Units will be quarantined and continue to be screened for symptoms twice per day by medical personnel for at least 14 days before being moved to any permanent Housing Unit. **[See Exhibit Four]**. If a test results in a positive case, the remaining inmates are quarantined for an additional 14 days after exposure. If a test comes back negative and the inmate is asymptomatic, the detainee can be let out of his or her cell in a cohort of no more than 10 detainees at a time during the remainder of the 14-day quarantine period. Once the initial quarantine period has been completed, the detainee is assigned to a housing unit.

⁷ Providing single cells for detainees pending return of their test results is possible because of the current number of arrests. Should those numbers rise and providing single cells pending results no longer be feasible in light of space, Director McDonough will consider alternative methods to ensure incoming inmates do not pose a risk of exposure to the existing population of the Jail.

B. Plan for Obtaining Additional Test Kits.

Director McDonough expects to receive sufficient testing kits through Corizon to continue testing detainees going through the Intake process so long as the current rate of approximately twenty (20) new inmates a day remains the same.⁸ If more test kits are required to meet PGCDOC's needs beyond what Corizon is able to provide, Director McDonough will again make requests to County and State Health Departments for those resources. Incoming detainees will continue to be isolated from the general population of inmates for fourteen (14) days, pending confirmation of a negative test.

C. Criteria for Isolating and Releasing COVID-19 Positive and Symptomatic Detainees.

The members of the Jail's medical staff will continue relying on guidelines provided by Corizon's clinical leaders and the CDC as testing becomes necessary following this initial round of testing for all detainees and the testing during the Intake process. If a detainee exhibits symptoms of COVID-19, including a temperature measuring above 100.4 degrees, the medical staff will request for the patient to be brought to the Medical Unit. Once the detainee arrives in the Unit, the medical staff will check his or her temperature a second time and assess for other symptoms. **[See Exhibit Two]**. If the detainee exhibits symptoms consistent with COVID-19, the medical staff will administer a test and isolate the detainee. If the detainee tests negative, he or she is returned to their housing unit.

⁸ This testing of new intakes remains subject to the availability of testing supplies. While Corizon currently has access to sufficient supplies, future events out of the control of Director McDonough and Corizon could interrupt access to these supplies, including a spike in demand for testing kits.

i. Medical Isolation.

If a test result is positive, a symptomatic detainee will remain isolated for fourteen (14) days in the Medical Unit. Once they become asymptomatic, they will be moved to Housing Unit 6, which only houses inmates that have tested positive for COVID-19 that are not displaying symptoms. An asymptomatic detainee with a positive test result will remain isolated in Housing Unit 6 in his/her own cell to ensure the patient does not remain contagious. The inmate's symptoms and temperature will be taken twice a day and if any symptoms occur, he/she will be moved back to the Medical Unit. Housing Unit 6 is equipped with showers, inmate telephones and a recreation yard, as well as a large common space for relaxation and reading. Inmates housed in this Unit have access to these features while maintaining isolation from inmates in other housing units who have not tested positive. Mental health treatment will still be provided to inmates, on a one on one basis, during medical isolation. Inmates will remain in medical isolation for at least fourteen days with no symptoms, which is four days longer than recommended by CDC.

ii. Quarantine.

Quarantine will be used for those inmates who have had close contact with another inmate who tested positive for COVID-19. Despite having a negative result from the test performed in Processing, any inmate that later displays symptoms of COVID-19 will be tested. In the event a negative test result is received for an asymptomatic inmate, but a concern exists that he/she may have been exposed, a 14-day quarantine will be imposed.

In the case of a positive case in a Housing Unit (not Initial Housing), all inmates in the same Housing Unit will be quarantined, regardless of whether they reside on the top or bottom level of the unit. Quarantined inmates will remain in the Housing Unit in which they are currently living, but will undergo twice-daily screenings for all symptoms, as recommended by the CDC,

for 14 days. **[See Exhibit Four]**. During this screening, special attention will be given to “high risk detainees,” whose names will be highlighted on the unit rosters for medical staff to ensure close monitoring of their health conditions as described above. Inmates will only be allowed out of their quarantined unit to go to the Medical Unit. Quarantined inmates will have access to showers, inmate phones, televisions, recreation yards and the large common room areas within their own Housing Units. Similar to medical isolation, mental health treatment is provided to inmates during this time. At the end of the quarantine period, inmates will be re-tested for COVID-19. Upon receiving a negative test result, the inmate will be released from quarantine status.

If the positive inmate had a cellmate, the cellmate will be moved to another cell by himself, and the previous cell will be locked and kept empty until it is thoroughly cleaned by a contracted cleaning crew using CDC recommended cleaning and disinfecting methods. Cellmates of infected inmates who have tested negative will be thoroughly screened by medical personnel and then placed on the twice per day screening protocol like all other inmates in the Unit.

In the case of a detainee who makes bond or is released prior to a positive test result being returned, PGCDoc will contact the Prince George’s County Health Department, who will make the necessary notifications. Under no circumstances would an individual be held by the Jail contrary to a court order pending test results or quarantine completion.

All protocols for quarantine, medical isolation and testing will be subject to regular review by the Jail’s Medical Director and subject to change based on new information made available about COVID-19. Any deviation from CDC guidance by the Jail, if any, would only be done at the direction of the Medical Director.

Respectfully submitted,

RHONDA L. WEAVER
COUNTY ATTORNEY

ANDREW J. MURRAY
DEPUTY COUNTY ATTORNEY

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Filed: 05/26/2020

Third Affidavit of Mary Lou McDonough

My name is Mary Lou McDonough. I am over 18 years of age and am competent to testify. The following statements are made based upon my personal knowledge and my knowledge as Director of the Prince George's County, Maryland Department of Corrections (DOC). I have previously submitted two Affidavits in this Case.

On Monday, May 11, 2020, I reached out to Dr. Ernest Carter, the Health Officer for Prince George's County and head of its Health Department. I explained that Dr. Carlos Franco-Paredes, the Court-appointed Infectious Disease Expert, had completed his report on conditions at the Jail and made several recommendations that the Department wants to implement. The major one that I needed the Health Department's assistance with is obtaining enough COVID-19 tests to test the inmates in Housing Units 1, 9, 10 and 17 approximately 200 tests, plus an additional 20 tests per day (or 140 per week) in order to start testing all new inmates who are committed to the Jail. Dr. Carter explained that availability of tests through the State had loosened somewhat very recently and that he was somewhat confident that we would be able to obtain tests. He put me in touch with his Associate Director, Diane Young, RN. After I had a conversation with Ms. Young, she placed an order for the tests with the State of Maryland's Department of Health.

On Thursday, May 14, 2020, Ms. Young informed me that the State was not releasing tests for correctional facilities at this time, as it was not deemed a priority under their criteria. She has asked the State Lab Director to reconsider our request. In the meantime, the County Health Department is pursuing other sources for the tests. Prince George's County has not seen a slowing of the spread of COVID-19 in the community as other counties have, and still needs

additional tests for community usage. The State Health Department has stated that testing asymptomatic individuals is not a priority because all available tests are being used for symptomatic patients. As of Friday, May 15, 2020 we currently had access to tests for symptomatic patients only.

I continued to pursue the procurement of tests for the purposes of testing inmates through our Medical Provider, CORIZON Correctional Healthcare. On Friday evening, I was notified by CORIZON that they were able to purchase tests from a medical lab who they had a Contract with, Bio-Reference. While CDC is still recommending testing symptomatic individuals only, there is no restrictions on how tests are used. I approved the order of the tests and notified CORIZON that the County would reimburse them for purchase and laboratory fees to use the tests to test asymptomatic inmates as recommended by Dr. Franco. We are working with CORIZON staff to begin the testing of inmates on Tuesday, May 19, 2020 and continue testing until all the inmates in the Housing Units recommended by Dr. Franco are tested, along with all newly committed inmates.

Individuals who test positive will be quarantined in accordance with CDC and Health Department guidelines.

As stated above, the Prince George's County Department of Corrections contracts medical services for its inmate population with CORIZON Health Services. Dr. Meskerem Asresahegn (often referred to as "Dr. Meski") is the Physician at the Department and specializes in correctional health care. Early in 2020, during our planning for a possible Coronavirus outbreak in Prince George's County, I discussed with Dr. Meski and our Medical Administrator, Abu Kalokoh, how we would handle chronically ill inmates who were recognized by the Centers for Disease Control ("CDC") to be at "High Risk" from the Coronavirus. Together, we agreed

that Dr. Meski would share a listing of these inmates in an attempt to have them released early by the Courts or to have them returned to the community through our pre-trial release program. More than 10% of these inmates have been released through those efforts. Knowing that many were charged with serious crimes and/or had a long criminal history, we also discussed their treatment in the Jail during an outbreak. It was agreed that those who could not be released would remain in place, with additional medical supervision provided by our medical provider, Corizon. Many of these inmates would normally attend Chronic Care Group sessions in the Medical Unit. It was decided that if a COVID-19 outbreak occurred in the Jail, all inmate movement would stop and inmates, both High Risk and not, would remain in their current Housing Units.

The lack of movement in the Jail was done for the protection of all the inmates, particularly those identified by the CDC as being at higher risk from COVID-19. I consulted with both our Physician and Medical Administrator about the possibility of moving high risk inmates from their current units into one unit. Their medical opinion was, and continues to be, that such a move would create more risk for them than medically supervising them in their current housing units throughout the Jail.

At the bottom of page 9 and top of page 10 of Dr. Franco's inspection report, he credits the intervention of no new transfers between Housing Units and lack of inmate movement as an important impact in reducing transmission of COVID-19. Dr. Franco recommends that we make an attempt to single cell the medically vulnerable inmates and we are attempting to do that, although it cannot be done completely because of the number of inmates in some of the larger Housing Units. We have marked each of these inmate files in our Jail Management System as "Single Cell Priority." Any double celled inmates are single celled as space allows.

I SOLEMNLY SWEAR AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND BASED UPON MY PERSONAL KNOWLEDGE AND THE KNOWLEDGE OF THE COUNTY CORRECTIONAL FACILITY.

A handwritten signature in blue ink, reading "Mary Lou McDonough", is enclosed in a thin black rectangular border.

Mary Lou McDonough

May 18, 2020

Date



AFFIDAVIT OF EARNEST L. CARTER, MD, Ph.D

My name is Earnest Carter. I am over 18 years of age and am competent to testify.

The following statements are based upon my personal knowledge:

I am a licensed physician in the State of Maryland with a specialty in pediatrics. I also hold a Ph.D in bioengineering. I have been a licensed physician for over 30 years. A copy of my curriculum vitae is attached herewith. I am currently the Health Officer for Prince George's County, Maryland. Previously I was the Deputy Health Officer. My duties as the County Health Officer are to provide direct oversight and management of all 485+ employees in the divisions of Family Services, Assessment and Planning, Health & Wellness, Behavioral Health, Administration and Finance, Environmental Health and Communicable Disease Control, Communications, Public Health Emergency Preparedness as well as oversight of all clinical programs and providers. I maintain, as part of my staff, the Program Chief for Communicable and Vector-borne Disease Control, who is currently Angela Crankfield-Edmond.

When news of the seriousness of the Coronavirus (SARS, COVID 19) was received, the County Government began to coordinate efforts to combat its spread, beginning with a cabinet meeting held by the County Executive on March 4, 2020. Attendees of the meeting included Directors from all county agencies, including mine and the County's Office of Emergency Management. Numerous such meetings have been held since to include the attendance of Mary Lou McDonough, Director of the County Correctional Facility. I have spent the last two months,



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as have most officials within County government, predominantly addressing issues related to the COVID 19 outbreak. The County Detention Center's Director, Ms. Mary Lou McDonough, has consulted me multiple times over a period of two or more months concerning the appropriate steps to follow to prevent and/or control the spread of the virus within the Detention Center among both staff and the inmates. She has consulted me and Ms. Crankfield-Edmond numerous times about how to best implement the guidelines promulgated by the Centers for Disease Control, including proper cleaning, cleaning materials and solutions, social distancing, personal protection equipment, testing, and the decision to go to full inmate lock-down. I have also communicated extensively with the correction center medical care staff about the processes to follow for inmate testing and quarantine.

It should be noted that test kits were not readily available during the onset of the pandemic. This continues to be a challenge and has negatively impacted the County's ability to test adequately for a population of over 900,000 residents. We were able to receive a total of 3 test kits from Lab Corp on March 19, 2020 and 151 test kits from Quest Lab on March 28, 2020, in order to begin our testing operations. We subsequently received test kits from Lab Corp as follows: 100 on April 2; 200 on April 6; 450 on April 9; 150 on April 14; 850 on April 15; 1000 on April 27, and 2500 on April 30, totaling 5,255 test kits. The Maryland Department of Health provided testing protocols/prioritization criteria for local health departments, which were based on CDC Guidance. These are outlined as follows:



Priority 1

- Hospitalized patients; and
- Healthcare facility workers with symptoms.

Priority 2

- Patients in long-term care facilities with symptoms;
- Patients 65 years of age and older with symptoms;
- Patients with underlying conditions with symptoms;
- Healthcare facility workers with symptoms; and
- First responders with symptoms.

Priority 3 – As resources allow, test individuals in the surrounding community of rapidly increasing hospital cases to decrease community spread and ensure health of essential workers.

- Critical infrastructure workers with symptoms;
- Individuals who do not meet the above categories with symptoms;
- Healthcare facility workers and first responders;
- Individuals experiencing mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations;

Non-Priority

- Individuals without symptoms.

According to CDC (<https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm>),

hospitalization rates for COVID-19 positive persons increase with age. More specifically, those between the age of 19 years and 49 years have a hospitalization rate of 2.4, compared to a 7.4 hospitalization rate for those between 50 and 64 years of age. Since 90% of DOC's inmate population is under the age of 50, the likelihood of COVID-19 positive inmates experiencing complications that result in hospitalization is extremely low.

DOC has followed the CDC's guidance to identify persons with COVID-19 and follow prevention measures within the jail to protect incarcerated or detained persons, staff members,



and Prince George's County. Personal hygiene and cleaning supplies were provided to all units and are regularly replenished.

To reduce COVID-19 spread in the county jail and allow effective social distancing, DOC has coordinated with the Prince George's County State's Attorney's Office and the county public defender's office to reduce the jail population. These efforts have resulted in the release of non-violent offenders from the county jail since March 2020, thus resulting in a significant reduction in the jail population.

It is my opinion that given the circumstances, Ms. McDonough has implemented the best practices possible in a correctional setting. The contagiousness of the COVID 19 virus is unprecedented in our experience with communicable diseases and, although the virus is present in the jail, it has not spread nearly as quickly as would be expected in the jail setting. This is a testament to the efforts Ms. McDonough has taken to avoid its spread

**I SOLEMNLY SWEAR AND AFFIRM UNDER THE PENALTIES OF PERJURY
THAT THE FOREGOING STATEMENTS ARE TRUE AND BASED ON MY
PERSONAL KNOWLEDGE.**



Earnest L. Carter, M.D., Ph.D

05-17-20

Date



Angela D. Alsobrooks
County Executive

Headquarters Building
1701 McCormick Drive, Suite 200, Largo, MD 20774
Office 301-883-7834, Fax 301-883-7896, TTY/STS Dial 711
www.princegeorgescountymd.gov/health

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
GREENBELT DIVISION**

KEITH SETH, <i>et al.</i> ,	)	
Individually and on behalf of a class	)	
of similarly situated persons,	)	
	)	
Plaintiffs-Petitioners,	)	
	)	Case No.
v.	)	
	)	
MARY LOU MCDONOUGH,	)	
In her official capacity as	)	
Director of the Prince George's County	)	
Department of Corrections,	)	
	)	
	)	
Defendant-Respondent.	)	

**PLAINTIFFS' EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION**

Plaintiffs respectfully move this Court for the entry of a temporary restraining order and preliminary injunction. As more fully articulated in the attached memorandum, Defendant's actions in response to the COVID-19 pandemic have violated their rights under the Eighth and Fourteenth Amendments of the United States Constitution.

Further, a subset of Plaintiffs, all of whom are medically vulnerable persons, petitions this Court for writs of habeas corpus under 28 U.S.C. § 2241.

Respectfully submitted on April 20, 2020,

By s/Elizabeth Rossi
Elizabeth Rossi
Bar No. 19616
Katherine Chamblee-Ryan
application to the Bar of this Court pending
Olevia Boykin
application forthcoming
Ryan Downer
application pending

CIVIL RIGHTS CORPS
1601 Connecticut Ave. NW, Suite 800
Washington, D.C. 20009
katie@civilrightscorps.org
610-931-7715

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on April 21, 2020 I caused the foregoing document to be electronically transmitted to the Clerk's Office using the CM/ECF System for filing. This Emergency Motion for Temporary Restraining Order and Preliminary Injunction will be served in accordance with the Federal Rules of Civil Procedure.

Date: Apr. 21, 2020

/s/Elizabeth Rossi

Elizabeth Rossi



PRINCE GEORGE'S COUNTY DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE MANUAL

Number:	Chapter:	Subject:
12.5	Medical & Health Care Services	Pandemic Response Plan

I. POLICY:

The Department will provide training and establish guidelines to minimize employee and community exposure to communicable diseases and to delineate procedures to be followed in the event of an exposure.

The Department will implement an Infection Control Plan developed by the County's Infection Control Officer (CICO) Anita Hughes BSN, RN. This program will be developed in accordance with the Occupational Safety and Health Administration (OSHA) - Bloodborne Pathogens and Employee Health Standards.

The CICO may be reached 24 hours per day 5 days per week by contacting her cell phone at 202-510-1824 or by contacting the Public Safety Communications Facility at 301-352-1150 or the Fire Department's Operations Center 301-583-2200.

The Department of Corrections has decided to enact its health crisis/pandemic policy and procedures. Sworn and Civilian staff must remember during these trying times we are all Essential Employees. It is understandable that the wellbeing of family, friends, and loved ones are of the utmost importance and the Department intends to make every possible provision for staff to have access to contact their loved ones at all times. All personnel are to make all necessary arrangements to ensure that you are present at work and that your loved ones are being cared for in your absence. We all took an oath to protect the citizens of Prince George's County we must now fulfill our oath. Please remain dedicated to our profession and arrive for duty as scheduled with enough provisions for a double shift, if necessary.

To help minimize the spread of the pandemic Social Distancing will be practiced within the jail and at Satellite Facilities and it is recommended that you practice Social Distancing at home.. Please send an email or make a phone call rather than visit other offices in the Department. If you must meet in person, stay a minimum of six feet away from each other. No hugging or handshaking.

All visitors and staff will have their temperatures checked prior to entering the facility. Anyone with a temperature of 100 degrees or more, as read with an infrared forehead scanned thermometer, will be sent home and placed on their own leave. They will be informed to seek guidance from their medical provider. In addition, they will not be allowed to return to work for 14 days.

II. SOURCES:

OSHA, 1994, Bloodborne Pathogens Standard

CDC, 1988, Guidelines for Employee Health and Work Restrictions

Annotated Code of Maryland -- Health 18-337

III. DEFINITIONS:

- A. Immunization: The process or procedure by which a person is rendered immune to certain vaccine preventable diseases. Examples of vaccine preventable diseases are Measles, Mumps and Rubella (MMR) and Varicella Zoster (chickenpox).
- B. Personal Protective Equipment (PPE): Specialized clothing or equipment worn for protection against an infectious or communicable disease hazard. Splash resistant eyewear, cleaning gloves and fluid resistant clothing are examples of PPE used for cleaning and disinfecting.
- C. SOURCE INDIVIDUAL: Any individual, living or dead, whose blood or body fluids, or other potentially infectious materials (OPIM's) could be a source of an occupational exposure to an employee.
- D. STANDARD PRECAUTIONS: An approach to infection control in which all human blood and body fluids are treated as if known to be infected with bloodborne pathogens, including but not limited to, Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV). Therefore, appropriate personal protective equipment (PPE) shall be worn for all procedure/tasks where there may be a potential or anticipated exposure to blood and body fluids or other potentially infectious materials (OPIM's).
- E. WORK PRACTICE CONTROLS: Work practice controls reduce the likelihood of exposure to communicable diseases by altering the manner in which a task is performed.
- F. 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

IV. PROCEDURES:

A. General Program Management

The CICO is responsible for managing the agency's Infection Control Program; this individual will establish, monitor and ensure compliance with vaccine schedules, post exposure evaluation with follow-up and record keeping. In addition, the CICO will meet semi-annually with the Command Staff to review and update the Infection Control Program.

In the event there has been an established official Pandemic in Prince George's County the following procedures will take effect:

- 1. The Director will officially state that the Department of Corrections will assume all procedures concerning a Pandemic. Essentially, placing the jail in a state of emergency.
- 2. The Director will immediately convene a meeting with the following staff members:
 - a. Deputy Directors – Operations and Administrative
 - b. Chief of Staff – Associate Director
 - c. Division Chiefs
 - e. Shift Commanders
 - f. Special Operations Commander

3. The Director will advise as to what level the Department will assume. The following levels of preparedness is as follows:

LEVEL 1:

- **Heightened alert status.**
- Information sharing and gathering stage.
- The Department's daily operations will not be affected.
- Department will start the campaign to educate staff, inmates and visitors as to the heightened alert status.
- The Director will advise all internal stakeholders (listed above) to review the Pandemic Policy and Procedure and immediately have meetings with their staff.

LEVEL 2:

- **Active status.** ICS Structure is officially activated for Command Staff.
- The Department daily operations will be altered.
- Non-essential volunteers will be informed not to return to the facility until contacted.
- Division Chiefs will inform non-essential employees not to return to the facility and refer to the tele-work procedures.
- Visiting will be suspended until further notice.
- Aggressive cleaning of high traffic areas will commence.

LEVEL 3:

- **Full activation.**
- All sworn Officers working/assigned outside of direct Security positions will return Security to be assigned on a as needed bases.
- Tele-work procedures will be in effect.
- All non-essential movements and visitors will be suspended.
- All inmate programs and most inmate movement in the Jail will be curtailed.
- Dedicated Safety Team will be assigned to conduct sanitation inspections

Visitation:

The suspension of visits (Official and otherwise) will be dependent upon the number of identified cases experienced in the County or at the recommendation of CICO and CDC.

Vendor having to enter the facility to deliver critical supplies will be provided with masks and access to antibacterial hand gel. These persons will be required to wash their hands before entering the secure part of the facility and will be advised to do the same prior to exiting.

Tele-Working:

Employees who may be eligible for tele-working. This is different than the "essential" designation that they may already have. Some employees may normally be essential to continue our work, particularly during a Pandemic outbreak, but may be able to accomplish their job tasks from their homes.

Division Chiefs will assign the Codes as follows:

1. – Employees who must report to the Jail to perform their jobs, no matter the existing health or environmental conditions.
2. – Employees who are needed to work during an Emergency, but may accomplish the duties of their position from Home, with the aid of a Laptop, phone, etc.
3. – Employees who may be excused from performing their duties until the Emergency situation ends.

Note: Security/sworn personnel will be considered Code #1.

If Correctional Officers are assigned to Divisions from Security to a position that may not be required during an emergency, those Officers will be returned to Security for the duration of the Emergency. This includes Officers who are assigned to Training, Recruitment, Community Service, Education, IT, OPRLA, Population Management and Inmate Services. Division Chiefs should include them as a Code #1 on any listing. Officers who are assigned outside of Security because of health issues may remain in their assigned TDY positions and should be designated Codes #2 or #3.

B. Employees Responsibilities

In an attempt to prevent the spread of germs, bacteria and viruses, it is very important that all staff use extra caution while at work or at home. There are several measures that should be taken throughout your day. For starters, everyone should wash their hands continuously throughout the day or use a hand sanitizer. Employees should use a disinfectant wipe to clean all frequently touched surfaces. Avoid touching your face (eyes, nose & mouth). If you're sick and have a fever, stay home and get better!

Here at the jail we all need to do our part to prevent the spread of germs internally as well. Particularly in Intake, Processing, Reception, and Checkpoint. In those areas we must have sanitation workers wipe down all waiting chairs, door handles, telephones, drinking fountains and other surfaces. They must also thoroughly mop all floors with an approved cleaning solution such as Spray Nine. All holding cells must be cleaned at least once every shift (or more). **DON'T SHAKE HANDS OR GIVE HUGS.** Instead, don't take offense for not shaking hands. Clean your work surfaces throughout the day.

1. The employee will advise the immediate supervisor regarding the possible exposure and will **wait at their location** immediately **notifying** to the **Operations Commander's Office** to contact the CICO. **At no time will an employee who believes they have been possibly exposed should leave that area and cause additional contamination.**
2. The employee will be required to file a departmental Incident Report as soon as time allows. The employee will also file an Infection Control Report within 24 hours and either deliver this report in person or fax the report to 301-749-9714 or 301-583-1837, after completing the instructions/referrals given by the CICO.
3. Notifying the Shift Commander and Immediate Supervisor of an exposure to a communicable disease, blood and body fluids, or other potentially infectious materials (OPIM's).
4. The employee will ensure the Infection Control Exposure Report is completed once all instructions and referrals given by the CICO are completed. The Infection Control Exposure Report will be forwarded to the appropriate Deputy Director.
5. Completing the Workers Compensation/Injury Packet for all injuries or illness as the result of a confirmed communicable disease exposure and forwarding the completed packet to the CICO.
6. Maintaining confidentiality of *source person* regardless of an exposure to communicable diseases, blood and body fluids or other potentially infectious materials (OPIM's).

7. Reporting directly to the nearest medical center in the event of a *life threatening* exposure/injury involving communicable diseases, blood and body fluids or other potentially infectious materials (OPIM's).
8. Utilizing sick leave when experiencing *non-work related* fever, flu-like symptoms, vomiting, diarrhea, lesions, rashes of unknown origin and/or productive cough to minimize the risk of transmission of communicable diseases to other employees and to the public.

Roll Call:

Once the Director has initiated Level III protocols all Roll Calls on all shifts will be suspended. The following procedures will be in place.

- a. A **Lieutenant** will be present in the lobby at 2230, 0630, and 1430 hours to provide Sergeant assignments.
- b. A **Sergeant/Lieutenant** will be present in the lobby at 2245, 0645, and 1445 hours to provide line staff assignments.
- c. Upon arrival to the jail, staff will enter the lobby, receive their assignment, report to the Roll Call room to clock in, and will then report to their assigned post.
- d. Once properly relieved, the outgoing officer will report to the lobby and confirm with the designated supervisor that they are excused for the day.
- e. Each shift will be responsible for ensuring that all staff is adequately advised of their assignment.
- f. No staff member is authorized to leave their post without being relieved one for one unless otherwise instructed by the Shift Commander.
- g. All memorandums and pertinent Roll Call information will be sent via email by the Shift Operations Commander to all Sworn Officers.
- h. All Roll Call compensation will remain in place. Any questions should be addressed to your Shift Commander.

ERT Preparation:

As part of the precautionary move against pandemic outbreaks, all ERT members will be medically fitted with N95 mask. This test will be carried out in the medical unit by the medical staff. Each ERT member will need to be completed two forms prior to the test being conducted. These forms are OSHA approved. All members are to fill out **ONLY** the "OSHA Respirator Medical Evaluation Questionnaire". The second form "Respirator Fit Test and Training record" will be fill out in the presence of the medical staff.

This test is **MANDATORY** for all ERT members, and it must be completed. All ERT members must conform to the P&P 3.9 P12 of 18, regarding Hair Regulations.

Access to the facility:

Once the Director has initiated Level III Officers assigned to the Gate will start taking the temperatures of new arrestees as they enter the jail grounds; using a non-contact forehead thermometer. This would take place in the police officers' cars at the Gate, through an open window in the car. If an arrestee has a temperature of 100.4 the arrestee will not be allowed to enter the facility. The Gate Officer will then notify the Zone 1 Commander and log in OMS, the Officers name, Department, vehicle information and time they arrived at the Gate. In addition, the Gate Officer will log in OMS the temperature of the arrestee.

Once the Director has initiated Level III Officers, for the safety of everyone within our facility, all Staff, as well as Attorneys, Police Officers, Official Visitors, Vendors, and Prisoners must have their temperatures checked prior to being granted access to enter the Prince George's County Department of Corrections. Any person registering a temperature of 100 degrees or higher, will be denied access to our facility. Upon registering a temperature at or above 100 degrees, a second scan will be performed. If the second scan also registers 100 degrees or higher, the person will be advised that they are denied access to enter. Staff that display an elevated temperature will be instructed to return home and to initiate self-quarantine until a medical determination is made that they pose no viable threat to the health and safety of the facility. The person entering will be given the opportunity to self-scan, or to have the Officer scan for them. An alcohol prep pad will be provided. This scan is mandatory and cannot be refused. If self-scan is preferred, the assigned staff must monitor the scan to ensure that it was correctly performed and to witness the reading. These scans will take place at all entrances to the facility.

Procedures for Temperature Readings

Effective immediately ALL staff and visitors will have their temperatures checked, at Reception, Delivery Gate and main Gate before they are permitted to enter the main portion of the building. The below procedures are to be strictly adhered to. **The thermometer MUST be cleaned with an alcohol prep pad between each use.**

The Reception visiting officer will be responsible for checking the temperature of any person who enters the secure area of the building. However, 30 Minutes prior to the end of each shift the Operations Commander will designate an additional staff member to assist with checking temperatures during shift change. The Gate officers will be responsible for checking the temperatures of anyone who enters through the gate. Any arrestee exhibiting a temperature of 100 degrees or higher will be refused custody and Regional Processing will handle the Incident report.

If any person has a temperature of 100 degrees or higher, a second reading will be conducted to confirm the temperature. If the temperature read is still 100 degrees or higher, they will not be permitted to enter the building and advised to notify their supervisors immediately for instructions.

If the person who is refused entry is a non-staff member (i.e. attorney, police officer, etc.) a notation should be made in OMS. If a DOC staff member is refused entry, they should be listed on the Temperature Monitoring Facility Access form (see attached). This form should be submitted to the Operations Commander at the end of each shift.

NOTE: When not in use the non-contact forehead thermometers will be kept in the Operations Commanders Office.

Public Defenders will conduct interviews in the non-contact visiting booths on the second floor. The process will be as follows:

- a. The Public Defender will arrive at Reception at approximately 0830 hours

- b. Call the Housing Units and provide a list of all detainees that will be interviewed.
- c. The Housing Unit Officer will have all detainees on the second floor awaiting their interview.
- d. The Housing Unit Officer will coordinate all movement in the unit and will make every effort to expedite the interviews. The entire process must be completed by 1100 hours.
- e. It may be necessary for the Public Defenders to physically access detainees housed in the Medical Unit. Any discrepancies or problems must be directed to the Zone Commander immediately.

NOTE: Just to be clear, at the current time, if an attorney requests to conduct a contact visit, we are not to deny the contact visit. If this changes, a directive will be written.

Pre-Trial Services:

Pre-Trial Services will conduct interviews in the non-contact visiting booths on the second floor. The process will be as follows:

- a. Pre-Trial staff will report to Reception and will call the housing unit and provide a list of all detainees that will be interviewed.
- b. The Housing Unit Officer will have all detainees on the second floor awaiting their interview.
- c. The Housing Unit Officer will coordinate all movement in the unit and will make every effort to expedite the interviews.
- d. It may be necessary for the Pre-Trial Investigators to physically access detainees housed in the Medical Unit or 1st Floor Visiting. Any discrepancies or problems must be directed to the Zone Commander immediately.

Conference Call:

If the Director wishes to have a conference call with Senior Command Staff after normal work hours, the information below is to be used to participate in the call.

- 301-883-6600 is the number you should call to gain access to the call
- Once you dial in you will be asked to enter your access code / participant pin - which is 353794

Inmate Communications:

As a result of the recent suspension of inmate visitation, the Department will allow detainees to maintain contact with their loved ones during unsettling times. The Department will be arrange for detainees to receive three (3) free 10 minute telephone calls per day.

- a. Officers must monitor the telephones to ensure that all inmates are afforded an opportunity to use them.
- b. These telephone procedures will also be afforded to detainees on disciplinary status, during their 1 hour recreation period. However, should a detainee become disruptive, or display continued negative institutional behavior, they may be denied access to telephones. If telephone privileges are denied to any detainee, it will be documented in OMS and a on a disciplinary ticket.

NOTE: Staff are urged to exercise compassion and good judgment whenever possible, to prevent additional anxiety related to the current situation.

**Infectious Disease Exposure Procedures for all
Prince George's County Employees**

DURING REGULAR BUSINESS HOURS (8:00am-4:30pm) MONDAY THRU FRIDAY

- ✓ Employee notifies their Supervisor of the exposure.
- ✓ Employee or Supervisor call the Employee Infectious Disease office at 202-510-1824 (cellular number).
- ✓ Employee or Supervisor MUST STATE that it is a county employee exposure and request to speak with the Infection Control Nurse (ICN), Anita Hughes BSN, RN.
- ✓ The ICN will triage the suspected exposure and advise regarding the next steps.
- ✓ ICN will contact Concentra Medical Center and advise them of your pending arrival. The ICN will fax/email the appropriate paperwork to Concentra Medical Center.
- ☐☐ Employee must report to Concentra Medical Center with a photo ID for evaluation and treatment within two (2) hours of the exposure.

AFTER REGULAR BUSINESS HOURS (4:30pm to 7:00pm), MONDAY THRU FRIDAY

- ✓ Employee notifies their Supervisor of the exposure
- ✓ The Supervisor and the Employee will then call the Prince Georges' County Onsite Medical Center office at 301-459-9117.
- ✓ Once you are speaking with a person please state the following: "My name is (insert name) and I am a Prince George's County Employee. I have experienced an exposure and I am requesting to speak to the next available doctor for exposure triage." This statement will ensure that you speak to the appropriate clinician and receive priority medical attention.
- ✓ The doctor will triage the situation and provide further instructions.
- ✓ Prince George's County employees should not report to any Concentra Medical Center location without first speaking with a Concentra Medical Center provider.

AFTER REGULAR BUSINESS HOURS (7:00pm-7:00am), MONDAY THRU FRIDAY

- ✓ Employee notifies their Supervisor of the exposure
- ✓ The Supervisor and the Employee will then call the Concentra Medical Center's Arbutus office at 410-247-9595.
- ✓ Once you are speaking with a person please state the following: "My name is (insert name) and I am a Prince George's County Employee. I have experienced an exposure and I am requesting to speak to the next available doctor for exposure triage." This statement will ensure that you speak to the appropriate clinician and receive priority medical attention.
- ✓ The doctor will triage the situation and provide further instructions.
- ✓ Prince George's County employees should not report to any Concentra Medical Center location without first speaking with a Concentra Medical Center provider.

HOLIDAYS, (7:00am-7:00pm), MONDAY THRU FRIDAY

- ✓ Employee notifies their Supervisor of the exposure
- ✓ The Supervisor and the Employee will then call the Prince Georges' County Onsite Medical Center office at 301-459-9117.
- ✓ Once you are speaking with a person please state the following: "My name is (insert name) and I am a Prince George's County Employee. I have experienced an exposure and I am requesting to

✓ speak to the next available doctor for exposure triage." This statement will ensure that you speak to the appropriate clinician and receive priority medical attention.

- ✓ The doctor will triage the situation and provide further instructions.
- ✓ Prince George's County employees should not report to any Concentra Medical Center location without first speaking with a Concentra Medical Center provider.

HOLIDAYS, (7:00pm-7:00am), MONDAY THRU FRIDAY

- ✓ Employee notifies their Supervisor of the exposure
- ✓ The Supervisor and the Employee will then call the Concentra Medical Center's Arbutus office at 410-247-9595.
- ✓ Once you are speaking with a person please state the following: "My name is (insert name) and I am a Prince George's County Employee. I have experienced an exposure and I am requesting to speak to the next available doctor for exposure triage." This statement will ensure that you speak to the appropriate clinician and receive priority medical attention.
- ✓ The doctor will triage the situation and provide further instructions.
- ✓ Prince George's County employees should not report to any Concentra Medical Center location without first speaking with a Concentra Medical Center provider.

WEEKENDS AND HOLIDAYS THAT OCCUR ON A WEEKEND

- ✓ Employee notifies their Supervisor of the exposure
- ✓ The Supervisor and the Employee will then call Concentra Medical Center's Steeple Chase office at 301-499-4655. If that center is closed please call the Concentra Medical Center's Arbutus office at 410-247-9595.
- ✓ Once you are speaking with a person please state the following: "My name is (insert name) and I am a Prince George's County Employee. I have experienced an exposure and I am requesting to speak to the next available doctor for exposure triage." This statement will ensure that you speak to the appropriate clinician and receive priority medical attention.
- ✓ The doctor will triage the situation and provide further instructions.
- ✓ Prince George's County employees should not report to any Concentra Medical Center location without first speaking with a Concentra Medical Center provider.

Concentra Medical Center Locations

- ✓ (Prince George's County Onsite Medical Center) 4451 Parliament Pl., Suite F, Lanham, Maryland 20706: 301-459-9117
- ✓ (Steeple Chase) 9141 Alasking Ct. Suite 112, Capitol Heights, Maryland 20743: 301-499-4655
- ✓ (Arbutus) 1419 Knecht Avenue Arbutus, Maryland 21227 Telephone: 410-247-9595

C. Supervisors Responsibilities

1. Ensuring employees comply with the Infection Control Program.
2. Initiating the Infection Control Exposure Report, writing an Incident Report, and following the procedure for reporting an injury on the job (see Policy and Procedure 3.11, "Injury on the Job and Disability Leave").
3. Notifying the CICO immediately of all reported communicable disease exposures and coordinating, communicating and assisting the CICO with employee infection control concerns and exposure follow-up.

4. Monitoring the condition and availability of personal protective equipment (PPE) and ensuring minimum requirements are maintained at all times.

D. Infection Control Officer (CICO) Responsibilities

1. Providing 24-hour communicable disease exposure advice, post-exposure follow-up, and referral to the Physician or nearest medical center, as appropriate.
2. Documentation of pre and post-test counseling and medical treatment for exposure to communicable diseases, blood and body fluids, or other potentially infectious materials (OPIM's).
3. Documentation that employee's have been informed about medical conditions resulting from the exposure incident, maintaining related safety and compliance reports.
4. Coordinating employees' orientation and annual education and training programs.
5. Obtaining copies of the pre-employment physical examinations, immunizations and PPD skin tests, as appropriate, for investigation of communicable disease exposure incidents, workers compensation claims, and immunization reviews and PPD skin test screenings.
6. **(DELETED CONTENT)**

E. Standard Precautions

All employees will practice standard precautions. This is an approach to infection control in which all human blood and body fluids are treated as if known to be infectious with bloodborne pathogens, including but not limited to, Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV). Therefore, appropriate personal protective equipment (PPE) will be worn for all procedures/tasks where there may be a potential or anticipated exposure to blood and body fluids or other potentially infectious materials (OPIM's).

F. Personal Protective Equipment (PPE)

1. PPE will be worn for any task or procedure in which direct contact with blood or body fluids or other potentially infectious materials (OPIM's) of the individual is anticipated. Examples of PPE are gloves, masks, and eye protection (goggles).
2. Heavy gauge (reusable gloves) can be used when cleaning the unit or equipment. These gloves should be washed in the same manner as hands are washed, but both inside and out. These gloves should be discarded if they become cracked torn, punctured, or otherwise show signs of deterioration.
3. Gowns will be necessary in situations where blood or body fluids could be splashed onto clothing. Disposable paper gowns are found in the blood spill kit.
4. Disposable Exam Gloves will be worn when it can reasonably be anticipated that the staff employee may have hand contact with blood, or other potentially infectious materials, mucous membranes, and non-intact skin and when handling or touching contaminated items or surfaces. Open wounds or rashes must be covered with a waterproof dressing.
5. Goggles and masks will be worn whenever splashes, spray, splatter, or droplets of

blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.

6. Mask and eye protection (goggles, helmet, visor or glasses) will be worn when splashing of blood and body fluids or other potentially infectious materials (OPIM's) is likely, to prevent mucous membrane exposure of the eyes, nose, and mouth.
7. Resuscitation Devices- CPR pocket masks will be available in each first aid kit. After use, the CPR pocket masks will be discarded, replaced with a new pocket mask and returned to the first aid kit by Medical Unit staff. Correctional staff will not dispose of these pocket masks. The Medical Unit will check and restock the contents of first aid kits and blood spill kits on a monthly basis. The Medical Unit will replace all missing items.

G. Handwashing

1. Hands will be washed before and after touching blood and body fluids or other potentially infectious materials (OPIM's).
2. Hands will be washed before eating, drinking, applying cosmetics, and changing contact lenses and after using the lavatory facilities.
3. Hands will be washed immediately or as soon as feasible after removal of gloves or other personal protective equipment (PPE).
4. Foamed alcohol hand degermer and antibacterial towelettes will be used when handwashing facilities are not readily available. When towelettes or alcohol foam degermer are used, cleanse hands for 60 seconds and wash hands with soap and running water as soon as possible.

Small (hotel grade) bars of soap will be distributed by Regional Processing Upper Marlboro Regional Processing Officers. These bars of soap will be issued to every arrestee that is brought into RPUM. This soap will remain with the arrestee until they are either released, or Committed and receive a Hygiene kit containing soap. All arrestees and inmates must be afforded the opportunity to wash their hands frequently. 1 bar of soap will be given to every arrestee.

H. Food and Specimens

1. Eating, drinking, smoking, applying cosmetics or lip balm, chewing gum and handling contact lenses is prohibited in areas where there is a risk of occupational exposure to blood and body fluids or other potentially infectious materials (OPIM's).
2. Storage of food and drinks are prohibited in places where blood and body fluids or other potentially infectious materials (OPIM's) are kept.

I. Equipment and Clothing

1. All specimens of blood and body fluids or other potentially infectious materials (OPIM's) must be contained in leak-proof containers or bio-hazardous plastic bags during handling and transport.
2. Equipment that may become contaminated will be inspected for blood and body fluids

or other potentially infectious materials (OPIM's) on a regular basis and decontaminated as necessary.

3. Removal of blood and body fluids or other potentially infectious materials (OPIM's) from skin and/or clothing must be done as soon as possible.
4. Work uniforms contaminated with blood and body fluids or other potentially infectious materials (OPIM's) must be removed as soon as possible for more thorough cleaning.
5. The employer is responsible for cleaning and replacement of contaminated uniforms. If the clothing or linens of any inmate or staff employee have been contaminated with blood or other body fluids, inmates will place those items in a water-soluble bag, which will then be placed into a yellow "contaminated linen" bag. They will be laundered according to usual Correctional Center procedures. These bags will be available in the Blood Spill Kits. DO NOT USE THE RED BIOHAZARD BAGS!
6. A uniform that has become contaminated with blood or body fluids will be removed, placed in a water-soluble bag and then into the yellow "contaminated linen" bag. These bags can be found in the blood spill kit. The uniform will then be cleaned or disposed of properly, as soon as possible.
7. If skin under the uniform has been contaminated, it will immediately be washed thoroughly with soap and running water.
8. Handcuffs or other security equipment that become soiled with blood or body fluids will be placed, in a clear leak proof bag and taken to the Medical Unit for cleaning.
9. Radios or other equipment that is touched or handled while wearing gloves contaminated or soiled with blood or body fluids or other potentially infectious materials (OPIM's) must also be considered contaminated until disinfected. Equipment will be placed in a clear leak proof bag and taken to the Medical Unit for cleaning.

J. Fire and Sanitation Inspections

A dedicated Safety Inspector will be activated on Shift II. This Inspector will report daily findings to the Executive Assistant and to the Chief of Security. This assigned Safety Team Member will inspect all areas within the facility daily. In addition to the following:

- a. Any issue that needs attention and will attempt to resolve all issues in a timely manner. During the challenging COVID-19 inspect the facility for vulnerabilities.
- c. The daily Safety Report will be forwarded to the Chief of Security for review.
- d. A check of hand sanitizer dispensers, cleaning supplies throughout the facility and any sanitation concerns which could affect the safety and wellbeing of the facility.
- e. During this time, all Fire Safety inspections will be handled by this Safety Team Inspector as well.

Shakedown / SA:

During the Pandemic (Level III) all routine shake downs will be coordinated through the Chief of Security and all special shake downs must be approved by the Shift Commander. When any shake down is conducted, the Sergeant conducting the shake down will be responsible to ensure that Officers are not in close proximity to each other or inmates (exercising Social distancing) at any time during the assignment. This includes being in the Sallyport, or during cell searches. In addition, the amount of routine shake downs conducted will be limited. The Chief of Security or designee I will advise when and where any routine S/A will occur.

J. Vehicles and Equipment Disinfecting Procedures

1. All vehicles contaminated with blood and body fluids and other OPIM's will be removed from service and immediately cleaned/disinfected.
2. All areas of the vehicle such as radio scanners, walls, benches, floors and handles, where contact with blood and body fluids or other potentially infectious materials (OPIM's) is likely, must be thoroughly pre-cleaned with soap and water or approved germicide detergent solution then wiped dry. Cracks and crevices must be scrubbed with a brush.
3. The approved germicidal detergent solution must be mixed and labeled with the date the mixture was mixed and the discard date. (*See Manufacturer's Instructions*)
4. A solution of nine parts water to one part bleach may be substituted for the name brand disinfectant solution. Once mixed, bleach must be discarded within 24 hours.
5. The use of heavy gloves or double gloving is necessary when performing clean-up procedures and mixing disinfectant solutions.

NOTE: EMPLOYEES MUST REMEMBER NEVER TO PLACE A RED BAG OR CONTAMINATED ITEMS IN REGULAR OR UNMARKED TRASHCANS!

K. Immunization Program

The CICO will administer the Vaccination Program, which may include administration of the Tetanus, Measles, Mumps, and Rubella (MMR), Varicella (VZV), Hepatitis B vaccine (HBV) and Influenza. Documentation of immunizations, such as Hepatitis B, MMR, Varicella and Tetanus vaccination, as appropriate.

The CICO will administer and interpret the PPD skin tests and maintain all medical records in the County's Infection Control Office, as appropriate. (see Protocol 12.7, Tuberculosis Exposure Control Program).

1. Hepatitis B Vaccine (HBV) Background

This vaccine is a safe and effective vaccine that was developed in 1982. The vaccine stimulates the production of antibodies that are necessary for providing immunity against Hepatitis B Virus (HBV) infection. Research indicates that 90 percent of those receiving the vaccine will develop adequate titer (antibody levels).

2. HBV Prevention/Prophylaxis

- a. The Hepatitis B Vaccine is recommended for all employees with anticipated

occupational expose to blood and body fluids or other potentially infectious materials (OPIM's). Exceptions are employees who have received the complete vaccine series, have antibody testing that indicates immunity, or have a medical contraindication for the vaccine.

- b. The Hepatitis B vaccine is offered at no cost, within 10 working days of initial assignment, during education and training sessions and annually. The Hepatitis B vaccine is administered as a series of 3 injections at 0, 1 and 4 to 5 month intervals.
- c. Employees who accept or refuse the Hepatitis B vaccine must sign a consent or declination statement (waiver), annually, usually during the Infection Control refresher training session. The declination statement (wavier) can be rescinded at any time and the Hepatitis B vaccine will be provided at no cost to the employee.
- d. Compliance with the vaccine schedule is the employee's responsibility.

3. HBV Post – Exposure Follow up

- a. Hepatitis B vaccines are effective in 70 to 80 percent of cases when given within 96 hours (4 days) after Hepatitis B virus (HBV) exposure.
- b. Hepatitis B vaccine will be offered in combination with Hepatitis B Immune Globulin (HBIG). Concurrent administration of the Hepatitis B vaccine and (HBIG) is effective in over 90 percent of cases in preventing Hepatitis B infection following a documented significant exposure.

4. Measles, Mumps and Rubella Vaccine

- a. Measles is considered one of the most common and serious of childhood diseases. Measles usually affects children but can occur in adults.
- b. Employee providing Individual care services will provide written documentation of immunity to measles at the time of hire or at their scheduled health screening, as appropriate. Exceptions will be made for pregnant employees to receive vaccination at the end of their gestation period.
- c. Personnel born in or after 1957, who cannot provide documented proof of 2 doses of measles vaccine on or after their first birthday shall receive 1 dose of measles vaccine. Measles immunity can also be documented by a positive serologic (blood) titer or documentation of physician-diagnosed measles.
- d. Personnel born before 1957 are considered immune due to natural infection. It is recommended that personnel in this age group who have no history of vaccination or measles-like illness be immunized or have their blood tested (titer) to determine immune status.

5. Tetanus Toxoid

- a. Tetanus Toxoid vaccines will be administered at no cost to employees for prophylaxis and management of any breaks in the integrity of the skin due to

work-related injuries.

- b. For a minor wound with low potential of contamination, Tetanus-Diphtheria Booster dose will be given if no booster has been administered within the last 10 years.
- c. For wounds with a high potential of contamination, Tetanus Immune Globulin will be given regardless of when the last booster was administered.

6. Influenza (Flu) Vaccine

The influenza vaccine will be offered annually on a voluntary basis to all employees (October – November).

7. Varicella Vaccine (Chickenpox)

- a. Employee's immunity to varicella will be reviewed and documented at pre-employment and during their scheduled health screenings. Varicella immunity can be documented by proof of prior immunization, reliable history of varicella infection, or a positive serologic titer.
- b. If employee is determined to be non-immune to varicella, he will be offered the varicella vaccine at no cost for work-related exposures, unless medically contraindicated.
- c. The vaccine is administered as a series of 2 injections at 0 and 4-8 week intervals. Employees, who develop local or generalized skin lesions after vaccination will be evaluated by the physician and may be placed off duty until lesions are dried, crusted over and healed.
- d. If an employee receives a work – related exposure to varicella or (shingles) and is found to be non-immune to varicella, he will be offered the varicella vaccine and/or be placed on mandatory work restriction from the 10th through the 21st day post-exposure, as appropriate.
- e. If an employee receives a non-work related exposure to varicella or shingles or a work-related exposure to varicella and has declined vaccination; the employee must use sick leave to be paid for mandatory time off from the 10th – 21st day post-exposure, as appropriate.

L. Management of Employees with Bloodborne diseases

All employees will follow Standard Precautions. Therefore, neither mandatory nor voluntary screening programs for Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and other bloodborne diseases are warranted.

Employees infected with a bloodborne disease will not be prohibited from work/practice solely on the basis of their bloodborne pathogen infection/disease. (*Reference the American with Disability Act of 1990, Titles 1-5*).

No employment decision regarding any current or prospective employee in whom HIV/AIDS infections a consideration may be made unless the Director will have first conferred with the attorney in the Office of Law designated to handle HIV/AIDS related questions. After consultation with the Health Officer, when necessary, the County's Office of Law will advise

the Department on an appropriate course of action consistent with applicable policy and law.

M. Mandatory Equipment Requirements

1. All agency vehicles (special units, cruisers, transport vans and buses) must be equipped with the following minimum quantities of infection control equipment. All employees operating a vehicle are responsible for restocking the vehicle prior to returning the vehicle to services.
 - a. Gloves, disposable exam gloves, one (1) small, medium, large box
 - b. Surgical masks, disposable, six (6) each,
 - c. Eye irrigation solution (4) each,
 - d. Foamed alcohol hand degermer, two (2) (one in use and one spare)
 - e. Antibacterial towelettes, one (1) box
 - f. Clear plastic bags, two (2) each
 - g. Trash bags, two (2) each
 - h. Gloves, latex, heavy duty (cleaning), two (2) pair
 - i. Paper towels, one (1) roll or package
 - j. Red bags, two (2) each
 - k. Eye goggles, two (2) pair
 - l. Resuscitation device and face shield
 - m. Fabric cleaner
2. The Infection control equipment should be stored with the "first aid kit" that is carried on each agency vehicle. It is the responsibility of each employee assigned a vehicle to ensure that his vehicle is adequately equipped with the infection control equipment.

N. Mandatory Blood Spill Kits

1. Blood spill kits will be maintained throughout the Correctional Center. One kit will also be maintained at each satellite facility.

These kits will contain the following items:

- a. 1 hair net;
- b. 1 paper gown;
- c. 1 hepa mask;
- d. 1 pair of gloves;

- e. Paper towels;
 - f. 1 red biohazard plastic bag (oversize) for disposal of contaminated items;
 - g. 1 water-soluble bag for laundering of contaminated fabric items;
 - h. 1 fluid control solidifier;
 - i. 1 germicidal disposal wipe;
 - j. 1 ziplock bag;
 - k. Standard bio-safety instructions with Exposure Report Form; and
 - l. 1 scoop
- 2. In the housing units, the blood spill kits will be kept in the officer's restroom. On each shift, the incoming Housing Unit Officer, will inspect the blood spill kits and note this in the **OMS**. The condition of the kits will be included in the Zone Commander's Security Inspection Report.
 - 3. The Medical Unit will be responsible for supplying replacement items for the blood spill kits. When a kit has been used, the officer will complete an Incident/Infraction Report and forward to the Zone Commander. Civilians will forward a written memorandum to the Medical Unit. Officers will give the kit to his Zone Commander who will immediately obtain replacement items from the Medical Unit. Civilians will take the kit to the Medical Unit for replacement items.
 - 4. The Medical Unit will be responsible for keeping first aid kits stocked with pocket masks for use in administering mouth-to-mouth resuscitation. In the event an officer notices that stocks are low, he will arrange for the kit to be brought to the Medical Unit as soon as possible for replacement items.
 - 5. In the course of inspecting first aid kits each month, the Medical Unit will also inspect the blood spill kits in the designated area and restock, if necessary.
- O. Education and Training Programs
- 1. Education programs will be coordinated by the CICO in conjunction with the Training Section. Mandatory refresher training will be conducted annually.
 - 2. Training consists of, but is not limited to:
 - a. A general explanation of communicable diseases.
 - b. Information on the Hepatitis B Vaccine including, information on its efficacy, safety, method of administration, benefits of being vaccinated and that the vaccine and vaccination will be offered free of charge.
 - c. Information on the appropriate person to contact for communicable disease exposure incidents, including, but not limited to, medical follow-up.
 - d. An accessible copy of the OSHA Bloodborne Pathogen Standard, CDC Vaccination Fact Sheets, Post Exposure Prophylaxis, policy and procedures, visual aids etc.

P. Record-keeping

1. Medical Records:

The CICO will establish and maintain an accurate record for each employee with occupational exposure. This record shall include:

- a. Employee's name and work identification number.
 - b. Copy of employee's Hepatitis B vaccination status including the dates of all Hepatitis B vaccinations.
 - c. A copy of all results of examinations, medical testing and follow-up procedures.
2. All medical records will be maintained for the duration of employment plus thirty (30) years.
3. All employees' medical records regarding exposure will be kept confidential and are not disclosed without the employee written consent.
4. All files will include results of the Source Individual's HIV, and HCV infectivity, if feasible and not prohibited by state or local laws.
5. All files will include a description of the employee's duties related to the exposure incident. All files will include documentation on the routes of exposure and the circumstances under which the exposure occurred, including device specific information, if the incident is device related.
6. All medical records will be provided upon request for examination and copying to the employees, legal representatives, and OSHA representatives, where required by law.

Q. Training Records

1. Education and training records for employees will be maintained at the Infection Control Office and the Fire Service Building (FSB). Employee training records will be maintained by the CICO for a minimum of 3 years from the date on which the training occurred.
2. This record will include:
 - a. Date of the training;
 - b. Names and ranks/qualifications of persons conducting the training; and
 - c. Names and ranks of all persons attending the training.


Director