UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

JOSEPH A. DENBOW et al.,

Petitioners,

v.

MAINE DEPARTMENT OF CORRECTIONS et al.,

Respondents.

Docket No. 1:20-cv-00175-JAW

OPPOSITION TO MOTION FOR TEMPORARY RESTRAINING ORDER AND INCORPORATED MEMORANDUM OF LAW

Introduction

Respondents Maine Department of Corrections ("MDOC") and Commissioner Randall Liberty have taken dramatic and rapid action to reduce the risk of COVID-19 to inmates and staff by stopping all non-essential movement into the prisons, taking precautions to reduce the spread of germs among inmates, responding vigorously to the four positive tests, and evaluating inmates for potential community confinement. MDOC's aggressive actions have dramatically limited the spread of COVID-19 in its facilities. Maine has found only four confirmed cases of COVID-19, all at one facility and all arising in the last 10 days. MDOC's actions reflect a high level of concern for inmates in MDOC's prisons and do not show that Petitioners are "in custody in violation of the Constitution or laws" of the United States, as required for habeas relief.

Despite MDOC's actions, Petitioners ask the Court to order six wide-ranging categories of injunctive relief, including dictating MDOC's COVID-19 testing protocols (with no input from the Maine CDC) and "enlargement" (release) of inmates into the community while this case is pending. However, Petitioners have not shown they are entitled to the extraordinary and drastic

remedy of mandatory injunctive relief. They are unlikely to succeed on the merits, because the facts demonstrate MDOC's robust response to COVID-19 and because Petitioners' claims are barred by the exhaustion statute. Nor, given MDOC's aggressive policies and the small number of COVID-19 cases in the prisons, have Petitioners shown a likelihood—as opposed to a mere possibility—of irreparable harm. Similarly, the relief Petitioners seek (releasing hundreds of inmates, including those convicted of murder and other violent crimes) is counter to the public interest, and the balance of equities tips heavily in favor of MDOC. Because MDOC's efforts to combat COVID-19 do not support injunctive relief against it, the Court should deny Petitioners' motion for a temporary restraining order.[1]

Facts

I. MDOC's Aggressive Response to COVID-19

MDOC is currently engaged in extraordinary efforts to combat COVID-19, a respiratory ailment caused by the novel coronavirus that has spread throughout Maine[2] and globally. The U.S. CDC's "current best estimate" is that approximately 65% of individuals who contract COVID-19 will develop symptoms; 3.4% of those symptomatic COVID-19 cases will require hospitalization and 0.4% of symptomatic cases will result in death. *See* U.S. CDC, *COVID-19 Pandemic Planning Scenarios*, at 4-5 ("Scenario Five: Current Best Estimate"), at https://www.cdc.gov/coronavirus/

[1] Per the Court's directive at the May 21, 2020 status conference, this expedited filing is directed at Petitioners' request for an immediate temporary restraining order, which the Court has indicated it intends to rule upon separately from Petitioners' motion for preliminary injunction. As directed by the Court, this submission is focused primarily on MDOC's policies and practices to respond to the challenges of the COVID-19 pandemic in Maine's correctional facilities. Respondents reserve their right to present additional factual material and legal arguments in opposing Petitioners' motion for a preliminary injunction.

[2] As of May 27, 2020, there have been 1,914 confirmed cases of COVID-19 in Maine. Penobscot County, where Petitioners are incarcerated, has had 99 cases. Cumberland County, where the Maine Correctional Center is located, has had 1,065 cases. Knox County, where Maine State Prison and the Bolduc Correctional Facility are located, has had 20 cases. *See* Maine Center for Disease Control, "Novel Coronavirus 2019 (COVID-19)," https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml (last viewed May 27, 2020).

2019-ncov/hcp/planning-scenarios-h.pdf (last reviewed May 20, 2020).

In early March 2020, MDOC developed a three-phase approach to combating COVID-19, in consultation with the Maine CDC. Affidavit of Dr. Ryan Thornell, filed concurrently, ¶ 7. Each successive phase of MDOC's response plan contains escalating protective measures against the spread of COVID-19. *Id.* Phase 1 (Preparation and Prevention) occurred immediately. *Id.* MDOC moved to Phase 2 when there was a confirmed case in the Maine community, and Phase 3 began at MCC on May 19, when MDOC found the first confirmed inmate case of COVID-19. *Id.* Immediately after that first positive test, the entire population (inmates, staff, and medical) at MCC was tested within four days. *Id.* ¶ 55. Remarkably, only four positive cases were found. *Id.* In response to those positives, MDOC has already begun universal re-testing at MCC, in consultation with the Maine CDC, and expects it to conclude by June 1. *Id.* ¶ 57. Overall, MDOC has tested over 750 inmates and staff since the start of the pandemic. *Id.* ¶ 18.

The most important and effective parts of MDOC's wide-ranging response plan have been its efforts to stop movement into the prisons, prompt and vigorous responses to positive tests, evaluation of inmates with medical conditions for potential community confinement, and collaboration with Wellpath (MDOC's medical contractor) and the Maine CDC to prevent the spread of COVID-19.

II. MDOC's Early Halt to Movement Into Prisons

Key to delaying COVID-19 infiltrating MDOC facilities was that, as of April 13, MDOC and the county jails agreed to stop the transfer of inmates to MDOC. *Id.* ¶ 50. Now, by the Governor's Executive Order, there will be no intakes from county jails until the emergency declaration ends. *Id.* Even prior to intakes stopping, MDOC ordered that any inmates arriving from county jail would go only to MCC (with a very limited exception for intensive mental health treatment) and had all such intakes met upon arrival by staff in full PPE (n95 masks, face shields,

gowns, and gloves) and undergo medical assessments. *Id.* ¶ 38. Transferees were also quarantined for fourteen days. Affidavit of Dr. John Newby, filed concurrently, ¶ 36. MDOC also suspended work release programs, so that inmates would not be exposed in the community or bring the virus back. Thornell Aff. ¶ 32. In March, MDOC suspended all non-professional visits at the facilities.[3] *Id.* ¶ 26. These limitations contributed to MDOC's success in staving off the first COVID-19 cases in MDOC facilities until late May, while correctional systems in other states have had much larger case numbers. *Id.* ¶ 71.

Further, MDOC implemented strict screening requirements for everyone entering the prisons, which MDOC developed in consultation with the Maine CDC. *Id.* ¶ 31. Those entering have their temperatures taken and are questioned about possible exposure and symptoms. *Id*. In March, MDOC also limited staff to working in a single facility and limited movement of behavioral health staff between the facilities. *Id.* ¶¶ 24, 30; *see also* Newby Aff. ¶ 38 (limiting all non-essential travel between facilities by Wellpath's medical providers).

III. MDOC's Vigorous Response to the Positive Tests

After the positive test at MCC on May 19, MDOC began immediate universal testing there, and all inmates and staff at MCC were tested within four days, save for the handful of inmates who refused, resulting in four positive inmate tests and no positive staff tests. Thornell Aff. ¶ 55. The second positive inmate case was confirmed on May 22 and two additional cases were confirmed on May 23. *Id.* All four inmates who tested positive were housed at MCC and have been placed in isolation there, where nursing staff attend to them multiple times per day. *Id.*; Newby Aff. ¶ 47. None have required hospitalization. Thornell Aff. ¶ 55. Three are under age 50, and the

[3] MDOC has provided inmates with additional calls, messages, and Zoom visits to address the lack of in-person visits. Thornell Aff. ¶¶ 27, 39.

fourth is in his late 60s (and has been in prison since 1998). *Id.* MDOC will continue to isolate these inmates (and any future positives), as recommended by the Maine CDC, for at least fourteen days from the date of their positive test, and they will not be reintegrated until they are symptom-free and have had two confirmed negative tests. *Id.* ¶ 56.

Given the four total positive tests, on May 24, 2020, MDOC obtained approval from the Maine CDC for universal retesting at MCC. *Id.* ¶ 57. Retesting began today, May 27, and is expected to be completed June 1. *Id.* MDOC also follows the Maine CDC's recommendation that testing at other MDOC facilities occur when there is a reason to believe inmates or staff in those facilities have been exposed or are suspected of having COVID-19. *Id.* ¶¶ 57-58. There is very little risk that the cases found at MCC will be the source of infection at other MDOC facilities. *Id.* ¶ 53. The only recent inmate transfers from MCC were three inmates transferred to MSP (two had urgent mental-health needs and one required restrictive housing unavailable at MCC). *Id.* All three were tested for COVID-19 following the positive test on May 19. *Id.* ¶¶ 53-54.

Due to the positive tests, MCC is currently locked down, with inmate movement restricted to reduce the potential spread of COVID-19. *Id.* ¶¶ 52, 61. Inmates at MCC are receiving meals and medication in their housing units, and inmate "sick calls" (medical requests) are being triaged in the housing unit when possible, instead of the prison's clinic, to limit potential transmission. *Id.* ¶ 52; *see also* Newby Aff. ¶ 32. On May 23, MCC's Warden declared an emergency in order to obtain authorization from the Governor to divert staff to MCC to address the emergency and assist with universal re-testing. Thornell Aff. ¶ 61.

IV. MDOC Evaluated At-Risk Inmates For Supervised Community Confinement.

In March of 2020, as part of Phase 1, MDOC and Wellpath compiled a list of over 900 inmates with conditions considered by the U.S. CDC to place them at higher risk of illness from COVID-19, including asthma, hypertension, chronic lung disease, and other conditions. *Id.* ¶ 62.

MDOC and Wellpath also created a list of inmates whose medical conditions made them a priority for consideration for the Supervised Community Confinement Program (SCCP).[4] *Id.* MDOC's Classification Department then evaluated every inmate on these lists (starting with those identified as most at risk) for potential placement on SCCP. *Id.* ¶¶ 62-63. MDOC continues to update this list and evaluate inmates for SCCP. *Id.* ¶ 62.

Some of these 900+ inmates with pre-existing medical conditions are incarcerated for violent crimes, and some are currently housed in segregated housing units because they pose a danger to staff and other inmates. *Id.* ¶ 68. Releasing such inmates on unsupervised medical furlough or SCCP would pose a danger to the victims of these offenders and to the community at large. *Id.* Their release would also violate the SCCP statute, which makes the program only available to minimum custody inmates and sets specific terms for their housing and monitoring. *Id.*; 34-A M.R.S. § 3036-A(2)-(3). The Classification Department determined which of the 900+ inmates qualified for SCCP under the relevant statute and rules, based on their sentence and security level. Thornell Aff. ¶ 62. The Classification Department then reviewed each eligible inmate's case for potential SCCP placement. *Id.* ¶ 63. For inmates meeting certain criteria, aspects of the complex SCCP investigations that are typically required (which include inspecting the proposed residence and contacting victims) were modified to fast-track releases to SCCP. *Id.* Inmates not meeting the criteria for a fast-track placement were also considered for SCCP. *Id.* ¶ 64. Since March 1, 2020, 95 inmates have been released to SCCP. *Id.* ¶ 63. Five have since returned

[4] The Supervised Community Confinement Program (SCCP) is governed by 34-A M.R.S. § 3036-A and 03-201 C.M.R. ch. 10 (attached as Ex. H to the Thornell Declaration and also available at https://www.maine.gov/sos/cec/rules/03/chaps03.htm) and allows the Commissioner to consider inmates for release to approved residences in the community with supervision by probation. The statute limits which inmates qualify and sets strict requirements. For example, inmates are not eligible for SCCP if they have a security classification level higher than minimum, or until they have served a certain portion of their sentence, and their proposed residence must be approved by MDOC. Thornell Aff. ¶ 62; 34-A M.R.S. § 3036-A(2)(B)-(D), (3)(B).

to custody from SCCP for substance abuse, among other issues. *Id.* ¶ 63.

The statute and rules specify that an inmate must have a proposed residence that is approved by MDOC. *Id.* ¶ 66; 34-A M.R.S. § 3036-A(3)(B). It is especially important during a pandemic that inmates who are released have an appropriate residence. Thornell Aff. ¶ 67. Homeless shelters are not appropriate, because of documented outbreaks of COVID-19 in homeless shelters and because of the impossibility of determining if homeless shelters also house crime victims or other offenders, which the SCCP Policy does not allow. *Id.*

During the process of evaluating inmates for SCCP, MDOC Commissioner Liberty and others met several times with representatives of the Maine ACLU and provided them with the number of inmates with medical conditions associated with an increased risk from COVID-19. *Id.* ¶ 69. The ACLU requested that all 900+ inmates be released on medical furlough. *Id.* However, medical furlough is controlled by 34-A M.R.S. § 3035(2)(C),[5] and is used when medical treatment or a medical procedure is necessary and cannot be done within MDOC. *Id.* ¶ 70. There is no monitoring of inmates on medical furlough. *Id.* MDOC is not presently using medical furlough to release inmates with hypertension, for example, simply because of the risk of COVID-19, because such inmates do not meet the statutory requirements and would potentially endanger the community. *Id.* ¶¶ 68, 70.

V. MDOC Has an Aggressive Response Plan And Has Been Extremely Transparent.

On March 23, 2020, the U.S. CDC issued guidance specific to correctional facilities, which MDOC follows to the extent feasible given the physical parameters of the prisons. Thornell Aff. ¶ 33. Even before that guidance was issued, MDOC took widespread action to prevent COVID-

[5] 34-A M.R.S. § 3035(2)(C) states that a "furlough may be granted *for the obtaining of medical services* for a period longer than 10 days *if medically required*." (Emphasis added.)

19. In early March 2020, MDOC instituted aggressive cleaning protocols at the facilities. *Id.* ¶¶ 8-9, 21. MDOC also issued directives encouraging social distancing practices, directing modified medication administration procedures to occur within housing units, and limiting group activities. *Id.* ¶¶ 12, 21-22, 42-44. Inmates were educated about COVID-19 and its prevention. *Id.* ¶¶ 9, 21, 25; Newby Aff. ¶ 18-20. MDOC ensured adequate supplies of PPE and other crucial supplies. Thornell Aff. ¶¶ 9, 14; Newby Aff. ¶ 14-15. MDOC also ensured that each facility identified a location for isolating suspected COVID-19 cases and that each facility had a plan for potential staff shortages. Thornell Aff. ¶ 15. MDOC and Wellpath also altered the delivery of healthcare services in response to COVID-19, including the use of PPE by providers and patients during examinations, the cleaning and disinfecting of equipment and medical areas between patient visits, and the use of telehealth visits where possible. Newby Aff. ¶¶ 22-35.

MDOC has worked closely with the Maine CDC to prevent and respond to COVID-19, meeting daily with the Maine CDC Director and following their protocols on testing. Thornell Aff. ¶¶ 6, 7, 57-58. Immediately after the positive staff test at Bolduc Correctional Facility, MDOC issued a directive to all facilities regarding positive case reporting and "contact tracing[,]" as advised by the Maine CDC. *Id.* ¶ 37.

MDOC has also put in place protocols to maximize mask wearing, social distancing and other CDC-endorsed practices. Following new CDC guidance on masks in April, MDOC distributed cloth masks to all inmates. *Id.* ¶ 40. MDOC further changed its policy from encouraging to *requiring* social distancing where feasible, and further required inmates and staff to wear masks in all facility areas when and where social distancing is not available. *Id.* ¶¶ 42–43. And, contrary to Petitioners' allegations (PI Mot. 6, Petition 20), in every MDOC facility, inmates have access to hand sanitizer with a 70% alcohol content (Thornell Aff. ¶¶ 49, Ex. D). The U.S. CDC

recommends handwashing over hand sanitizer, but at Mountain View, as at other facilities, inmates have access to hand sanitizer, dispensed by officers due to the potential for misuse. *Id.* ¶ 49.

Because of the protective steps it has taken against COVID-19, MDOC facilities have been able to continue to provide chronic care visits and other necessary medical treatments to inmates suffering from chronic conditions, including the 900+ inmates described above. Newby Aff. ¶¶ 18-19. Protocols for distributing medication have been altered to minimize the potential for virus transmission. Thornell Aff. ¶¶ 12, 22, 52; Newby Aff. ¶ 23-24. In addition, to encourage inmates to seek treatment for any COVID-19 symptoms, MDOC has waived co-pays for sick calls for inmates with COVID-19 symptoms. Newby Aff. ¶ 30.

MDOC has also taken extensive measures to inform inmates, staff, and the public of best practices and important events related to COVID-19. Thornell Aff. ¶¶ 10, 35-36, 59-60. On March 31, 2020, MDOC began publishing daily information regarding COVID-19 in MDOC facilities on the web via the "Daily COVID-19 Dashboard," available at www.maine.gov/corrections. *Id.* ¶ 35. The information posted includes the number of inmates tested, the number of pending tests, the number of positive and negative results, the number of inmates refusing the tests, as well as population data and data on the SCCP Program. *Id.* As of today, May 27, 2020, the Dashboard reflects that 494 inmates have been tested, that 3 have refused, and that only 4 have tested positive. *Id.* These numbers include all inmates and staff at MCC. *Id.* MDOC has also kept inmates and staff constantly updated on new developments, guidance, and protocols relating to COVID-19. *E.g.*, *id.* ¶¶ 8, 21, 36-37, 40.

Within hours of learning of the five total staff and inmate positive tests, MDOC notified its staff and the public of the results and the steps taken to reduce the spread of the virus. *Id.* ¶¶ 36, 59-60. In short, MDOC's rapid and thorough response, in collaboration with the Maine CDC, has

been remarkably effective in limiting the spread of COVID-19 in Maine's prisons. *Id.* ¶¶ 55, 72.

Legal Standard

A temporary restraining order, like a preliminary injunction, is "an extraordinary and drastic remedy that is never awarded as of right." *Monga v. Nat'l Endowment for Arts*, 323 F. Supp. 3d 75, 82 (D. Me. 2018) (Woodcock, J.). The movant must establish that "he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *accord W Holding Co., Inc. v. AIG Ins. Co.-Puerto Rico*, 748 F.3d 377, 383 (1st Cir. 2014). "The *sine qua non* of this four-part inquiry is likelihood of success on the merits: if the moving party cannot demonstrate that he is likely to succeed in his quest, the remaining factors become matters of idle curiosity." *New Comm. Wireless Servs. v. SprintCom, Inc.*, 287 F.3d 1, 9 (1st Cir. 2002). Petitioners must show "'more than mere possibility' of success—rather, they must establish a 'strong likelihood' that they will ultimately prevail." *Sindicato Puertorriqueno de Trabajadores v. Fortuno*, 699 F.3d 1, 10 (1st Cir. 2012).

Petitioners' burden is especially high here because the injunctive relief they seek would alter, rather than preserve, the status quo. Such injunctions are disfavored and "normally should be granted only in those circumstances when the exigencies of the situation demand such relief." *Mass. Coal. of Citizens with Disab. v. Civil Def. Agency & Office of Emergency Preparedness of Mass.*, 649 F.2d 71, 76 n.7 (1st Cir. 1981); *United Steelworkers of Am., AFL-CIO v. Textron, Inc.*, 836 F.2d 6, 10 (1st Cir. 1987) (noting that First Circuit authority suggests that "courts disfavor injunctions that disturb, rather than preserve, the status quo").[6]

[6] Habeas is an appropriate vehicle where an inmate seeks "what can be fairly described as a quantum change in the level of custody[,]" not vague and wide-ranging changes to MDOC's practices. *Gonzalez-Fuentes v. Molina*, 607 F.3d 864, 873 (1st Cir. 2010) (quotation omitted). Even if some of the relief Petitioners seek could be understood as seeking "quantum" change in custody level, much of the relief requested does not. For example, Petitioners ask the

Argument

I. Petitioners Are Unlikely to Succeed on the Merits

A. Petitioners' Eighth Amendment Claim Is Unlikely to Succeed on the Merits.

"[A] prison official cannot be found liable under the Eighth amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety[.]" *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). The state of mind required for deliberate indifference is "akin to criminal recklessness." *Kosilek v. Spencer*, 774 F.3d 63, 83 (1st Cir. 2014); *Farmer,* 511 U.S. at 837-38. A reasonable response to a known risk negates deliberate indifference, even if harm is not averted,[7] and even a negligent response to a known risk "that was colorable and taken in good faith might still be enough to negate deliberate indifference." *Burrell v. Hampshire Cty.*, 307 F.3d 1, 8 (1st Cir. 2002). Petitioners claim that MDOC does not adequately protect them from COVID-19, but MDOC's early and expansive response to the virus shows an extraordinarily careful and active approach to trying to protect inmates and staff. *E.g.,* Thornell Aff. ¶¶ 33, 37-38, 50, 42-44. MDOC's actions and collaboration with the Maine CDC reflect best practices, not reckless disregard of an excessive risk, and do not violate the Eighth Amendment. *Id.* ¶¶ 7, 12, 57-58.

Even assuming that Petitioners can show a sufficiently grave risk of harm from COVID-19,[8] they cannot show that MDOC officials were deliberately indifferent to that risk. MDOC

Court to "mandat[e] compliance with [U.S.CDC] guidance" inside MDOC facilities. Mot. at 3. This request is not for "a quantum change in the level of custody," and is beyond the scope of what is available in habeas.

[7] Here, harm has thus far been largely averted, as the four inmates who have tested positive have not required hospitalization. Thornell Aff. ¶ 55.

[8] MDOC does not dispute that the COVID-19 is a highly contagious virus that puts everyone at risk, but compared to the community, where literally thousands more cases of COVID-19 have been identified (*see* Maine CDC, "Novel Coronavirus 2019 (COVID-19)," https://www maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml (last viewed May 23, 2020)), the conditions in MDOC's facilities do not reflect a level of risk

officials are aware of the risks of COVID-19, but they are not deliberately indifferent unless they recklessly disregard an excessive risk to inmate health or safety. *Farmer*, 511 U.S. at 839. The inquiry must "incorporate[ ] due regard for [the] unenviable task of keeping dangerous men in safe custody under humane conditions.'" *Burrell*, 307 F.3d at 8 (quoting *Farmer*, 511 U.S. at 845).

Petitioners cannot show that MDOC's response to COVID-19 and the measures MDOC has put in place to protect inmates and staff were reckless. MDOC's prevention efforts have been vast and were accomplished early. MDOC halted outside visitation and work release programs and screened all those entering the prisons, including the Wardens, in March, stopped all intakes from county jails to MDOC's facilities on April 6, and ceased movement of staff and behavioral workers between prisons in April. Thornell Aff. ¶¶ 24, 30, 31, 50. MDOC made substantial efforts to educate staff and inmates by reinforcing good hygiene, intensifying cleaning and disinfecting practices, and implementing social distancing and masking strategies. Newby Aff. ¶¶ 17-18; Thornell Aff. ¶¶ 21, 42-43. These proactive and serious steps show a robust response, not deliberate indifference.

MDOC has found only four confirmed inmate cases, all at one facility, despite MDOC immediately testing that entire facility within four days of the first positive result.[9] Thornell Aff. ¶ 55. MDOC did not stop there. MDOC traced the only two inmates who had recently transferred out of MCC, and tested and isolated them. *Id.* ¶¶ 53-54. These actions do not evidence reckless disregard of an excessive risk for any inmate. *Farmer*, 511 U.S. at 839.[10]

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actionable under the Eighth Amendment. *See Kosilek*, 774 F.3d at 82 (the objective prong of *Farmer* "does not impose upon prison administrators a duty to provide care that is ideal, or of the prisoner's choosing").

[9] This massive testing effort stands in stark contrast to the "shockingly limited" 75 total tests found to be available to the federal facility at issue in *Wilson v. Williams*, No. 4:20-cv-00794, 2020 WL 1940882, at *2 (N.D. Ohio Apr. 22, 2020), relied upon by Petitioners. Mot. at 14.

[10] Petitioners demand in the joint status report that MDOC immediately test inmates at other facilities (ECF No. 13 p. 3), but the Maine CDC's own guidance on testing in correctional facilities does not call for testing at other

Even before any positive cases, MDOC took extensive actions to protect inmates and staff, including increased cleaning of facilities and shared items, giving inmates and staff information on COVID-19 and its prevention, ensuring adequate supplies of medication and other essentials, creating isolation units, and planning for staff shortages. Thornell Aff. ¶¶ 9, 14-15, 21, 25. Early on, inmates were encouraged to seek medical care when ill and not to share personal items with others. *Id.* ¶ 21. MDOC worked with Wellpath to test suspected COVID-19 cases and developed protocols to encourage social distancing where feasible. *Id.* ¶¶ 17, 22; Newby Aff. ¶¶ 17, 20, 42.

Petitioners argue that MDOC is deliberately indifferent because, like the federal facility that was enjoined in *Martinez-Brooks v. Easter*, No. 3:20-CV-00569 (MPS), 2020 WL 2405350, at *22 (D. Conn. May 12, 2020), MDOC has allegedly been "slow and inflexible" in considering inmates for SCCP. Mot. at 14. But the record does not support Petitioner's claim. MDOC has considered for SCCP all of the eligible 900+ inmates in its custody with a medical condition that increases their susceptibility to COVID-19—nearly half of all inmates—making 95 placements so far. Thornell Aff. ¶¶ 62-63. In *Martinez-Brooks*, in contrast, the defendant officials considered only 159 of roughly 1,000 inmates for home confinement, approved only 21, and ignored Department of Justice guidance directing them to take COVID-19 risk factors into consideration. *Id.* at **22–23. Moreover, MDOC has far less flexibility with regard to home confinement than did the defendants in *Martinez-Brooks.* While the federal Bureau of Prisons is authorized under the federal emergency pandemic law to place *any* inmate in home confinement, *id.* at *22, MDOC

facilities until there is a reason to believe someone there has been exposed or is suspected of having COVID-19. Thornell Aff. ¶ 58. Petitioners' disagreement with MDOC's decision to follow the Maine CDC's guidance does not show deliberate indifference. *See Sires v. Berman*, 834 F.2d 9, 13 (1st Cir. 1987) (citations omitted) ("where the dispute . . . evidences mere disagreement with considered medical judgment, we will not second guess the doctors."); *see also Estelle v. Gamble,* 429 U.S. 97, 107 (1976).

can only place inmates in SCCP if they meet the statutory eligibility requirements.[11]

Because MDOC did not recklessly disregard an excessive risk to inmates, Petitioners' Eighth Amendment claim is unlikely to succeed on the merits.

B. Petitioners' ADA Claim Is Unlikely to Succeed on the Merits.

Petitioners claim that MDOC's response to the COVID-19 pandemic violates Title II of the Americans with Disabilities Act by discriminating against prisoners with certain conditions that are risk factors of the disease. But to make a Title II claim, the Petitioner must establish: (1) that he is a qualified individual with a disability; (2) that he was excluded from participating in, or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of his disability." *Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274, 283 (1st Cir. 2006) (quoting *Parker v. Universidad de Puerto Rico*, 225 F.3d 1, 5 (1st Cir. 2000)). Discrimination can be established in three ways: (1) disparate treatment, (2) disparate impact—that a government policy neutral on its face "falls more harshly on one group than another and cannot be justified by business necessity," or (3) failure to accommodate. *Nunes v. Mass. Dep't of Corr.*, 766 F.3d 136, 145 (1st Cir. 2014) (internal citations and quotations omitted). The first and third theory of discrimination require little discussion. There is no evidence that MDOC's COVID-19 policies and practices treat inmates with disabilities less favorably than the non-disabled. In fact, MDOC created a list of inmates with certain medical conditions at particular risk of COVID-19, shared those numbers with Petitioners' counsel in several meetings, and evaluated those inmates for potential expedited release on SCCP. Thornell Aff. ¶¶ 62-63, 69. Moreover, Petitioners' demand for the "reasonable

[11] As described in Dr. Thornell's affidavit, Petitioners' claim that MDOC is applying "stricter-than-usual" criteria to SCCP, Mot. at 15, is false. Rather, those criteria are for *expedited* placement through SCCP. Inmates not meeting those criteria continue to be considered for SCCP if they are eligible. Thornell Aff. ¶ 64.

accommodation" of granting all subclass members SCCP or medical furlough, regardless of eligibility, Mot. at 19, misconstrues MDOC's obligation under the ADA, which is to ensure that disabled inmates receive accommodations needed to allow them access those programs to the same extent as non-disabled inmates. There is no evidence that subclass members are being denied such accommodations.

That leaves only a disparate impact theory—that MDOC's neutral policies on medical furlough and home confinement nonetheless disproportionately impact individuals with disabilities and cannot otherwise be justified. While Petitioners cite the increased vulnerability to COVID-19 of individuals with certain medical conditions, that increased vulnerability is not caused by any act of MDOC, or its policies. *See Money v. Pritzker,* No. 20-cv-2093, 2020 WL 1820660, at *19 n.14 (N.D. Ill. Apr. 10, 2020) (rejecting claim that increased susceptibility of disabled inmates to COVID-19 established that prison's medical furlough and home confinement policies had a disparate impact on those inmates); *see also generally Frazier v. Kelley*, No. 4:20-cv-00434, 2020 WL 2561956, at *35 (E.D. Ark. May 19, 2020) (rejecting claim that prison officials' COVID-19 policies discriminated against disabled inmates). Instead, MDOC took action to identify inmates with medical conditions that make COVID-19 particularly risky, including a list of priority inmates from MDOC's medical provider, and evaluated them for SCCP confinement in March. Thornell Aff. ¶¶ 62-63. Petitioners have not shown that MDOC's policies "fall[] more harshly" on the disabled and "cannot be justified by business necessity." *Nunes,* 766 F.3d at 145. Not only is there no disparate impact, but MDOC's policies and actions are "justified by business necessity" for the same reasons that MDOC's robust response to COVID-19 satisfies the Eighth Amendment. *Id.* MDOC is tasked by statute with housing and caring for inmates for the duration of their sentences, and MDOC has taken innumerable actions that are within MDOC's power to

try to protect them from COVID-19. *See, e.g.*, Thornell Aff. ¶ 9-12, 21-24, 43, 52. Their actions are justified and do not discriminate against disabled inmates.[12]

C. Petitioners' Claims Are Barred for Failure to Exhaust.

Petitioners are also unlikely to succeed on the merits because they failed to exhaust remedies available in Maine courts. 28 U.S.C. § 2254 requires petitioners to have "exhausted the remedies available in the courts of the State" and further decrees that the petitioner "shall not be deemed to have exhausted . . . if he has the right under the law of the State to raise, by any available procedure, the question presented." *Id.* at § 2254(b)–(c). Petitioner Denbow is currently petitioning the Maine Superior Court for early release in a post-conviction review proceeding and thus has the right to raise the question presented in the State court. *See* ECF No. 13-2, 13-3. Petitioner Ragsdale has not even attempted to invoke state judicial processes to challenge his confinement. Because neither Petitioner has exhausted, their petitions are barred by § 2254.

Petitioners argue that § 2554 is inapplicable and that they must only overcome the more flexible non-statutory exhaustion requirement applicable to petitions under 28 U.S.C. § 2241. But the First Circuit has expressly rejected this minority view of § 2241, and instead takes the "majority view" that "prisoners in state custody are required to comply with all the requirements laid out in § 2254 whenever they wish to challenge their custodial status, *no matter what statutory label the prisoner uses*." *Gonzalez-Fuentes v. Molina*, 607 F.3d 864, 875 n.9 (1st Cir. 2010) (emphasis added); *see also In re Wright*, 826 F.3d 774, 778 (4th Cir. 2016) ("the majority view is that § 2241

[12] Petitioners frame their disability discrimination claim in part as an alleged failure of MDOC to provide appropriate medical care to inmates with certain medical conditions. Mot. at 18. The First Circuit has made clear that allegations of inadequate medical care, standing alone, are insufficient to state a claim under Title II. Rather, such a claim must be "framed within some larger theory of disability discrimination," such as evidence that alleged inadequate care was "pretext for some discriminatory motive, such as animus, fear, or apathetic attitudes" or evidence that the care was "discriminatory on its face, because it rested on stereotypes of the disabled rather than an individualized inquiry[.]" *Kiman*, 451 F.3d at 285 (quoting *Lesley v. Chie,* 250 F.3d 47, 55 (1st Cir. 2001)). Petitioners have not alleged pretext or facially discriminatory animus.

habeas petitions from convicted state prisoners challenging the execution of a sentence are governed by § 2254"). Nor can Petitioners avoid exhaustion by showing circumstances "that render [state] process ineffective to protect the rights of the applicant." 28 U.S.C. § 2254(b)(2)(ii). The Superior Court is moving forward with Petitioner Denbow's PRC petition. (ECF No. 13 p. 2.) Other putative class members are free to file similar petitions. Petitioners cite no authority for their novel argument that the lack of a class-action mechanism dispenses with the exhaustion requirement.[13] Petitioner's proposed class-action exception would erase § 2254's exhaustion requirement. Because state processes are pending and available, § 2254 bars this petition and renders Petitioners unlikely to succeed on the merits.

II. Petitioners Have Not Demonstrated Likely Irreparable Injury.

In addition to failing to demonstrate likelihood of success on the merits, Petitioners also cannot demonstrate that they are likely to suffer irreparable injury to justify a temporary restraining order or preliminary injunction. It is not enough for a party seeking injunctive relief to demonstrate a "possibility" of irreparable harm; rather, the movant must demonstrate that irreparable harm is "likely." *Winter*, 555 U.S. at 20. Basing preliminary injunctive relief "only on a possibility of irreparable harm is inconsistent with [the Supreme Court's] characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Id.* at 22.

Petitioners have not shown they are likely to suffer irreparable injury without an injunction. To date, there have only been four cases of COVID-19 in a single MDOC facility that is

[13]Courts have dismissed § 2254 petitions for failure to exhaust despite the petitions being styled as class actions. *See, e.g.*, *Mays v. Dart*, No. 20-C-2134, 2020 WL 1812381, at *6 (N.D. Ill. Apr. 9, 2020) (dismissing class-action habeas petition over COVID-19 response where named petitioners failed to exhaust); *Pace v. Chino Inst. for Men*, No. EDCV 09-00841CBM, 2009 WL 2189885, at *2 (C.D. Cal. July 21, 2009) (finding "no need to consider" whether a § 2254 petition may be brought as a class action where named petitioners failed to exhaust); *Robinson v. Leahy*, 401 F. Supp. 1027, 1032 (N.D. Ill. 1975) (dismissing class action for failure to exhaust under § 2254).

considerably less remote than the facility housing Petitioners. *See Dawson v. Asher*, No. C20-0409JLR-MAT, 2020 WL 1304557, at *3 (W.D. Wash. Mar. 19, 2020) (finding no irreparable harm to an inmate from COVID-19 where there was "no evidence of an outbreak at the detention center or that Defendants' precautionary measures are inadequate to contain such an outbreak or properly provide medical care should it occur"). MDOC's impressive track record in keeping COVID-19 out of the prisons stands in stark contrast to other correctional systems that have been subject to injunctive relief in other states. *See, e.g. Robenson v. Decker*, No. 20-5141, 2020 WL 2611544, at 7 (D.N.J. May 22, 2020) (identifying "large number of cases" at correctional facility as key factor in TRO analysis); *Martinez-Brooks v. Easter*, No. 3:20-CV-00569 (MPS), 2020 WL 2405350, at *27 (D. Conn. May 12, 2020) (finding irreparable harm where prison was suffering "one of the worst [COVID-19 outbreaks] in the federal prison system").

Here, Petitioners are not likely to suffer irreparable harm if the Court fails to award them the six categories of injunctive relief they seek, ranging from directing MDOC's COVID-19 testing protocols (with no input from the Maine CDC), release of inmates into the community while their petition is pending, and "mandating compliance with" CDC "guidance including adequate physical distancing and necessary hygiene." ECF No. 5 pp. 2-3; ECF No. 13 p. 3. Petitioners ask the Court to ignore U.S. Supreme Court precedent mandating deference to State prison officials in managing its prisons[14] and instead issue an injunction consisting of widely varying types of relief that are unmoored from the status quo. The named Petitioners remaining at Mountain View, in rural Maine, until the end of their sentences (both this summer) does not show

[14] *See Preiser v. Rodriguez*, 411 U.S. 475, 491-92 (1973) ("It is difficult to imagine an activity in which a State has a stronger interest . . . than the administration of its prisons"); *Bell v. Wolfish*, 441 US. 520, 562 (1979) (warning courts against becoming "enmeshed in the minutiae of prison operations.").

a likelihood of irreparable injury. Similarly, given that MDOC provides medical care on site (often in the housing unit), requires social distancing and cloth masks except where infeasible, and has implemented near constant cleaning, Petitioners have not shown that remaining in place creates a likelihood of irreparable injury. Petitioners have not shown an "imminent—rather than speculative—possibility" that they will suffer irreparable harm from COVID-19 if not released from custody[,]" and their request for injunctive relief should be denied. *Engelund v. Doll*, No. 4:20-CV-00604, 2020 WL 1974389, at *12 (M.D. Pa. Apr. 24, 2020).

III. The Balance of Equities and the Public Interest Favors MDOC.

When the government is the opposing party, the balance of equities and the public interest merge into a single factor. *See Pursuing Am.'s Greatness v. FEC*, 831 F.3d 500, 511 (D.C. Cir. 2016) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)). Here, MDOC and the State of Maine as a whole have a compelling interest in having inmates serve the sentence imposed by the judicial system and completing the attendant rehabilitative programs. *See United States v. Salerno*, 481 U.S. 739, 750 (1987) (stating in the face of a challenge to pretrial detention that the "Government's general interest in preventing crime is compelling").

Certain putative class members are convicted of serious and violent crimes, and others are segregated from the general prison population because they pose a safety risk. Thornell Aff. ¶ 68. Indiscriminately releasing these inmates into the community—particularly on unmonitored medical furloughs, as Petitioners propose—would significantly threaten public safety. *Id.* MDOC already evaluated inmates with certain medical conditions for potential release through SCCP. *Id.* ¶¶ 62-63. That program's requirement that an inmate have a low security classification ensures that the community is protected from higher-risk inmates. 34-A M.R.S. § 3036-A(2)(D). The statutory requirement that the inmate have a residence approved by the Commissioner, *id.* § 3036-A(3)(B), ensures that inmates are not released into unsafe or unstable living situations. The record

shows that MDOC is in fact using the SCCP for inmates susceptible to COVID-19 complications and that MDOC has reviewed every such inmate, in order to determine if they are eligible for SCCP, and, if so, if that program is appropriate. Thornell Aff. ¶¶ 62-63. Ninety-five individuals have been released to SCCP since the start of the pandemic. *Id.* ¶¶ 11, 63. The remaining inmates are either categorically ineligible, or MDOC determined that SCCP was otherwise inappropriate based on the specific factual circumstances for that inmate. *Id.* ¶¶ 62-63. The public interest supports keeping the program's statutory safeguards in place, rather releasing inmates who are either potentially dangerous or who do not have a safe, appropriate place to live.

Conclusion

The evidence shows that MDOC took early, immense, and successful steps to protect inmates from the threat of COVID-19, and that these actions do not violate the ADA or the Eighth Amendment. Because Petitioners are unlikely to succeed on the merits, are unlikely to suffer irreparable harm given MDOC's response to the virus, and because the balance of equities and the public interest weigh strongly in MDOC's favor, this Court should deny Petitioners' motion.

Dated: May 27, 2020

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UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

JOSEPH A. DENBOW et al.,	)	
	)	
Petitioner	)	
	)	
v.	)	**Case No. 1:20-cv-00175-JAW**
	)	
MAINE DEPARTMENT OF CORRECTIONS et al.,	)	
	)	
Respondents	)	

AFFIDAVIT OF DR. RYAN THORNELL, Ph.D., IN OPPOSITION TO MOTION FOR TEMPORARY RESTRAINING ORDER

I, Ryan Thornell, Ph.D., declare as follows:

1. I am over the age of 18 years and not myself a party to this action. I understand and believe in the obligations of an oath.

2. I have personal knowledge of the facts stated in this affidavit, and if called upon to testify, I would testify to those facts. In preparing this affidavit, I have also reviewed records and reports regularly kept by the Maine Department of Corrections (MDOC) that are available to me and that I rely on in my official duties.

3. I am Deputy Commissioner of Corrections for Respondent MDOC. I have been Deputy Commissioner since January 2018. I have worked for MDOC for five years. I previously led the Maine Board of Corrections (Maine's coordinated jail system) and formerly served as faculty at the University of Sioux Falls in criminal justice.

4. I have a Ph.D. in Political Science from the University of South Dakota. I have a Master of Science degree in criminal justice from the University of Cincinnati, and a Bachelor of Science degree in criminal justice and sociology from the University of Sioux Falls.

MDOC's COVID Response Team:

5. I am in charge of MDOC's response to the COVID-19 pandemic. I lead the MDOC COVID-19 Planning and Response Team, which was formed on March 3, 2020. I report all updates and pertinent information from the Response Team to MDOC Commissioner Randall Liberty. Since March 3, 2020, I have held daily briefings (every weekday and on weekends as necessary) with this team regarding developments in the prior 24 hours, regional and facility updates, planning, and requests from the Maine Center for Disease Control and Prevention (Maine CDC). Other members of this team include MDOC Associate Commissioners, the MDOC Health Services Coordinator, the MDOC Director of Classification and Pre-Release, Dr. John Newby (Regional Vice President for Wellpath, MDOC's contracted medical provider for all MDOC facilities), MDOC's Deputy Director of Operations, MDOC's Director of Security, and the Chief Administrative Officers[1] of the facilities. This team is responsible for implementing MDOC's COVID-19 Response Plan.

6. I also confer daily on weekdays and weekends, and more often as necessary, by telephone with Dr. Nirav Shah, Director of the Maine CDC.

Timeline of MDOC's COVID-19 Response:

7. During the first week of March 2020, MDOC developed a three-phase approach to combating COVID-19, in consultation with the Maine CDC, the Maine Emergency Management Agency (MEMA), and the Governor's Office. Each successive phase implements escalating

[1] The term "Chief Administrative Officers" refers to the heads of the facilities and probation, including the wardens of adult facilities and the Superintendent of the Long Creek Youth Development Center.

protective measures within MDOC against the spread of COVID-19, and is triggered based on specific risk-based benchmarks. Phase 1 (Preparation and Prevention) occurred immediately. MDOC moved to Phase 2 when there was a confirmed case in the Maine community. Phase 3 began at the Maine Correctional Center (MCC) in Windham on May 19, when MDOC found the first confirmed case of COVID-19.

Phase I Response

8. On March 5, 2020, MDOC sent a memo to all staff, alerting them that while there were no confirmed COVID cases in Maine, MDOC had established a phased approach to COVID-19 prevention. The memo stated that Phase 1 had begun and included increased cleaning at the facilities, particularly with respect to the tablet computers available for inmates[2] to check out on a daily basis, communal TVs, kiosks, computers, gym equipment, and other shared items. The memo also included the U.S. CDC's recommendations regarding handwashing. A true and correct copy of that memo is attached to this affidavit as Exhibit A.

9. As part of Phase 1, MDOC implemented increased cleaning practices (like those done during past influenza outbreaks), including giving inmates and staff cleaning supplies and cleaning living and educational areas, computers, tablets, gym equipment, and common areas, along with staff training, and posting and disseminating information to inmates and staff about COVID-19 from the U.S. CDC. In addition, MDOC inventoried supplies and strongly encouraged inmates to get flu vaccines. MDOC also began planning for potential staffing shortages due to COVID-19.

[2] I use the term "client" to refer to those individuals served by MDOC or in MDOC's custody, including juveniles, probationers, and adults housed in MDOC facilities. For clarity, this affidavit refers to the clients housed in adult MDOC facilities as "inmates."

10. On March 6, 2020, MDOC put information regarding COVID-19 on the tablet computers that inmates use daily in MDOC housing units.

11. As discussed further in paragraphs 62-68 below, in mid-March 2020, MDOC and Wellpath compiled a list of inmates with conditions considered by the U.S. CDC to place them at higher risk of illness from COVID-19, and MDOC reviewed whether each of them was eligible for the Supervised Community Confinement Program ("SCCP"), a program by which inmates are housed in the community under certain conditions and with supervision. As a result, 95 inmates have been moved to community confinement since March 1, 2020.

12. In early March 2020, MDOC consulted with its medical provider, Wellpath, and the Maine CDC to review and update previously-developed protocols for viral outbreaks and aligned the protocols with the U.S. CDC's then-existing recommendations for COVID-19. Medical staff conducting "med-line" (giving out medication) and medication-assisted treatment ("MAT")[3] in the facilities also began using Personal Protective Equipment (PPE) (surgical masks, face shields, and gloves) to reduce the spread of germs.

13. MDOC also restricted non-staff access to the facility infirmaries and medical assisted living units, meaning that inmates (such as inmate hospice workers and inmate janitorial workers) would no longer enter those units.

14. Since early March 2020, MDOC has actively monitored the U.S. CDC's materials for updated guidance, implemented N-95 mask and PPE training, orchestrated trainings by medical staff of MDOC staff interacting with inmates, and had facility food services prepare by maintaining a one-month supply of paper goods and food. MDOC also ensured that facilities stocked up on

[3] MAT involves the use of a medication (such as methadone or suboxone) in combination with counseling and behavioral therapies to treat substance addiction. In MDOC, nearly 200 inmates with opioid use disorder receive such medications.

medical supplies, prescription medications, and cleaning supplies. There have not been any shortages of these in MDOC to date, nor are any shortages anticipated.

15. MDOC also ensured that each facility identified a location for isolating suspected COVID-19 cases and that each facility had a plan for any staff shortages caused by COVID-19.

16. Also as part of Phase 1, Wellpath and MDOC contacted hospitals local to the prisons (such as Maine Medical Center, PenBay, and Mercy Hospital) to discuss procedures for emergency medical transports and treatment of suspected COVID-19 cases that required hospital attention. During Phase 1, MDOC and Wellpath instituted rapid flu and Respiratory Syncytial Virus (RSV) testing for inmates to address flu-like symptoms. MDOC and Wellpath also worked together to project and monitor use of PPE, flu vaccines, and rapid influenza tests.

17. During Phase 1, MDOC also worked with Wellpath regarding testing of suspected COVID-19 cases at MDOC facilities. MDOC's Health Services Coordinator Holly Howieson and Wellpath Regional Medical Director Dr. Robert Clinton consult regarding any inmates to be tested, and Dr. Clinton gives the physician order for the tests. Medical staff collect the swabs for the tests on site. The Maine Health and Environmental Testing Laboratory has processed the majority of inmate samples.

18. Overall, MDOC has performed over 750 COVID-19 tests on inmates and staff since the start of the pandemic.

19. On March 13, 2020, MDOC sent a memo to all MDOC staff regarding the first presumptive community case of COVID-19 in Maine, and explaining additional steps being taken to reduce the spread of germs. A true and correct copy of this memo is attached to this affidavit as Exhibit B.

20. On March 12, the Governor suspended all non-essential State employee travel outside of Maine, which MDOC applied to its staff.

21. On March 12, 2020, MDOC issued information for the Chief Administrative Officers to provide to inmates, alerting them that they would see increased cleaning practices and posted signage about hand washing, symptoms, and facts about COVID-19. Inmates would also see the medication line and medically-assisted treatment staff using PPE as a precautionary measure. Inmates were instructed on proper handwashing and noted that the CDC did not recommend the use of facemasks as a preventative measure for those without symptoms. Inmates were encouraged to alert medical personnel if they are sick, not to share personal items with others, and to get flu shots if they had not already (to prevent the spread of the flu) and informing them that the flu shot would not prevent COVID-19. MDOC sent the information to the Chief Administrative Officers, who held unit "town halls[,]" put the information on tablet computers available to inmates, and used print memos. The Chief Administrative Officers reported back to the Response Team during the daily calls after providing the information to the inmate population. Also in March, MDOC developed a protocol for cleaning inmates' cells and property that MDOC sent to the Chief Administrative Officers to communicate to inmates.

Phase II Response

22. Due to confirmed cases in Maine communities, on March 13, in consultation with MEMA and the Maine CDC, MDOC implemented Phase 2 of the Response Plan and alerted all staff. As part of Phase 2, MDOC encouraged social distancing practices where feasible, modified medication administration procedures (so they could happen in the housing unit where feasible), and limited group sizes for dining, gym, and fitness areas. MDOC also developed in-cell educational and program materials in the event of prolonged restrictions on inmate movement.

23. Also during Phase 2, MDOC had facility kitchen staff (including inmates) be questioned and temperature-checked for fever at each shift before beginning work. MDOC also began and continues to require that kitchen staff wear masks.

24. As part of Phase 2, MDOC began logging the monitoring and quarantining of staff and inmates, as well as possible exposures. MDOC also limited movement of behavioral health staff between the facilities, assigning each person to a single primary facility. MDOC further began tracking PPE use and providing periodic updated guidance on PPE use.

25. As part of Phase 2, MDOC posted signs in the facilities regarding hand washing, symptoms, and general fact sheets about COVID-19. MDOC also began using medical questionnaires regarding COVID-19 and taking vital signs on new inmate intakes.

26. As of March 14, all facility visits were suspended for family, friends, volunteers, and other non-professional visitors. MDOC also made alternate reporting arrangements for probationers so that in-person reporting would not be required.

27. Due to the restrictions on visits, inmates were given 20 free messages per week on the tablet computers and 2 free 10-minute phone calls per week. Extra weekly postage was made available to inmates without tablet access.

28. As of March 14, MDOC had Juvenile and Adult Community Corrections Officers (probation) revise their detention protocols, limiting detention to those posing an immediate threat to public safety.

29. On March 16, 2020, MDOC activated an internal "Incident Command" (the process used to respond to emergencies) and set up an incident command center at the central office and at each correctional facility to manage the prevention of COVID-19 and to prepare for its eventual infiltration of MDOC facilities.

30. As of March 16, MDOC ordered that any intakes from county jails would go to MCC only (except for inmates needing to be housed in the intensive mental health unit at Maine State Prison (MSP)). Also as of March 16, there would be no more cross-facility shift work by staff. Staff would have permanent posts at a single facility.

31. On March 18, 2020, MDOC distributed strict entrance screening requirements for entrance to the prisons that MDOC developed in consultation with the Maine CDC and MEMA. This screening applied to everyone entering MDOC facilities, from the warden all the way down and required that temperatures be taken and entrance questionnaires be completed. These screening requirements dictated that entry would be automatically denied if the person had done any air or cruise travel within the last 14 days. In addition, anyone displaying symptoms of COVID-19 would be denied entry. Any cases requiring additional discussion were to be referred to the MDOC Incident Command.

32. On March 18, 2020, MDOC suspended work release and community work programs, so that inmates would not be going out into and returning from the community and potentially being exposed to COVID-19.

33. On March 23, 2020, the U.S. CDC issued particular guidelines for correctional facilities. A true and correct copy of those guidelines is attached to this affidavit as Exhibit C. The guidelines lay out best practices and often lay out alternatives. MDOC adheres to the U.S. CDC guidelines except in limited cases in which adherence is infeasible given the physical parameters of MDOC's facilities. For example, MSP has two large ball fields for recreation, making it easier to keep the recommended distance there than in recreation spaces and program areas at Mountain View. Similarly, staff are being screened in the lobby at MSP but are being screened outside in a tent at MCC, based on the extremely small lobby area at its entrance.

34. MDOC issued N-95 mask fit-testing and facial hair guidance to staff on March 24, 2020, and provided guidance to the Chief Administrative Officers regarding staff returning to work after absences.

35. On March 31, 2020, MDOC began publishing on the web every weekday information regarding COVID-19 in MDOC facilities on the "Daily COVID-19 Dashboard," available at maine.gov/corrections. That Dashboard continues to be updated every weekday. The information posted includes the number of inmates tested, the number of pending tests, the number of positive results and negative results, the number of inmates refusing the tests, as well as population data and data on the Supervised Community Confinement Program. As of today, May 27, 2020, the Dashboard reflects that 494 inmates have been tested, that 3 have refused, that only 4 have tested positive, and that 487 have tested negative for COVID-19. The testing numbers include all inmates and staff at MCC.

36. On March 31, the Commissioner sent a notice to all MDOC staff regarding an employee at Bolduc Correctional Facility who had tested positive for COVID-19. The same day, the Commissioner issued a statement to the press about the positive staff test.

37. As a result of this positive staff test, on April 1, 2020, MDOC issued a directive regarding positive case reporting and "contact tracing" to the Chief Administrative Officers. The Maine CDC provided MDOC with guidelines for "contact tracing" upon any positive COVID-19 test, which means identifying contacts within six feet of the positive-tested person for 30 minutes or longer during the forty-eight hours prior to the person showing symptoms and testing and quarantining them, and identifying other, less significant contacts. MDOC's directive also calls for notifying all inmates and staff at the site of a positive test, without the person's identifying information.

38. As of April 6, 2020, MDOC dictated that all new inmate intakes would be met in receiving by staff wearing full PPE (n95 masks, face shields, gowns, and gloves) for an initial assessment by medical, including COVID-19 screening questions.

39. Also as of April 6, all MDOC facilities implemented video-based visitation (utilizing Zoom technology). All inmates are permitted at least one fifteen-minute Zoom visit per month and more as facility schedules and resources allow.

40. On April 7, MDOC issued guidance to the Chief Administrative Officers on staff and inmate use of cloth masks. This guidance followed guidance issued by the U.S. CDC on April 3, 2020, recommending use of such masks by non-symptomatic individuals. As of April 10, each inmate would and did receive a cloth mask, and a second mask was issued on April 13. Those inmates refusing masks were logged (but also permitted to later request a mask). The guidance stressed that the U.S. CDC recommended physical distancing and hand washing to manage the spread of virus and that cloth masks were not a substitute for this and other U.S. CDC recommendations. The MDOC guidance also specified that medical-grade PPE would only be utilized by facility staff and medical providers potentially coming into contact with someone exposed to COVID-19, symptomatic for COVID-19 or influenza, confirmed positive for COVID-19 or influenza, or staff performing off-site transports in high risk locations such as the emergency room.

41. Since mid-April, MDOC industries workers have been producing PPE, including reusable gowns, face shields, and masks for use in DOC facilities (and distribution to jails and DHHS crisis workers).

42. As of April 13, MDOC required social distancing practices to be followed in all facility areas outside of an inmate's individual cell/living area, where practical and possible.

43. Also on April 13, MDOC required that cloth face masks be used in all facility areas when and where social distancing is not available. This is subject to practical limits. In a dining hall, for example, inmates cannot eat while wearing a mask. MDOC is issuing disciplinary sanctions against inmates failing to comply with this policy. I am unaware of any staff thus far refusing to abide by this directive, but any refusal would be treated the same as that employee refusing any other order.

44. As of April 13, MDOC required each facility to implement plans to modify necessary operations to allow for enhanced social distancing practices (i.e. to accommodate altered meal schedules, or reduced numbers in activities areas), while maintaining activities and recreation periods, where practical.

45. On April 28, 2020, MDOC industries produced an N95 fit-testing hood prototype, at the request of Maine CDC, to provide hoods for statewide usage.

46. On April 29, MDOC launched a process for inmates to request to see behavioral health by using the tablet computers, rather than having to make an in-person or hand-written request.

47. Also in April, MDOC developed a plan to expand medical services in secure facilities, in case of an overflow of COVID-19 cases at local hospitals and emergency rooms.

48. Within a prison housing unit, inmates are instructed to distance to the extent possible. Just as the U.S. CDC advises members of the general population to distance outside of their direct household, inmates are encouraged to distance outside of their cells. For example, in a four-person dorm room at a Mountain View dormitory, those four inmates are not always able to maintain six feet of distance during the times they are confined to their rooms (overnight and for two daytime count periods of approximately 60-90 minutes). These inmates are not required to

wear masks in their four-person dorm room or while they are on their own floor of the building but are instructed to distance as much as possible. The dormitory inmates also eat and move separately from inmates assigned to other floors.

49. In every MDOC facility, including in each dorm at Mountain View, inmates have access to hand sanitizer with a 70% alcohol content. The U.S. CDC generally recommends handwashing over hand sanitizer, but if hand sanitizer is used, the CDC recommends that it contain at least a 60% alcohol content. At Mountain View, as at other facilities, this hand sanitizer is stored behind the officer's desk, and the officer dispenses it, due to the 70% alcohol content and potential for misuse. Attached as Exhibit D to this affidavit are true and correct copies of photographs (taken May 22, 2020) of the hand sanitizer in use at the Mountain View dormitories. The same hand sanitizer was in use in April 2020.

50. On April 13, the county jails and MDOC agreed that admissions of inmates to MDOC facilities from county jails would be suspended. On May 15, 2020, Governor Mills issued Executive Order 54, mandating that there would be no admissions from county jails to MDOC until the emergency declaration ends.

51. On April 29, Governor Mills extended the Stay-Healthy-at-Home Order until June 1, and MDOC also alerted inmates and staff that all of MDOC's COVID-19 related practices would extend until June 1, 2020, including restrictions on in-person visitation. This information was also posted on MDOC's website.

Phase III Response

52. Phase 3 of the Response Plan was initiated on May 19 for MCC, due to the positive test there. Phase 3 means that recreation, education, and other programming and most inmate movement are stopped at MCC ("locked down") to limit contact between groups of inmates. Phase

3 also means that officers coming into contact with inmates are using n95 masks, that inmates receive meals in their housing units, that medication is administered in the housing unit, and that inmate "sick calls" (medical requests or needs) are triaged in the housing unit when possible, instead of having the inmates visit the clinic at MCC. Emergency medical care and care in the MCC clinic are still provided, as needed. This lockdown period will last at least through the next round of testing, which began on May 27. Depending on the results of that re-testing, the lockdown may need to continue.

53. The other MDOC facilities continue to take Phase 2 precautions. MDOC applies Phase 3 procedures only to facilities where a positive case has been found, because these restrictions result in a lockdown status that substantially limits inmate access to recreation, programs like education, and out of cell time. MDOC works to limit the duration of those substantial restrictions. There is very little risk that the cases found at MCC will be the source of infection at other MDOC facilities. In the last month, the only inmate transfers from MCC to another facility were three inmates who had to be transferred to MSP. One was transferred to the Intensive Mental Health Unit at MSP due to his urgent mental health needs. The second inmate transferred from MCC to MSP after seriously assaulting a staff member at MCC. Due to this staff assault, that inmate would likely be housed in restricted housing for several weeks at a minimum (depending on the outcome of the disciplinary process). That inmate could not remain at MCC, because MCC's restrictive housing area is designed for only short stays. At MSP, that inmate would have expanded recreation and out-of-cell time. The third transfer (on May 27, 2020) was necessary for the inmate to obtain medical and behavioral health treatment. He was tested for COVID-19 for a second time before transfer, and the result was negative.

54. When MDOC received the first positive MCC test, MDOC isolated the two inmates who had recently transferred from MCC and tested them for COVID-19.

Current Status of COVID-19 in MDOC Facilities:

55. MDOC did not have a confirmed case of COVID-19 until May 19, 2020, when an inmate at MCC tested positive. At that point, MDOC began immediate testing, starting with those potentially exposed to that confirmed case. All inmates and staff at MCC were tested by May 22, 2020, save for the handful of inmates who refused, resulting in four positive inmate tests and no positive staff tests. The second positive inmate case was confirmed on May 22, 2020, and two additional cases were confirmed on May 23. All four inmates who tested positive were housed at MCC and have been placed in isolation there. Wellpath medical providers are caring for them, with nursing staff attending to them multiple times per day. None of the four have required hospitalization. Their identities are not being released to protect their privacy. Three are under age 50, and one in is in his late 60s (and has been in prison since 1998).

56. These inmates will remain isolated for at least fourteen days from the date of their positive test and will not be reintegrated with other inmates until they are symptom-free and have had two confirmed negative COVID-19 tests.

57. Given these four positive tests, on May 24, 2020, MDOC submitted a plan to the Maine CDC to perform another round of universal testing. The Maine CDC approved the plan, and the re-testing began May 27. It will be conducted in waves and is expected to be completed by June 1. This is in line with the Maine CDC's universal re-testing recommendations, in particular that correctional staff who tested negative not be tested again for seven days. *See* May 23, 2020 Maine Health Alert Network Public Health Advisory, a true and correct copy of which is attached as Exhibit E to this affidavit.

58. The Maine CDC does not recommend testing at other MDOC facilities until there is a reason to believe inmates or staff in those facilities have been exposed or are suspected of having COVID-19. *See* May 23, 2020 Maine Health Alert Network Public Health Advisory (Ex. E) p. 1.

59. Within hours of learning of the first positive test, MDOC notified staff, and Commissioner Liberty notified the appropriate legislative representatives. Also within hours of the first positive test, MDOC issued a press release to keep the public apprised of the current status of COVID-19 in MDOC facilities and the steps taken to reduce the spread of the virus. The MDOC press release regarding the first positive inmate was filed with the Court on May 20, 2020, at ECF No. 13-1.

60. Within hours of each subsequent confirmed test, MDOC has issued a press release, keeping the public apprised of the current status of COVID-19 in MDOC facilities and the steps taken to reduce the spread of the virus. A true and correct copy of the MDOC press releases regarding the confirmed positive cases on May 22 and 23 are attached to this affidavit as Exhibits F and G.

61. On May 23, 2020, the warden of Maine Correctional Center, Scott Landry, declared an emergency at the prison, and Commissioner Liberty obtained approval from Governor Mills to divert staff to the Maine Correctional Center to ensure the facility can adequately address the emergency and to assist in universal re-testing at MCC. During this emergency period at MCC, more staff is needed, because the facility will be locked down and inmate movement restricted to reduce the spread of COVID-19. Additional officers are needed for meal delivery, laundry, and escorting medical personnel during COVID-19 re-testing.

Supervised Community Confinement & Medical Furlough Programs:

62. In mid-March 2020, MDOC and Wellpath compiled a list of inmates with conditions considered by the U.S. CDC to place them at higher risk of illness from COVID-19, including asthma, hypertension, chronic lung disease, chronic kidney disease, diabetes, liver disease, and certain other conditions. MDOC continues to maintain that list, which comprises over 900 inmates, and evaluate inmates for SCCP. MDOC also asked Wellpath to provide a list of inmates with such conditions who should have priority for consideration for the Supervised Community Confinement Program ("SCCP"). MDOC's Classification Department then evaluated every inmate on these lists (starting with those identified by Wellpath as most at risk) for potential placement on SCCP. The Classification Department had to determine which inmates were statutorily eligible under 34-A M.R.S. 3036-A and 03-201 C.M.R. ch. 10. Many of these inmates did not meet statutory or regulatory eligibility requirements based on their sentence and/or security level (*see* 34-A M.R.S. §§ 3036-A(2) & 03-201 C.M.R. ch. 10, pt. VI(B)).

63. For the remaining potentially-eligible inmates, the MDOC Classification Department reviewed each inmate's case for potential SCCP placement. Certain aspects of the SCCP investigations that are typically required (which include inspecting the proposed residence, contacting local law enforcement, and contacting victims, among other steps) were modified to fast-track releases to SCCP for inmates meeting certain criteria. Since March 1, 2020, 95 inmates (including men and women) have been released to SCCP. Five have since returned to custody for substance abuse, removal from sober living programs, and other issues. Twenty more inmates are currently in some phase of the SCCP process (completing the application process with their unit team, having probation evaluate their proposed transition plan, or awaiting their SCCP release date).

64. It is not accurate to claim that MDOC has imposed stricter-than-usual requirements on the SCCP program since the start of the pandemic. Rather, as described above, MDOC is expediting placements for inmates who meet certain criteria, such as having less than one year remaining on their sentences, by conducting expedited investigations of the proposed home in which the inmate would live. MDOC continues to consider inmates for SCCP if they meet statutory and regulatory requirements even if they do not meet the new criteria for an expedited placement.

65. The authority for the Commissioner to release inmates to SCCP is by statute, and the statute sets limits on that authority. For example, inmates are not eligible for SCCP if they have a security classification level higher than minimum. 34-A M.R.S. § 3036-A(2)(D). Inmates are also not eligible until they have less than 18 months left on their sentence and until they have served a portion of their sentence (1/2 of the prison term if it is less than five years, 2/3 of the prison term if it is more than 5 years).[4] 34-A M.R.S. §§ 3036-A(2)(B), (C).

66. As directed by 34-A M.R.S. § 3036-A(1), the Commissioner set rules governing the SCCP program in a written policy, a true and correct copy of which is attached as Exhibit H. The SCCP Policy and the statute specify that to be approved for SCCP, an inmate must have a proposed residence that is approved by MDOC. (Ex. H Procedure C; 34-A M.R.S. § 3036-A(3)(B). The SCCP Policy specifies that the residence must also not be the residence of other offenders or crime victims. (Ex. H Procedure C).

67. It is especially important during a pandemic that inmates not be released without an appropriate residence.[5] Homeless shelters are not appropriate residences for inmates released

[4] The statute is more nuanced, addressing "split sentences" (not straight prison time), which are more common.
[5] For inmates who finish their sentence and are to be released during the COVID-19 pandemic, MDOC staff coordinates release plans and placements with those inmates months in advance, helping them prepare for office and service closures due to COVID-19. Even before the pandemic, MDOC has done pre-release planning for inmates, which involves assisting inmates in searching for housing and obtaining medical insurance and care (including medically-assisted treatment for addiction) after release.

on SCCP, because of the impossibility of determining if the homeless shelter also houses other offenders or crime victims. In addition, there have been media reports of large-scale spread of COVID-19 in homeless shelters, both in Maine and elsewhere. *See, e.g.*, Callie Ferguson, "Bangor homeless shelter records coronavirus outbreak among 20 residents and staff," *Bangor Daily News* (May 5, 2020), https://bangordailynews.com/2020/04/29/mainefocus/bangor-homeless-shelter-records-coronavirus-outbreak-among-20-residents-and-staff/. Release of an inmate on SCCP to a homeless shelter would place the inmate at a high risk of contracting the virus.

68. Some of the 900+ inmates with pre-existing medical conditions are incarcerated for violent crimes, including murder, sex offenses, arson, and other violent crimes. Some are currently housed in higher security housing units due to the danger that they have been deemed to pose to staff and other inmates. Releasing such inmates on unsupervised medical furlough would pose a danger to the victims of these offenders and to the community at large. Such releases would also violate the SCCP statute, which makes the program only available to minimum custody inmates.

69. During the process of evaluating inmates for SCCP, the Commissioner of MDOC and others met several times with representatives of the Maine ACLU, including Emma Bond, and provided her with the number of inmates with the medical conditions identified by the U.S. CDC as having an increased risk from COVID-19. MDOC also provided the Maine ACLU with information on their crimes (whether violent or non-violent). The Maine ACLU requested that all 900+ inmates be released on medical furlough.

70. Medical furlough is controlled by 34-A M.R.S. § 3035(2)(C), which states that a "furlough may be granted *for the obtaining of medical services* for a period longer than 10 days *if medically required*." (Emphasis added.) In the past, MDOC has used medical furlough (usually for a short time) when a medical provider believes that medical treatment or a medical procedure

is necessary, and it cannot be done within MDOC or within ten days at a hospital. There is no monitoring of individuals on medical furlough. MDOC is not presently using medical furlough to release inmates with hypertension, for example, simply because of the risk of COVID-19. Such inmates are not seeking release to obtain medical services, nor has a physician deemed it medically required to release these inmates for obtaining medical services to bring them within 34-A M.R.S. § 3035(2)(C). Not only that, but many medical services normally available in the community have been halted due to COVID-19, unless they are emergent.

Conclusion:

71. Prison populations in other states face a much graver threat from COVID-19 and have many more inmates afflicted with the virus. I or another member of the Department's Incident Command Team participate in weekly calls with the heads of other state prison systems. From these interactions, I have learned that Ohio has over 4,400 confirmed inmate cases of COVID-19 and has had over 60 inmate deaths. Michigan has over 3,000 confirmed cases and has had over 50 inmate deaths.

72. MDOC has been able to stave off the entrance and spread of COVID-19 in Maine's facilities for quite some time. It is remarkable that after testing the entire population (inmates, staff, and medical) at MCC over a four-day span, only four positive cases were found. I attribute MDOC's ability to delay and limit COVID-19's impact to MDOC's immense early planning and the swift action MDOC took to limit movement in and out of the prisons, to maintain clean facilities, and to provide inmates and staff with information regarding the virus and effective means of stopping the spread of germs.

73. I believe that these continued efforts and the measures MDOC has taken since learning of the positive cases show that the leadership at MDOC, in conjunction with the Maine CDC and the Governor's Office, are acting with the highest concern for MDOC inmates and staff.

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

May 27, 2020

/s/ Ryan Thornell
Ryan Thornell, Ph. D.
Deputy Commissioner of Corrections
Maine Department of Corrections

Exhibit A

STATE OF MAINE
DEPARTMENT OF CORRECTIONS
111 STATE HOUSE STATION
AUGUSTA MAINE
04333-0111

JANET T. MILLS
GOVERNOR

RANDALL A. LIBERTY
COMMISSIONER

Memo

To: All staff of the Department of Corrections

From: Commissioner Randall A. Liberty

Cc: Robert Long, Maine CDC
Scott Ogden, Governor's Office

Date: March 5, 2020

Re: Coronavirus

Dear Staff,

On Tuesday, March 3, Governor Mills sent an email to all State employees outlining Maine's preparations and response to the coronavirus (COVID-19). If you have not read it, please do so. Even though there are no confirmed cases in Maine and the risk to Mainers remains low I encourage you to also review the federal CDC's website and the Maine CDC's website on COVID-19. These websites provide factual, up to date information and offer useful strategies to help us think about and plan for the potential spread within DOC facilities and offices.

I am part of the Governor's Coronavirus Response Team, which means I am receiving regular briefings from the Maine CDC and Maine Emergency Management Agency (MEMA). As part of this response team I am in regular communication with other agencies, health authorities and leaders focused on prevention, preparedness, and management of any future cases in Maine.

This memo serves as official communication to all staff on DOC's approach and response to COVID-19. I will utilize this method going forward to make you aware of new information or changes to DOC practices and procedures.

To keep an organized flow of communication I ask that you reach out to your CAO or office director when you have questions. They, in turn, will reach out to Deputy Commissioner Thornell and myself who will confer with an internal team and others including Maine CDC and MEMA as necessary. It is important staff respect this chain of communication, rather than individually reaching out to CDC, MEMA or others.

Under my direction the DOC is taking a phased approach to prevention and management related to COVID-19. The first phase, which is what we are currently in, is focused on prevention and preparation. You will find these methods similar to approaches taken during influenza outbreaks.

Your CAO or office director will provide you details on implementation of the following phase one prevention and preparation procedures:

- Increased cleaning practices at all facilities and offices.
- Increased cleaning of tablets, TVs, kiosks, computers, gym equipment, other shared items.
- Review of practices related to visitation.
- Use of appropriate signage and communication in our facility and office lobby areas.
- Review of practices related to outside volunteers and vendors.
- Review of practices related to work release and employers.
- Review of exposure and quarantine practices, in line with CDC recommendations.
- Review of medical practices related to transmission prevention and management.
- Review of and changes to MAT and medication administration practices.
- Review of HR-related policies.
- Review of communication plans within facilities, offices, and between other State agencies.

Additional prevention and preparation procedures may be added in phase one depending on your location and responsibilities.

Please note the CDC does not recommend the use of facemasks as a preventative measure for those without symptoms. For now, facemask use remains necessary only for individuals showing symptom of a virus, like the flu or RSV as deemed necessary by Wellpath.

Phase two will focus on changes to procedures if there are confirmed COVID-19 cases in Maine. Phase three will focus on facility and office management if there are confirmed cases in a DOC or county jail facility.

It is my goal to provide you information about how the DOC will handle phase two and phase three before we enter these phases. DOC staff are working closely with Wellpath, Maine CDC, MEMA, Bureau of Human Resources, Department of Labor and the Governor on these plans now.

There are many steps we should be taking personally to prevent the spread of germs, but please don't forget to check in on one another's emotional wellness too. The safety and security of our operations is paramount, and so is your personal health and wellness.

Panic, stress and anxiety can impact our health. I'm requesting that our peer-support teams pay close attention to the toll this virus may have on staff mental health and, in consultation with CAOs put practices in place to support one another.

The State of Maine has experienced and dedicated public health and emergency management staff. I am confident in their abilities to lead us through prevention, preparedness and response to COVID-19.

As we work through this new and everchanging situation I ask you to be pillars of calm. Review the CDC's website, communicate your questions and concerns to your CAOs, allow for the flow of communication to work, and take the precautions outlined below by the CDC.

You do good work on behalf of the people of Maine. Let's keep informed, let's keep safe, and let's keep on track.

Thank you for all you do.

Commissioner Liberty

Memo 001-COVID-19.

STATE OF MAINE
DEPARTMENT OF CORRECTIONS
111 STATE HOUSE STATION
AUGUSTA MAINE
04333-0111

JANET T. MILLS
GOVERNOR

RANDALL A. LIBERTY
COMMISSIONER

From the U.S. Center for Disease Control and Prevention: When and How to Wash Your Hands

Handwashing is one of the best ways to protect yourself and your family from getting sick. Learn when and how you should wash your hands to stay healthy.

Wash Your Hands Often to Stay Healthy

You can help yourself and your loved ones stay healthy by washing your hands often, especially during these key times when you are likely to get and spread germs:

- **Before, during,** and **after** preparing food
- **Before** eating food
- **Before** and **after** caring for someone at home who is sick with vomiting or diarrhea
- **Before** and **after** treating a cut or wound
- **After** using the toilet
- **After** changing diapers or cleaning up a child who has used the toilet
- **After** blowing your nose, coughing, or sneezing
- **After** touching an animal, animal feed, or animal waste
- **After** handling pet food or pet treats
- **After** touching garbage
- **After** going to the store

Follow Five Steps to Wash Your Hands the Right Way

Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities and hospitals.

Follow these five steps every time.

1. **Wet** your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. **Lather** your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. **Scrub** your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. **Rinse** your hands well under clean, running water.
5. **Dry** your hands using a clean towel or air dry them.

Maine CDC website: https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml
U.S. CDC website: https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Exhibit B

STATE OF MAINE
DEPARTMENT OF CORRECTIONS
111 STATE HOUSE STATION
AUGUSTA MAINE
04333-0111

JANET T. MILLS
GOVERNOR

RANDALL A. LIBERTY
COMMISSIONER

Memo— UPDATE

To: All Staff of the Department of Corrections
From: Commissioner Randall A. Liberty
Date: March 13, 2020
Re: Coronavirus, Memo

Dear Staff,

Given the speed with which we are hearing about presumptive COVID-19 cases in Maine communities, we are now in phase two.

This memo communicates changes to current practices in the prevention of COVID-19. Dates for when these changes go into effect are noted below. We will monitor and reevaluate these practices and dates as necessary.

In keeping with national trends to reduce the spread of COVID-19 the Department of Corrections will:

Effective Saturday, March 14, 2020:

1. DOC facilities are suspending visits. This includes visits from family, friends, other non-professional visitors and volunteers who lead programs and activities. The Department is actively working on reducing or eliminating phone commission rates during this time.
   This will remain in effect for 14 days: March 14-March 28, 2020.

2. Alternate reporting requirements for adult and juvenile probation clients will go into effect.
   All reporting will take place via phone, video chat, or email.
   Additional information for probation staff will be communicated by Director of Adult Community Corrections Susan Gagnon and Associate Commissioner of Juvenile Services Colin O'Neill.
   This will remain in effect for 14 days: March 14-March 28, 2020.

3. Home visits, site visits, and field work performed by adult and juvenile probation staff will be suspended. Staff will continue to report to assigned offices, as normal.
   Additional information for probation staff will be communicated by Director of Adult Community Corrections Susan Gagnon and Associate Commissioner of Juvenile Services Colin O'Neill.
   This will remain in effect for 14 days: March 14-March 28, 2020.

Effective Monday, March 16, 2020

4. All general population adult intakes and transfers will go through MCC only. This does not apply to IMHU clients or approved county jail safekeepers, which will continue to go directly to MSP.
   This will remain in effect until further notice.

5. All juvenile intakes will go through Long Creek, including those in Northern Maine. This will remain in effect until further notice.

6. As per the Governor's direction on March 12, 2020 all non-essential State employee travel outside the State of Maine will be suspended for 30 days.

7. All non-essential Department of Corrections in-person meetings should be conducted electronically.

8. Cross facility shift work will be suspended. Staff will work in their assigned locations unless otherwise altered. MSP and BCF are considered one location for now.

Our phased approach has been working well. I urge you to continue to remain calm, follow U.S. CDC guidelines to keep yourself healthy. Our goal remains safety, security, and health of our staff and clients.

Unless otherwise directed, or noted above, all employees will continue to work as usual.

If you are ill and unable to come to work, please follow current practices of notifying your shift commander or supervisor. If your call-out is clearly not related to COVID-19 your shift manager will approve or deny as usual.

Call-outs that are related or potentially related to COVID-19 will be reported by your manager to CAOs or office director through already established communication channels. If notification to the Maine CDC or MEMA is required, I will make that notification. At this point you do not need to contact the Maine CDC or MEMA unless directed to do so by your medical practitioner.

When calling out, be advised that you will be using sick leave, as current practice. If your illness is related or potentially related to COVID-19 and you do not have enough accumulated sick leave you may be approved to use available vacation, comp time, and/or personal leave.

If COVID-19 progresses in Maine and in DOC facilities, we anticipate fielding many unique HR scenarios, we also anticipate changes to mandated overtime or identification of essential staff. Please speak with your facility or office HR representative ASAP if you foresee issues to your ability to work.

Lastly, thank you for your continued professionalism. This is uncharted territory, but we're in it together. We will remain calm.

Commissioner Liberty

Exhibit C

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

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

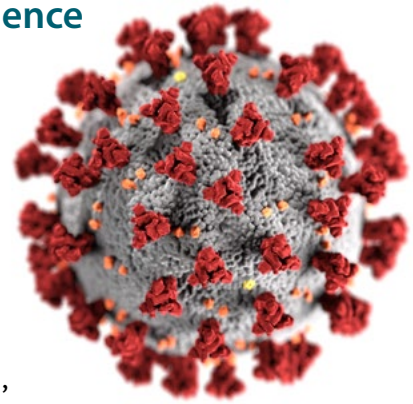
The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

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

In this guidance

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

Who is the intended audience for this guidance?



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

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

Why is this guidance being issued?

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

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

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

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

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

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

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

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

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

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

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

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

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

Personnel Practices

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

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

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

Operations & Supplies

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

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

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

- See CDC guidance optimizing PPE supplies.

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

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

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

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

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

Prevention

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

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

Operations

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

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

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

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

Cleaning and Disinfecting Practices

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

Hygiene

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

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

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

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

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

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

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

Prevention Practices for Incarcerated/Detained Persons

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

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

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

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

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

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

Prevention Practices for Staff

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

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

√ **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

√ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**

√ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.

- Staff performing temperature checks should wear recommended PPE.
- Exclude visitors and volunteers who do not clear the screening process or who decline screening.

√ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**

√ **Provide visitors and volunteers with information to prepare them for screening.**

- Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
- If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
- Display signage outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.

√ **Promote non-contact visits:**

- Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
- Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
- Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.

√ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**

- If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
- Inform potential visitors of changes to, or suspension of, visitation programs.
- Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
- If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

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

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

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

Management

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

Operations

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

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

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

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

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

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

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

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

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

Hygiene

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

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

Cleaning and Disinfecting Practices

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

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

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cleaning Spaces where COVID-19 Cases Spent Time

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

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

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

- o If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- o For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
  - Consult a list of products that are EPA-approved for use against the virus that causes COVID-19. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
  - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
    - 5 tablespoons (1/3rd cup) bleach per gallon of water or
    - 4 teaspoons bleach per quart of water

√ **Soft (porous) surface cleaning and disinfection**

- o For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
  - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
  - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.

√ **Electronics cleaning and disinfection**

- o For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
  - Follow the manufacturer's instructions for all cleaning and disinfection products.
  - Consider use of wipeable covers for electronics.
  - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

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

√ **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)

√ **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

√ Laundry from a COVID-19 cases **can be washed with other individuals' laundry.**

- o Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- o Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- o Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.

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

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

Quarantining Close Contacts of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

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

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

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

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

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

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

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

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

Management Strategies for Staff

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

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

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

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

Infection Control

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

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

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

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

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

Clinical Care of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **N95 respirator**

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

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

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

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

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

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

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

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

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

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

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

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

√ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**

- *Today or in the past 24 hours, have you had any of the following symptoms?*
  - *Fever, felt feverish, or had chills?*
  - *Cough?*
  - *Difficulty breathing?*
- *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*

√ **The following is a protocol to safely check an individual's temperature:**

- Perform hand hygiene
- Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
- Check individual's temperature
- **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
- Remove and discard PPE
- Perform hand hygiene

Exhibit D


1
Inoculex
Hand
Sanitizer
Kills 99.9% of Germs
1 GAL (128 fl oz) 3.78L
MAIL

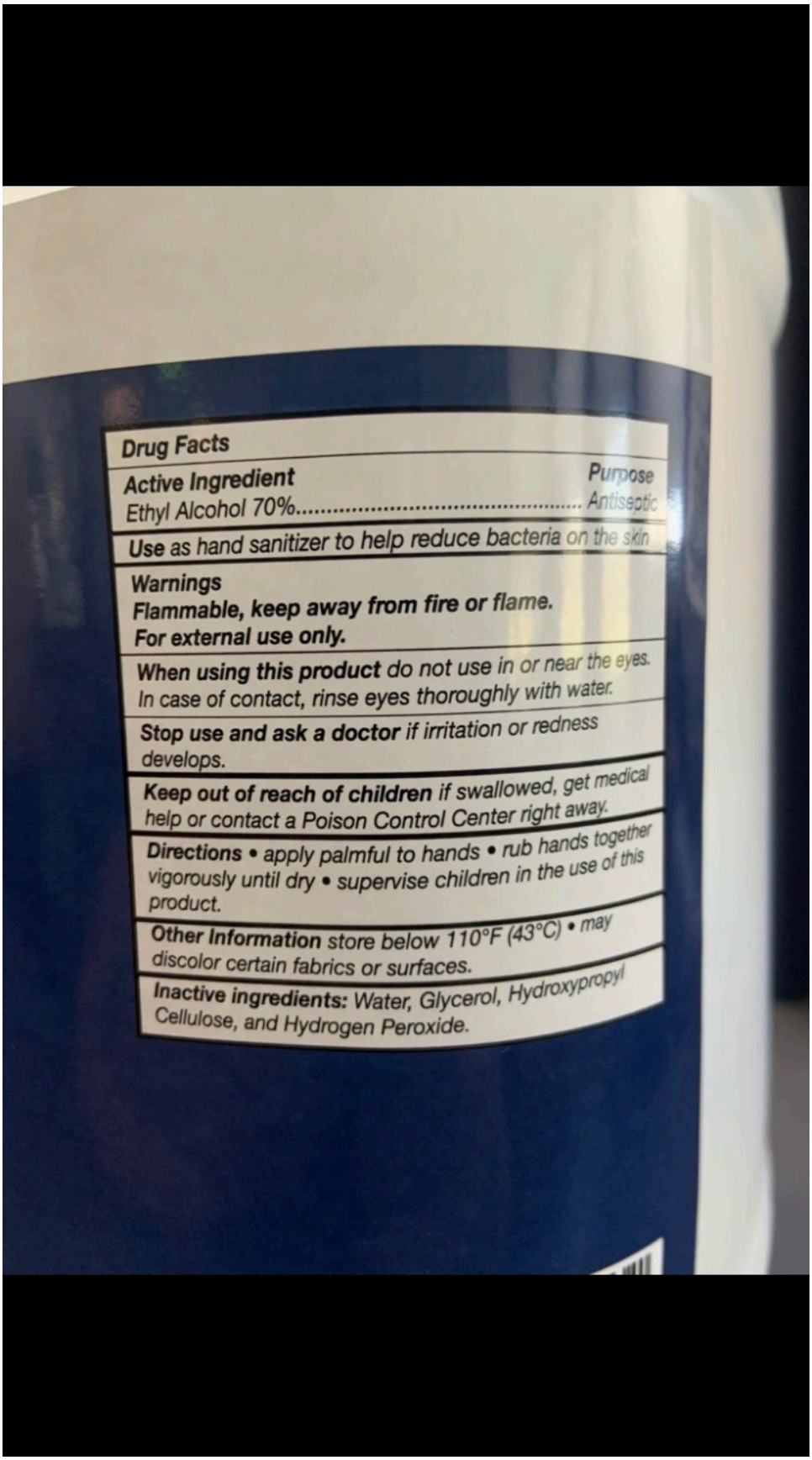

Drug Facts
Active Ingredient
Ethyl Alcohol 70%
Purpose
Antiseptic
Use as hand sanitizer to help reduce bacteria on the skin
Warnings
Flammable, keep away from fire or flame.
For external use only.
When using this product do not use in or near the eyes.
In case of contact, rinse eyes thoroughly with water.
Stop use and ask a doctor if irritation or redness develops.
Keep out of reach of children if swallowed, get medical help or contact a Poison Control Center right away.
Directions • apply palmful to hands • rub hands together vigorously until dry • supervise children in the use of this product.
Other Information store below 110°F (43°C) • may discolor certain fabrics or surfaces.
Inactive ingredients: Water, Glycerol, Hydroxypropyl Cellulose, and Hydrogen Peroxide.

Exhibit E

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-8016; Fax (207) 287-9058
TTY Users: Dial 711 (Maine Relay)

Maine Health Alert Network (HAN) System

PUBLIC HEALTH ADVISORY

To:	All Health Care
From:	Dr. Siiri Bennett, State Epidemiologist
Subject:	**Universal Testing in Congregate Living Settings**
Date / Time:	Saturday, May 23, 2020 at 6:10PM
Pages:	2
Priority:	Normal
Message ID:	2020PHADV023

UNIVERSAL TESTING IN CONGREGATE LIVING SETTINGS

Maine CDC has adopted the following recommendations regarding universal testing in congregate living settings. This policy may be updated as scientific understanding of COVID-19 evolves.

I. BACKGROUND

- This guidance applies **where a single, confirmed case of COVID-19 (using a SARS-CoV-2 PCR test) is detected among staff or residents of a congregate living setting.** Such settings include, though are not limited to, long-term care facilities, shelters for people experiencing homelessness, correctional facilities, group homes, and assisted living facilities.
- Universal testing in this context refers to testing done by unit or building, not at a facility level, unless staff are shared or rotate among various units or buildings.
- This policy is a recommendation; facilities may opt to pursue universal testing before a single case is confirmed.
- For mass testing at this time, Maine CDC's Health and Environmental Testing Laboratory (HETL) will only test samples collected pursuant to this policy (*i.e.*, when there has been at least one confirmed COVID-19 case).

II. UNIVERSAL TESTING RECOMMENDATIONS

- When a congregate living setting as described above has a single case of confirmed COVID-19 among staff or residents, Maine CDC recommends universal testing for all other staff and residents in the unit or building, except as noted above.
- Facilities should conduct the sample collection using their own staff or outside staff, and must coordinate with a health care provider to order the tests and obtain all necessary and appropriate consent.
- HETL will test specimens collected by a facility pursuant to this policy. If a facility opts to send specimens to HETL for testing pursuant to this policy, the facility must:

  - Arrange for appropriate transport of the specimens to HETL; and
  - Notify Maine CDC epidemiology staff that samples are being sent to HETL prior to transport.
  - Facilities should email Coronavirus@maine.gov or call the case investigator and include the number of specimens being sent and the approximate arrival time.
  - Facilities must first establish an account with HETL prior to sending any specimens.
- Maine CDC may be able to furnish PPE and/or swabs and viral transport media, as Maine CDC supplies allow.
- Tests done using supplies furnished by Maine CDC must be sent to HETL for testing.
- Facilities may choose to use other laboratories to accomplish universal testing. Those laboratories may have preferred swabs and test kits, so please check with that laboratory before initiating sample collection.

III. RE-TESTING RECOMMENDATIONS

- For facilities in which universal testing has been recommended:
  1. Maine CDC recommends re-testing of COVID-negative staff in facilities 7 days after the initial specimen collection.
  2. If re-testing yields further COVID-positive staff, Maine CDC recommends re-testing of COVID-negative staff every 7 days until there are 2 successive weeks of only negative tests, or when all staff have tested positive. Additional re-testing beyond these guidelines will not be performed at HETL.

- Maine CDC may recommend re-testing residents in the following circumstances:
  1. There is a newly identified positive staff who worked in a unit where there are no COVID-positive residents.
  2. There is a newly identified, symptomatic, COVID-positive resident in a unit where there are no other known COVID-positive residents.
  3. There are a significant number of new COVID-positive staff.

IV. CONSIDERATIONS FOR FACILITIES

- Staff who are COVID-positive will not be allowed to work for a minimum of 10 days.
  - Thus, facilities must ensure that they have a staffing plan in place prior to pursuing universal testing in accordance with this policy.
  - Certain facilities, such as long-term care facilities, are required to have such plans in place.
- Facilities will need to furnish a medical order for testing. This will not be supplied by Maine CDC.
- Facilities must ensure that testing is on an opt-in basis and that residents and staff may decline.
- Resident who decline testing should be considered close contacts and placed into quarantine for 14 days.
- Staff who decline testing should be referred to internal HR policies.
- Testing may be traumatic for certain patients. Mid-turbinate swabs are an acceptable alternative to nasopharyngeal (NP) swabs, especially for clients for whom sedation is required or who are medically frail.

Exhibit F

STATE OF MAINE
DEPARTMENT OF CORRECTIONS
111 STATE HOUSE STATION
AUGUSTA MAINE
04333-0111

JANET T. MILLS
GOVERNOR

RANDALL A. LIBERTY
COMMISSIONER

May 22, 2020

PRESS RELEASE

Media Contact: Randall A. Liberty, Commissioner
(207) 530-3794
Anna.Black@Maine.Gov

Maine Department of Corrections Confirms Second Case of COVID-19

The Maine Department of Corrections (MDOC) today confirmed that a prisoner at the Maine Correctional Center (MCC) in Windham tested positive for COVID-19. This is the second case of a MDOC prisoner to be diagnosed with COVID-19.

The male inmate in his 30s was tested as part of the MCC campus wide testing that began May 19. The universal testing began in response to the first positive case confirmed on May 19. MDOC received confirmation from the state lab of this second positive case late this afternoon. To date, more than 700 test samples have been collected from staff, inmates and contracted vendors. MDOC has received back nearly 600 results, all but two negative.

The Department, in consultation with the Maine Center for Disease Control and Prevention (Maine CDC), has initiated previously developed protocols, including contact tracing in response.

The individual who has been in MDOC custody since March 2, 2018 has been moved to an isolation unit, as is standard MDOC practice in response to COVID-19. The individual has not required hospitalization.

##

Exhibit G

STATE OF MAINE
DEPARTMENT OF CORRECTIONS
111 STATE HOUSE STATION
AUGUSTA MAINE
04333-0111

JANET T. MILLS
GOVERNOR

RANDALL A. LIBERTY
COMMISSIONER

May 23, 2020

PRESS RELEASE

Media Contact: Randall A. Liberty, Commissioner
(207) 530-3794
Anna.Black@Maine.Gov

Maine Department of Corrections Confirms Third and Fourth Case of COVID-19

The Maine Department of Corrections (MDOC) today confirmed that two additional inmates at the Maine Correctional Center (MCC) in Windham tested positive for COVID-19. This is the third and fourth case of prisoners at MCC to be diagnosed with COVID-19.

The two inmates are both male, one in his early 40s the other in his late 60s. These individuals were tested as part of the MCC campus-wide testing that began May 19. This universal testing began in response to the first positive case confirmed on May 19. MDOC received confirmation from the state lab of these two new cases this afternoon. To date, 744 test samples have been collected from staff, inmates and contracted vendors. MDOC has received back all 283 staff tests, all of which are negative for COVID-19. All 461 inmates' samples have been returned with four positives. The four positive include: the two announced today, one announced on May 22, and the first, announced May 19.

The man in his 40s has been in MDOC custody since May 2016. The other man has been in MDOC custody since June 1998. No hospitalization has been required for either individual. Both men have been moved to an isolation unit, as is standard MDOC practice in response to COVID-19. In the coming days Maine Center for Disease Control and Prevention (Maine CDC) and MDOC will discuss retesting.

The Department, in consultation with Maine CDC, is continuing previously developed protocols, including contact tracing and restricted movement within the facility in response.

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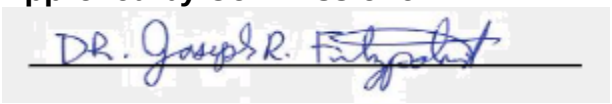
Exhibit H

POLICY TITLE: SUPERVISED COMMUNITY CONFINEMENT POLICY NUMBER: 27.2 CHAPTER 27: RELEASE PREPARATION		PAGE 1 of 21
	STATE of MAINE DEPARTMENT OF CORRECTIONS Approved by Commissioner: 	PROFESSIONAL STANDARDS: See Section VII
EFFECTIVE DATE: July 8, 1998	LATEST REVISION: December 1, 2017	CHECK ONLY IF APA [X]

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 3036-A.

II. APPLICABILITY

All Adult Correctional Facilities and Adult Community Corrections

III. POLICY

The purpose of the Supervised Community Confinement Program is to provide a means of successful reentry of prisoners into the community. Prisoners transferred to supervised community confinement are still considered prisoners while in the program. The place of confinement is in the community, rather than in a correctional facility. Participation in this program is a privilege that may be afforded to prisoners who meet the established criteria.

IV. CONTENTS

Procedure A: Supervised Community Confinement Program, General
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Procedure C: Residence Requirements
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Procedure G: Additional Conditions
Procedure H: Supervision of Prisoners on Supervised Community Confinement
Procedure I: Supervised Community Confinement for a Terminally Ill or Severely Incapacitated Prisoner
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Procedure K: Appeals of Denial of Transfer to or Removal from the Supervised Community Confinement Program

V. ATTACHMENTS

Attachment A: Supervised Community Confinement Application
Attachment B: Authorization for the Disclosure of Information for the Purpose of Investigation by the Department of Corrections
Attachment C: Request for Investigation for Transfer of Prisoner to Supervised Community Confinement
Attachment D: Supervised Community Confinement Investigation Format
Attachment E: Agreement for Warrantless Searches
Attachment F: Notification of Consideration for Prisoner Transfer to Supervised Community Confinement
Attachment G: Supervised Community Confinement Agreement
Attachment H: Notification of Prisoner Transfer to Supervised Community Confinement
Attachment I: Notice of Change(s) in Condition(s) of Supervised Community Confinement

VI. PROCEDURES:

Procedure A: Supervised Community Confinement Program, General

1. All transfers to supervised community confinement are granted at the discretion of the Department of Corrections and are considered a privilege, not a right.

2. Supervised community confinement allows eligible prisoners to be transferred to an approved residence in the community for reentry purposes. An approved residence in the community may consist of:

   a. a home;

   b. a full-time treatment facility, such as a residential substance abuse treatment facility or mental health facility;

   c. transitional housing that provides support services for targeted groups, e.g., veterans, domestic violence victims, persons with mental illness, persons with substance abuse problems, etc.;

   d. temporary housing associated with academic or vocational training or employment; or

   e. a hospital or other appropriate care facility, such as a nursing facility, residential care facility or a facility that is a licensed hospice program pursuant to Title 22, section 8622.

3. A prisoner transferred to supervised community confinement must be involved in a program of work or education that is approved by the Commissioner, or designee, together with any treatment program that the Commissioner, or designee, might require. The Commissioner, or designee, may waive the requirement of involvement in a program of work or education while a prisoner is involved in an approved full-time treatment program.

4. The Commissioner, or designee, shall be responsible for the overall administration of the Department's Supervised Community Confinement Program (SCCP), which shall include, but not be limited to, the following:
   a. application and screening for eligibility;
   b. approval or denial;
   c. conditions for prisoners while on supervised community confinement;
   d. notifications to the Department's Director of Victim Services and appropriate criminal justice agencies;
   e. supervision of prisoners while on supervised community confinement;
   f. documentation; and
   g. a system for evaluating the Supervised Community Confinement Program's effectiveness.

5. The Chief Administrative Officer, or designee, of each adult facility from which prisoners may be transferred to supervised community confinement shall maintain a process that allows a prisoner who meets the eligibility criteria to apply to participate in the Supervised Community Confinement Program.

6. The Commissioner, or designee, may approve a transfer of a prisoner located in a facility that is not a Maine Department of Corrections facility through any process that the Commissioner, or designee, determines appropriate and may exempt the prisoner from meeting the one hundred twenty (120) day eligibility requirement. All decisions made pursuant to this provision are at the complete discretion of the Commissioner, or designee, and may not be appealed.

7. The Regional Correctional Administrator, or designee, of each adult community corrections region shall be responsible for the day-to-day management of the Supervised Community Confinement Program and supervision of prisoners while on supervised community confinement.

8. Except as specified below, a prisoner who violates a curfew, residence, time or travel condition or fails to return from supervised community confinement to the facility when directed to do so is an escapee. The probation officer shall notify the Regional Correctional Administrator, or designee, who shall immediately notify the Department's Fugitive Coordinator, or designee. The probation officer shall also refer this to the appropriate criminal justice agencies for arrest and prosecution for the crime of escape, and if applicable, for a revocation of probation or supervised release for sex offenders.

9. If a prisoner becomes ill or injured or another unforeseen emergency prevents the prisoner from abiding by a curfew, residence, time or travel condition, or returning to the facility when directed to do so, the prisoner shall notify the probation officer as soon as possible for instructions.

Procedure B: Eligibility Requirements

1. A prisoner may not be transferred to supervised community confinement unless the prisoner has no more than eighteen (18) months remaining on the term of imprisonment, or, in the case of a split sentence, on the unsuspended portion, after consideration of any deductions that the prisoner has received and retained under Title 17-A, Section 1253.

2. If the Commissioner determines that the average statewide case load is no more than ninety (90) offenders to one probation officer, the Commissioner may allow a prisoner who meets all other eligibility requirements and who has no more than two (2) years remaining on the term of imprisonment, or, in the case of a split sentence, on the unsuspended portion, after consideration of any deductions that the prisoner has received and retained under Title 17-A, Section 1253, to be transferred to supervised community confinement.

3. Each prisoner's case manager is responsible for checking CORIS periodically in order to be aware of when the prisoner is approaching eighteen months (or, if applicable, two years) prior to his or her earliest possible release date to review if the prisoner is eligible for supervised community confinement and, if so, meet with the prisoner to assist him or her with the application process.

4. If the term of imprisonment or, in the case of a split sentence, the unsuspended portion is more than five (5) years, a prisoner may not be transferred to the supervised community confinement program until the prisoner has served at least 2/3 of the term of imprisonment or, in the case of a split sentence, at least 2/3 of the unsuspended portion, after consideration of any deductions that the prisoner has received and retained under Title 17-A, Section 1253.

5. If the term of imprisonment or, in the case of a split sentence, the unsuspended portion is five (5) years or less, a prisoner may not be transferred to supervised community confinement until the prisoner has served at least 1/2 of the term of imprisonment imposed or, in the case of a split sentence, at least 1/2 of the unsuspended portion, after consideration of any deductions that the prisoner has received and retained under Title 17-A, Section 1253.

6. A prisoner who is serving consecutive sentences is not eligible until the prisoner has served 2/3 or 1/2, as applicable, of the time to be served on the combined sentences, after consideration of any deductions that the prisoner has received and retained under Title 17-A, Section 1253.

7. A prisoner may not be transferred to supervised community confinement unless the prisoner:

   a. has served at least one hundred twenty (120) days of the term of imprisonment in a departmental facility;

   b. is classified community custody; and

   c. has no unresolved detainers, warrants, or other legal holds pending.

8. In addition to the above eligibility requirements, any prisoner who has been convicted as an adult with any sex offense may not be transferred to supervised community confinement unless the prisoner is within six (6) months of his or her current custody release date, and, if male, has completed the intensive phase of a Department residential sex offender treatment program or, if female, the prisoner has successfully participated in a Department sex offender treatment program for at least one (1) year.

9. In addition to the above eligibility requirements, any prisoner who has been formally charged but not convicted as an adult with any sex offense may not be transferred to supervised community confinement unless the prisoner is within six (6) months of his or her current custody release date, and, if male, has completed the intensive phase of a Department residential sex offender treatment program or, if female, the prisoner has successfully participated in a Department sex offender treatment program for at least one (1) year. The Department's Director of Classification may make an exception to the sex offender treatment program requirement and/or the requirement of being within six (6) months of current custody release date for a prisoner who has been formally charged but not convicted as an adult with a sex offense. If the prisoner has applied for supervised community confinement, the facility Chief Administrative Officer, or designee, shall make a recommendation to the Department's Director of Classification regarding a possible exception to these requirements.

10. A prisoner must not have been found guilty of an A or B disciplinary violation within ninety (90) days, a C disciplinary violation within sixty (60) days, or a D disciplinary violation within thirty (30) days of the prisoner's application to participate in the Supervised Community Confinement Program or anytime thereafter prior to the scheduled transfer to supervised community confinement and must not have a disciplinary matter pending at the time of application or scheduled transfer, unless an exception has been made by the Commissioner, or designee.

11. A prisoner who has lost the privilege to participate in any community based program as a result of an interim reclassification following a finding of guilt of a drug or alcohol violation shall not be eligible to apply for supervised community confinement for the time period specified at the reclassification, unless an exception has been made by the Commissioner, or designee.

12. No transfer to supervised community confinement may be granted if the prisoner is likely to have contact with a victim of the prisoner for domestic violence, unless a waiver has been granted by the Commissioner, or designee, for visits between them.

13. No transfer to supervised community confinement may be granted if the prisoner is likely to have contact with a victim of the prisoner for a sex offense or child abuse committed when the victim was a minor, unless a waiver has been granted by the Commissioner, or designee, for visits between them.

Procedure C: Residence Requirements

1. The prisoner's proposed residence while on supervised community confinement must be approved by the Regional Correctional Administrator, or designee.

2. If the residence is a home, it shall only be approved if any other adults living in the residence with the prisoner:
   a. are aware of, and not opposed to, the prisoner's plan to participate in the Supervised Community Confinement Program;
   b. agree that the home may be searched at any time; and
   c. agree not to have firearms or other dangerous weapons, alcohol, illegal drugs or other illegal substances, or marijuana in the home.

3. Any other persons living in the residence:
   a. must be at least eighteen (18) years old, unless an exception has been granted by the Regional Correctional Administrator, or designee;
   b. may not be a departmental staff member, volunteer, or student intern;
   c. may not be a person who is currently charged with murder or a Class A, B or C criminal offense;
   d. may not be a person who is currently charged with a Class D or E criminal offense, unless an exception has been granted by the Regional Correctional Administrator, or designee;
   e. may not be a former prisoner, unless an exception has been granted by the Chief Administrative Officer, or designee, and the Regional Correctional Administrator, or designee;
   f. may not be a person under current supervision of the Department in the community, unless an exception has been granted by the Chief Administrative Officer, or designee, and the Regional Correctional Administrator, or designee;
   g. may not be a victim of the prisoner for domestic violence, unless a waiver has been granted by the Commissioner, or designee, for visits between them; and
   h. may not be a victim of the prisoner for a sex offense or child abuse committed when the victim was a minor, unless a waiver has been granted by the Commissioner, or designee, for visits between them.

Procedure D: Application and Approval Process

1. A prisoner may apply for transfer to supervised community confinement when the prisoner has served one hundred twenty (120) days in a Department facility, is no more than three (3) months from meeting the other time eligibility requirements set out in Procedure B, and is no more than minimum custody.

2. A prisoner who wishes to apply for transfer to supervised community confinement must submit to the facility's Community Programs Coordinator, or other designated staff, at least two (2) months in advance of his or her proposed date of transfer to supervised community confinement, the following:
   a. Supervised Community Confinement Application (Attachment A);
   b. Authorization for the Disclosure of Information for the Purpose of Investigation by the Department of Corrections (Attachment B); and
   c. Authorization for Disclosure of Substance Abuse Information Acquired in Connection with the Provision of Substance Abuse Services by the Department of Corrections found in Department Policy (AF) 11.2, Confidentiality of Prisoner Information, (Attachment D).

3. If a prisoner is furlough eligible and a furlough investigation has been completed, the prisoner may be granted a furlough pass for the purpose of making tentative arrangements for housing, employment, education, or a treatment program for inclusion in the prisoner's Supervised Community Confinement Application. If a prisoner is furlough eligible but has not yet had a furlough investigation completed, the prisoner may be transported by facility staff for the purpose of making tentative arrangements for housing, employment, education or a treatment program.

4. The facility's Community Program Coordinator, or other designated staff, shall determine whether the supervised community confinement application has been submitted by the date required and the forms are complete. If not, any incomplete form shall be returned to the prisoner to submit the complete form in a timely manner.

5. The facility's Community Program Coordinator, or other designated staff, shall determine whether other persons living in the proposed residence are prohibited from visits with the prisoner.

6. The facility's Community Program Coordinator, or other designated staff, shall notify the facility classification staff of the application.

7. The facility's classification staff shall review the prisoner's administrative record to screen for eligibility and ensure an electronic records check is conducted for any outstanding detainers, warrants or other legal holds or requests for notification from a criminal justice agency. If there is a request for notification from a criminal justice agency, the facility classification staff shall notify the agency of the prisoner's possible transfer to supervised community confinement. The result of the records check and any response to a notification shall be entered into CORIS.

8. The facility's Community Program Coordinator, or other designated staff, shall determine if the prisoner is eligible for supervised community confinement, including that the prisoner will be time eligible as of the date of the proposed transfer to supervised community confinement date. If so, the facility's

Community Program Coordinator, or other designated staff, shall refer the application to the Unit Management Team for review.

9. If the prisoner is not already classified community custody, a Department approved classification instrument shall be completed by the Unit Management Team to ensure that the prisoner is eligible for community custody.

10. The prisoner's Unit Management Team shall review the following in considering a prisoner for a transfer to supervised community confinement and an investigation and site review:
    a. prisoner's institutional adjustment;
    b. prisoner's compliance with his or her individualized case plan;
    c. criminal history;
    d. history of revocation while on supervision in the community or of violations of conditions of release (bail);
    e. any previous violation of a community transition program or of the supervised community confinement program;
    f. community risk assessment;
    g. safety of the public and the prisoner;
    h. behavior, conduct and social attitudes of the prisoner;
    i. prisoner's work record;
    j. prisoner's mental and emotional stability;
    k. suitability of the proposed residence;
    l. adequacy of the prisoner's plan for work/education/treatment; and
    m. any other relevant factors.

11. If the Unit Management Team recommends that a prisoner be considered for transfer to supervised community confinement, then an investigation and site review shall be conducted. The facility's Community Program Coordinator, or other designated staff, shall forward the Request for Investigation for Transfer of Prisoner to Supervised Community Confinement (Attachment C) to the appropriate Regional Correctional Administrator, or designee, and shall document the recommendation in CORIS, including any special conditions recommended by the team.

12. Upon receipt of the Request for Investigation for Transfer of Prisoner to Supervised Community Confinement and the completed supervised community confinement packet, the Regional Correctional Administrator, or designee, shall ensure the community investigation and site review is completed within thirty (30) days, to include, at a minimum, all the information contained in the Supervised Community Confinement Investigation Format (Attachment D) listed below:
    a. review of the police report for the current crime(s);

b. community sentiment investigation;

c. criminal background check of any other persons living in the proposed residence and of other persons with whom the prisoner is likely to have contact, if appropriate;

d. input from the primary law enforcement agency with jurisdiction over the place of residence;

e. necessary follow up to any victim impact statement;

f. the suitability of the proposed residence and other occupants (including, if applicable, a signed Agreement for Warrantless Searches, Attachment E), if any;

g. the employment, education or treatment program;

h. method of transportation;

i. interview with prisoner (in person or by phone);

j. need for additional conditions; and

k. recommendations.

13. At the time the supervised community confinement packet is forwarded for investigation and site review, the Community Program Coordinator, or other designated staff, shall notify the Department's Director of Victim Services and the Department's Director of Classification that there has been a request for investigation. The Department's Director of Victim Services shall ensure that any victim of any crime for which the prisoner has served, is serving or will be serving a sentence during the present period of incarceration is notified of the application of the prisoner for supervised community confinement. The victim shall be given the opportunity to submit a victim impact statement, including any objections to the prisoner being placed on supervised community confinement. Information received from the victim shall be forwarded to the Regional Correctional Administrator, or designee, for inclusion in the materials to be reviewed.

14. The Community Program Coordinator, or other designated staff, shall ensure that the Notification of Consideration for Prisoner Transfer to Supervised Community Confinement (Attachment F) is provided to appropriate law enforcement officials, to include the prosecuting attorney and the district attorney for the district of the proposed residence. The written notification(s) shall request that any objections to the prisoner being placed on supervised community confinement be made to the Chief Administrative Officer, or designee, of the facility where the prisoner is located. Any objections shall be reviewed and copies forwarded to the appropriate Regional Correctional Administrator, or designee.

15. Once the investigation and the site review form is completed, the Regional Correctional Administrator, or designee, shall ensure the information is entered into CORIS. The Regional Correctional Administrator, or designee, shall make a recommendation on whether to grant or deny transfer to supervised community

confinement and shall forward the recommendation to the Community Program Coordinator, or other designated staff.

16. In the case of a prisoner not recommended for transfer to supervised community confinement, the Regional Correctional Administrator, or designee, shall discuss the recommendation with the Chief Administrative Officer, or designee, prior to forwarding the recommendation.

17. If the Regional Correctional Administrator, or designee, does not recommend transfer to supervised community confinement, the Community Program Coordinator, or other designated staff shall notify the prisoner.

18. If the Regional Correctional Administrator, or designee, recommends transfer to supervised community confinement, and if the prisoner still remains eligible for transfer to supervised community confinement, the Community Program Coordinator, or other designated staff, shall meet with the prisoner to review the Supervised Community Confinement Agreement (Attachment G) and obtain the prisoner's signature on both the original and a copy of the agreement and shall forward a copy of all completed documentation to the Chief Administrative Officer, or designee, for a decision.

19. If the decision of the Chief Administrative Officer, or designee, is to grant a transfer to supervised community confinement, the Chief Administrative Officer, or designee, shall document the approval on the application. All completed documentation shall be forwarded to the Department's Director of Classification, or designee, for review and approval or disapproval of the decision.

20. Specific information about input from prosecutors, law enforcement, victims and victim services shall not be disclosed to the prisoner under any circumstances. A prisoner may be told in general that community sentiment was "negative."

21. Approval for supervised community confinement shall be withdrawn for a prisoner who does not continue to meet all the eligibility criteria up to the time of departing the facility, unless an exception is made as set out in Procedure B. 10 or 11. If an exception is necessary in order for a prisoner to be transferred to supervised community confinement, the Chief Administrative Officer, or designee, shall contact the Commissioner, or designee, for a decision on the exception.

22. If a prisoner who has been approved for supervised community confinement is transferred to a less secure facility, the receiving facility may contact the Department's Director of Classification for permission to withdraw the approval pending a review by the Unit Management Team of the prisoner's adjustment to the receiving facility and any other pertinent factors. If permission is granted by the Director of Classification for a review by the Unit Management Team, the review shall take place within fourteen (14) days of the prisoner's transfer unless the Director of Classification specifies another time. After the review, the Unit Management Team shall recommend to the Chief Administrative Officer, or designee, whether to grant or deny the transfer to supervised community confinement. If the decision of the Chief Administrative Officer, or designee, is to

deny the transfer, all documentation supporting that decision shall be forwarded to the Department's Director of Classification, or designee, for review and approval or disapproval of the decision.

23. If the prisoner is approved for transfer to supervised community confinement, the prisoner may be granted a furlough pass or furlough leave for the purpose of arranging housing, employment, education, or a treatment program in accordance with the approval. A furlough leave for the purpose of arranging employment, education, or a treatment program may be granted to the address approved for supervised community confinement, regardless of whether the prisoner has an approved furlough sponsor. The prisoner may receive furlough passes or furlough leaves as frequently as set forth in Department Policy (AF) 27.4, Furlough Pass/Furlough Leave Program.

24. If the prisoner is approved for transfer to supervised community confinement, and, if not already transferred to the supervised community confinement program, the prisoner may apply for participation in a community transition program (work release, education release, or public service release) when eligible and shall be given priority for placement in the program over prisoners who have not been approved for transfer to supervised community confinement.

25. Once a prisoner has been approved for supervised community confinement, the prisoner may not be transferred to a program that would delay the prisoner's transfer to supervised community confinement, unless approved by the Commissioner.

26. Approval for transfer to supervised community confinement may be withdrawn at any time for any reason at the complete discretion of the Commissioner, or designee.

Procedure E: Documentation and Notification

1. If the transfer to supervised community confinement is denied or approval is withdrawn, the Community Programs Coordinator, or other designated staff, shall notify the prisoner and document the notification in CORIS.

2. If the transfer to supervised community confinement is approved by the Department's Director of Classification, or designee, the Chief Administrative Officer, or designee, shall document the approval on the application. The Community Programs Coordinator, or other designated staff, shall make a copy of the Supervised Community Confinement Agreement (Attachment G) and forward both the original and a copy to the prisoner's Unit Manager.

3. If there are any special conditions for transfer to supervised community confinement, they shall be specified in the Supervised Community Confinement Agreement.

4. At least fourteen (14) days before the prisoner's transfer to supervised community confinement, the Community Programs Coordinator, or other designated staff,

shall complete the Notification of Prisoner Transfer to Supervised Community Confinement, (Attachment H), and forward a copy of the notification to the Unit Manager, Central Control, facility classification staff, facility health care staff, the Department's Director of Classification, the Department's Director of Victim Services, the Regional Correctional Administrator, or designee, and the same criminal justice agencies that were initially notified of the application for transfer to supervised community confinement.

5. If a residential or transitional housing placement must be accepted sooner to prevent the bed space from being lost, and if, the Commissioner, or designee, after consultation with the Department's Director of Victim Services, or designee, approves a waiver of the fourteen (14) day requirement, the Regional Correctional Administrator, or designee, and appropriate criminal justice agencies shall be notified as soon as possible verbally of the transfer. This notice shall include, but not be limited to, the name of the prisoner, the address of the placement, and special conditions or unusual situation(s), if any.

6. The Community Programs Coordinator, or other designated staff, shall ensure that facility health care staff is notified to determine whether the prisoner needs to be provided any medication upon transfer to supervised community confinement. If the prisoner does need to be provided medication, the health care staff shall provide the medication to the prisoner and shall provide instructions for the taking of the medication. The prisoner shall only be provided medication for fourteen (14) days, unless otherwise authorized by the Commissioner, or designee.

7. No earlier than the day prior to the prisoner transferring to supervised community confinement, the Community Programs Coordinator, or other designated staff, shall check to ensure that the prisoner continues to meet all the eligibility criteria and shall initial the agreement indicating that the check has been made.

8. If the prisoner remains eligible, the Community Programs Coordinator, or other designated staff, shall issue to the prisoner an official Supervised Community Confinement Identification card, which the prisoner shall sign. A copy of the signed card shall be forwarded to the Regional Correctional Administrator, or designee.

9. If approval of the transfer to supervised community confinement is withdrawn or the transfer is delayed, the Community Programs Coordinator, or other designated staff, shall notify the Department's Director of Victims Services as soon as possible.

10. When the prisoner departs the facility for transfer to supervised community confinement, designated facility staff shall make an entry in CORIS to include the date and time of the prisoner's departure.

11. Once the prisoner is transferred to supervised community confinement, the facility classification staff shall be responsible for performing sentence calculations as if the prisoner were still at the facility.

12. A copy of every supervised community confinement application, whether or not processed, and the Supervised Community Confinement Agreement, if applicable, shall be maintained in the prisoner's Case Management Record.

13. All decisions made with respect to a supervised community confinement application, whether or not processed, and all meetings with the prisoner required under this policy shall be documented in CORIS.

Procedure F: Mandatory Conditions

1. A prisoner approved for transfer to supervised community confinement is responsible for making arrangements for transportation to his or her community residence and any transportation necessary to meet the program's conditions.

2. The prisoner shall report in person to his or her supervising probation officer within the first twenty-four (24) hours of his or her transfer to the supervised community confinement program.

3. The prisoner shall be employed, actively involved in seeking employment and employed within forty-five (45) days, receiving disability benefits adequate for support, or otherwise in a program of work and/or education that is approved by the Commissioner, or designee, together with any treatment program(s) the Commissioner, or designee, might require. The Commissioner, or designee, may waive the requirement of involvement in a program of work or education while a prisoner is involved in an approved full-time treatment program.

4. If applying for disability benefits that will be a sufficient means for support, the prisoner shall have, while waiting to receive those benefits, the resources to maintain an adequate means of support for at least one hundred twenty (120) days.

5. The prisoner shall agree to be placed on electronic monitoring at any time and shall also agree to be responsible for all or part of the costs associated with electronic monitoring, when and to the extent the Regional Correctional Administrator, or designee, determines that the prisoner has the financial resources.

6. The prisoner shall live in a residence approved by the Commissioner, or designee.

7. There shall be no firearms or other dangerous weapons, alcohol, illegal drugs or other illegal substances, or marijuana in the approved residence.

8. The prisoner shall remain at the prisoner's approved residence except for those occasions that have been approved by the probation officer.

9. The prisoner shall be subject to travel or movement restrictions, set by the probation officer, limiting the prisoner's travel to times and places directly related

to approved employment, education, treatment, or such other specific purposes as are approved in advance by the probation officer.

10. The prisoner shall not leave the State of Maine except for medical care outside the State of Maine if the Department's Director of Medical Care determines the care is necessary and unavailable within the State of Maine.

11. The prisoner shall submit to searches of the prisoner's person, residence, papers, effects, electronic data processing or data storage devices, including, but not limited to, computers, desktops, laptops, tablets, personal assistive devices (PDAs), or wearable devices, compact disks, and electronic communication devices, including, but not limited to, cell phones and pagers, at any time without a warrant and without probable cause, for items prohibited by law or by the conditions of supervised community confinement or otherwise subject to seizure, upon the request of the probation officer. The prisoner must provide the probation officer with all usernames and passwords/passcodes required to access the devices.

12. The probation officer may prohibit the prisoner from residing with anyone who does not consent to search of the residence to the extent necessary to search the prisoner's person, residence, papers, effects, and electronic devices.

13. The prisoner shall not possess or use firearms or other dangerous weapons, alcohol, illegal drugs or other illegal substances, or marijuana.

14. The prisoner shall submit to urinalysis, breath testing, or other chemical tests at the direction of the probation officer.

15. The prisoner shall not be in the presence of firearms or other dangerous weapons, alcohol, illegal drugs or other illegal substances, or marijuana.

16. The prisoner shall carry the Department's official Supervised Community Confinement Identification card at all times and show the card to any law enforcement officer that he or she comes in contact with. The prisoner shall notify the probation officer immediately of any such contact with any law enforcement officer.

17. The prisoner shall not violate any state or federal law or any other law.

18. When required by the Regional Correctional Administrator, or designee, and to the extent the Regional Correctional Administrator, or designee, determines that the prisoner has the financial resources, the prisoner shall pay all or part of the costs of the prisoner's participation in the supervised community confinement program.

19. The prisoner shall pay court-ordered restitution through Adult Community Corrections on a schedule determined by the Commissioner, or designee.

20. The prisoner shall sign a waiver of extradition to the State of Maine from any other jurisdiction to answer any charge of escape or any violation of supervised community confinement conditions.

21. The prisoner shall be responsible for his or her own personal expenses, including health care costs. The prisoner shall inform the probation officer of any major illness, injury, or medical condition and any changes in prescribed medications while participating in this program.

22. The prisoner shall obtain permission from the probation officer prior to allowing any visitors to his or her place of residence.

23. The prisoner shall sign any release of information forms determined necessary by the probation officer.

24. The prisoner shall not own or be in the possession of any type of vehicle without the permission of the probation officer and, if permission is granted, the vehicle shall be fully insured and registered through the State of Maine's Bureau of Motor Vehicles with a valid State Inspection Sticker. The prisoner shall submit to searches of the vehicle at any time, without a warrant and without probable cause, for items prohibited by law or by the conditions of supervised community confinement or otherwise subject to seizure, upon the request of the probation officer. In addition, the prisoner must possess a valid State of Maine driver's license and shall operate only the aforementioned vehicle to destinations and at times approved by the probation officer.

25. For a prisoner who has been sentenced to a split sentence, the prisoner shall comply with all court-ordered conditions of probation while participating in the supervised community confinement program regardless of whether the period of probation has commenced.

26. For a prisoner who has been sentenced to supervised release for sex offenders, the prisoner shall comply with all court-ordered conditions of supervised release while participating in the supervised community confinement program even though the period of supervised release has not commenced.

Procedure G: Additional Conditions

1. Additional conditions of supervised community confinement may be imposed on a prisoner at any time either prior to or after the transfer to supervised community confinement, and may include, but not necessarily be limited to:

   a. any condition that may be imposed as a condition of probation pursuant to Title 17-A, Section 1204; and

   b. any condition that would be appropriate for the prisoner and the supervised community confinement program. The conditions imposed may be as stringent or restrictive as, but not more stringent or restrictive than, those that may be constitutionally imposed if the prisoner were actually in a maximum security facility.

2. After a prisoner is transferred to supervised community confinement, either the probation officer or the prisoner may initiate, in writing, a request for the addition, modification, or removal of a condition(s), other than mandatory conditions.

3. The probation officer may temporarily add, modify, or remove a condition except that the probation officer may not modify or remove a mandatory condition as set out in Procedure F. The probation officer shall notify both the prisoner and the Regional Correctional Administrator, or designee, in writing, of the addition, modification, or removal of a condition(s). The prisoner shall sign the Notice of Change(s) in Condition(s) of Supervised Community Confinement Form (Attachment I), acknowledging his or her understanding that he or she must abide by the change temporarily imposed by the probation officer and his or her right to appeal its imposition within five (5) working days. A prisoner wishing to appeal shall submit the appeal, in writing, to the probation officer, who shall forward it to the Regional Correctional Administrator, or designee. If the change is approved, the Regional Correctional Administrator, or designee, shall sign the Notice of Change(s) in Condition(s) of Supervised Community Confinement Form and shall forward it to the probation officer, who shall forward a copy to the prisoner.

4. A prisoner may request clarification, removal, or modification of a condition, by applying in writing, to the probation officer, who shall forward the request to the Regional Correctional Administrator, or designee, for review. If the change is approved, the Regional Correctional Administrator, or designee, shall sign the Notice of Change(s) in Condition(s) of Supervised Community Confinement Form and shall forward it to the probation officer, who shall forward a copy to the prisoner.

Procedure H: Supervision of Prisoners on Supervised Community Confinement

1. Within the next business day after transfer of a prisoner to the supervised community confinement program, the probation officer shall have one (1) face-to-face contact with the prisoner.

2. Except as set out below, thereafter, the probation officer shall have no less than one (1) face-to-face contact with the prisoner on a weekly basis, with at least one (1) face-to-face contact required at the prisoner's residence every month.

3. If approved by the Regional Correctional Administrator, or designee, the minimum requirement for face-to-face contacts may be reduced, but to no less than one (1) face-to-face contact per month, with at least one (1) face-to-face contact required at the prisoner's residence every other month.

4. The probation officer shall also make at least one (1) collateral contact per month.

5. Monitoring by a probation officer of a prisoner's compliance with the conditions of supervised community confinement may include, but is not limited to, the following:

   a. personal contact with the prisoner at the prisoner's residence, place of employment, education, or treatment, or any other place;

   b. direct inquiry of the prisoner's employer, school, treatment program, or any other person or entity;

   c. criminal, court, and law enforcement agency investigations; and

   d. credit and other financial inquiries.

6. If the probation officer observes, receives a report of, or otherwise discovers that the prisoner may have violated any condition(s) of supervised community confinement, or is failing to adjust to the program, the probation officer, to the extent appropriate, shall use graduated sanctions which may include, but are not limited to, those sanctions outlined below:

Response Level I

- Verbal warning or counseling by probation officer or Regional Correctional Manager
- Written warning
- Additional conditions
- Increase in drug/alcohol testing
- Community service work
- Referral for substance abuse treatment
- Referral for mental health counseling
- Referral for other treatment services, including up to forty-five (45) days residential placement, if eligible
- Increase in level of supervision
- Increase in reporting requirements

Response Level II

- Referral for intensive outpatient substance abuse treatment
- Referral for residential substance abuse placement
- Referral for mental health residential placement
- Day Reporting

Response Level III

- Electronic monitoring
- Confinement in a county jail for up to three (3) days, with the approval of the Regional Correctional Administrator, or designee
- Removal from supervised community confinement in accordance with Procedure J

Procedure I: Supervised Community Confinement for a Terminally Ill or Severely Incapacitated Prisoner

1. The Commissioner, or designee, may permit a prisoner committed to the Department to be transferred from a correctional facility to supervised community confinement without meeting the above eligibility requirements if the Department's Director of Medical Care has determined that the prisoner has a terminal or severely incapacitating medical condition and that care outside a correctional facility is medically appropriate.
    a. The prisoner shall live in a hospital or other appropriate care facility, such as a nursing facility, residential care facility, or a facility that is a licensed hospice program pursuant to Title 22, Section 8622, approved by the Commissioner, or designee.
    b. As approved by the Commissioner, or designee, the prisoner may receive hospice services from an entity licensed pursuant to Title 22, Chapter 1681, Subchapter I or other care services provided by an entity approved by the Commissioner, or designee, and subject to approval by the Commissioner, or designee, may live at home while receiving these services.

2. The Commissioner, or designee, may approve a transfer pursuant to this provision through any process that the Commissioner, or designee, determines appropriate and may exempt a prisoner transferred to supervised community confinement pursuant to this provision from any mandatory conditions under Procedure F that the Commissioner, or designee, determines to be inapplicable. All decisions made pursuant to this provision are at the complete discretion of the Commissioner, or designee, and these decisions may not be appealed.

3. The prisoner shall provide any information pertaining to the prisoner's medical condition or care that is requested by the Commissioner, or designee, at any time while the prisoner is on supervised community confinement. If the Commissioner, or designee, determines that the prisoner has failed to fully comply with a request or if at any time the Department's Director of Medical Care determines that the prisoner does not have a terminal or severely incapacitating medical condition or that care outside a correctional facility is not medically appropriate, the Commissioner, or designee, shall revoke the transfer to supervised community confinement. In addition, a prisoner transferred to supervised community confinement pursuant to this provision may be removed from supervised community confinement at any time for any reason at the complete discretion of the Commissioner, or designee, and this decision may not be appealed.

Procedure J: Removal from Supervised Community Confinement

1. A prisoner transferred to supervised community confinement shall be governed by the Supervised Community Confinement Agreement (Attachment G), including any special conditions.

2. A prisoner's failure to follow any condition of the Supervised Community Confinement Program may result in removal from the program. It may also result in disciplinary action, revocation of probation or supervised release for sex offenders, and/or criminal prosecution.

3. If a probation officer observes, receives a report of, or otherwise discovers that the prisoner may have violated any condition(s) of supervised community confinement, or has failed to adjust to the program, and determines that removal from supervised community confinement and return to a Department facility might be appropriate, he or she shall immediately notify the Regional Correctional Administrator, or designee. The Regional Correctional Administrator, or designee, shall notify the Commissioner, or designee, to determine whether to remove the prisoner from supervised community confinement and return the prisoner to a Department facility and whether to arrest the prisoner and have him or her held in a county jail pending return to a Department facility. If the probation officer believes it is necessary to arrest the prisoner, based on probable cause that the prisoner has violated a condition of supervised community confinement, prior to notifying the Regional Correctional Administrator, or designee, the probation officer may do so.

4. If the prisoner is to be returned to a Department facility, then the Regional Correctional Administrator, or designee, shall notify the Department's Director of Classification, or designee. The Director of Classification, or designee, shall determine which Department facility the prisoner is to be returned to and notify that facility of the prisoner's name, status, location, and the name and telephone number of the probation officer. The receiving facility shall immediately contact the probation office providing him or her of the approximate time the facility's transport officers will arrive at the location where the prisoner is being held.

5. The probation officer shall ensure that the prisoner's records, including medical history and any medications or accessories for medical needs such as braces, crutches, etc., are properly prepared and ready for pickup by the transport officers, if possible.

6. The probation officer shall complete a written report stating the reasons for return. If the reason for return was a violation of the program's conditions, the probation officer shall forward the report to the facility Chief Administrative Officer, or designee, of the receiving facility, within two (2) working days of the prisoner's return to the facility, with a copy to the Regional Correctional Administrator, or designee, and the Department's Director of Classification. Facility staff receiving the report shall complete a disciplinary report to initiate the prisoner disciplinary process.

7. If a prisoner is returned to a Department facility, all applicable Department policies and procedures shall be followed, including disciplinary procedures and special management and other classification procedures.

8. Regardless of whether a prisoner has failed to follow any condition of the Supervised Community Confinement Program, a prisoner may be removed from the supervised community confinement program at any time for any reason in the complete discretion of the Commissioner, or designee.

Procedure K: Appeals of Denial of Transfer to or Removal from the Supervised Community Confinement Program

1. A prisoner wishing to appeal denial of or withdrawal of approval for his or her transfer to the supervised community confinement program may submit the appeal to the Department's Director of Classification within five (5) working days of receiving the decision. The Department's Director of Classification is the final authority for this appeal (no further appeals are allowed).

2. A prisoner wishing to appeal his or her removal from the supervised community confinement program, may submit the appeal to the Department's Director of Classification within five (5) working days of receiving the decision. The Department's Director of Classification is the final authority for this appeal (no further appeals are allowed).

3. The Department's Director of Classification shall make a decision on an appeal within thirty (30) days after receiving a timely prisoner appeal.

4. Upon review of the appeal, the Department's Director of Classification may:
   a. approve the decision;
   b. reverse the decision; or
   c. modify the decision.

5. If the denial, withdrawal or removal was by the Commissioner, or designee (including a decision by the Department's Director of Classification to not make an exception under Procedure B.9), the appeal shall be submitted by the prisoner to that person and shall be decided by that person as the final authority for the appeal.

6. A copy of the appeal and the decision on the appeal shall be placed in the prisoner's Case Management Record.

PROFESSIONAL STANDARDS

ACA:

ACI 4-4443 Temporary release programs should include but not be limited to the following:

- **written operational procedures**
- **careful screening and selection procedures**
- **written rules of conduct and sanctions**
- **a system of supervision to minimize inmate abuse of program privileges**
- **a complete record keeping system**
- **a system for evaluating program effectiveness**
- **efforts to obtain community cooperation and support**

ACI 4-4444 **Written policy, procedure, and practice include graduated release through a systematic decrease in supervision and corresponding increase in inmate responsibility as part of the classification program.**

4-ACRS-5A-14 **Each offender should be given gradual increased responsibility in the community prior to release, dependent upon his or her ability to accept responsibility.**

4-ACRS-5A-15 **A report is prepared at the termination of program participation that reviews the offender's performance. A copy of the report is maintained in the offender's case record. The report shall include, at a minimum:**

- **A summary of the offender's program activities**
- **Any unusual circumstances**
- **Community resource references that affected the outcome of supervision**
- **Objective assessment of the offender's program participation**

4-ACRS-5A-16 **Offenders have opportunities for involvement with family and participation in community activities before the final release.**

UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

JOSEPH A. DENBOW et al.,	)	
	)	
Petitioners	)	
	)	
v.	)	**Case No. 1:20-cv-00175-JAW**
	)	
MAINE DEPARTMENT OF CORRECTIONS et al.,	)	
	)	
Respondents	)	

AFFIDAVIT OF DR. JOHN NEWBY, D.P.M., IN OPPOSITION TO MOTION FOR TEMPORARY RESTRAINING ORDER

I, John Newby, D.P.M., declare as follows:

1. I am over the age of 18 years and not myself a party to this action. I understand and believe in the obligations of an oath.

2. I have personal knowledge of the facts stated in this affidavit and if called upon to testify, I would testify to those facts. In preparing this affidavit, I have also reviewed records regularly kept by Wellpath that are available to me and that I rely on in my official duties.

3. I am the Regional Vice President for Wellpath, a company contracted by the Maine Department of Corrections to provide medical care to inmates incarcerated in state correctional facilities, including the Mountain View Correctional Facility.

4. I have served as the Regional Vice President for Wellpath since 2012, and before that time I served in various other roles within Wellpath (formerly known as Correct Care Solutions) in Memphis, TN. I studied at Ohio College of Podiatric Medicine in Cleveland, Ohio,

where I obtained Doctorate of Podiatric Medicine. I have worked in correctional medical facilities in leadership and professional oversight management since 2002.

5. Wellpath medical providers work in the state's correctional facilities to provide healthcare services to inmates in the custody of the Maine Department of Corrections ("MDOC"). Because the healthcare setting refers to these individuals as patients, I use that term throughout this affidavit to refer to inmates in MDOC's custody.

Operational Preparedness:

6. For several months now, Wellpath has been working in conjunction with MDOC and the Maine Center for Disease Control and Prevention ("Maine CDC") to prepare for and respond to COVID-19, a global pandemic caused by the novel coronavirus SARS-CoV-2.

7. Before the onset or first positive case of COVID-19 in the State of Maine, Wellpath and MDOC have worked together to develop an aggressive and targeted response to COVID-19, in an effort to mitigate the effects of the virus and reduce the risk of its transmission inside the state's correctional facilities.

8. This response planning has been guided by recommendations from the Maine CDC and the U.S. Centers for Disease Control and Prevention ("U.S. CDC"), including the U.S. CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. Our coordinated response continues to be revised and updated as additional information is learned about COVID-19 and new guidance is provided.

9. A multi-disciplinary pandemic preparedness committee ("PPC") has been formed to address pandemic COVID-19 preparedness specifically, which includes Wellpath's President, Chief Clinical Officer, Chief Compliance Officer, Chief Human Resource Officer, and Associate Chief Clinical Officer (an infectious disease expert), among others, who convened twice per day

for several months to discuss the evolving clinical recommendations, as well as to prepare strategies to prevent challenges related to staffing and supplies.

10. To prepare for COVID-19, Wellpath providers and MDOC staff have been offered education, guidance, and support, including through weekly webinars, by Wellpath's Chief Clinical Officer and infectious disease experts, and have received education and training updates by individual site Health Services Administrators regarding, among other things, how COVID-19 is transmitted, how to help prevent the spread of COVID-19, the symptoms of COVID-19, and how to respond if someone is experiencing symptoms. Medical providers have also received ongoing regularly occurring educational updates, tools, and guidance from the Chief Clinical Officer, Regional Medical Director, and Wellpath corporate operations and continue to receive training in the use of screening tools to detect, target, and isolate the disease to help prevent its spread; methods for collecting a specimen for testing purposes; and the management and care of patients suspected or confirmed to have the disease, among other things.

11. In further preparation, medical staff members have been cross-trained to other positions and critical functions to medical care have been identified. These measures are designed to ensure adequate staffing needs and operating capacity in the event of staffing shortages and include contingency plans. Personnel who are at increased risk for COVID-19 complications have been identified with precautions and accommodations made, and staff in the facilities have been informed and advised how to immediately report their own possible COVID-19 illness.

12. Additionally, Wellpath providers continue to monitor updated guidance from the CDC, Maine CDC, World Health Organization ("WHO"), and local public health partners.

13. In addition to these measures, medical providers and MDOC staff have been fit-tested for N95 masks for respiratory protection in the event it is needed within the scope of their responsibilities.

14. MDOC and Wellpath have worked together to inventory and stock recommended hygiene supplies, cleaning supplies, personal protective equipment ("PPE"), and medical supplies, to ensure that those supplies are on hand and available. Wellpath has a sufficient supply of PPE to meet the anticipated needs of all MDOC facilities.

15. Further, a plan has been developed to rapidly restock PPE under crisis conditions. This has also involved making contingency plans in the event of PPE shortages during the COVID-19 pandemic, monitoring supply chains for potential disruption or impact, and following CDC guidance on optimizing PPE supplies.

16. To prepare for COVID-19, Wellpath and MDOC have worked to identify and develop plans for the movement, housing, and care of infected and non-infected individuals. These plans include preparing separate intake and housing areas for suspected and ill patients, including a quarantine unit and a medical isolation area at each facility.

Prevention:

17. Wellpath and MDOC have developed and implemented measures to prevent the introduction of COVID-19 from the community into the correctional facilities and to reduce its transmission inside a facility by reinforcing good hygiene practices among patients, staff, and visitors, intensifying cleaning and disinfecting practices, and implementing social distancing strategies.

18. All persons in the facility, including staff and patients, are encouraged and instructed to practice good hand hygiene and cough etiquette; to avoid touching their eyes, nose,

or mouth without cleaning their hands first; to avoid sharing eating utensils, dishes, and cups; and to avoid all non-essential physical contact.

19. Similarly, educational information has been provided to patients regarding how COVID-19 is transmitted, how to help prevent its spread (including hygiene and cough etiquette instructions), the symptoms of the disease, and what to do if a person is experiencing any symptoms of COVID-19. This has included signage in each of the facilities that is understandable for non-English speaking persons and those with low literacy, and necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

20. In addition, social distancing has been taught, encouraged, and practiced among staff and patients in the facilities, to the maximum extent possible.

21. Other measures in place include ensuring that all patients have access to soap and water to allow for frequent hand washing, as well as alcohol-based hand sanitizer that contains alcohol levels recommended by the CDC.

22. There have also been operational changes in the way in which healthcare services are delivered and provided to patients in the state's correctional facilities.

23. First, the procedures and practices relating to the administration and delivery of medication have been altered to better protect our medical providers and patients. This includes eliminating administration and delivery methods that involve patients congregating in waiting areas or closely together in large lines, and instead delivering medication to fewer patients at one time more locally in the housing units. Specifically, social distancing practices are followed where medication is administered and delivered to patients. There are still medication lines in some facilities with MDOC staff present who instruct patients on proper distancing while waiting in line.

24. Further, the use of "Keep on Person" or "KOP" medication protocols have been reviewed and maximized to allow additional patients to be provided with and store their medications for self-administration in accordance with medical instructions and when appropriate, patients are provided with more doses of medication to last for a longer time period.

25. In addition, all patients and staff have been offered the seasonal influenza vaccine, as preventing influenza cases may help to speed the detection of COVID-19 cases and reduce pressure on healthcare resources in the facilities.

26. In addition to caring for patients suspected or confirmed as being infected by COVID-19, Wellpath providers utilize standard precautions in caring for all patients, and these precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting.

27. Providers practice hand hygiene recommended by the CDC before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE.

28. During an examination, depending on the level of care and nature of the visit, healthcare providers are ensuring the use of appropriate PPE for both the medical provider and the patient. This includes the use of masks, face shields and gloves by providers when examining patients, and the use of masks by patients during the examination.

29. Additionally, education and communication with patients concerning COVID-19 has continued during medical visits, including discussions about changes to their daily routine and how they can contribute to risk reduction.

30. In order to encourage patients to voluntarily seek treatment of potential COVID-related symptoms, medical co-pays have been waived for patients seeking medical evaluation for respiratory symptoms and for those feeling sick and needing medical attention.

31. Between patient visits or examinations, medical equipment and surface areas are cleaned and disinfected to ensure the safety of patients and staff. Staff are also following guidelines recommended by the CDC for donning and doffing of PPE to ensure proper disposal and infection control procedures to reduce risk of transmission.

32. Further, where possible in some medical clinic areas of the facilities we are scheduling and performing limited telehealth visit with patients. Telehealth visits permit the providers to interact with the patients in real-time and provide medical orders. Currently we perform telehealth visits for both medical and psychiatric providers.

33. A patient seeking medical care or other healthcare services may submit a "Sick Call Slip," which is screened by medical nursing staff for initial response in addressing needs or based on medical concern submitted to Wellpath providers for review and response. In conjunction with MDOC, many patients are now able to use their tablets to request mental health services without the exchange of paper slips.

34. Patients needing chronic care examination visits are continuing to receive them, with additional precautions being taken in the clinic areas. Such precautions include the use of appropriate PPE being worn and limiting physical examinations generally to focus on reported symptoms and chronic care concerns.

35. Necessary medical care, including dialysis and chemotherapy, for patients has also continued, including any necessary off-site transport for medical care with appropriate infection

control procedures and screening protocols in place before and after transport and upon return to the facility.

36. For any new patients or admissions into MDOC's custody (before they were stopped in early April 2020), new intake procedures were implemented in response to COVID-19, including screening measures and temperature checks. Further, any new intakes or admissions to a state correctional facility are placed in a quarantine unit for fourteen days (separate from other individuals who are quarantined) and monitored medically before entry into a housing unit with other individuals. If the individual has or develops symptoms of COVID-19, the individual is placed in medical isolation with continued monitoring by medical staff and testing for COVID-19. Providers continue to provide care for and treat the individual unless the individual requires a hospital level of care, in which case the individual will be transported to the hospital, as explained further below.

37. Any person seeking to physically enter a state correctional facility, including MDOC staff, medical staff, and any allowed visitors, must comply with and pass enhanced screening protocols and temperature checks.

38. All non-essential travel between correctional facilities by providers has been limited.

39. Each correctional facility has developed and implemented a quarantine unit and a separate isolation unit, as described further below. In addition, at the state's largest correctional facility, the Maine State Prison, a second infirmary has been developed and implemented in the quarantine unit that is staffed with twenty-four-hour nursing coverage when there are patients admitted to this area. Currently we do not have any patients admitted.

40. Wellpath and MDOC have also worked to ensure that the local hospitals in the community of each of the correctional facilities have been contacted to establish an appropriate response plan in the event a patient at a correctional facility were to need a hospital level of care.

41. In terms of any patients needing emergency care, patients continue to be transported to community hospitals for that care. Before and after transport, and upon return to the facility, infection control procedures, including the donning of appropriate PPE and disinfection of all affected areas, are observed. Upon return to the facility from the hospital, the patient is placed in a quarantine unit for 14 days, with daily temperature checks and nursing visits. If a patient in such a position were to develop any signs or symptoms of COVID-19, the patient would be tested for COVID-19.

Management Measures:

42. All patients that present to a Wellpath provider with COVID-19 symptoms are tested for COVID-19.

43. When there is a suspected COVID-19 case inside an MDOC facility, that individual is placed under medical isolation, his or her close contacts are quarantined, and the individual is monitored and treated under the direction of our medical providers.

44. A patient under medical isolation is housed separately with his or her own bathroom, in a single cell with solid walls (not bars) and a solid door that closes fully, as recommended by the U.S. CDC. The individual's movements are restricted to the medical isolation space, and he or she is provided with clean masks as needed. Medical care is provided inside the medical isolation space, as are meals.

45. All patients who are close contacts of a confirmed or suspected COVID-19 case are placed under quarantine for fourteen days. Similarly, patients under quarantine are placed

separately in a single cell with solid walls (not bars) and solid doors that close fully, with access to their own bathroom. Their movement is restricted to the quarantine space and meals are provided inside that space. Medical care, if needed, is provided in that area, and if the individual develops any symptoms, they are tested for COVID-19.

46. To date, there have been no severe cases of COVID-19 in MDOC facilities. Should a patient present with a severe case of COVID-19, the patient will be transported to the nearest local hospital emergency department for treatment. The process would include us contacting the hospital first to inform them that we are requesting transport.

47. As of the date of this affidavit, there are four positive COVID-19 cases in the state's correctional system, all isolated at the Maine Correctional Center ("MCC") in Windham, Maine. These individuals while in isolation are being monitored daily with vital signs being taken three times per day.

48. On May 17, 2020, a male patient in his 20s at MCC began showing symptoms of COVID-19 and he was promptly moved to medical isolation. Medical personnel monitored and treated this patient, in addition to monitoring that patient's housing unit (close contacts). He was immediately tested for COVID-19, and his result returned as positive on May 19, 2020. He has not required a hospital level of care, and providers are managing and treating his symptoms.

49. On May 22, 2020, a second patient at MCC tested positive for COVID-19. This patient was immediately moved to a medical isolation unit, he was tested as part of the MCC-wide testing plan, and he has not required hospitalization.

50. On May 23, 2020, two additional patients at MCC tested positive for COVID-19. These patients were tested as part of the universal testing campaign at MCC, following the first positive test there. Both patients were immediately moved to a medical isolation unit.

51. MDOC and Wellpath continue to monitor for COVID-19 at MCC and the state's correctional facilities.

52. All patients being released from incarceration into the community are screened for COVID-19 symptoms. Wellpath and MDOC have developed a plan for discharging released inmates with known or suspected COVID-19, including communication with community resources and local public health officials.

53. Due in large part to MDOC, Maine CDC and Wellpath's response planning and overall preparedness to COVID-19, providers in the state facilities continue to have sufficient personal protective equipment to continue providing medical care safely to patients at the facilities.

54. In summary, Wellpath and MDOC continue to develop and implement a collaborative and aggressive response to COVID-19, rooted in medically-based evidence and recommendations provided by the Maine and U.S. CDC, to target, isolate, and mitigate the effects of COVID-19, in order to protect the health and safety of all patients and staff in the state's correctional facilities.

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

Signed under the penalties of perjury, this 27th day of May, 2020.

/s/ John Newby
John Newby, DPM