IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
No. __:___-CV-___-__

CHARLES HALLINAN, JOSEAN KINARD, GEORGE RIDDICK, JORGE L. MALDONADO, WILLIAM BROWN, TERRANCE FREEMAN, ANTHONY BUTLER, DARYL WILLIAMS, QUAMAIN JACKSON, AND LASALLE WALDRIP, on behalf of themselves and similarly situated individuals, *Plaintiffs/Petitioners,* v. THOMAS SCARANTINO, Complex Warden, Federal Correctional Complex Butner; MICHAEL CARVAJAL, Federal Bureau of Prisons Director; and JEFFERY ALLEN, Federal Bureau of Prisons Medical Director, in their official capacities, and the FEDERAL BUREAU OF PRISONS, *Defendants/Respondents.*	**Class Action Complaint for Injunctive and Declaratory Relief and Petition for Writ of Habeas Corpus** **Class Action**

INTRODUCTION

1. A crisis at Federal Correctional Complex Butner ("Butner") continues to threaten the lives, health, and safety of incarcerated people and staff because Defendants have not taken adequate measures to control the spread of the virus that causes COVID-19. Although the risk of COVID-19 is generally higher in facilities where people reside in close quarters, the risk is especially acute at Butner, which is home to a federal medical facility and, consequently, a large number of elderly and medically vulnerable people who face a heightened risk of suffering severe illness and/or death from COVID-19.

2. The Bureau of Prisons ("BOP") has the power to undertake measures that will protect prisoners from harm, including implementing appropriate practices for both prisoners and staff such as testing, contact tracing, quarantine, isolation, physical distancing, cleaning, provision of personal protective equipment, medical care, and release to home confinement or compassionate release. In a prior lawsuit, the BOP admitted to having such authority, yet it has taken grossly insufficient measures at Butner. Defendants' deliberate indifference to the risks faced by the men in their custody, despite knowledge of the harm and what it would take to correct it, violates the Eighth Amendment.

3. Defendants' failure to take sufficient measures to address the crisis violates the rights of people with disabilities who are entitled to a reasonable accommodation under the Rehabilitation Act of 1973 ("Rehab Act"). Defendants must ensure that persons with disabilities incarcerated at Butner have the opportunity to benefit from Butner's programs, services, and activities on an equal basis as those without disabilities. They have not done so.

4. Defendants' failure to take sufficient measures to address the crisis is a method of administration of Butner that disparately impacts people incarcerated there who have a disability. The failure to mitigate the risks from COVID-19 more harshly affects persons with disabilities than persons without disabilities.

5. Seven months after the first documented case of SARS-nCoV-2 ("coronavirus" or "virus")[1] at Butner, the virus has spread widely through Butner's population, endangering thousands of lives.[2] More than a quarter of the people incarcerated at Butner, and more than 50 staff

[1] SARS-nCoV-2 causes the disease COVID-19.

[2] *See* BOP Press Release, *Inmate Death and FCI Butner I*, https://www.bop.gov/resources/news/pdfs/20200412_press_release_inmate _death_but_covid19.pdf (April 12, 2020).

members, have been infected so far. ***Twenty-six people at Butner, including one correctional officer, have died from COVID-19***. This figure represents more than twice as many deaths as at any other BOP facility and ***one-fifth*** of all the deaths in BOP facilities nationally. Each of the deceased Butner residents was medically vulnerable and had a disability under federal law. And at least one contracted the virus a second time, more than two months after first contracting it and then testing negative.[3]

6. People at Butner are packed into crowded dormitories, small cells, and narrow hallways. They cannot physically distance themselves from others or self-quarantine. They cannot ensure that *others* are effectively quarantined from them if they are infected. Instead, they must sleep within a few feet of one another, use communal bathroom facilities, and line up close together several times a day for food and medicine.

7. Butner's health care "system" is grossly inadequate to treat sick men in its custody, and specifically those with disabilities, including pre-existing medical conditions that make them especially vulnerable to COVID-19. The BOP has inadequate infection surveillance, testing, quarantine, and isolation practices at Butner. What is more, due to the BOP's bungled response to the COVID-19 pandemic at Butner, many people with serious medical conditions unrelated to COVID-19 have not received necessary treatment.

8. The BOP knows of the conditions at Butner, the extreme threat they pose, and the necessary measures that must be implemented to protect elderly and otherwise medically vulnerable

[3] *See* Press Release, *Inmate Death at FCI Butner (Low)*, U.S. Dep't of Justice Federal Bureau of Prisons (Sept. 17, 2020), https://www.bop.gov/resources/news/pdfs/20200917_press_release_bux.pdf ("On Monday, June 1, 2020, inmate Ricky Lynn Miller tested positive for COVID-19. On Monday, July 6, 2020, Mr. Miller tested negative for COVID-19 . . . . On Wednesday, September 16, 2020, Mr. Miller tested positive for COVID-19 at the outside hospital.")

and disabled prisoners incarcerated there. Yet Defendants have failed to take critical steps to address the crisis.

9. This action seeks injunctive relief to protect the people in BOP custody at Butner, including medically vulnerable people and people with disabilities who, because of their medical conditions and/or advanced age, are at higher risk of severe injury or death from COVID-19. Named Plaintiffs Charles Hallinan, Josean Kinard, George Riddick, Jorge L. Maldonado, William Brown, Terrance Freeman, Anthony Butler, Daryl Williams, Quamain Jackson, and Lasalle Waldrip seek to represent a class of all persons currently or in the future incarcerated at Butner while anyone on the premises is infected with COVID-19 (the "Class"). Plaintiffs Hallinan, Riddick, Maldonado, Brown, Freeman, Butler, Williams, and Waldrip seek to represent a subclass of current and future people incarcerated at Butner who are medically vulnerable and at high risk of severe illness or death from COVID-19 due to disabilities protected under Section 504 of the Rehabilitation Act, including those with the following conditions: cancer; chronic kidney disease; chronic obstructive pulmonary disease ("COPD") or moderate to severe asthma; immunocompromised state from solid organ transplant, blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids or other immune weakening medicines; serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; sickle cell disease; diabetes; cerebrovascular disease; cystic fibrosis; hypertension; neurologic conditions such as dementia; liver disease; pulmonary fibrosis; and thalassemia (the "Disability Subclass").

10. COVID-19 is a highly contagious and deadly pandemic that raced across the globe, fundamentally altering life for everyone. There is no cure and no vaccine.

11. With more than 40 million known infections worldwide and more than 1.1 million people dead, the number of people affected by COVID-19 is staggering.[4] In the United States, more than 8.1 million people have tested positive for the virus, and more than 210,000 have died. Our country's prisons have been especially hard-hit: almost ***150,000*** incarcerated people and more than 32,000 staff have tested positive, with at least 1,245 deaths among incarcerated people and 86 deaths among staff.[5]

12. Testing for COVID-19 at Butner is irregular, inconsistent, and relatively limited. The BOP has not tested all the men incarcerated there. The true number of infected people at Butner is unknown.

13. Under even the best of circumstances, with people following rigorous physical distancing and good hygiene practices, our society can only hope to limit the spread of coronavirus and "flatten the curve" to keep from overwhelming hospital resources and allow a better chance of survival for those with serious symptoms. But in Butner, where physical distancing and good hygiene practices are impossible, the circumstances are much worse.

14. Crowded spaces make the situation more dire. Butner is operating at more than 99 percent of its capacity, making it impossible for the men incarcerated there to physically distance themselves from one another.

15. Butner houses many of the most medically vulnerable people in BOP custody. It includes a large Federal Medical Center ("the FMC" or "FMC Butner"), where those needing the most intensive medical care provided by the BOP are placed. Butner also has a large low-security

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[4] *COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins*, Johns Hopkins Univ. & Med. Coronavirus Resource Center, https://coronavirus.jhu.edu/map.html (last visited Oct. 19, 2020).

[5] The Marshall Project, https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (last visited Oct. 19, 2020).

prison that houses hundreds of men with serious medical conditions. Others housed in other parts of the complex also have serious medical conditions.

16. Defendants/Respondents Director Carvajal, Warden Scarantino, and Medical Director Allen (hereinafter, "Individual Defendants") have shown deliberate indifference to the severe and obvious risk of illness and death that COVID-19 poses to people incarcerated at Butner. Their actions violate the U.S. Constitution's Eighth Amendment prohibition against cruel and unusual punishment. In addition, Defendant BOP has failed to make reasonable modifications to Butner's policies, practices, and procedures to allow individuals with disabilities incarcerated at Butner to enjoy the full benefits of its programs, services, and activities, including food, medicine and medical care, housing, communications, and recreation.

17. The Individual Defendants and BOP (collectively, "Defendants") have failed to take the necessary steps to address the severe risks faced by the Class. Despite direction from the U.S. Attorney General months ago to expeditiously consider medically vulnerable people for home confinement or other release, Defendants continue to oppose motions for compassionate release made by medically vulnerable people, and they have failed to order furloughs or transfers to home confinement with sufficient speed and in sufficient numbers. They have also failed to make other arrangements within the facility to allow for adequate physical distancing, in particular for people who are more vulnerable due to age, medical condition, or disability.[6] And they have failed to implement effective isolation, quarantine, testing, screening, hygiene, and disinfecting policies or meaningfully modify movement

[6] Beyrer Decl. at 8–12.

protocols for staff and incarcerated people, thereby increasing the risk that people incarcerated at Butner will contract COVID-19 and suffer serious illness or death.[7]

18. Defendants' failures not only endanger people incarcerated at Butner, they put Butner's staff, local health care workers, family members, and the broader community at extreme risk.[8]

19. Without the ability to physically distance from one another, medically vulnerable people incarcerated at Butner remain at extraordinary risk of infection, serious illness, and death from COVID-19.[9] At current population levels, people incarcerated at Butner cannot practice meaningful physical distancing and are at continuing, increased risk of serious illness and death.

20. These conditions are well-known to Defendants, as are the steps they must take to accommodate prisoners with disabilities and prevent constitutional violations. They must act quickly to prevent the further spread of COVID-19 at Butner. The only effective option—and reasonable accommodation—is to immediately release Butner residents based on defined categories, including but not limited to those who are medically vulnerable, and to develop and implement a plan that provides for (1) adequate physical distancing; (2) consistent and effective testing, quarantining, and medical isolation; and (3) consistent and effective cleaning and disinfecting practices.[10]

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[7] *See, e.g.*, Beyrer Decl. 13–25.

[8] *See, e.g.*, Beyrer Decl. at 10–11, 26.

[9] *See, e.g.*, Beyrer Decl. at 8–14.

[10] *See, e.g.*, Beyrer Decl. at 32–33. The term "release," as used throughout this Complaint/Petition, refers to discharge of incarcerated persons from the physical confines of Butner, not necessarily release from custody. Release options may include, but are not limited to: enlargement of custody, release to parole or community supervision; transfer furlough (as to another medical facility, hospital, or halfway house); or non-transfer furlough, which could entail a released person's eventual return to Butner once the pandemic is over and the viral health threat is abated. Any releases would include requirements for testing, care, and physical distancing, as informed by a public health expert. Incarcerated people should not be sent to another dangerous and crowded BOP facility to address the concerns at Butner.

21. In connection with a prior suit, the Individual Defendants asserted on June 3, 2020—when 15 people had died at Butner—that "FCC Butner's efforts have been effective in managing infections and treating inmates."[11]

22. Within a week after the Individual Defendants asserted the effectiveness of their efforts, the reported number of positive COVID-19 tests for people incarcerated at Butner climbed from 654 to 928.[12] Within a month, another ten people were dead, including John Dailey, one of that lawsuit's petitioners.[13] Although the reported infection rates at Butner have declined since then, the risk of another deadly surge remains—particularly given that the number of confirmed infections in North Carolina is again rising. Without action by this Court, more people at Butner will become infected and more people will die.[14]

JURISDICTION AND VENUE

23. Plaintiffs/Petitioners (hereinafter, "Plaintiffs") bring this class action pursuant to 28 U.S.C. § 1331 (federal question jurisdiction) and 28 U.S.C. § 2241 (habeas corpus) for relief from detention that violates their Eighth Amendment rights under the U.S. Constitution, and pursuant to 29 U.S.C. § 794 for relief from disability discrimination.[15]

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[11] Ex. 1 (Opp. to Emergency Mtn for TRO, PI, and Writ of Habeas Corpus, *Hallinan v. Scarantino*, No. 5:20-HC-2088-FL (E.D.N.C. June 3, 2020), ECF No. 42, at 3).

[12] Ex. 2 (June 3, 2020 Screenshot of BOP COVID-19 Cases from BOP Coronavirus Resource Page); *see also* Ex. 3 (June 10, 2020 Screenshot of BOP COVID-19 Cases from BOP Coronavirus Resource Page). These numbers include all incarcerated persons who have tested positive, including those who have recovered and those who died.

[13] Ex. 4 (July 6, 2020 Screenshot of BOP COVID-19 Cases from BOP Coronavirus Resource Page); *see also* Ex. 5 (BOP Press Release regarding the death of John Dailey).

[14] *Compare* Mem. of Law in Supp. of Resp'ts' Mot. to Dismiss, or in the Alternative, Mot. for Summ. J., *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 35 ("Conditions at FCC Butner are far less dire than Petitioners' often generic and sensationalized allegations suggest.") *with* Exs. 4, 5 (July 6, 2020 Screenshots of BOP COVID-19 Cases from BOP Coronavirus Resource Page; BOP Press Release regarding the death of John Dailey).

[15] In a previous action brought by some of the Plaintiffs, Judge Flanagan made a preliminary, non-binding determination that their claims were not cognizable in a habeas corpus action. Order Denying Mot. for TRO, Prelim. Inj., and Writ of Habeas Corpus, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 11, 2020), ECF 65. Plaintiffs here include claims under 28 U.S.C. § 2241 (habeas corpus) to preserve those claims for appeal purposes.

24. This Court has subject matter jurisdiction over these claims pursuant to 28 U.S.C. § 2241 (habeas corpus), Article I, § 9, cl. 2 of the U.S. Constitution (Suspension Clause), 28 U.S.C. § 1331 (federal question jurisdiction), 28 U.S.C. §§ 2201–02 (authority to provide declaratory and other necessary and proper relief), and based on the Court's inherent equitable powers.

25. This Court has jurisdiction over this Class-Wide Petition for Writ of Habeas Corpus because Plaintiffs are detained within its jurisdiction in the custody of Thomas Scarantino, Complex Warden of Butner. Plaintiffs are therefore in custody for the purposes of the federal habeas corpus statute, 28 U.S.C. § 2241.

26. Venue is proper in this judicial district and division pursuant to 28 U.S.C. § 2241(d) because Plaintiffs and all other class members are in custody in this judicial district.

27. Venue is proper pursuant to 28 U.S.C. § 1391(e)(1)(B) because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in this district.[16]

PARTIES

28. PLAINTIFF Charles Hallinan—BOP Register No. 75207-066—is 79 years old. He suffers from bladder cancer and prostate cancer. Both are in remission but require additional checks or treatment that Mr. Hallinan is not currently receiving due to Defendants' failure to adequately provide treatment during the pandemic. Mr. Hallinan also suffers from hypertension, cardiovascular disease (including a bypass surgery), and celiac disease (an autoimmune disorder), resulting in anemia. Mr. Hallinan is serving a 14-year sentence for RICO, money laundering, and wire fraud charges. He is housed in FCI Butner Low ("Butner

[16] "A civil action in which a defendant is an officer or employee of the United States or any agency thereof acting in his official capacity or under color of legal authority . . . may, except as otherwise provided by law, be brought in any judicial district in which . . . a substantial part of the events or omissions giving rise to the claim occurred, or a substantial part of property that is the subject of the action is situated." 28 U.S.C. § 1391(e)(1)(B).

Low"), and his projected release date is July 3, 2030. Mr. Hallinan tested positive for COVID-19 in early June. Mr. Hallinan is an individual with a disability for the purposes of the Rehab Act.

29. PLAINTIFF Josean Kinard—BOP Register No. 33603-058—is 34 years old and has no known medical conditions. He has served about 25 months of a 70-month sentence for two counts of drug possession with intent to distribute and possession of a firearm by a person convicted of a felony. He is housed in Butner Low, and his projected release date is May 9, 2022.

30. PLAINTIFF George Riddick—BOP Register No. 72403-053—is 52 years old and in BOP custody from a sentence under the D.C. Code. Mr. Riddick has lymphoma, which is in remission. He is diabetic and suffers from asthma, sleep apnea, and has a history of arthritis. Mr. Riddick had a corneal transplant in February 2019 and takes an immunosuppressant to prevent rejection of the graft. Mr. Riddick has served 15 years of a 15-years-to-life sentence for second-degree murder while armed, possession of a firearm during the commission of a crime, and carrying a pistol without a license. Mr. Riddick is housed in FCI Butner Medium II. Mr. Riddick is an individual with a disability for the purposes of the Rehab Act.

31. PLAINTIFF Jorge L. Maldonado—BOP Register No. 63756-018—is 52 years old. He has kidney disease and has had two kidney transplants, and he must remain on immunosuppressant medication for the rest of his life. Mr. Maldonado is experiencing blood in his urine, and based on recent tests, his kidney may be failing; however, Defendants have chosen not to take him to see a nephrologist. Mr. Maldonado also has malignant hypertension due to his kidney disease, tachycardia, and squamous cell carcinoma. Mr. Maldonado has served about 41 months of an 84-month sentence for tax fraud. Mr.

Maldonado is housed at the minimum-security camp adjacent to FCI Butner Medium I. Mr. Maldonado is an individual with a disability for the purposes of the Rehab Act.

32. PLAINTIFF William Brown—BOP Register No. 26720-045—is 49 years old. He has had two kidney transplants, and he must remain on immunosuppressant medication for the rest of his life. He also suffers from diabetes, hypertension, and sleep apnea, for which he uses a breathing machine. Mr. Brown is currently serving an 11-year sentence for conspiracy to distribute cocaine. Mr. Brown is housed at the minimum-security camp adjacent to FCI Butner Medium I, and his projected release date is March 21, 2026. Mr. Brown is an individual with a disability for the purposes of the Rehab Act.

33. PLAINTIFF Terrance Freeman—BOP Register No. 27135-076—is 43 years old. He has a history of heart problems, most recently congestive heart failure that required open heart surgery. He also suffers from hypertension, respiratory deficiency, and a kidney injury. Mr. Freeman is currently serving a 12-year sentence for conspiracy to distribute drugs. Mr. Freeman is housed at the minimum-security camp adjacent to FCI Butner Medium I, and his projected release date is February 8, 2025. Mr. Freeman is an individual with a disability for the purposes of the Rehab Act.

34. PLAINTIFF Anthony Butler—BOP Register No. 65583-056—is 35 years old. He suffers from diabetes, Hepatitis B, and a heart murmur that causes him shortness of breath. Mr. Butler is currently serving a five-year sentence for one count of felony in possession of a firearm and one count of possession of a firearm in furtherance of a drug trafficking crime. Mr. Butler is housed in Butner Low, and his projected release date is November 1, 2025. Mr. Butler is an individual with a disability for the purposes of the Rehab Act.

35. PLAINTIFF Daryl Williams—BOP Register No. 08283-082—is 60 years old. He suffers from Type 2 diabetes and chronic kidney disease. Mr. Williams previously had colon cancer and skin cancer. Mr. Williams is currently serving an 80-month sentence for bank robbery. Mr. Williams is housed in FCI Butner Medium I. His projected release date is July 3, 2024. Mr. Williams is an individual with a disability for the purposes of the Rehab Act.

36. PLAINTIFF Quamain Jackson—BOP Register No. 22401-084—is 27 years old and has no known medical conditions. He has served about one year of a 20-month sentence for possession of a firearm by a person convicted of a felony. He is housed in FCI Butner Medium II, and his projected release date is April 25, 2021.

37. PLAINTIFF Lasalle Waldrip—BOP Register No. 14525-047—is 53 years old. He suffers from Type 2 diabetes and hypertension. Mr. Waldrip has served 11 months of a 46-month sentence for possession of marijuana with intent to distribute. He is housed in Butner Low. His projected release date is January 23, 2023. Mr. Waldrip is an individual with a disability for the purposes of the Rehab Act.

38. DEFENDANT Thomas Scarantino is the Warden of Butner and, in his official capacity, has immediate custody of Plaintiffs and all proposed Class Members. Mr. Scarantino is a final policymaker for running and administering Butner.

39. DEFENDANT Michael Carvajal is the Director of BOP and, in his official capacity, is responsible for the safety and security of all persons—including Plaintiffs and all proposed Class Members—serving federal and D.C. Code sentences at BOP facilities, including Butner. Mr. Carvajal is a final policymaker for running and administering BOP.

40. DEFENDANT Jeffery Allen, M.D. is the Medical Director of BOP and, in his official capacity, is the final BOP health care authority responsible for all health care delivered to

incarcerated people, including assessing each individual's risk factors for severe COVID-19 illness, risks of COVID-19 at the Butner, and risks of COVID-19 at the location in which an incarcerated person seeks home confinement before the BOP may grant discretionary release.[17] Dr. Allen also evaluates the suitability for and reviews requests for compassionate release.[18] Among others, Dr. Allen is a final policymaker for BOP.

41. DEFENDANT Federal Bureau of Prisons is a United States federal law enforcement agency within the DOJ. BOP was established in 1930 pursuant to Pub. L. No. 71-218. 46 Stat. 325 (May 14, 1930) and is charged with managing and regulating federal penal and correctional institutions. BOP controls and operates Butner and has immediate custody over Plaintiffs and all other putative class members. BOP is an executive agency for the purposes of the Rehab Act. Messrs. Carvajal and Barr, among others, are policymakers for BOP.

NOTICE OF RELATED CASES

42. Per Rule 40.3(b) of the local civil rules of the U.S. District Court for the Eastern District of North Carolina, Plaintiffs provide notice that this case arises from a common nucleus of operative facts with, and therefore is a "related case" to the following:

- *Hallinan et al. v. Scarantino et al.*, No. 5:20-HC-02088-FL. *See* Dkt. 66, June 29, 2020 (stipulation of voluntary dismissal without prejudice).
- *United States v. Antwan Harris*, No. 5:11-CR-247-BO. *See* Dkt. 126, Sep. 1, 2020 (motion for compassionate release granted).

[17] Attorney General William Barr, *Memorandum for Director of Bureau Prisons*, Office of the Attorney General, 2 (Mar. 26, 2020), https://www.justice.gov/file/1262731/download [hereinafter, "Barr March 26 Memo"]; *Program Statement 6010.05*, Federal Bureau of Prisons, Health Services Administration, 3 (June 26, 2014), https://www.bop.gov/policy/progstat/6010_005.pdf.

[18] *Program Statement 5050.50, Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. §§ 3582 and 4205(g)*, Federal Bureau of Prisons, Health Services Administration 6, 13-14 (Jan. 17, 2019), https://www.bop.gov/policy/progstat/5050_050_EN.pdf.

- *United States v. Anthony Butler*, No. 5:18-CR-00475-BO. *See* Dkt. 77, Sep. 17, 2020 (motion for compassionate release denied; appeal pending).

FACTUAL ALLEGATIONS

I. COVID-19 Is a Dangerous, Contagious Illness that Poses a Significant Risk of Serious Illness and Death

43. COVID-19 is a deadly and highly contagious disease caused by a novel coronavirus.[19] COVID-19 spreads through respiratory droplets, close personal contact, and contact with contaminated surfaces and objects, where the virus can survive for up to three days.[20] People who are asymptomatic can unknowingly transmit the virus, making its spread particularly difficult to slow.[21]

44. As of October 19, 2020, there have been more than 40 million confirmed cases of COVID-19, and more than 1.1 million related deaths.[22] More than 8.1 million of these cases and more than 210,000 deaths were in the United States.[23] The mortality rate for COVID-19 in the United States by population equates to about 60 deaths per every 100,000 people. At Butner, in comparison, the rate equates to about 600 deaths per every 100,000 people.[24]

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[19] On March 11, 2020, the World Health Organization ("WHO") classified COVID-19 as a pandemic. *WHO Characterizes COVID-19 as a Pandemic*, World Health Organization (Mar. 11, 2020), https://bit.ly/2W8dwpS (last visited Oct. 19, 2020).

[20] Ex. 6 (*How COVID-19 Spreads*, Centers for Disease Control and Prevention (Oct. 18, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html); *see also* Beyrer Decl. at 5–6, 16.

[21] *How COVID-19 Spreads; see also* Beyrer Decl. at 5, 17, 20–21.

[22] COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHHU), Johns Hopkins Univ. & Med. Coronavirus Resource Center, https://coronavirus.jhu.edu/map html (last visited Oct. 18, 2020).

[23] *Id.*

[24] *Mortality Analysis*, Johns Hopkins University of Medicine, https://coronavirus.jhu.edu/data/mortality (last updated August 13, 2020)).

45. All people, regardless of age or health, risk serious illness and death from COVID-19.[25] The case fatality rate can be significantly higher depending on the presence of certain demographic and health factors. The rate is higher in men, and varies significantly with advancing age, rising after age 50, and is above 10 percent (1 in 10 cases) for those with pre-existing medical conditions including cardiovascular disease.[26]

46. Certain categories of people face especially high risks of serious illness or death from COVID-19, including people aged 50 years or older.[27] If infected, people in this group are more likely to require hospitalization, more likely to be admitted to intensive care units ("ICUs"), and more likely to die.[28] According to the CDC, people aged 50-64 who develop COVID-19 are four times more likely to be hospitalized than 18 to 29-year-olds, and 30 times more likely to die.[29] People aged 65 to 74 are five times more likely to be hospitalized than 18 to 29-year-olds and 90 times more likely to die.[30]

47. People of all ages face higher risk of hospitalization and death if they have underlying medical conditions, including cancer, diabetes, chronic obstructive pulmonary disease ("COPD"), moderate to severe asthma, serious heart conditions (such as heart failure or coronary artery disease), obesity (Body Mass Index, or "BMI," of 30 or higher), chronic kidney disease, or compromised immune systems (such as from a solid organ transplant,

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[25] Ex. 7 (*Assessing Risk Factors*, Centers for Disease Control and Prevention (Oct. 18, 2020), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/assessing-risk-factors.html).

[26] *See, e.g.*, Beyrer Decl. at 3, 9.

[27] *See, e.g.*, Exs. 8, 9, 10 (Xianxian Zhao, et al., *Incidence, Clinical Characteristics and Prognostic Factor of Patients with COVID-19: A Systematic Review and Meta-Analysis* (March 20, 2020), https://cutt.ly/etRAkmt; *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart*, https://cutt.ly/ytEimUQ (data analysis based on WHO China Joint Mission Report); *Older Adults*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults html)/.

[28] Xianxian Zhao, *et al.*; *see also* Beyrer Decl. at 3, 8–9.

[29] Ex. 11 (*COVID-19 Hospitalization and Death by Age*, Centers for Disease Control and Prevention (Oct. 18, 2020) https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age html).

[30] *Id.*

blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids or other immune weakening medicines), sickle cell disease, stroke, or other immune deficiencies, cerebrovascular disease, cystic fibrosis, hypertension, neurologic conditions (such as dementia, liver disease, or pulmonary fibrosis), current or former smoking, and thalassemia.[31]

48. According to the World Health Organization ("WHO")-China Joint Mission Report, the COVID-19 mortality rate is 13.2 percent for those with cardiovascular disease, 9.2 percent for diabetes, 8.4 percent for hypertension, 8.0 percent for chronic respiratory disease, and 7.6 percent for cancer.[32] The WHO reports that people with high blood pressure are more likely to develop serious COVID-19 illness than others.[33]

49. According to a CDC report published in May 2020, 30 percent of all hospitalized COVID-19 patients required mechanical ventilation.[34] The mortality rate among COVID-19 patients on mechanical ventilation is estimated to be between 30 and 50 percent.[35]

50. People who survive COVID-19 can suffer severe damage to lung tissue, including permanent loss of respiratory capacity, and damage to other vital organs, such as the heart,

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[31] Xianxian Zhao, *et al.*; *see also* Beyrer Decl. at 20–21.

[32] *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, World Health Organization 12 (Feb. 28, 2020), https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf.; *see also* Beyrer Decl. at 20–21.

[33] *Q&A on Coronaviruses (COVID-19)*, World Health Organization, https://www.who.int/news-room/q-a-detail/q-a-coronaviruses (last visited Oct. 19, 2020).

[34] Beyrer Decl. at 3.

[35] *Id.*

central nervous system, and liver.[36] COVID-19 may also target the heart, causing a medical condition called myocarditis, or inflammation of the heart muscle.[37]

51. Even young, healthy people who contract COVID-19 may require supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.[38]

52. Serious complications from COVID-19 can develop rapidly.[39] Some individuals show the first symptoms of infection within two days of exposure, and their conditions can seriously deteriorate in less than five days.[40]

53. People who develop serious illness often require advanced medical support, including specialized equipment, such as ventilators and large teams of highly trained care providers such as ICU doctors, nurses, and respiratory therapists. The artificial ventilation process is itself invasive and dangerous, and some patients must be placed in medically induced comas for such treatment.[41]

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[36] Panagis Galiatsatos, *What Coronavirus Does to the Lungs*, Johns Hopkins Medicine (Apr. 13, 2020), https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/what-coronavirus-does-to-the-lungs (last visited October 19, 2020). COVID-19 can trigger an over-response of the immune system, further damaging tissues in a cytokine release syndrome that can result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury. *Id.*; *see also* Beyrer Decl. at 3–4.

[37] Beyrer Decl. at 3. Myocarditis can reduce the heart's ability to pump. *Id.*

[38] Kerry Kennedy Meltzer, *I'm Treating Too Many Young People for the Coronavirus*, The Atlantic (March 26, 2020), https://www.theatlantic.com/ideas/archive/2020/03/young-people-are-not-immune-coronavirus/608794/ (last visited Oct. 19, 2020); *see also What is ECMO*, 193 Am. J. Respir. Care Med 9–10 (2016), https://www.thoracic.org/patients/patient-resources/resources/what-is-ecmo.pdf (describing function of extracorporeal membrane oxygenation machine to replace function of heart and lungs).

[39] *See* Sarah Jarvis, *Coronavirus: How Quickly Do COVID-19 Symptoms Develop and How Long Do They Last?*, Patient (Apr. 20, 2020), https://patient.info/news-and-features/coronavirus-how-quickly-do-covid-19-symptoms-develop-and-how-long-do-they-last (last visited Oct. 19, 2020).

[40] *Id.*; *see also* Beyrer Decl. at 4.

[41] Kathryn Dreger, *What You Should Know Before You Need a Ventilator*, NY Times (Apr. 4, 2020), https://www.nytimes.com/2020/04/04/opinion/coronavirus-ventilators html (last visited Oct. 19, 2020).

II. The Risk from COVID-19 Is Particularly High in Prisons

54. According to CDC guidelines, only three measures are known to effectively reduce the spread of this fatal disease: (i) diligent "social or physical distancing" to avoid transmission of the virus;[42] (ii) covering the mouth and nose with a mask or cloth;[43] and (iii) vigilant hygiene practices, including frequently washing hands and disinfecting surfaces.[44]

55. Physical distancing is a necessary predicate for hygiene practices, such as handwashing, to have a meaningful impact.[45] Because asymptomatic people can transmit the virus, it is critical to maintain physical distance, even among people who show no signs of illness.[46]

56. In prisons, incarcerated persons and staff interact in close proximity and cramped quarters designed to confine people rather than distance them. Incarcerated people, by the fact of their incarceration, have little autonomy or control of their movements. As a result, incarcerated people are highly susceptible to rapid transmission of the virus through contact with other people, including asymptomatic carriers, and touching common surfaces.[47]

57. Incarcerated people, correctional staff, medical staff, and contractors regularly move in and out of correctional facilities and across different housing units within prisons. Such

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[42] *See, e.g.*, Ex. 12 (*Social Distancing, Quarantine, and Isolation*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing html); Beyrer Decl. at 5–6.

[43] *See, e.g.*, Ex. 13 (*How to Protect Yourself & Others*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention html).

[44] *See id*. For additional guidance related to prevention of COVID-19 in prisons specifically, *see also* Ex. 14 (*COVID-19 in Correctional and Detention Facilities – United States, February-April 2020*, Centers for Disease Control and Prevention, https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1 htm (last visited Oct. 19, 2020)) [hereinafter, "*COVID-19 in Correctional and Detention Facilities*"]; Ex. 15 (*Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, https://web.archive.org/web/20201006113319/https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention html (July 22, 2020 edition as archived on October 6, 2020)) [hereinafter, "*Interim Guidance*"]; Beyrer Decl. at 6–8; 13–14; 16–17.

[45] *See COVID-19 in Correctional and Detention Facilities*.

[46] *See* Beyrer Decl. at 5, 10, 13, 25.

[47] *See id*. at 5–7, 9, 13.

movement creates an ever-present risk that persons, including asymptomatic carriers, will carry the virus in and out of those facilities, spreading infection and triggering outbreaks.

58. In addition, prisons are at an increased risk for the rapid spread of an infectious disease—like COVID-19—because of the high number of people with chronic, often untreated, illnesses housed in a setting with minimal levels of sanitation, limited access to personal hygiene, limited access to medical care, and limitations on physical distancing.[48]

59. As the chart below illustrates, health conditions that make COVID-19 particularly dangerous are more prevalent in the incarcerated population than in the general public.[49]

	Prevalence of health condition by population			
Health condition	**Jails**	**State prisons**	**Federal prisons**	**United States**
Ever tested positive for Tuberculosis	2.5%	6.0%		0.5%
Asthma	20.1%	14.9%		10.2%
Cigarette smoking	n/a	64.7%	45.2%	21.2%
HIV positive	1.3%	1.3%		0.4%
High blood pressure/hypertension	30.2%	26.3%		18.1%
Diabetes/high blood sugar	7.2%	9.0%		6.5%
Heart-related problems	10.4%	9.8%		2.9%
Pregnancy	5.0%	4.0%	3.0%	3.9%

Health conditions that make respiratory diseases like COVID-19 more dangerous are far more common in the incarcerated population than in the general U.S. population. Pregnancy data come from our report, Prisons neglect pregnant women in their healthcare policies, the CDC's 2010 Pregnancy Rates Among U.S. Women, and data from the 2010 Census. Cigarette smoking data are from a 2016 study, Cigarette smoking among inmates by race/ethnicity, and all other data are from the 2015 BJS report, Medical problems of state and federal prisoners and jail inmates, 2011-12, which does not offer separate data for the federal and state prison populations. Cigarette smoking may be part of the explanation of the higher fatality rate in China among men, who are far more likely to smoke than women.

[48] *See generally* I.A. Binswanger *et al*., *Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared With the General Population*, 63 J. Epidemiology & Community Health 912 (2009) (concluding that incarcerated people in the U.S. had a higher burden of most chronic medical conditions than the general population, even adjusting for sociodemographic differences and alcohol consumption); *see also* Letter from Faculty at Johns Hopkins School of Medicine, School of Nursing, and Bloomberg School of Public Health to Hon. Larry Hogan, Gov. of Maryland (Mar. 25, 2020), https://cutt.ly/stERiXk; Beyrer Decl. at 6–7, 9, 13.

[49] Peter Wagner & Emily Widra, *No Need to Wait for Pandemics: The Public Health Case for Criminal Justice Reform*, Prison Policy Initiative (Mar. 6, 2020), https://cutt.ly/7tJXmlC (color in chart adjusted); *see also* Beyrer Decl. at 9 ("Prison and jail populations are at additional risk due to high rates of chronic health conditions among these people, estimated at more than 38% of people in correctional custody nationally.")

60. In addition to Dr. Chris Beyrer (whose declaration is attached at Exhibit 29), multiple public health experts, including Dr. Gregg Gonsalves,[50] Dr. Ross MacDonald,[51] Dr. Marc Stern,[52] Dr. Oluwadamilola T. Oladeru, Dr. Adam Beckman,[53] Dr. Homer Venters,[54] the faculty at Johns Hopkins schools of nursing, medicine, and public health,[55] and Dr. Josiah Rich[56] strongly caution that incarcerated people are likely to face serious, even grave, harm due to the COVID-19 outbreak.

61. The CDC and WHO have also identified prisons as especially susceptible to rapid outbreaks of infection due to close person-to-person contact among large, confined populations.[57] According to the CDC:

- Environments like prisons "heighten[] the potential for [COVID-19] to spread once introduced";
- "Many opportunities exist for [COVID-19] to be introduced into a correctional or detention facility, including daily staff movements";
- "Options for medical isolation for people with COVID-19 are limited";
- Incarcerated people "may hesitate to report symptoms of COVID-19 . . . due to co-pay requirements . . . and fear of isolation";

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[50] Kelan Lyons, *Elderly Prison Population Vulnerable to Potential Coronavirus Outbreak*, Connecticut Mirror (Mar. 11, 2020), https://cutt.ly/BtRSxCF.

[51] Craig McCarthy & Natalie Musumeci, *Top Rikers Doctor: Coronavirus 'Storm is Coming,'* New York Post (Mar. 19, 2020), https://cutt.ly/ptRSnVo.

[52] Marc F. Stern, MD, MPH, *Washington State Jails Coronavirus Management Suggestions in 3 "Buckets,"* Washington Assoc. of Sheriffs & Police Chiefs (Mar. 5, 2020), https://cutt.ly/EtRSm4R.

[53] Oluwadamilola T. Oladeru, *et al*., *What COVID-19 Means for America's Incarcerated Population – and How to Ensure It's Not Left Behind* (Mar. 10, 2020), https://cutt.ly/QtRSYNA.

[54] Madison Pauly, *To Arrest the Spread of Coronavirus, Arrest Fewer People*, Mother Jones (Mar. 12, 2020), https://cutt.ly/jtRSPnk.

[55] Letter from Faculty at Johns Hopkins School of Medicine, School of Nursing, and Bloomberg School of Public Health to Hon. Larry Hogan, Gov. of Maryland (Mar. 25, 2020), https://cutt.ly/stERiXk.

[56] Amanda Holpuch, *Calls Mount to Free Low-risk US Inmates to Curb Coronavirus Impact on Prisons*, The Guardian (March 13, 2020 3:00 p m.), https://cutt.ly/itRSDNH.

[57] *See Interim Guidance*.

- "Incarcerated/detained persons and staff may have underlying medical conditions that increase their risk of severe illness from COVID-19"; and
- Incarcerated persons have limited ability to "exercise disease prevention measures (*e.g.*, frequent handwashing)" due to restrictions put in place by many prison facilities.[58]

62. Among the specific recommendations from the CDC for mitigating the risk of COVID-19—tailored to the prison realities—is the implementation of distancing strategies to increase physical space between incarcerated people—"ideally 6 feet between all individuals, *regardless of symptoms*."[59] According to the CDC, distancing is "a cornerstone of reducing transmission of . . . COVID-19."[60] Distancing strategy includes reassigning and/or rearranging bunks to provide more space, enforcing increased space between people in common areas, staggering recreation times, and staggering meals.[61]

63. The CDC also recommends, among other things: (i) individually quarantining and medically monitoring close contacts of confirmed COVID-19 cases—including testing;[62] (ii) daily temperature checks in housing units where COVID-19 cases have been identified;[63] (iii) face mask requirements for all individuals showing symptoms of COVID-19;[64] (iv) immediately placing symptomatic individuals into *individual* medical isolation that is "distinct from punitive solitary confinement" and ensuring that they "receive[] regular visits from medical

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[58] *Interim Guidance*.
[59] *Id.* (emphasis added).
[60] *Id*.
[61] *Id.*; Beyrer Decl. at 25.
[62] *COVID-19 in Correctional and Detention Facilities – United States, February-April 2020* at 19.
[63] *Id*. at 22.
[64] *Id*. at 15–16. CDC also recommends encouraging all staff and incarcerated people to wear masks "as much as safely possible." *Interim Guidance*.

staff";[65] (iv) actively encouraging staff to stay home when sick;[66] and (v) frequent and thorough cleaning and disinfection of surfaces, objects, and areas.[67]

64. Jail administrators in Washington County, Oregon;[68] Cuyahoga County, Ohio;[69] Los Angeles, California;[70] San Francisco, California;[71] Jefferson County, Colorado;[72] and the state of New Jersey,[73] among others, have concluded that widespread jail release is a necessary and appropriate public health intervention.[74] These non-judicial avenues underscore the importance of release.

III. COVID-19 Has Spread Rapidly at Butner

65. Butner is a complex of BOP facilities—FMC Butner, Butner Low, FCI Butner Medium I ("Medium I"), and FCI Butner Medium II ("Medium II")—collectively housing approximately 3,974 men.[75]

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[65] *Id.* (emphasis added); *Interim Guidance*. CDC defines "medical isolation" as "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." *COVID-19 in Correctional and Detention Facilities – United States, February-April 2020* at 4.

[66] *Interim Guidance*.

[67] *Id.* at 9.

[68] KATU, *Washington Co. Jail Releases Inmates to Meet Social Distancing Guidelines*, KCBY (April 28, 2020), https://kcby.com/news/local/washington-co-jail-releases-inmates-to-meet-social-distancing-guidelines.

[69] Scott Noll, *Cuyahoga County Jail Releases Hundreds of Low-Level Offenders to Prepare for Coronavirus Pandemic* (March 20, 2020 6:04 p.m.), https://cutt.ly/CtRSHkZ.

[70] Alene Tchekmedyian, *More L.A. County Jail Inmates Released Over Fears of Coronavirus Outbreak*, L.A. Times, (March 19, 2020 6:55 p m.), https://cutt.ly/ltRSCs6.

[71] Megan Cassidy, *Alameda County Releases 250 Jail Inmates Amid Coronavirus Concerns, SF to Release 26*, San Francisco Chronicle (March 20, 2020), https://cutt.ly/0tRSVmG.

[72] Jenna Carroll, *Inmates Being Released Early from JeffCo Detention Facility Amid Coronavirus Concerns*, KDVR Colorado (March 19, 2020 2:29 pm.), https://cutt.ly/UtRS8LE.

[73] Erin Vogt, Here's NJ's Plan for Releasing Up to 1,000 Inmates as COVID-19 Spreads (March 23, 2020), https://cutt.ly/QtRS53w.

[74] Internationally, governments and jail staff have recognized the threat posed by COVID-19 and released large numbers of detained persons. For example, France released approximately one-seventh of its total prison population. Benjamin Dodman, *As France Releases Thousands, Can Covid-19 End Chronic Prison Overcrowding?*, FRANCE24.COM (April 27, 2020), https://www.france24.com/en/20200427-as-france-releases-thousands-can-covid-19-end-chronic-prison-overcrowding. In Iran, more than 85,000 people were released from jails to curb the spread of coronavirus. Morning Edition, *Iran Releases 85,000 Prisoners But Not Siamak Namazi*, NPR (March 18, 2020), https://www npr.org/2020/03/18/817606513/iran-releases-85-000-political-prisoners-but-not-siamak-namazi.

[75] *See Population Statistics: Inmate Population Breakdown, Federal Bureau of Prisons,* https://www.bop.gov/mobile/about/population_statistics.jsp (last updated October 22, 2020) (showing populations for

66. Butner has experienced one of the worst COVID-19 outbreaks of any BOP facility.

67. At the end of March 2020, BOP reported that two incarcerated people at Butner had COVID-19. By April 10, BOP reported that 60 incarcerated people at Butner had it. By April 13, four people at Butner had died of COVID-19. By the end of April, more than 200 people at Butner had COVID-19.

68. In the first half of May, the reported active cases dropped below 100, but then came roaring back to more than 600 active cases by mid-June.

69. Twenty-six people held at Butner have died from COVID-19—more than twice as many as at any other BOP facility and one-fifth of all the deaths in the BOP.[76] The most recent death was a man who had COVID-19 in June and apparently contracted it again near the end of the summer, dying from it on September 17, 2020.[77]

70. So far, nearly a quarter of the total population of incarcerated people at Butner (at least 900) and 81 staff members have tested positive for the virus.[78]

71. Although the number of reported current infections has declined in the last couple of months, there continue to be a steady stream of cases, demonstrating that the virus remains circulating at Butner. Further, Defendants are progressively opening the facility without taking the precautions necessary to prevent a resurgence. As demonstrated earlier this year, the number of infected people can grow exponentially and rapidly, with deadly consequences.

Butner Low FCI (970), Butner Medium I FCI (591), Butner Medium II FCI (1,389), and Butner FMC (816). FCI Butner Medium I also houses another 146 men in an adjacent minimum-security satellite camp. *Id.*

[76] *COVID-19 Coronavirus: COVID-19 Cases*, Federal Bureau of Prisons, https://www.bop.gov/coronavirus/ (last visited Oct. 19, 2020) [hereinafter, "*COVID-19 Cases*"].

[77] *COVID-19 Cases.*

[78] *Id.*

IV. Defendants' Actions – and Inaction – Put People Incarcerated at Butner at a Very High Risk

72. Butner's housing conditions make it impossible for incarcerated people to physically distance.

73. The increased risks of the prison layout are exacerbated by the presence of a large number of people housed at the prison with disabilities and who are otherwise medically vulnerable.

74. Despite the high risk, Defendants have tested too few people at Butner, too infrequently, and too late. What is more, even where Defendants conducted widespread testing in a housing unit or facility, they failed to separate people who tested positive from those who tested negative for *several days after* receiving the test results. In the meantime, Defendants forced potentially COVID-positive and COVID-negative incarcerated persons to continue sleeping, receiving meals, picking up medications, and conducting other day-to-day activities in close proximity to one another without the ability to physically distance.

75. Screening for symptoms has also been sporadic and ineffectual. Whether a person incarcerated at Butner will be removed from other incarcerated people due to potential COVID status appears to be determined solely by whether the person has a high temperature. Staff at Butner occasionally have checked the temperatures of all people in a housing unit, but even then, Defendants inconsistently asked questions about other COVID-19 symptoms. If an incarcerated person suspected that he may be running a temperature, Defendants generally have required the person to request "sick call," which requires a $2.00 co-pay. In some—but not all—cases, Defendants checked temperatures for men who were required to leave their unit for work assignments or hospital visits outside Butner.

76. Defendants have failed to implement cleaning and disinfection procedures to adequately protect the men housed at Butner.

77. Rather than take established measures to stop the spread of the virus, around the beginning of April 2020, Butner purported to "lockdown." This lockdown had a number of adverse effects—described more fully in the sections that follow—such as:

- People housed in facilities other than the FMC with serious medical conditions who ordinarily would have been treated at the FMC could no longer go there, so they did not receive necessary medical treatments.
- People housed in celled units could leave their units only during certain times. Therefore, large groups of people were required to use the showers, phones, and computers in a short time period, concentrating the use of these facilities and ensuring that people congregated in these confined areas.
- BOP placed people believed to have COVID-19 in solitary confinement cells known as the Special Housing Unit ("SHU"). The SHU is not medical isolation;[79] rather, it is essentially punitive solitary confinement, with some reporting that those placed in the SHU were denied access to necessary medications, phone usage, and/or hot water. Further, because of the SHU's punitive nature, some incarcerated people who were sick reportedly concealed their conditions as long as they could to avoid being sent to the SHU, demonstrating that the BOP policy increased the likelihood of spreading the illness within the facility. As early as March, Defendants knew that their policy of placing symptomatic people into the SHU resulted in people hiding their symptoms to avoid placement in the SHU.[80]

[79] *See, e.g.*, Beyrer Decl. at 22–24 (describing medical isolation).

[80] Declaration of Mary Strassel, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (E.D.N.C. June 3, 2020), ECF 37-11 at 11-12.

- During the lockdown, meals and medicines were delivered to housing units in most facilities at Butner. As a result, people in dormitory-style housing units had to line up in confined spaces multiple times a day to receive their meals and medications.

78. When people do get sick with COVID-19, treatment is almost non-existent. In some cases, staff check vital signs and give Tylenol. In others, there is not even that level of care and monitoring. Individuals who test positive for COVID-19 should have increased access to medical personnel who consistently check on those individuals, not limited medical treatment.[81]

79. Although Butner has an FMC, BOP generally leaves people in their respective Butner facility until they are already experiencing respiratory failure. Only then do Defendants transfer them to a hospital.[82]

80. As described in further detail below, Defendants' actions put all people who are incarcerated at Butner at substantial risk of serious harm.

81. Additionally, Defendants have failed to make reasonable modifications for people at Butner whose disabilities put them at a heightened risk from the virus. Defendants have not ensured that people with disabilities can access food, medicine and medical treatment, recreation, housing, or communications on an equal basis with the other people housed at Butner. Because there have been no modifications made for them, in order to access these programs, services and activities, the Disability Subclass must subject themselves to an increased risk of serious illness and death to access these programs, services, and activities.[83]

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[81] Beyrer Decl. at 23.

[82] *See, e.g.*, Ex. 5 (Press Release, Inmate Death at FCI Butner I, U.S. Dep't of Justice Federal Bureau of Prisons (Apr. 13, 2020), https://www.bop.gov/resources/news/pdfs/20200413_3_press_release_butner.pdf ("John Doe, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I . . . . He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation.")).

[83] *See generally* Beyrer Decl.

82. These conditions and risks are known to Defendants.

A. FMC Butner

83. FMC Butner is a federal medical center that houses men designated as Care Level 4.[84] This is the highest level of healthcare need in the BOP.[85]

84. Patients at Care Level 4 "require services available only at a BOP Medical Referral Center, which provides significantly enhanced medical services and limited inpatient care."[86] Examples of conditions that result in a Care Level 4 are: "Cancer on active treatment, dialysis, quadriplegia, stroke or head injury patients, major surgical treatment, and high-risk pregnancy."[87]

85. FMC Butner provides specialized services in all areas of medicine and is BOP's primary referral center for oncology, chemotherapy, and radiation therapy.[88]

86. FMC Butner also manages a broad range of subacute and chronically ill incarcerated men.[89]

87. The fifth floor of the FMC houses patients who are extremely ill, including those on hospice care. The fourth floor houses patients undergoing treatment for cancer. The third floor houses patients who are having ambulatory surgeries. The second floor houses patients who are seriously mentally ill for psychiatric care.

88. Most of the men who are housed in FMC Butner live in two-person cells.

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[84] *See* Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs, United States Government Accountability Office, 64 (June 2017), https://www.gao.gov/assets/690/685544.pdf ; PREA Audit Report at 2. The FMC houses people at Care Level 4 for medical and mental health reasons.

[85] *Care Level Classification for Medical and Mental Health Conditions or Disabilities*, Federal Bureau of Prisons, 2–3 (May 2019), https://www.bop.gov/resources/pdfs/care_level_classification_guide.pdf.

[86] *Id.* at 3.

[87] *Id.*

[88] *Id.*

[89] *Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs*, United States Government Accountability Office, 64 (June 2017) https://www.gao.gov/assets/690/685544.pdf.

89. The fourth floor, for patients receiving cancer treatment, is divided into four units of roughly 60 people each. The residents of each unit must all share two phones.

90. Some cells on the fourth floor of the FMC share ventilation systems such that individuals in one cell can hear those in the cell next to them when they speak or cough.

91. On the third floor, prior to the lockdown, people were allowed out of their cells from 6:00 a.m. until 9:00 p.m. There are two phones for each side of the third floor. When patients are allowed out of their cells, the phones are used fairly constantly.

92. COVID-19 was first reported at the FMC at the end of March 2020 and the FMC was locked down around that time.[90]

93. Shortly thereafter, in April 2020, the BOP informed people housed in the FMC that there were cases of COVID-19 on the second and fifth floors of the FMC.

94. Movement of patients and incarcerated people who live in the Cadre unit ("Cadre workers") between areas of the FMC continued during the lockdown, despite the presence of COVID-19 within the facility.

95. For at least two months, Defendants housed—purportedly for purposes of quarantining—some people who transferred into Butner on the fourth floor of the FMC, where the residents are immunocompromised due to cancer treatment.

96. Cadre workers move from floor to floor picking up and distributing laundry, food trays, and commissary. People who worked on the fourth floor of the FMC distributed food and medicine to both the cancer patients and those people in quarantine.

[90] Ex. 16 (Mar. 30, 2020 Screenshot of BOP COVID-19 Cases from BOP Coronavirus Resource Page as archived by the Internet Archive on April 15, 2020). When BOP first reported COVID-19 at FCC Butner, it reported all cases at the FMC. *See id*. (reporting two cases at the FMC), *see also* Ex. 17 (April 1, 2020 Screenshot of BOP COVID-19 Cases from BOP Coronavirus Resource Page as archived by the Internet Archive on April 15, 2020) (reporting nine cases at the FMC). By April 5, BOP started disaggregating the cases of COVID-19 at Butner by facility. Ex. 18 (April 6, 2020 Screenshot of BOP COVID-19 Cases from BOP Coronavirus Resource Page as archived by the Internet Archive on April 15, 2020) (reporting seven cases at the Low, one case at the FMC and three cases at Medium 1).

97. Defendants also quarantined people on the third floor of the FMC, including people who were symptomatic, had been tested, and were awaiting their test results.

98. In early July, the BOP relaxed the lockdown of the FMC. Defendants permitted people to come out of their cells into the dayroom area two days a week to use the phone, get ice and hot water, and, on one day a week, use the computer. They were also allowed to go outside for recreation two days a week for an hour.

99. After the lockdown was relaxed, people lined up to use the phones and computers. Defendants did not require physical distancing at the computers in the FMC, or in the lines to use the phones and computers.

100. In late July 2020, BOP re-imposed the lockdown because there was another outbreak of COVID-19 on the second floor.

101. As of October 19, 2020, at least 17 people incarcerated at FMC Butner and 25 staff members have tested positive for COVID-19.

102. Defendants have not conducted widespread testing of people housed at the FMC. Generally, people have been tested only before leaving for an appointment outside Butner or if they had certain COVID-19 symptoms.

103. Defendants' cleaning and disinfecting practices at the FMC have been inadequate. For example, during the 78 days from March 13 to May 29, the third, fourth, and fifth floors of the FMC were cleaned approximately 30 times and there was no additional cleaning for "high touch" areas.[91]

104. Critically, the serious problems posed by Defendants' response (or lack thereof) to COVID-19 do not come solely from the infection itself. As part of Butner's response to COVID-19,

[91] *See* Butner FMC Sanitation Log, *Hallinan et al. v. Scarantino et al*., No. 5:20-HC-02088-FL (M.D.N.C.), Dkt. No. 40-4.

medical visits and treatments at FMC Butner for *existing* serious chronic illnesses have been severely curbed or halted for people residing in other parts of Butner. For example:

- Plaintiff Ross was supposed to be transferred to the FMC to have a port placed and to begin dialysis. The procedure has not yet occurred and he continues to suffer from the effects of his failing kidneys.
- Plaintiff Riddick was supposed to have stitches in his eye removed in February following a cornea implant; however, as of September, all of his stitches have still not been removed.
- Plaintiff Hallinan is supposed to have treatments for bladder cancer at the FMC every four to six months to prevent recurrence. His last treatment was in early January 2020.

105. There are approximately 120 people housed in the Cadre Unit, a dormitory-style unit in the FMC where incarcerated people who work in the FMC live. The unit has cubicles that are roughly 6 feet by 9 feet. The cubicles are separated by walls about six feet high and house two or three people each.

106. The Cadre Unit has communal phones and computers that can only be used after waiting in lines, and a shared TV room and restroom facilities where it is impossible for people to maintain physical distance from one another.

107. Some men in the Cadre Unit work jobs that require them to travel to other units within the FMC, such as those who work in the Inmate Companion Program, through which they assist FMC nurses with incarcerated or committed patients who cannot care for themselves. Some of the men in the Cadre Unit are responsible for picking up and distributing laundry, commissary orders, and food trays for patients. People who do these jobs move from cell to cell, and from floor to floor.

B. Butner Low

108. Butner Low[92] is a low-security federal correctional institution.

109. A primary function of Butner Low is to house individuals designated as Care Level 3.[93] These men "have complex, and usually chronic, medical or mental health conditions and who require frequent clinical contacts to maintain control or stability of their condition, or to prevent hospitalization or complications, . . . [such as] [c]ancer in partial remission, advanced HIV disease, severe mental illness in remission on medication, severe congestive heart failure, and end-stage liver disease."[94] In other words, Butner Low houses a large number of medically vulnerable and disabled people, including several Plaintiffs.

110. Butner Low contains eight dormitory-style units, each with a capacity of about 150 men.

111. The housing units are large, open rooms divided into cubicles. The cubicles are about 10 feet by 7 feet, with walls about 5 to 6 feet high. The photo below, published by the Associated Press, purports to show a dorm with cubicles at Butner Low.

[92] Butner Low is sometimes referred to as "LSCI Butner."

[93] *PREA Audit Report*, at 2.

[94] *Care Level Classification for Medical and Mental Health Conditions or Disabilities*, https://www.bop.gov/resources/pdfs/care_level_classification_guide.pdf., at 5.

112. Most cubicles house two or three people, though a small number house only one, often due to wheelchairs. There is only about a 4 foot by 4 foot space, if that, to move around in the cubicles.

113. Because of the cubicle arrangement, most people housed in Butner Low sleep within six feet of several other people. In other words, the hundreds of men in Butner Low—many of them elderly, medically vulnerable, or disabled—spend several hours *every night* within the CDC's suggested minimum physical distancing zone.

114. Like all facilities in the complex, due to the COVID-19 outbreak, Butner Low was on lockdown from late March or early April through sometime in July 2020, meaning Defendants curtailed certain normal activities.

115. During the lockdown, people requiring medication had to line up at one or more of three daily "pill calls." Defendants did not require people to physically distance in the pill line. Sometimes the lines had as many as 60 people in them. Thus, every day—and sometimes

more than once a day—Defendants forced medically vulnerable people to stand in very close proximity to one another for extended periods of time to receive their medications.

116. The same medical staff conducted multiple pill calls per shift across multiple housing units, and they did not change protective gear, disinfect equipment, or otherwise decontaminate themselves as they moved from unit to unit.

117. Defendants did not make reasonable accommodations to allow members of the Disability Subclass, all of whom are at increased risk of suffering severe illness from exposure to COVID-19, to safely obtain their medication without increased exposure to COVID-19. Instead, members of the Disability Subclass were forced to choose between not receiving their medication or lining up with dozens of other people in close proximity to one another, thereby increasing their exposure to this deadly disease.

118. During the height of the lockdown, the situation was similarly grim at mealtime. From April through sometime in July 2020, those housed in Butner Low were forced to line up in their housing units, with only one to two feet between one another, to receive their meals. In at least one case, Defendants made men from one unit line up with men from another unit, substantially defeating any intended purpose behind the staggered meal-time process. Defendants did not make reasonable accommodations to allow members of the Disability Subclass, all of whom are at increased risk of suffering severe illness from exposure to COVID-19, to safely obtain their meals without increased exposure to COVID-19. Instead, Defendants forced them to choose between eating or lining up with dozens of other people in close proximity to one another, thereby increasing their exposure to this deadly disease.

119. The current process at mealtime similarly requires close contact with others. For some meals, the men of each unit are required to walk to the kitchen to receive their meals and

walk back to the unit—all in a single-file line. For other meals, they line up in their housing unit to receive the meals at the front of the unit.

120. Likewise, access to phones and computers is problematic, with people densely packed in lines for extended time periods. Plaintiffs report that the six to eight phones shared in each unit—which are in regular use—are about two feet apart and are not disinfected between uses. People wait in line for about 30 to 60 minutes to use the phone. Computers are also within a few feet of one another, and in regular use. In some housing units, there is a spray bottle and rag by the phones and computers available for people to use. However, because there are lines of people waiting, if someone chooses to use it, they cannot leave the disinfectant on for ten minutes, as is required for it to kill the virus.

121. Moreover, Defendants have not adequately instructed the incarcerated people on the use of the anti-viral disinfectant. In some housing units, a notice was posted in early August informing people of the need to let the disinfectant sit for ten minutes. Defendants have not made reasonable accommodations for members of the Disability Subclass to be able to safely use the phones, computers, and/or other communal resources. The policy of not taking measures to allow people incarcerated at Butner to safely use phones, computers, and/or other communal resources affects people with disabilities more harshly than those without.

122. People housed in Butner Low share a small number of toilets, showers, and sinks across the entire housing unit. The fixtures are all within three feet of each other, meaning that people are in very close contact with one another in the bathroom areas. Cleaning supplies are not made readily available. The soap and chemicals used to clean the bathrooms are routinely diluted with water.

123. Once again, Defendants have failed to make reasonable accommodations for the Disability Subclass to use restroom and bathing facilities without increasing their risk of exposure to COVID-19.

124. TV rooms were closed during the height of the lockdown, but according to some Plaintiffs, the TVs were on and visible from an area just outside the computer room. People gathered closely together outside the computer room to watch the TVs. Because the TV rooms were closed, people used the common area for other purposes, like as a makeshift seating area for playing games. Notably, because the lockdown allowed for limited opportunities to exercise, people exercised in the common area, leading to more close contact with others.

125. The TV rooms were reopened in July. Originally, there were 80 chairs in the TV rooms. After the lockdown, there were only supposed to be 25 chairs in the TV rooms. Some chairs were removed at first, but they were brought back.

126. The TV rooms are often crowded, and physical distancing is not enforced.

127. In late August, the people in one of the housing units in Butner Low were informed that there was going to be an inspection. In connection with the inspection, they needed to remove the extra chairs from the TV room until 4:00 p.m., when the visitors were there. After the visitors left, they were told that they could bring the extra chairs back into the TV room. Others received similar instructions to clean up, go to their units, and wear their masks when visitors arrived. After the visitors left, physical distancing and mask wearing were no longer enforced.

128. Some Plaintiffs report being given cloth masks. Some do not fit. Some are made of material so thin it is translucent. If masks are damaged or lost, Defendants do not provide a way to repair or replace them. The BOP has not given Plaintiffs gloves.

129. BOP inconsistently enforces the requirement to wear masks. Not all staff wear masks. Some incarcerated people also do not wear their masks.

130. Many people have frequent contact with people from other housing units. Work details in housing facilities, laundry, the commissary, food service, and safety and recreation all include men from multiple housing units.

131. Butner Low has a Federal Prison Industries ("UNICOR") operation where people from different housing units work. At some points during the last six months, in one housing unit, at least 24 people were going to their jobs with UNICOR where they worked with people from other housing units. Similarly, people worked in the kitchen with people from other housing units.

132. A man in one housing unit was an orderly assigned to clean the SHU, where some people who had COVID-19 were housed. This orderly would then come back to the housing unit where he lived.

133. A man in another housing unit had a job cleaning personal protective equipment used by sick people in other housing units, meaning he came into frequent contact with items used by people with COVID-19.

134. Currently, correctional officers and other staff move between housing units where some have COVID-19 and some do not. For example, during count, the officers in one housing unit help the officers in another, and vice versa.

135. Men from different housing units also intermingle during recreation time. For example, six or seven days a week, men from at least two different units take photos of individuals from all eight housing units. The photographers and subjects do not wear masks, even when standing shoulder-to-shoulder to view the photos on screens.

136. People from different housing units also intermingle when seen by medical staff. Men called to medical from one unit often arrive to find men from another unit still waiting to be seen. Medical staff do not consistently change their personal protective equipment between patients or between units.

137. Defendants do not conduct routine temperature checks to identify feverish people.

138. Where temperature checks previously occurred, they were sporadic, ineffectual, and inconsistent across units. For example, on one housing unit, Wake A, medical staff took everyone's temperature every day for about a week at the beginning of the lockdown in early April, then again on May 11 or 12, and then three times during the last week of May. Outside of those times, a person had to request a sick call to get a temperature check—which costs $2.00. In another housing unit, there was a single temperature check around May 7. People leaving their housing units for jobs were supposed to be checked for a fever each time they left, but the checks happened only occasionally.

139. Making all these issues worse, Butner Low is at or over maximum capacity. The facility was designed to hold 992 people, but as of October 19, 2020, BOP reports that 999 men are housed there.[95]

140. All these conditions—crowding in already tight quarters; shared use of limited facilities with frequent close contact; lengthy, daily line-up requirements; inconsistent mask use amongst staff and incarcerated people; and limited testing and screening—created the extraordinarily dangerous conditions that made the COVID-19 outbreak at Butner Low fully foreseeable.

[95] *See Population Statistics: Inmate Population Breakdown*, https://www.bop.gov/mobile/about/population_statistics.jsp.

141. At the beginning of May 2020, roughly one month after COVID-19 was first reported at Butner, 27 incarcerated people at Butner Low had tested positive for the virus.[96] None had died.

142. About a month later, by May 31, 2020, 180 people housed at Butner Low had tested positive, of whom four had died and 39 had reportedly recovered.[97] One of the men who died had informed staff that he was not feeling well, had trouble breathing, and could not eat, but staff did not remove him from his unit because he had no fever. He died of COVID-19 days later after going into respiratory failure.[98]

143. On or around June 1, 2020, Defendants tested everyone housed in the Low.

144. Over the ten following days, Defendant BOP reported increasing numbers of people testing positive at Low:

- June 3: BOP reports 418 people have tested positive;[99]
- June 7: BOP reports 587 people have tested positive;[100]
- June 8: BOP reports 670 people have tested positive;[101]
- June 9: BOP reports 676 people have tested positive;[102] and

[96] Ex. 19 (May 1, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

[97] Ex. 20 (May 31, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

[98] *See* Press Release, *Inmate Death at FCI Butner (Low)*, U.S. Dep't of Justice Federal Bureau of Prisons (May 21, 2020), www.bop.gov/resources/news/pdfs/20200531_press_release_butner.pdf.

[99] Ex. 21 (June 3, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

[100] Ex. 22 (June 7, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

[101] Ex. 23 (June 8, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

[102] Ex. 24 (June 9, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

- June 10: BOP reports 696 people have tested positive.[103]

145. Despite the total number of COVID-positive cases at Butner rising by almost *100 cases per day* between June 3 and June 9, Defendants waited until June 10—an entire week—before finally beginning to separate those who had contracted the virus as of June 1 from those who had not.

146. Between June 1, when people were tested, and June 10, when the facility was divided into positive and negative units, the staff failed to consistently check temperatures or monitor symptoms across the units in Low.

147. During this period, in some units, if a person got so sick that Defendants removed him from the unit, the BOP would evaluate the people in his cubicle, but not the people in adjacent cubicles.

148. On June 10, BOP identified over half the facility as having the virus. Based on the tests from June 1, 2020, Defendants divided the Low facility into housing units where people tested positive and housing units where people tested negative. This process took place over the course of about three days.

149. The so-called negative units were not disinfected between when people who had tested positive were moved out and when people who had tested negative were moved in.

150. In one of the units established as a negative unit, Granville A, three to four people were removed because they were sick. One man who had no symptoms was moved to a positive unit, suggesting that he was moved because of his test results.

151. After the housing units were divided between positive and negative units, temperatures were not checked and there was no symptom screening unless someone made a sick call.

[103] Ex. 25 (June 10, 2020 Screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp).

152. In the positive units, where everyone was believed to have COVID-19, for the first couple of weeks, there was no COVID-19 care or monitoring at all. Staff did not take people's temperatures or check vital signs. Starting about the last week of June, medical staff began asking people in at least one of the positive housing units whether they had symptoms. Medical staff no longer making rounds to assess symptoms.

153. Between the positive and negative units, medical staff circulated with the pill cart, with the same staff conducting pill call for both positive and negative units.

154. Administration of tests for COVID-19 is inconsistent and has yielded inaccurate results. Some staff insert the nose swab into the sinus, and some insert it just inside the nostril.

155. In late July, one of the negative units was tested for COVID-19. Fourteen people tested positive and were taken to the SHU.

156. At least one person who tested negative was mistakenly assigned to a positive unit. He was moved to a negative unit weeks later, and was not quarantined in between.

157. BOP staff sent individuals who had been exposed to COVID-19 to negative housing units and failed to correct this problem before those individuals had the opportunity to interact with others within the negative unit.

158. Some people from positive units who have been determined to have recovered have been moved into negative units, but they have been assisted in making the moves by people still housed in the positive unit.

159. In many instances, adjacent units have different designations, so one is maintained as a positive unit, and the other as a negative unit. However, on multiple occasions, Defendants assigned only one officer to monitor both a positive unit and its adjacent negative unit—

leaving the doors separating the units unlocked to enable individuals to walk back and forth between the two units.

160. People within Butner Low who previously held or currently hold jobs at UNICOR have been reassigned to new units without first being screened or re-tested for COVID-19. As of October 15, 2020, BOP reports that one person housed in the Low has tested positive and that 620 have recovered.

161. However, from the end of May through mid-August, Defendants re-tested only those men who tested positive in May. Men who tested negative in May were not re-tested, even when other men in the same unit or even the same cubicle became seriously ill with COVID-19 or tested positive.

162. Some men within FCC Butner have tested positive for the virus more than once, with a negative test in between. In Butner Low, an older man with underlying conditions tested positive in June, then negative in July, then positive again in September at an outside hospital, where he died of COVID-19. Despite his negative test in early July, Defendants continued to house him in a unit with men who continued to test positive through at least mid-August.[104]

163. Defendants stopped testing the population at Butner Low by mid-August.

C. FCI Butner Medium I and Camp

164. FCI Butner Medium I is made up of a medium-security federal correctional institution and a minimum-security camp ("Camp").

[104] *See* Press Release, *Inmate Death at FCI Butner (Low)*, U.S. Dep't of Justice Federal Bureau of Prisons (Sept. 17, 2020), https://www.bop.gov/resources/news/pdfs/20200917_press_release_bux.pdf.

165. As of October 15, more than 180 people incarcerated at FCI Butner Medium I and 30 staff members have tested positive for COVID-19. Nine people incarcerated in Medium I have died so far from the disease.[105]

1. The Camp

166. BOP reports that 149 men are housed at the Camp.[106] Many of the conditions at the Camp are substantially similar to those at Butner Low. For instance, the Camp has dormitory-style housing divided into shared cubicles that do not allow for physical distance from bunkmates.

167. Incarcerated people are moved among the four housing units within the Camp based on their current medical status. People who test positive for COVID-19 and are symptomatic are housed communally in the Hatteras East unit. Those who test positive and are asymptomatic are housed in Catawba East if they have been classified as care level 1 or 2, or Catawba West if classified as care level 3. Those who test negative are housed in Hatteras West.

168. The doors between the four units are unlocked, and men from different units frequently open the doors to speak with one another.

169. People in each Camp housing unit share a single bathroom with about four stalls, five showers, and five sinks. There is no hand sanitizer, and the soap sometimes runs out. People wait in line to use the toilets and sinks one right after the other.

170. People line up within two feet of each other to use the phones. People are permitted to clean the phones between uses, but no one is responsible for this job, and no disinfectant is provided. Some people attempt to clean phones between uses by wiping them on their clothes.

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[105] *COVID-19 Cases.*

[106] *See Population Statistics: Inmate Population Breakdown*, https://www.bop.gov/mobile/about/population_statistics.jsp. (last updated October 15, 2020) (last visited October 19, 2020).

171. The TV room is always crowded, and people place chairs within six feet of one another to watch TV for long periods of time.

172. Men leave their housing units for meals and medication, which sometimes involves contact with men from other units. Entire housing units line up at the unit door for meals, and men from different units line up together for medication. As in Butner Low, people line up no more than two feet apart from one another.

173. Throughout the lockdown, men in the Camp continued to go to work at their jobs in the UNICOR operation at Medium I, the kitchen, commissary, warehouse, landscaping, or elsewhere, alongside people from other housing units. At some of these jobs, incarcerated people regularly come into contact with outside contractors or people making deliveries. Other jobs, such as landscaping, involve work in close proximity to men from other housing units on the recreation yard and officers who go to the hospitals and back. Men on work detail have their temperatures checked at the beginning of their shift, but are not monitored for any other symptoms of COVID-19. After their shifts, men on work detail have recreation time together before going back to their separate units.

174. On at least one occasion, a shift has been canceled when someone on the work detail tested positive for COVID-19. The next day, everyone was sent back to work.

175. Access to laundry has been reduced in the Camp during the pandemic. Defendants have eliminated two laundry days per week and cut in half the number of sheets and blankets the men can wash. The entire unit's laundry is combined into one bin, which sits in the unit overnight before being washed together.

176. Everyone in the Camp is provided with a thin cloth mask, but mask-wearing is inconsistent and not enforced. No instructions have been provided on how to clean masks.

177. Staff do not consistently wear masks. Some staff consistently do *not* wear masks, including one staff member whose mask is always pushed down around her neck, not covering her mouth or nose, while she works handling food for the men who live at the Camp.

178. In March 2020, the Camp Administrator held a town hall meeting with at least one housing unit, Hatteras East, during which she told people housed in that unit that they should not worry about the virus or masks. Additionally, the Assistant Warden told men in that unit that wearing a mask would result in a disciplinary write-up.

179. When people housed in the Camp have reported COVID-19 symptoms to BOP staff, they have been ignored, and people with symptoms (but no fever) have received no medical treatment.

180. For example, one man who suffers from a rare autoimmune disease passed out in his unit and was taken to see medical staff, who told him that he should drink more water before being returned to his unit in the Camp. Only after he passed out in his unit for a second time the following day did medical staff test him for COVID-19 and discover that he was positive.

181. Plaintiff Freeman told medical staff during a temperature check that he was experiencing loss of taste and smell, chills, night sweats, body aches, congestion, coughing, shortness of breath, and fighting to get out of bed. Because he did not have a fever, he was not taken out of his unit. He later tested positive for COVID-19. He was not taken to see a doctor, has not been re-tested for COVID-19, and has not seen a doctor since initially reporting his symptoms. He remains in his housing unit and continues to experience a persistent hacking cough and digestive issues, and he has woken up at night unable to breathe.

182. During a temperature check, Plaintiff Brown also reported his symptoms, which included fatigue, inability to eat, diarrhea, hot and cold sweats, dry throat, dry cough, and loss of taste

and smell. The nurse he spoke with wrote down his name and said someone would follow up with him, but no one ever did. He remained in his unit and had trouble getting out of bed for about two weeks. He never received pain reliever, fluids, a doctor's visit, or any follow-up assistance from anyone on the medical or custodial staff. He continues to experience COVID-19 symptoms.

183. Plaintiff Brown was tested for COVID-19 only after a man in his unit died of the virus. The man had told staff more than once that he didn't feel well, but he was not taken out of the unit. Not long after that, the man lost consciousness and hit his head on the sink. He was taken to the hospital, where he died of COVID-19.

184. Another sick man in Plaintiff Brown's unit lost consciousness during a lockdown, and no officers or other staff were present. Plaintiff Brown helped fan the man and put a continuous positive airway pressure ("CPAP") mask on him while other people in the unit pounded on the doors for help, but no one came. Ultimately, someone used an off-limits phone to call for outside help. Medical personnel arrived about 45 minutes after the man lost consciousness.

185. Given the conditions at the Camp and inconsistent adherence to whatever policies BOP purports to have enacted to address COVID-19, it is unsurprising that the disease has spread rapidly throughout the Camp. As one person housed there explained:

> I first heard of someone in my unit becoming sick and having to be removed in early April, after which it felt like a chain reaction within the camp. . . . [S]uddenly it seemed as if everyone in my unit was ill. . . . At night, I would hear coughing all throughout the unit. . . . My entire unit was tested for coronavirus on or around April 23, 2020. We were not isolated or separated from one another in any way while we waited for results. On or around April 30, 2020, Dr. Beyer gathered our unit together and told us that the entire unit had tested positive for coronavirus. She also told us that as many as 80% of the entire Camp population tested positive for coronavirus, and that a large number of people testing positive for the virus had only mild or no symptoms.

186. Defendants are providing inadequate medical care for men with conditions other than COVID-19 during the pandemic, including underlying conditions that increase the risk of serious illness and death from COVID-19.

187. Plaintiff Maldonado, a kidney transplant recipient, has been prescribed a renal diet, weekly bloodwork to monitor his kidney, and visits to a nephrologist every six months. He has not received a renal diet, has not had weekly bloodwork since July, and has not seen the nephrologist since January. He has also been prescribed visits to the dermatologist every six months for his squamous cell carcinoma, but he has not been taken to the dermatologist in about a year. He is not receiving any other treatment. He has lost about 50 pounds since the summer and does not know why.

188. Plaintiff Maldonado has yet to be released despite the recommendations of his doctor and social worker, and despite his home plan being approved. Defendants' explanations for denying his requests for release have included both that he is too sick to leave prison and too healthy to qualify for release. Although his medical condition is currently stable, his transplanted kidney has begun to fail. He understands from his doctor that the longer Defendants prevent him from accessing the care he needs, the more likely he is to lose his kidney.

189. The BOP houses men who are new arrivals or awaiting early release in makeshift spaces throughout the Camp, which have at various times included the chapel, classroom, and beside the pool tables in the indoor recreation area. These spaces are set up with cots, and physical distancing is not required. The doors to these makeshift housing spaces are not consistently locked, so men inside can open the doors and talk to people from other units on the recreation yard and elsewhere.

190. There is no shower in the makeshift housing spaces, so the men who live there use showers in the Catawba East and Hatteras West housing units. In the Hatteras West unit, the only safeguard against infection is a partial wall inside the bathroom installed by BOP staff to separate the people who are being quarantined from those who are not. Air flows freely from one side of the wall to the other. An orderly from the housing unit enters the bathroom after the men who are quarantined leave, cleans it, and then returns to the common area.

191. Men awaiting release sometimes spend months in these makeshift spaces. One man currently housed in quarantine was approved for release in May. Another has been in quarantine since he had a heart attack over the summer and was approved for release.

192. Defendants are not performing regular temperature checks in the Camp to identify people who have fevers and are not asking people if they have symptoms. Men in the Camp have not been offered flu shots.

193. However, men in the Camp are currently experiencing new symptoms of COVID-19, including coughing and chills in the Catawba West unit. The men in Catawba West have not been tested for the virus since their new symptoms began.

194. On October 18, a man from the Hatteras West unit who had previously tested positive for COVID-19 and recovered from it then tested positive for the virus for a second time. He

was taken to the SHU. The other men in his unit have not been tested for the virus and are now locked down in their unit together.[107]

2. FCI Butner Medium I

195. Like Butner Low, Medium I houses men with health care needs classified as Care Level 3.[108]

196. At Medium I, people are housed in cubicle-style housing and celled units. The celled units generally hold two people per cell. Medium I houses approximately 579 people.

197. In the spring of 2020, there was a COVID-19 outbreak in Medium I.

198. Despite that outbreak, Defendants do not routinely check temperatures or consistently screen for symptoms of COVID-19.

199. After he was sick for about two weeks and experienced a fever of 105 degrees, Defendants placed Desmond Garrett, who is housed in Medium I, into quarantine on March 31. At that time, Mr. Garrett was having trouble breathing. He was given a COVID-19 test and placed in a cell in the SHU with another man, although neither of the two men had received their test results. The test results did not come back for five more days.

200. On March 24, Plaintiff Ross experienced COVID-19 symptoms and put in a sick call. He went to medical, was told he had the flu, and was sent back to his unit. On March 28, after a unit-wide temperature check, he learned that he had a fever and was taken to medical, where a nasal swab was administered. He was placed into quarantine the same day in the North Carolina unit, which is a celled unit. When he was placed into the unit, he had a

[107] Another man previously housed in Hatteras East, Ernest Rowland, died at the beginning of October. Mr. Rowland had previously tested positive for COVID-19 and recovered. He was in his mid-60s and wheelchair-bound, and had trouble breathing. In the days prior to his death, he had coughed up blood and had an abnormally high heartrate, of which the doctors at the FMC were aware. It is unclear whether Mr. Rowland's death was related to COVID-19.

[108] *See FCC Butner Doctoral Psychology Internship 2019–2020 Brochure*, Federal Bureau of Prisons, 11 (July 15, 2018), https://www.bop.gov/jobs/docs/BUX%20Brochure%202019-2020.pdf ("Additionally, Care Level Three inmates (chronically mentally ill persons) who can function adequately on an outpatient basis are housed throughout the complex.").

cellmate and neither of them had received their test results. They received the test results the following day; both were positive.

201. Currently, if Defendants determine a person needs to be isolated, BOP places the person in the celled North Carolina unit. People are not tested either when they are placed in isolation or when they are released from isolation. In general, people are released back to general population after 14 days in quarantine, though sometimes it is far less.

202. The lockdown was relaxed at Medium I in May or June 2020. After that, meals were brought to the housing units, and the men had to line up to receive their meals, three times a day. There are roughly 50 to 60 people in the lines. There is no physical distancing.

203. Similarly, since the lockdown was relaxed, pill call has been conducted in the housing units. The men who need medications must line up one or more times a day to receive their medications. The lines have 10 to 15 people in them. There is no physical distancing.

204. There are usually lines for the phones and computers. The phones are about five feet from each other. The computers are right to each other. Because they are in use most of the time, people using them are within five feet of other people. In the lines where people wait to use the phones and computers, people do not physically distance.

205. Since the COVID-19 lockdown in Medium I, healthcare for other conditions has also been extremely limited. For example, Plaintiff Ross' ankles and stomach swell up about three times a month, and the swelling lasts from three days to one week, due to his kidney disease. Although Plaintiff Ross needs dialysis, BOP has told him that he cannot have that medical procedure yet due to COVID-19.

206. The cleaning and disinfecting protocols in Medium I are inadequate.

207. For several weeks in June and July, the cells were sprayed down with a backpack sprayer once a week when people were outside in the recreation yard. This cleaning process stopped around mid-July.

208. The dayroom area is mopped down every two days with a mop. The backpack sprayer is not used for the dayroom area.

209. When disinfecting solutions are applied to phones, computers, or tables, they are not left on for ten minutes but are instead wiped off right away. Door handles, garbage bins, ice machines, water dispensers, and shared recreational items are not cleaned.

D. FCI Butner Medium II

210. Medium II is a medium security federal correctional institution.

211. Many people in Medium II are at high risk of serious illness or death from COVID-19.

212. People incarcerated in Medium II are housed in celled units of about 120 to 130 people, with one to four people per cell. Cells range from 8 feet by 8 feet to 8 feet by 12 feet, depending on the number of people housed in them. People housed in these cells sleep on bunk beds, and in four-person cells, the beds are about two feet apart in an "L" shape.

213. Medium II was on lockdown from late March or April to early July 2020. Since July 3, the restrictions in Medium II have been slowly loosened.

214. Other than during the lockdown, people housed in Medium II are out of their cells for most of the day, mingling with each other. There is no physical distancing.

215. Medium II is also home to the SHU, where some people with COVID-19 symptoms have been placed. The SHU is not medical isolation; it is typically used for administrative detention (such as inmate transfers) or disciplinary segregation.

216. Medium II has a UNICOR operation at which numerous people housed in Medium II work. Many people housed in Medium II have jobs with either UNICOR or a private contractor.

And, like men who work in the other UNICOR operations, they work side-by-side with men from other housing units.

217. Staff move between housing units. They also move into the community. At some point in May, one staff member informed an incarcerated person that he was responsible for watching three incarcerated people with COVID-19 at an outside hospital.

218. Medium II is overcrowded. BOP reports that 1,422 men are housed there,[109] exceeding the facility's maximum capacity of 1,152 people by approximately 23 percent.[110]

219. Each cell has a shared toilet and sink. People in each 120-person housing unit share about 12 showers spaced about three feet apart.

220. Since the end of the lockdown, people housed in Medium II walk to the cafeteria each day for lunch. Only one housing unit at a time eats, but the cafeteria is not cleaned between each group of people.

221. As in other facilities, there are communal phones spaced a few feet apart; people stand in close proximity to each other in lines waiting for the phones. There is no physical distancing in these lines. An orderly cleans the phones twice a day, but the disinfectant is not left on for ten minutes. Incarcerated people can use personal items to wipe the phones between uses, but such items may not be clean themselves, and Defendants do not make readily available the supplies to disinfect the phones in between each use.

222. The Medium II computer room is similar to that in other parts of Butner: a common room where people sit shoulder-to-shoulder at computers that are constantly in use with groups of people waiting in close proximity for their turn.

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[109] *See Population Statistics: Inmate Population Breakdown*, https://www.bop.gov/mobile/about/population_statistics.jsp. (last updated October 15, 2020) (last visited October 19, 2020).

[110] *See PREA Audit Report*, at 1.

223. Defendants have not provided any instruction or implemented any protocol for cleaning certain areas within Medium II. Those housed there are instead responsible for taking the initiative to clean the areas themselves. For instance, the laundry room and staircases are cleaned infrequently and only when an incarcerated person decides to clean them.

224. The dayroom tables are generally cleaned twice a day by an orderly. The cleaning solution is sprayed on and wiped off immediately.

225. Door handles do not get cleaned.

226. At the beginning of the outbreak of COVID-19, people housed in Medium II were provided very thin, ill-fitting, and poorly made cloth masks. They were not provided with any instruction as to how to properly wear and/or clean their masks. And, as in other facilities, not all staff wear masks.

227. Hand sanitizer has not been readily available in Medium II.

228. There has been no widespread testing for the virus in Medium II.

229. If a person in the unit feels sick, he typically must request a $2.00 sick call to get a temperature check. At best, temperature checks have been administered sporadically.

230. Defendants have taken some people with high enough temperatures or other symptoms to the SHU. Still, people taken to the SHU are not necessarily tested for COVID-19. One man was taken to the SHU at the beginning of the outbreak after he began experiencing flu-like symptoms, but he was not tested for COVID-19 before returning to Medium II. On information and belief, the men in the cells surrounding his were also not tested.

231. Individuals experiencing symptoms other than a fever are not evaluated or removed from their housing units. For instance, Plaintiff Riddick reported that he was coughing and sneezing for a couple of days without a staff member asking about his symptoms.

V. BOP's Failure to Implement Adequate Prevention and Mitigation Measures Is Deliberate Indifference to the Risk of Harm to Plaintiffs

A. BOP Is Aware of the Risks to Plaintiffs

232. Defendants have a "profound obligation to protect the health and safety of all [incarcerated people]."[111] Despite this obligation, BOP as a whole—and Butner in particular—has failed to adequately protect the incarcerated people under its charge who have disabilities or other conditions that render them medically vulnerable to COVID-19.

233. Based on confirmed cases, in addition to Butner, COVID-19 has entered more than 100 of the total 130 facilities BOP runs, including Butner.[112]

234. As of October 19, 2020, BOP houses 125,905 people and has a staff of approximately 37,000.[113] As of the same date, more than 18,237 incarcerated people and more than 2,000 BOP staff members had tested positive for coronavirus, for a total of more than 20,000 *known* positive individuals.[114]

235. So far, 128 people held in BOP facilities have died from COVID-19.[115] Twenty-six of those people died while incarcerated at Butner.[116] Two BOP staff members have died, including one at Butner.

236. In a March 26, 2020 memorandum to Defendant Carvajal regarding the COVID-19 "crisis" (the "March 26 Memo"), Attorney General William Barr identified home confinement as

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[111] Ex. 26 (Attorney General William Barr, *Memorandum for Director of Bureau Prisons*, Office of the Attorney General, (Apr. 3, 2020), https://www.justice.gov/file/1266661/download, at 1).

[112] *COVID-19 Cases.*

[113] *COVID-19 Cases*.

[114] *Id.* The significant week-to-week jump in positive cases may be a result of increased testing within BOP, but the point remains.

[115] *COVID-19 Cases*.

[116] *Id.*

"[o]ne of BOP's tools to manage the prison population and keep [incarcerated people] safe" from COVID-19.[117]

237. The Attorney General directed Defendant Carvajal "to prioritize the use of [the BOP's] various statutory authorities to grant home confinement for [incarcerated people] seeking transfer in connection with the ongoing COVID-19 pandemic," because "for some eligible [people], home confinement might be more effective in protecting their health."[118]

238. Attorney General Barr further identified "[t]he age and vulnerability of the [incarcerated person] to COVID-19, in accordance with the Centers for Disease Control and Prevention (CDC) guidelines," as one of the critical, discretionary factors for consideration.[119]

239. Five days later, on April 1, Defendants issued an order to lock down Butner because of COVID-19. This, too, is an acknowledgment of the risk posed by the virus.

240. A few days later, following dramatic increases in confirmed COVID-19 cases at BOP facilities, Attorney General Barr issued a second memorandum underscoring BOP's "profound obligation to protect the health and safety of all [incarcerated people]" and finding that "emergency conditions are materially affecting the functioning" of BOP.[120]

241. The Attorney General recognized that BOP efforts to prevent the spread of COVID-19 within its facilities "have not been perfectly successful."[121] He ordered Defendant Carvajal to take more aggressive steps—immediately—to transfer incarcerated people to home confinement where possible, even if electronic monitoring will be not be available, explaining that "time is of the essence."[122]

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[117] Barr March 26 Memo at 2.
[118] *Id.*
[119] *Id.*
[120] *See* Barr April 3 Memo at 1.
[121] *Id.* at 2.
[122] *Id.*

242. Additionally, in an acknowledgment of the risks from COVID-19, BOP issued a COVID-19 Action Plan and implemented modified operations.[123] The Action Plan requires quarantine or isolation for all new admissions, all close contacts of confirmed or suspected cases, and all incarcerated people set for release.[124]

243. Defendants recognize the importance of continual monitoring of the population for symptoms.[125]

244. At Butner, as early as March 2020, Defendants recognized the need "to ensure social distancing between inmates and staff."[126] They acknowledged the importance of minimizing contact between people in different parts of the prison. [127] They were aware of the need to quarantine incarcerated people with exposure risk factors, even if they were not symptomatic.[128] They were also aware of the need to ensure the continuity of care for individuals who needed health care at the FMC but were not housed there.[129] They further recognized the importance of sanitizing the facility.[130] By late March, Defendants had recognized the importance of mask usage.[131]

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[123] *See BOP Implementing Modified Operations*, Federal Bureau of Prisons, https://www.bop.gov/coronavirus/covid19_status.jsp (last visited Oct. 19, 2020).

[124] *See* Ex. 27 (*Memorandum for All Chief Executive Officers: Coronavirus (COVID-19) Phase Six Action Plan*, Federal Bureau of Prisons (Apr. 13, 2020), https://prisonology.com/wp-content/uploads/2020/04/COVID-19-Phase-6-Plan-2020-04-13.pdf).

[125] *See BOP Correcting Myths and Misinformation*, Federal Bureau of Prisons, https://www.bop.gov/coronavirus/docs/correcting_myths_and_misinformation_bop_covid19.pdf (stating that throughout the BOP, "health services staff are conducting rounds and checking inmate temperatures at least once a day. In those locations where inmates are in quarantine or isolation, Health Services staff are conducting rounds and temperature checks twice a day.")

[126] Declaration of Mary Strassel, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 37-11 at ¶ 14.

[127] *Id.*

[128] March 13, 2020 Memorandum for the Inmate Population (LSCI), *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 37-20 at 2.

[129] Declaration of Mary Strassel, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 37-11 at ¶ 16.

[130] *Id.* at ¶¶ 14, 53.

[131] *Id.* at ¶¶ 40, 46, 53.

245. Defendants know this deadly disease devastated Butner and that their "Kafkaesque approach"[132] to mitigation is inadequate to address the very real threat posed by COVID-19 and to protect the people incarcerated there. In one opinion granting compassionate release for a person previously housed at Butner, the court noted, "*by the government's own admission*, [medical care] would be hard to come by should defendant be infected with the deadly disease currently spreading widely through his prison."[133]

246. Despite knowing full well the urgency of the situation, Defendants have not implemented most of the mitigation measures they identified in early March—before any of the hundreds of cases at Butner, before any of the 27 deaths—and have instead maintained conditions that allow the virus to ravage the prison population.

B. Defendants Have Failed to Meaningfully Respond to the Grave Risk Facing Incarcerated People at Butner

247. Defendants know the risk to incarcerated people at Butner but have not taken well-known and essential measures to address the risk, including making reasonable accommodations for the Disability Subclass to allow them to participate in everyday activities without placing them at increased risk of contracting the deadly disease.

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[132] *United States v. Scparta*, 2020 WL 1910481, at *1 (S.D.N.Y. Apr. 20, 2020).

[133] *United States v. Bikundi*, 2020 WL 3129018, at *5 (D.D.C. June 12, 2020) (emphasis added); *see also United States v. Heitman*, 2020 WL 3163188, at *4 (N.D. Tex. June 12, 2020) (referring to the number of confirmed active COVID-19 cases at Butner Low as "staggering"); *United States v. Malone*, 2020 WL 3065905, at *6 (W.D. La. June 9, 2020) ("[I]it is understandably concerning that at a time when social distancing is critical, FCI Butner Medium I is housing ninety-three inmates in a thirty-eight-person unit where the inmates share five showers, four toilets, and two phones. While this is worrisome for all of the inmate population, it is more so for . . . high-risk individuals."); *United States v. Howard*, 2020 WL 2200855, at *4 (E.D.N.C. May 6, 2020) (noting that the number of infected persons at Butner is among "the highest in the nation"); *United States v. Joling*, 2020 WL 1903280, at *5 (D. Or. Apr. 17, 2020) (referring to BOP's response to the COVID-19 pandemic as "insufficient as evidenced by the number of infections and deaths which have already occurred in federal custodial institutions").

248. Instead, Defendants have taken only minimal action. Failing to adequately respond to the deadly virus ravaging Butner constitutes deliberate indifference to Plaintiffs' health and safety in violation of the Eighth Amendment.[134]

1. Defendants have failed to use the tools available to them to reduce the population at Butner

249. Because of the severity of the threat posed by COVID-19 and its proven ability to rapidly spread through a correctional setting, public health experts recommend the rapid release from custody of people most vulnerable to COVID-19, including the Class.[135] Release protects the people with the greatest vulnerability to COVID-19 from transmission of the virus and also mitigates risks for people in prison and the broader community.[136] Release of the most vulnerable people from custody also reduces the burden on the region's health care infrastructure by reducing the likelihood that many people will become seriously ill from COVID-19 at the same time.[137] But, even though BOP officials have been instructed to transfer people to home confinement, Defendants have opposed such measures at Butner. A court order is therefore necessary to provide adequate care that does not violate federal law.

250. On March 26, Attorney General Barr instructed Defendant Carvajal to prioritize transferring people from BOP facilities to home confinement because of the risk from COVID-19.[138] On March 27, President Trump signed the CARES Act, giving the Attorney General expanded power to immediately release prisoners on account of COVID-19. On April 3, Attorney

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[134] *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *see also Scinto v. Stansberry*, 841 F.3d 219, 225 (4th Cir. 2016); *see also De'lonta v. Johnson*, 708 F.3d 520, 523 (4th Cir. 2013) (finding deliberate indifference standard could be met even though there was not a "total failure to give medical attention" or provide adequate support; *Heyer v. United States Bureau of Prisons*, 849 F.3d 202, 211 ("the mere fact that prison officials provide some treatment does not mean they have provided '*constitutionally adequate* treatment.'") (emphasis in original).

[135] *See, e.g.*, Josiah Rich, Scott Allen, and Mavis Nimoh, *We Must Release Prisoners to Lessen the Spread of Coronavirus*, Washington Post (March 17, 2020), https://wapo.st/2JDVq7Y; Beyrer Decl. at 9–10, 12–14, 26.

[136] Beyrer Decl. at 9, 12, 26.

[137] Beyrer Decl. at 11, 13.

[138] *See* Barr March 26 Memo.

General Barr instructed Defendant Carvajal to take aggressive steps—immediately—to transfer people in BOP custody to home confinement where possible, explaining that "time is of the essence."[139]

251. As discussed above, Butner houses many medically vulnerable people. Over 1,000 people at Butner, including many of the medically vulnerable population, are considered either minimum or low security prisoners. Thus, many people at Butner should have been transferred to home confinement pursuant to Attorney General Barr's instructions. And yet, across all BOP facilities, BOP has transferred only one person per facility every two days. Defendants have transferred very few of the people incarcerated at Butner to home confinement.[140] As of June 3, 2020, two months after Attorney General Barr's second memo, just 42 people had been transferred to home confinement from Butner.[141]

252. Moreover, even once a person is approved for home confinement, Defendants choose to delay transfer. John Dailey, a plaintiff in a prior suit, was approved for transfer to home confinement in late April. But, instead of transferring him immediately, BOP delayed his transfer until August. Mr. Dailey's transfer to home confinement—a measure expressly taken to reduce his risk of contracting COVID-19—never came. As a direct result of BOP's unwarranted delay, Mr. Dailey contracted COVID-19 and died on July 3.

253. Defendants could support the people in their custody in their efforts to obtain compassionate release. They choose not to. For example, Lewis Huntley filed a motion for compassionate

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[139] *See* Barr April 3 Memo at 2.

[140] In fact, while Attorney General Barr directed BOP to release *more* vulnerable incarcerated people, BOP paradoxically *heightened* the standard for eligibility, *decreasing* the number of people eligible for home confinement. Ian MacDougall, *Bill Barr Promised to Release Prisoners Threatened by Coronavirus—Even as the Feds Secretly Made It Harder for Them to Get Out*, ProPublica (May 26, 2020), https://www.propublica.org/article/bill-barr-promised-to-release-prisoners-threatened-by-coronavirus-even-as-the-feds-secretly-made-it-harder-for-them-to-get-out (last visited Oct. 19, 2020).

[141] Memo. in Supp. of Mot. to Dismiss, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 35, at 9.

release based on, among other things, hypertension that made him especially vulnerable to COVID-19. The court granted his motion over Defendants' opposition. Similarly, Defendants opposed John Krokos' motion for compassionate release over the course of nine months, before a court granted the motion and he was released. Antwan Harris, a plaintiff in the former class action lawsuit filed against Butner, was released over Defendants' objection in August.[142] Similarly, courts granted motions for compassionate release over Defendants' objections in August for former plaintiffs Arnold Hill and Lee Ayers.[143] Roger Duane Goodwin, a declarant in the earlier class action suit, was released over Defendants' objection in September.[144] In at least 20 instances, the court has ordered a person's release from Butner after Defendants opposed the motion for compassionate release.[145]

254. Despite the spread of COVID-19 at Butner, infecting hundreds and killing 26 incarcerated men already, Defendants remain unwilling to use the tools available to them to move the most vulnerable people out of Butner with sufficient urgency. This failure constitutes

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[142] Order, *United States v. Harris*, No. 5:11-CR-247-BO (E.D.N.C. Aug. 31, 2020).

[143] *United States v. Hill*, No. 1987 FEL 11252 (D.C. Super. Ct. Aug. 3, 2020); *United States v. Ayers*, No. 2008 CF3 020985 (D.C. Super. Ct. Aug. 13, 2020).

[144] Order Granting Defendant's Renewed Motion for Compassionate Release, *United States v. Goodwin*, No. 4:18-cr-00021 (S.D. Iowa Sept. 21, 2020).

[145] Ex. 28 (Opinion and Order Granting Defendant Wesam El-Hanafi's Motion for Compassionate Release, *United States v. El-Hanafi*, No. 1:10-cr-00162-KMW (S.D.N.Y. May 19, 2020), ECF No. 252); *see also Miller v. United States,* No. CR 16-20222-1, 2020 WL 1814084 (E.D. Mich. Apr. 9, 2020) (compassionate release granted involving prisoner at Butner due to COVID-19 concerns); *United States v. Dunlap*, 2020 WL 2062311 (M.D.N.C. Apr. 29, 2020) (same); *United States v. Krokos*, No. 12-cr-00527, Dkt. 1016 (C.D. Cal. May 1, 2020) (same); *United States v. Thompson*, No. 15 CR 00448, Dkt. 80 (N.D. Ill. Apr. 17, 2020) (same); *United States v. Saladrigas*, 2020 WL 4248676 (E.D. Mich. May 13, 2020) (same); *United States v. Rachal*, 2020 WL 3545473 (D. Mass. June 30, 2020) (same); *United States v. Howard*, 2020 WL 2200855 (E.D.N.C. May 6, 2020) (same); *United States v. Perez Alvarado*, 2020 WL 5203386 (S.D. Cal. Sept. 1, 2020) (same); *United States v. Hardnett*, 2020 WL 5074023 (E.D. Va. Aug. 27, 2020) (same); *United States v. Black*, 2020 WL 4583056 (S.D. Ind. Aug. 10, 2020) (same); *United States v. Hamrick,* 2020 WL 4548308 (M.D.N.C. Aug. 6, 2020) (same); *United States v. Luna*, 2020 WL 4696621 (N.D. Cal. Aug. 13, 2020) (same); *United States v. Archer*, 2020 WL 4059694 (D. Nev. July 20, 2020) (same); *United States v. Smith*, 2020 WL 2844222 (N.D. Iowa June 1, 2020) (same); *United States v. Camacho*, 2020 WL 4498796 (W.D. La. Aug. 4, 2020) (same); *United States v. Weems*, 2020 WL 4558381 (S.D. Fla. Aug. 7, 2020) (same); *United States v. Ireland*, 2020 WL 4050245 (E.D. Mich. July 20, 2020) (same); *United States v. Ranck*, 2020 WL 4193487 (S.D. Iowa July 9, 2020) (same); *United States v. Griggs*, 2020 WL 2614867 (D.S.C. May 22, 2020) (same); *United States v. Malone*, 2020 WL 3065905 (W.D. La. June 9, 2020) (same).

deliberate indifference because the incarcerated people must expose themselves to a deadly infectious disease that constitutes a serious risk to health.

255. Releasing people from Butner is essential to control the spread of this deadly virus, but Defendants have chosen not to do so.

2. Defendants have not created conditions to allow for physical distancing at Butner

256. To prevent the spread of the virus, the CDC recommends that people should maintain a distance of at least six feet between themselves and others. Defendants recognize the importance of this risk mitigation measure.[146]

257. The CDC recommends rearranging bunks in prisons so that people have more space between them while they sleep.[147] In Butner, Defendants have failed to release people or transfer them to home confinement so there would be fewer people in the sleeping arrangements. And no such rearrangement of sleeping quarters has occurred. Instead, people sleep within a few feet of multiple other people. Nearly every cubicle and cell are full.

258. Further, Defendants allow crowding in dormitories, which results in people being forced to wait in close-packed lines multiple times a day for meals and medicines. Defendants have chosen not to reduce the population so that meal and medication distribution can be accomplished in a manner that does not require scores of men to line up close to one another multiple times a day. Also, Defendants have chosen to distribute meals and medications in a manner that requires large numbers of men to line up in close proximity to each other multiple times a day.

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[146] Declaration of Mary Strassel, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 37-11 at ¶ 14.

[147] *Interim Guidance* at 11–12 (emphasis added).

259. Similarly, Defendants have not ensured physical distancing in connection with the use of phones and computers. The people incarcerated at Butner are physically close to each other when they use the phones and computers. Because so many people are housed at Butner, phones and computers are in constant use when people are allowed to use them. Further, people wait for the phones and computers in areas that do not provide for physical distancing. Defendants have failed to take any measures to enable people to use the equipment without being close to others.

260. In TV rooms, Defendants have not taken steps to ensure physical distancing either. Though Defendants previously limited TV access and the number of chairs in TV rooms, Defendants have not limited the numbers of chairs in the TV rooms since July 2020, despite their initial recognition of the importance of this step. The TV rooms are frequently crowded.

3. Defendants have chosen not to find out who in Butner has COVID-19, a crucial step for addressing the risk from the virus.

261. Despite the deaths of at least 26 incarcerated men from COVID-19 at Butner, Defendants have not conducted widespread testing. As of October 19, 2020, 2,177 coronavirus tests had been administered to incarcerated people at the Butner complex, out of a total of approximately 3,974 people. Of these 2,177 tests, approximately 826 were positive.[148]

[148] *COVID-19 Cases*. There is reason to be skeptical of BOP's reported statistics. For instance, as of May 12, 2020, BOP's data showed 358 people (including staff) at FCC Butner had tested positive *at some point*, including those who had tested positive and recovered. However, as of May 17, 2020, BOP's reported data showed only 341 people having tested positive at some point at FCC Butner—17 people fewer than five days earlier. While there may be legitimate reasons for the disparity, it is clear that BOP's reported data on COVID-19 in its facilities does not present the full picture.

262. Defendants do not test Butner's staff.[149] Instead, they rely on "self-reporting and temperature checks."[150] As of October 13, BOP reported that 75 staff members at Butner had tested positive.[151]

263. Even when they do conduct tests on the people in their custody, Defendants fail to conduct them in a manner designed to help limit the spread of the virus.[152] For example, after the COVID-19 deaths of four people at Medium I, Defendants tested one housing unit there on or around April 18, and eventually moved those who tested positive to a different unit, Catawba East. However, Defendants did not move some of those who tested positive out of the unit until about *five days after they learned they had tested positive.*

264. Similarly, after the deaths of five men at Butner Low from COVID-19, Defendants tested everyone there on or around June 1. Results were returned starting June 3. Despite many results showing infections—and publicly reporting the increase in infections—Defendants did not move people who had tested positive out of their housing units until after June 10.

265. Thus, with full knowledge of the danger posed by being in close proximity to someone who is COVID-19-positive, Defendants kept known COVID-positive people in close quarters with uninfected people for five or more days. In all that time, the people who tested positive were not quarantined or isolated, and they shared the same common bathrooms and other resources with those who had tested negative.

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[149] Gov't Opp. to Mtn. Compassionate Release, *El-Hanafi* S7 10-cr-162 (KMW) at 16.

[150] *See BOP Implementing Modified Operations*, Federal Bureau of Prisons https://www.bop.gov/coronavirus/covid19_status.jsp (last visited Oct. 19, 2020).

[151] *COVID-19 Cases.*

[152] Beyrer Decl. at 10–11, 17–22. "Universal testing at this point is the only way to understand how many active infections are present and the extent to which community transmission in the facility is occurring. Without this information, the extent of restrictions necessary to control the infection cannot be ascertained." *Id.* at 22.

266. Even now, Defendants continue to refuse to test people who are symptomatic or who have been in close contact with someone who is infected. For example, in Medium I, if a person presents with symptoms, he is quarantined but not tested, allowing BOP to continue to report no new positive tests. In the Camp adjacent to Medium I, Defendants have not tested the men who shared the same dormitory and even the same cubicle as the man who tested positive on October 18. Instead, they have locked all the men inside the Hatteras West unit together, without spraying or cleaning the unit, and without determining who is positive and who is negative.

267. Instead of proactively testing for the virus, Defendants sporadically conduct temperature checks. Defendants have informed the public that "Health Services staff throughout the BOP are conducting rounds and checking inmate temperatures at least once a day. In those locations where inmates are in quarantine or isolation, Health Services staff are conducting rounds and temperature checks twice a day."[153] However, temperature checks are rare:

- In one housing unit in Butner Low, temperatures were taken daily for about a week in April, four times in May, and not at all in June, even though the people in that housing unit in June had all tested positive for COVID-19.
- In a housing unit in FCI Butner Medium I, temperatures were taken of everyone in the housing unit a few times in March and April, but not since.
- In a housing unit at FCI Butner Medium II, temperatures of the entire unit have not been taken a single time. A man housed there estimates that he has seen nursing staff take the temperature of three to four people in his housing unit since the beginning of the outbreak.

[153] *See BOP Correcting Myths and Misinformation*, Federal Bureau of Prisons, https://www.bop.gov/coronavirus/docs/correcting_myths_and_misinformation_bop_covid19.pdf.

268. Additionally, when staff do take temperatures, they rarely ask about other symptoms, other than sometimes asking generally if people are "okay."

269. Defendants have chosen to remain willfully ignorant as to who at Butner has COVID-19 until they are forced to acknowledge that someone has it. In so doing, they limit the number of people who are deemed to require quarantine or isolation, leaving an untold number of people infected with the virus in the general population where they can infect others.

4. Defendants have failed to establish safe and effective quarantine and isolation practices at Butner

270. The quarantine and isolation practices at Butner are ineffective and dangerous.[154]

271. BOP has a "COVID-19 Action Plan" that requires quarantine for all close contacts of confirmed or suspected cases.[155] Those with symptoms are required to be placed in medical isolation.[156] Neither of these policies has been followed at Butner.

272. According to the Action Plan, quarantine is supposed to last for 14 days,[157] but it often lasts longer. Defendants keep people in quarantine for lengthy periods but take few precautions to prevent people from becoming infected while in quarantine or from infecting others.

273. For example, some people transferring into Butner have been quarantined on the fourth floor of the FMC with cancer patients who are immunocompromised. People who provided services (food, medicine, laundry) to people in quarantine went on to interact with other people in the FMC. The quarantine of new intakes on the patient floors at the FMC allows for the introduction of the virus into the FMC and the spread of the virus from people in the FMC to the people in quarantine.

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[154] *See* Beyrer Decl. at 18–19, 22–24.
[155] *See Phase Six Action Plan* at 3.
[156] *See Phase Nine Action Plan* at 6.
[157] *See Phase Nine Action Plan* at 6.

274. Defendants also transport people together to quarantine. In late July, Plaintiff Jackson was transported from FMC Butner to FCC Butner II, where he was quarantined prior to being released into the general population. He was transported in a van with approximately six other people from FMC Butner. The other people in the van came from different floors at the FMC, including floors that had active outbreaks of COVID-19 at the time.

275. In the SHU at Medium II, people from different parts of Butner, including locations where there are cases of COVID-19, are quarantined together.

276. In quarantine in the SHU, people are housed with cellmates without any test results indicating whether they are positive or negative.

277. In the minimum-security camp at Medium I, men arriving or awaiting release are quarantined together in improvised spaces including the chapel, classroom, and indoor recreation room. Because these spaces are not designed for residential use, men quarantined there use the shower facilities in housing units that are not under quarantine.

278. People who come into quarantine at the same time are not separated from other people who come into quarantine before or after them. For example, about five to six days after Plaintiff Jackson arrived in quarantine, eight people on the floor where he was quarantined were released from quarantine. Two days later, six new people were brought in.

279. Defendants do not quarantine people who are close contacts of persons who are confirmed to have the virus. In the dormitories, Defendants screen only the individuals who share a cubicle with a person who is found to have the virus, but they do not test them and do not quarantine them. They do not screen everyone who shares the open dormitory or even the people in surrounding cubicles. People who are housed close to or have other close contacts with those who fall sick are not quarantined, screened, or tested.

280. As in the rest of Butner, use of masks appears to be optional in the quarantine area.

281. Isolation practices are also dangerous. Defendants do not immediately put people with symptoms into medical isolation. For example:

- In March 2020, there was an outbreak of COVID-19 at Medium I and its minimum-security camp. Nonetheless, people with symptoms were not removed from the housing units and placed into isolation. For example, Antonio Ross asked to go to sick call in mid-March because he had a cough, body aches, and a sore throat, but was forced to wait more than a week before he was seen. When he was finally seen at sick call, he was not tested for COVID-19 and was not placed into isolation. He was told he had the flu and was sent back to his housing unit. Four days later, medical staff did temperature checks on people in his housing unit, and Mr. Ross was finally placed into isolation.
- In Butner Low, in May 2020, many people had symptoms but were not placed in isolation. For example, John Dailey, a plaintiff in an earlier class action case against Defendants, was sick for several weeks before he was taken out of the housing unit. By the time he was removed, his symptoms were so severe, he had to be transported to the hospital by ambulance. By the end of May, in one housing unit, about half of the people had COVID-19 symptoms and about a third of the people in another housing unit had symptoms.
- Over the course of two to three days starting on June 10, 2020, people at Butner Low were divided into COVID-19-positive and COVID-19-negative units. But the placements were made based on the results of tests taken on June 1, allowing time for people who tested negative to contract the virus. People who had or developed symptoms between the time of the test and the division of people into positive and

negative units were not taken out of the housing units. People who tested negative but developed symptoms between the date of the test and the division into positive and negative units were placed in negative units. And, in some cases, people with negative test results were knowingly placed in positive units.

282. Since the spring, Defendants have continued to shuffle people among the open dormitories within Butner Low and the minimum-security Camp at Medium I. There is no clear correlation between these movements and COVID-19 test results. While waiting for test results, or after someone who tests positive is removed from a housing unit, people who are COVID-19 positive continue to be housed and share communal spaces with people who are negative.

283. Further, within isolation units, symptomatic people are not isolated from each other, even when their test results are not known.

- For example, at Medium I, people in isolation have been housed in the North Carolina unit. People have been placed into "isolation" there with a cellmate, neither of whom has test results for the coronavirus.
- Further, in North Carolina unit, the men who had COVID-19 symptoms, but did not necessarily have test results, had to come into close contact with each other frequently. The cells in North Carolina unit do not have toilets or sinks. This means that prisoners had to share bathroom facilities. The meals were brought to the unit, but the men had to line up to pick them up. A kitchen worker would bring the food cart to North Carolina unit, and then go back to the kitchen.
- Additionally, some isolation units are not actually isolated. For example, people with COVID-19 symptoms are being "isolated" on the third floor of the FMC. As noted

above, the people who bring food, medicine, and commissary to other patients on the floor also bring them to the people in isolation. As of late July 2020, the use of the third floor for isolation was being expanded.

- In April or May 2020, Defendants set up an isolation area in the chapel in the minimum-security camp at Medium I. However, men housed in the chapel use the bathroom in the Catawba West unit, separated from the men not in isolation only by a partial wall. An orderly who lives in the Catawba West unit is assigned to clean the bathroom after men in the chapel use it. Men who are isolated in the chapel are also able to interact with men from other units during recreation time.
- The chapel has been simultaneously used for both quarantine for people awaiting release and isolation for people who test positive for COVID-19. People newly assigned to the chapel are not kept separate from people who are already in the chapel. Distancing is not enforced, and men sleep on cots in an open room.

284. Additionally, the lack of adequate medical monitoring of people in isolation places people at risk. In the first few weeks after the housing units in Butner Low were divided into positive and negative units, Defendants did not conduct any temperature checks or screen for symptoms in the positive units. Toward the end of June, medical staff started walking through the units asking if people had symptoms. In the minimum-security camp at Butner I, even those who reported symptoms did not receive medical attention.

285. Finally, the poor conditions and lack of care in isolation units discourage people from reporting their symptoms.

286. In some parts of Butner, Defendants use the SHU for isolation of incarcerated people with COVID-19 symptoms. This is dangerous because the SHU is often used punitively, so some people try to hide their symptoms from staff because they fear being sent to the SHU.

287. Roger Duane Goodwin was moved to the SHU after testing positive. He reported being confined to a cell with dirty floors and no hot water, without toiletries, necessary medications, or even a cup to drink from for the first few days. He was not given any specific instructions or COVID-19 medical treatment. Despite feeling better after only a few days of isolation, he was confined in the SHU for 17 days. He was not re-tested, and states that he does not know how the officials at Butner determined when he should be released back to his housing unit.

288. Sick men at Butner are also afraid to be sent to the SHU because they are afraid they could become sicker without anyone noticing in time to help them. Some of these men hide their symptoms, making it more likely that the virus will spread. Defendants have been aware of this issue since March,[158] but have not changed the conditions to encourage sick people to self-report their symptoms.

5. <u>Defendants have failed to eliminate contact between people in different housing units, thereby facilitating the spread of the virus between housing units.</u>

289. Defendants have not eliminated contact between people in different housing units.

290. Staff move between housing units, often without wearing masks.

291. Incarcerated people go to work in their jobs in the kitchen, where they interact with people from other housing units and prepare food for people in each of the housing units. On or

[158] Declaration of Mary Strassel; *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 37-11 at ¶ 33.

about May 13, two people working in the kitchen had a fever and were taken from the kitchen to the isolation units.

292. Some incarcerated people have jobs requiring them to clean the areas used by people believed to have COVID-19. They then return to their own housing units.

293. Some doors between units are unlocked, and incarcerated people may move freely between the units. In the Camp, a door is left unlocked between a unit housing people who had tested positive for the virus and an adjacent unit housing people who had tested negative, and residents move between the two units.

294. In the Low facility, while the facility was divided into COVID-19-positive and negative housing units, medical staff moved from unit to unit for pill call, stopping to distribute pills in both positive units and COVID-19-negative units. Additionally, staff failed to take care in assigning people who have been exposed to COVID-19 to the appropriate housing unit, allowing them to come into close contact with people in negative units.

295. In recent weeks, people have begun interacting even more with people from other housing units. People are returning to their jobs. People are going to the chow hall to get meals. The recreation yards are open more frequently.

296. Defendants' decision to require staff and incarcerated people to move between housing units or interact with people from other housing units increases the likelihood that the virus will spread from housing unit to housing unit.

6. Defendants have failed to take even the most basic measures to prevent the spread of the virus.

297. Defendants have not ensured adequate cleaning or disinfecting of living spaces and common-use equipment, such as bathroom facilities, phones, and computers. According to CDC guidelines, to prevent the spread of COVID-19, "surfaces and objects that are

frequently touched," such as "doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, telephones, and computer equipment," should be cleaned and disinfected "several times a day."[159] Defendants recognized the importance of disinfecting, as shown by their sanitation schedule.[160] However, despite the clear guidance from the CDC, and contrary to their schedule, Defendants fail to clean and disinfect Butner adequately. Bathrooms used by more than 100 people are cleaned only once a day. Phones, computers, and tables are cleaned, at most, twice a day. In the meantime, scores of men in a housing unit touch the surfaces in the bathrooms, and on the phones and computers—one after another. Other high-touch surfaces, such as the ice machine and hot water dispensers, are rarely if ever cleaned. At the FMC, a medical facility where many of the most vulnerable people in the BOP are housed, days or even weeks go by between cleanings.[161]

298. Additionally, Defendants have been aware since March that the cleaning solution they are using to disinfect must be allowed to sit on a surface for ten minutes prior to being wiped off.[162] They did not make any efforts to inform incarcerated people, who do most of the cleaning, of this requirement until approximately August 10. Further, staff supervising the cleaning of the facility have not ensured that the cleaning solution is left on for ten minutes. To the contrary, the cleaning solution is generally sprayed on and immediately wiped off.

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[159] *Interim Guidance*.

[160] March 17, 2020 Memorandum for All FCC Staff Regarding Cleaning and Disinfection of Daily Equipment, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 40-3.

[161] FMC COVID-19 Preventative Measures/Sanitation Tracking Sheet, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 40-4.

[162] March 17, 2020 Memorandum for All FCC Staff Regarding Cleaning and Disinfection of Daily Equipment, *Hallinan v. Scarantino*, 5:20-hc-02088-FL (June 3, 2020), ECF 40-3 at 3.

299. Defendants also do not enforce mask use by staff. They sporadically enforce mask use by incarcerated people. Defendants' lax mask use enforcement increases the likelihood that staff will spread the virus.

7. Other courts have recognized the dire COVID-19 conditions at Butner

300. Earlier this year, in *U.S. v. El-Hanafi*, the Southern District of New York recognized the problems with housing conditions, the lack of disinfectants, and failure to provide personal protective equipment at Butner. The court went so far as to say that it was "difficult to conceive of an environment more conducive to the rapid spread of infection than the type of prison dormitory" at Butner. No. 1:10-cr-00162-KMW, Dkt. 252 (S.D.N.Y. May 19, 2020); *see also Miller v. United States,* No. CR 16-20222-1, 2020 WL 1814084 (E.D. Mich. Apr. 9, 2020) (compassionate release granted involving prisoner at Butner due to COVID-19 concerns); *United States v. Dunlap*, 2020 WL 2062311 (M.D.N.C. Apr. 29, 2020) (same); *United States v. Krokos*, No. 12-cr-00527, Dkt. 1016 (C.D. Cal. May 1, 2020) (same); *United States v. Thompson*, No. 15 CR 00448, Dkt. 80 (N.D. Ill. Apr. 17, 2020) (same); *United States v. Saladrigas*, 2020 WL 4248676 (E.D. Mich. May 13, 2020) (same); *United States v. Rachal*, 2020 WL 3545473 (D. Mass. June 30, 2020) (same); *United States v. Howard*, 2020 WL 2200855 (E.D.N.C. May 6, 2020)(same); *United States v. Heitman*, 2020 WL 3163188 (N.D. Tex. June 12, 2020) (same); *United States v. Perez Alvarado*, 2020 WL 5203386 (S.D. Cal. Sept. 1, 2020) (same); *United States v. Hardnett*, 2020 WL 5074023 (E.D. Va. Aug. 27, 2020) (same); *United States v. Black*, 2020 WL 4583056 (S.D. Ind. Aug. 10, 2020) (same); *United States v. Hamrick,* 2020 WL 4548308 (M.D.N.C. Aug. 6, 2020) (same); *United States v. Luna*, 2020 WL 4696621 (N.D. Cal. Aug. 13, 2020) (same); *United States v. Archer*, 2020 WL 4059694 (D. Nev. July 20, 2020) (same); *United States v. Smith*, 2020 WL 2844222 (N.D. Iowa June 1, 2020) (same); *United States v. Camacho*, 2020 WL

4498796 (W.D. La. Aug. 4, 2020) (same); *United States v. Weems*, 2020 WL 4558381 (S.D. Fla. Aug. 7, 2020) (same); *United States v. Ireland*, 2020 WL 4050245 (E.D. Mich. July 20, 2020) (same); *United States v. Ranck*, 2020 WL 4193487 (S.D. Iowa July 9, 2020) (same); *United States v. Griggs*, 2020 WL 2614867 (D.S.C. May 22, 2020) (same); *United States v. Malone*, 2020 WL 3065905 (W.D. La. June 9, 2020) (same); *United States v. Scparta*, 2020 WL 1910481 (S.D.N.Y. Apr. 20, 2020) (expressing particular concern about quarantine because "many inmates who are on the cusp of relief to home confinement to protect them from COVID-19, which is spreading rampantly at FCI Butner, are housed together in closed quarters for at least 14 days").

VI. BOP's Policies, Practices, and Procedures to Prevent and Mitigate COVID-19 Violate the Rehab Act

301. Defendants' actions and inactions in response to the COVID-19 pandemic constitute disability discrimination. Defendants have discriminated against people with disabilities by failing to make reasonable accommodations and by implementing facially neutral policies that affect people with disabilities more harshly than those without disabilities.

302. Apart from age, BMI, and a history of smoking, all conditions that increase risk for COVID-19 complications or death—including but not limited to lung conditions, asthma, heart conditions, diabetes, kidney disease, liver disease, HIV, immune dysfunction, autoimmune disorders, cancer treatment, and history of organ or bone marrow transplantation—are disabilities under federal disability rights law.

303. Incarcerated people at Butner who have any of these conditions are medically vulnerable people with disabilities protected by the Rehab Act in addition to being protected by the constitutional provisions that protect all incarcerated people who are medically vulnerable

to COVID-19 complications or death. By continuing to detain members of the Disability Subclass, Defendants' policies and practices violate the Rehab Act.

304. The Rehab Act imposes an affirmative obligation on all covered entities to ensure that their policies, practices, and procedures are accessible to people with disabilities, including providing reasonable modifications in order to give people with disabilities an equal opportunity to benefit from the covered entity's programs, services, and activities.[163] BOP is a covered entity under the Rehab Act. Butner has failed to make modifications to ensure that individuals with disabilities can benefit from Butner's programs, services, and activities on an equal basis as people without disabilities who are incarcerated at Butner. To access programs, services, and activities at Butner, people with disabilities are required to place themselves at a higher risk of suffering serious medical harm or death as a result of contracting COVID-19 than people without disabilities. Further, Defendants have discriminated against people with disabilities by managing Butner in a manner that affects persons with disabilities more harshly than those who do not. Indeed, every single incarcerated person who died at Butner from COVID-19 had one or more "long-term, pre-existing medical condition[s], which the CDC lists as risk factors for developing more severe COVID-19 disease."[164] The vast majority of those pre-existing medical conditions, in turn, constitute a disability under the Rehab Act. In short, every single incarcerated person who has died from COVID-19 appears to have had a disability.

305. Incarcerated persons have a right to healthcare, which includes the provision of medication. As described above, in order to receive medication, people incarcerated at Butner must stand

[163] *A Guide to Disability Rights Laws*, U.S. Dep't of Justice: Civil Rights Division (Feb. 2020), https://www.ada.gov/cguide htm (last visited Oct. 19, 2020) ("[Public entities] are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination.").

[164] *See* Ex. 5 (U.S. Dept. of Justice, Fed. Bureau of Prisons Press Releases on Inmate Deaths at FCC Butner).

in a pill line, where it is impossible to physically distance. Because of their disability, Plaintiffs with disabilities face a greater risk of suffering serious symptoms from COVID-19 and requiring hospitalization or death than do other people at Butner. Defendants have not made modifications to reduce the risk to incarcerated people with disabilities to enable them to enjoy the benefits of healthcare on an equal basis with those who do not have disabilities. Further, the method of administration of the provision of medication disparately impacts people with disabilities, as it puts them at higher risk of death than those without disabilities.

306. Incarcerated persons have a right to food. Yet people with disabilities incarcerated at Butner, including Plaintiffs with disabilities, cannot receive meals without facing a greater risk of serious medical harm or death from COVID-19 than people without disabilities. Defendants have not made modifications to reduce the risk to incarcerated people with disabilities to enable them to enjoy the benefits of food on an equal basis with those who do not have disabilities. Further, the method of administration of the provision of food disparately impacts people with disabilities, as it puts them at higher risk of death than those without disabilities.

307. Incarcerated persons have a right to housing. Yet people with disabilities incarcerated at Butner, including Plaintiffs with disabilities, cannot live in their assigned housing without facing a greater risk of serious medical harm or death from COVID-19 than people without disabilities. Defendants have not made modifications to reduce the risk to incarcerated people with disabilities to enable them to enjoy the benefits of housing on an equal basis with those who do not have disabilities. Further, the method of administration of housing

arrangements disparately impacts people with disabilities, as it puts them at higher risk of death than those without disabilities.

308. The Rehab Act also prohibits covered entities from using methods of administration that defeat or impair the accomplishment of the objectives of the covered entity's program. BOP's purpose, by law, is to provide safety, care, and protection for individuals in its custody.[165]

309. All Plaintiffs, including those with disabilities, have a right to safekeeping, care, and protection while in BOP's custody. Continued confinement and BOP's inadequate policies, practices, and procedures regarding COVID-19, which allow mass infection, physical harm, and death, are disproportionately affecting Plaintiffs with disabilities. Butner has failed to establish methods of administration that protect individuals with disabilities from discrimination.

310. As a result of BOP's failures to make reasonable modifications, including release, and its failure to establish a non-discriminatory method of administering its program, individuals with disabilities are being denied the benefits of BOP's safety, care, and protection program and are being disparately impacted by the rapid spread of COVID-19 throughout Butner.

311. The modifications sought are reasonable and would impose no fundamental alteration on BOP.

VII. BOP's Lack of Adequate Prevention and Mitigation Measures at Butner also Pose a Serious Risk to Public Safety

312. Butner's conditions affect the broader community and those incarcerated there.

[165] 18 U.S.C. §§ 4042(a)(2)-(3).

313. Prison staff interact routinely and frequently with the people incarcerated at Butner. As stated above, at least 80 staff members at Butner have reported to BOP a positive test for the virus. But because Defendants do not test staff, the real number of infected staff is unknown.

314. Defendants' failure to implement meaningful precautionary and mitigating efforts put the health and lives of Butner staff at just as grave a risk as the incarcerated people.

315. More than 1,400 people work at Butner.[166] Some of the employees may themselves be medically vulnerable. And every one of them presumably returns home to the Granville County area or greater Raleigh-Durham area after their shift ends.

316. Doubtless many of the Butner employees live with one or more family members or roommates, some of whom may be medically vulnerable. And, unless the Butner employees have managed to completely isolate themselves from contact with any person outside of the prison, they come into contact with other members of their communities.[167]

317. Moreover, every single person incarcerated at Butner who has died from COVID-19 did so at a nearby hospital.[168] People at Butner will continue to need to go to outside hospitals for care as long as COVID-19 spreads through the prison.

VIII. Immediate Release of Eligible People Is Necessary to Save Lives

318. More than 1,000 people at Butner have already been infected with COVID-19. Twenty-six incarcerated people have already died, at least one of whom contracted COVID-19 a second time after previously testing positive and recovering, according to BOP.[169]

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[166] *See PREA Audit Report* (indicating 1,475 staff at FCC Butner).

[167] *See, e.g.*, Beyrer Decl. at 10–11, 13.

[168] *See, e.g.*, Press Release, *Inmate Death at FCI Butner I*, U.S. Dep't of Justice Federal Bureau of Prisons (Apr. 13, 2020), https://www.bop.gov/resources/news/pdfs/20200413_3_press_release_butner.pdf ("John Doe, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I . . . . He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation.").

[169] *See* Press Release, *Inmate Death at FCI Butner (Low)*, U.S. Dep't of Justice Federal Bureau of Prisons (Sept. 17, 2020), https://www.bop.gov/resources/news/pdfs/20200917_press_release_bux.pdf ("On Monday, June 1, 2020, inmate Ricky Lynn Miller tested positive for COVID-19. On Monday, July 6, 2020, Mr. Miller tested negative for

319. The population is medically vulnerable. The complex is overcrowded, exacerbating the already inherent difficulty in practicing effective physical distancing.

320. BOP's failures in screening, testing, quarantining, and isolating people—as well its failures in providing regular, adequate access to hygiene and disinfecting products, enabling effective physical distancing, and enforcing mask use policies—will certainly lead to even more infections and deaths.[170] This is especially true of those who are over 50 and/or medically vulnerable.[171]

321. The immediate release of medically vulnerable people incarcerated at Butner will undoubtedly save lives.[172] It is the sole effective remedy for the ongoing Constitutional violations described herein.

322. Reducing the population at Butner will give other mitigation strategies the greatest chance of success by allowing for more effective physical distancing and by allowing BOP to more closely focus its health and safety resources and planning on those remaining in custody.

CLASS ACTION ALLEGATIONS

323. Plaintiffs bring this class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of themselves and a class of similarly situated individuals.

324. Plaintiffs seek to represent a class of persons currently or in the future incarcerated at FCC Butner while anyone on the premises is infected with COVID-19 (the "Class"). Plaintiffs Hallinan, Riddick, Maldonado, Brown, Freeman, Butler, Williams, and Waldrip are representatives of the Class.

COVID-19 . . . . On Wednesday, September 16, 2020, Mr. Miller tested positive for COVID-19 at the outside hospital. On Thursday, September 17, 2020, Mr. Miller . . . was pronounced dead by hospital staff.")

[170] *See, e.g.*, *id.*

[171] *See, e.g.*, Beyrer Decl. at 9, 10, 12.

[172] *See, e.g.*, Beyrer Decl. at 12–14.

325. The Class also includes a Disability Subclass, consisting of current and future people incarcerated at Butner who are medically vulnerable and at high risk of severe illness or death from COVID-19 due to disabilities protected under Section 504 of the Rehabilitation Act, including those with the following conditions: cancer; chronic kidney disease; chronic obstructive pulmonary disease ("COPD") or moderate to severe asthma; immunocompromised state from solid organ transplant, blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids or other immune weakening medicines; serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; sickle cell disease; diabetes; cerebrovascular disease; cystic fibrosis; hypertension; neurologic conditions such as dementia; liver disease; pulmonary fibrosis; and thalassemia. The Disability Subclass includes those who suffer from pre-existing medical conditions that the CDC has identified as placing a person at a heightened risk of suffering complications from COVID-19.

326. This action has been brought and may properly be maintained as a class action under federal law. It satisfies the numerosity, commonality, typicality, and adequacy requirements for maintaining a class action under Fed. R. Civ. P. 23(a).

327. Joinder is impracticable because (i) the Class and Disability Subclass are numerous, (ii) the Class and Disability Subclass include future members, and (iii) the Class and Disability Subclass members are incarcerated, limiting their ability to institute individual lawsuits.

328. Everyone in Butner is a member of the proposed Class.[173] There are more than 3,900 members of the proposed Class.

[173] *See Population Statistics: Inmate Population Breakdown*.

329. There are more than 200 people in the proposed Disability Subclass. On the fourth floor of FMC Butner alone, there are around 200 people who are immunocompromised due to cancer treatment.

330. Common questions of law and fact exist as to all members of the proposed Class and Disability Subclass, namely whether:

- All are at unreasonable risk of serious harm, including death, from contracting coronavirus due to the conditions in Butner;
- All are at unreasonable risk of serious harm, including death, from Defendants' failure to take reasonable and proactive measures to ensure their safety from the disease;
- All have a right to adequate COVID-19 prevention, testing, and treatment;
- Defendants have been deliberately indifferent to the risk of harm to the Class from COVID-19; and
- The conditions in Butner expose them to heightened risk of contracting COVID-19.

331. Common questions for all members of the Disability Subclass include whether Butner's policies, practices, and procedures with respect to COVID-19 discriminate against people with disabilities in violation of federal disability rights laws and whether Defendants have failed to make reasonable modifications for the Disability Subclass as alleged in this Complaint.

332. Plaintiffs' claims are typical of the Class and the Subclass members' claims. Defendants have placed Plaintiffs at significant risk of harm by failing to take appropriate steps to address the risk of contracting, and being rendered seriously ill or injured by, COVID-19 in Butner. Plaintiffs, like every person in Butner, face heightened risk of contracting the virus if they are not adequately protected by Defendants. Plaintiffs with disabilities, like all

members of the proposed Disability Subclass, face a heightened risk of serious illness or death if they contract COVID-19.

333. Plaintiffs have the requisite personal interest in the outcome of this action and will fairly and adequately protect the interests of the Class. Plaintiffs have no interests adverse to the interests of the proposed Class. Plaintiffs retained pro bono counsel with experience and success in the prosecution of civil rights litigation and specifically in the prosecution of prisoners' civil rights litigation. Counsel for Plaintiffs know of no conflicts among proposed class members or between counsel and proposed class members.

334. Defendants have acted on grounds generally applicable to all proposed class members, and this action seeks declaratory and injunctive relief. Plaintiffs therefore seek class certification under Rule 23(b)(2).

FIRST CAUSE OF ACTION

Discrimination on the Basis of Disability in Violation of Section 504 of the Rehabilitation Act of 1973
Plaintiffs Hallinan, Riddick, Maldonado, Brown, Freeman, Butler, Williams, and Waldrip versus Defendant BOP
29 U.S.C. § 794 et seq.

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

336. Section 504 of the Rehab Act states that "no otherwise qualified individual with a disability in the United States . . . shall, solely by reason of [] disability, be excluded from the participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a). The regulations implementing Section 504 of the Rehab Act require that entities receiving federal financial assistance avoid unnecessary policies, practices, criteria or methods of administration that have the effect of discriminating against persons with disabilities. 28 C.F.R. § 41.51(b)(3)(i).

337. Section 504 forbids not only facial discrimination against individuals with disabilities, but also requires that executive agencies such as BOP alter their policies and practices to prevent discrimination on the basis of disability. Reasonable modifications are required unless those modifications would create a "fundamental alteration" of the relevant program, service, or activity, or would impose an undue hardship. *See Sch. Bd. of Nassau Cty., Fla. v. Arline*, 480 U.S. 273, 288 n.17 (1987); *Alexander v. Choate*, 469 U.S. 287, 300 (1985); *see also* 28 C.F.R. § 35.130(b)(7) ("A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.").

338. Defendants are final policymakers for, or in the case of Defendant BOP is itself, an executive agency within the meaning of 29 U.S.C. § 794(a).

339. Plaintiffs Hallinan, Riddick, Maldonado, Brown, Freeman, Butler, Williams, and Waldrip are individuals with disabilities for the purposes of the Rehab Act, 42 U.S.C. § 12012, 29 U.S.C. § 705(20)(B). As people held at Butner, they are "qualified" for the programs, services, and activities being challenged herein.

340. Plaintiffs Hallinan, Riddick, Maldonado, Brown, Freeman, Butler, Williams, and Waldrip bring this claim on their own behalf and on behalf of the Disability Subclass.

341. Defendants are violating section 504 of the Rehab Act by failing to make the reasonable modifications necessary to ensure equal access to programs, services, and activities for people with disabilities who face high risk of complications or death in the event of COVID-19 infection.

342. Plaintiffs at Butner are under the custody and control of Defendants and are not able to take steps to protect themselves from the spread of the virus. BOP has a duty to provide safety, care, and protection to Plaintiffs, including those with disabilities. Defendants have not provided reasonable accommodations. As COVID-19 continues to spread at Butner, the already deplorable conditions at Butner are only exacerbated further.

343. Defendants are aware that exposure to COVID-19 could be harmful or deadly to Plaintiffs who are members of the Disability Subclass and have failed to protect them.

344. Defendants have failed to provide reasonable accommodations, including the release of persons with disabilities, to mitigate these significant risks, which continuously subject Plaintiffs to a grave and serious risk of harm from serious illness, permanent injury, or death.

345. Defendants have also enacted policies and procedures that deny Plaintiffs access to necessary medical care, which further subject Plaintiffs to a grave and serious risk of harm from serious illness, permanent injury, or death.

346. Defendants' failure to protect Plaintiffs with disabilities from these conditions by releasing prisoners and otherwise taking additional measures to ensure they are not forced to take on greater risk of serious injury or death than other people incarcerated at Butner to access programs, services, and benefits constitutes discrimination under Section 504 of the Rehab Act.

347. Defendants are further violating section 504 of the Rehab Act by employing methods of administration of Butner (including a policy of non-release even in the face of COVID-19) that discriminate against people with disabilities by falling more harshly on people with disabilities than on people without disabilities. Twenty-six incarcerated people have died at Butner from COVID-19; each of them—according to the BOP press releases—had one or

more pre-existing medical conditions that placed them at heightened risk of suffering complications from COVID-19. The vast majority of those conditions, in turn, constitute disabilities under the Rehab Act. Therefore, Plaintiffs believe that no incarcerated people without disabilities have died from COVID-19 at Butner.

348. Section 504 forbids not only facial discrimination against individuals with disabilities, but also any policies or practices that have a disparate impact on disabled individuals. *White v. City of Annapolis by & through City Council*, 439 F. Supp. 3d 522, 542 (D. Md. 2020). "[A] facially neutral practice may be discriminatory if it 'fall[s] more harshly on one group than another.'" *Id*.

349. Defendants have enacted policies and procedures that have a disparate impact on the Disability Subclass by subjecting them to a much higher risk of, and rate of, death from COVID-19 than persons incarcerated at Butner who do not have disabilities.

350. Defendants' failure to protect Plaintiffs with disabilities from these conditions by releasing prisoners and otherwise taking additional measures to ensure they are not disparately impacted by the policies and practices at Butner constitutes discrimination under Section 504 of the Rehab Act.

SECOND CAUSE OF ACTION

Unconstitutional Conditions of Confinement in Violation of the Eighth Amendment to the U.S. Constitution
All Named Plaintiffs versus All Defendants
28 U.S.C. § 1331

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

352. Plaintiffs Hallinan, Kinard, Riddick, Maldonado, Brown, Freeman, Butler, Williams, Jackson, and Waldrip bring this claim on their own behalf and on behalf of the Class.

353. The Eighth Amendment guarantees incarcerated persons the right to necessary and adequate medical care, and to be free from cruel and unusual punishment. *See* U.S. Const., amend. VIII. As part of the right, the government cannot subject incarcerated persons to a substantial risk of serious harm to their health and safety. *See, e.g.*, *Farmer v. Brennan*, 511 U.S. 825, 828 (1994); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

354. Plaintiffs at Butner are under the custody and control of Defendants and are not able to take steps to protect themselves from the spread of the virus. Defendants have not provided adequate protections. As COVID-19 continues to spread at Butner, the already deplorable conditions at Butner are only exacerbated further.

355. Defendants are aware of these conditions, which were and are obvious throughout Butner.

356. Defendants know of and have disregarded an excessive risk to health and safety.

357. Defendants have failed to take reasonable steps, including the release of medically vulnerable persons, to mitigate these significant risks, which continuously subject Plaintiffs to a substantial risk of harm from serious illness, permanent injury, or death.

358. Defendants have also failed to provide adequate medical care and have taken affirmative steps to deny Plaintiffs access to necessary medical care, which further subjects Plaintiffs to a substantial risk of harm from serious illness, permanent injury, or death.

359. Defendants' failure to protect Plaintiffs from these conditions by releasing prisoners and otherwise remedying the conditions of confinement constitutes deliberate indifference to the health, safety, and serious medical needs of Plaintiffs and all members of the Class, thereby establishing a violation of the Eighth Amendment to the United States Constitution.

360. Federal courts have inherent equitable authority to order injunctive and declaratory relief to remedy violations of the Constitution by federal actors. *Armstrong v. Exceptional Child Ctr., Inc*., 575 U.S. 320, 327 (2015).

THIRD CAUSE OF ACTION

Unconstitutional Confinement in Violation of the Eighth Amendment to the U.S. Constitution
Plaintiffs Hallinan, Kinard, Riddick, Maldonado, Brown, Freeman, Butler, Williams, Jackson, and Waldrip versus Defendants Scarantino and Carvajal
28 U.S.C. § 2241 (Habeas Corpus)

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

362. Plaintiffs Hallinan, Kinard, Riddick, Maldonado, Brown, Freeman, Butler, Williams, Jackson, and Waldrip bring this claim on their own behalf and on behalf of the Class.

363. The Eighth Amendment guarantees incarcerated persons who have been sentenced the right to necessary and adequate medical care, and to be free from cruel and unusual punishment. *See* U.S. Const., amend. VIII. As part of the right, the government cannot subject incarcerated persons to a substantial risk of serious harm to their health and safety. *See, e.g.*, *Farmer*, 511 U.S. at 828; *Estelle*, 429 U.S. at 104.

364. Plaintiffs at Butner are under the custody and control of Defendants and are not able to take steps to protect themselves—such as physical distancing and avoiding high-touch surfaces—and Defendants have not provided adequate protections from the risk of harm from COVID-19. As COVID-19 continues to rapidly spread at Butner, the incarcerated men have no adequate ability to protect themselves from this disease.

365. Defendants are aware that the Plaintiffs are confined at Butner and cannot avoid the spread of COVID-19 due to their confinement.

366. Defendants know of and have disregarded excessive risks to Plaintiffs' health and safety.

367. Defendants have failed to take reasonable steps to mitigate these significant risks, which continuously subject Plaintiffs to a substantial risk of harm from serious illness, permanent injury, and death.

368. Defendants have also failed to provide adequate medical care and taken affirmative steps to deny Plaintiffs access to necessary medical care, which further subject Plaintiffs to a substantial risk of harm from serious illness, permanent injury, or death.

369. Defendants' failure to take reasonable steps to protect Plaintiffs from these conditions by releasing them from the conditions altogether constitutes deliberate indifference to the health, safety, and serious medical needs of Plaintiffs and all members of the Class, thereby establishing a violation of the Eighth Amendment to the United States Constitution.

REQUEST FOR RELIEF

Wherefore, Plaintiffs and the Class members respectfully request that the Court order the following relief:

A. Enter a declaratory judgment that Butner's policies and practices violate the Eighth Amendment right against cruel and unusual punishment with respect to the Class and Disability Subclass;

B. Enter a declaratory judgment that Butner's policies and practices violate Section 504 of the Rehab Act with respect to the Disability Subclass;

C. Order Defendants to create and implement a mitigation plan for prevention of COVID-19 that is consistent with CDC guidelines, overseen by a qualified public health expert, and provides appropriate and reasonable accommodations to those with disabilities.

D. Order the Defendants to provide all necessary and appropriate health care consistent to ensure that health care needs of individuals incarcerated at FCC Butner are being met, including continued attention to non-COVID-19 related medical needs.

E. Establish a process to identify all incarcerated persons who are appropriate for release on home confinement, furlough or other release mechanisms, and order and/or grant a writ of habeas corpus requiring Defendants to release, without quarantining at Butner, all persons identified through that process as appropriate for release;

F. Award Plaintiffs costs, expenses, and reasonable attorneys' fees pursuant to the Equal Access to Justice Act, the Rehab Act, and any other applicable laws; and

G. Any further relief that this Court deems just, necessary, or appropriate.

Respectfully submitted this 26th day of October, 2020.

/s/ Jeffrey S. Wilkerson

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
No. __:___-CV-___-__

CHARLES HALLINAN, JOSEAN KINARD, GEORGE RIDDICK, JORGE L. MALDONADO, WILLIAM BROWN, TERRANCE FREEMAN, ANTHONY BUTLER, DARYL WILLIAMS, QUAMAIN JACKSON, AND LASALLE WALDRIP, on behalf of themselves and similarly situated individuals, *Plaintiffs/Petitioners,* v. THOMAS SCARANTINO, Complex Warden, Federal Correctional Complex Butner; MICHAEL CARVAJAL, Federal Bureau of Prisons Director; and JEFFERY ALLEN, Federal Bureau of Prisons Medical Director, in their official capacities, and the FEDERAL BUREAU OF PRISONS, *Defendants/Respondents.*	**DECLARATION OF JEFFREY S. WILKERSON IN SUPPORT OF CLASS ACTION COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF AND PETITION FOR WRIT OF HABEAS CORPUS**

I, Jeffrey S. Wilkerson, declare as follows:

1. I am an attorney licensed to practice law in North Carolina and admitted to this Court, a partner at Winston & Strawn LLP, and counsel for Plaintiffs/Petitioners in this matter. I have personal knowledge of the facts herein.

2. Exhibit 1 is a true and accurate copy of the Response in Opposition Regarding Emergency Motion for Temporary Restraining Order, Preliminary Injunction, and Writ of Habeas Corpus, *Hallinan v. Scarantino*, No. 5:20-HC-2088-FL (E.D.N.C. June 3, 2020), ECF No. 42.

3. Exhibit 2 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 3, 2020, and sorted to show data related to FCC Butner.

4. Exhibit 3 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 10, 2020, and sorted to show data related to FCC Butner.

5. Exhibit 4 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on July 6, 2020, and sorted to show data related to FCC Butner.

6. Exhibit 5 is a true and accurate copy of the U.S. Department of Justice, Federal Bureau of Prisons Press Releases on Inmate Deaths at FCC Butner.

7. Exhibit 6 is a true and accurate copy of *How COVID-19 Spreads*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html, (last accessed October 18, 2020).

8. Exhibit 7 is a true and accurate copy of *Assessing Risk Factors*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/assessing-risk-factors.html, (last accessed October 18, 2020).

9. Exhibit 8 is a true and accurate copy of a March 20, 2020 article by Xianxian Zhao, et al. titled *Incidence, clinical characteristics and prognostic factor of patients with COVID-19: a systematic review and meta*-analysis, which is available online at https://cutt.ly/etRAkmt, (last accessed October 18, 2020).

10. Exhibit 9 is a true and accurate copy of *Age, Sex, Existing Conditions of COVID-19 Cases and Deaths Chart*, WorldOMeter, which is available online at https://cutt.ly/ytEimUQ, (last accessed October 18, 2020).

11. Exhibit 10 is a true and accurate copy of *Older Adults*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html, (last accessed October 18, 2020).

12. Exhibit 11 is a true and accurate copy of *COVID-19 Hospitalization and Death by Age*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html, (last accessed October 18, 2020).

13. Exhibit 12 is a true and accurate copy of *Social Distancing, Quarantine, and Isolation*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html, (last accessed October 18, 2020).

14. Exhibit 13 is a true and accurate copy of *How to Protect Yourself & Others*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html, (last accessed October 18, 2020).

15. Exhibit 14 is a true and accurate copy of *COVID-19 in Correctional and Detention Facilities – United States, February-April 2020*, Centers for Disease Control and Prevention, which is available online at https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm, (last accessed October 19, 2020).

16. Exhibit 15 is a true and accurate copy of the July 22, 2020 edition of *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, as archived by the Internet Archive (Wayback Machine) on October 6, 2020, and which is available online at https://web.archive.org/web/20201006113319/https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

17. Exhibit 16 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website https://www.bop.gov/coronavirus/index.jsp, taken on March 30, 2020, as archived by the Internet Archive (Wayback Machine) on April 15, 2020.

18. Exhibit 17 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on April 1, 2020, as archived by the Internet Archive (Wayback Machine) on April 15, 2020.

19. Exhibit 18 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on April 6, 2020, as archived by the Internet Archive (Wayback Machine) on April 15, 2020.

20. Exhibit 19 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on May 1, 2020.

21. Exhibit 20 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on May 31, 2020.

22. Exhibit 21 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 3, 2020.

23. Exhibit 22 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 7, 2020.

24. Exhibit 23 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 8, 2020.

25. Exhibit 24 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 9, 2020.

26. Exhibit 25 is a true and accurate copy of a screenshot of the Federal Bureau of Prisons' COVID-19 website at https://www.bop.gov/coronavirus/index.jsp, taken on June 10, 2020.

27. Exhibit 26 is a true and accurate copy of an April 3, 2020 memorandum from Attorney General William Barr titled *Memorandum for Director of Bureau of Prisons*, which is available online at https://www.justice.gov/file/1266661/download, (last accessed October 18, 2020).

28. Exhibit 27 is a true and accurate copy of an April 13, 2020 memorandum from Andre Matevousian and L. Cristina Griffith titled *Memorandum for All Chief Executive Officers*, which is available online at https://prisonology.com/wp-content/uploads/2020/04/COVID-19-Phase-6-Plan-2020-04-13.pdf, (last accessed October 18, 2020).

29. Exhibit 28 is a true and accurate copy of the Opinion and Order, *United States v. Wesam El-Hanafi*, No. 1:10-cr-00162-KMW (S.D.N.Y. May 19, 2020), ECF No. 252.

30. Exhibit 29 is a true and accurate copy of the Declaration of Expert Chris Beyrer, M.D., M.P.H.

Executed on October 26, 2020.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Jeffrey S. Wilkerson

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CERTIFICATE OF SERVICE

I, Jeffrey S. Wilkerson, hereby certify that a true copy of the of the foregoing was served on Respondents/Defendants' counsel of record with the Clerk of the Court via the CM/ECF Document Filing System.

This 26th day of October 2020.

/s/ Jeffrey S. Wilkerson
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Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
NO. 5:20-HC-2088-FL

CHARLES HALLINAN, JOSEAN KINARD, ARNOLD J. HILL, BENJAMIN D. McRAE, JOHN DAILEY, LEE M. AYERS, GEORGE B. RIDDICK, JORGE LUIS MALDONADO, ANTWAN HARRIS, ANTHONY BUTLER, and TROY A. TITUS, on behalf of themselves and similarly situated individuals, Petitioners/Plaintiffs, v. THOMAS SCARANTINO, Complex Warden, Federal Correctional Complex Butner; MICHAEL CARVAJAL, Federal Bureau of Prisons Director; and JEFFERY ALLEN, Federal Bureau of Prisons Medical Director, in their official capacities, Respondents/Defendants.	RESPONDENTS' RESPONSE IN OPPOSITION TO PETITIONERS' MOTION FOR TEMPORARY RESTRAINING ORDER, PRELIMINARY INJUNCTION, AND WRIT OF HABEAS CORPUS [D.E. 24]

Respondents, by and through the United States Attorney for the Eastern District of North Carolina, hereby submit this Response in Opposition to Petitioners' Motion for Temporary Restraining Order, Preliminary Injunction, and Writ of Habeas Corpus, [D.E. 24]. For the following reasons, Petitioners' motion should be denied.

PRELIMINARY STATEMENT

Federal Bureau of Prisons ("BOP") officials at the Federal Correctional Complex in Butner, North Carolina ("FCC Butner") are working around the clock

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amidst this unprecedented global pandemic to protect the health and well-being of inmates at their facility and the public at large. BOP employees are working tirelessly to fulfill their statutory duties and control the spread of COVID-19.

As early as March 13, 2020, BOP modified its operations in accordance with its COVID-19 Action Plan to minimize the risk of COVID-19 transmission into and inside its facilities.[1] The Attorney General also directed BOP to immediately review all inmates who have COVID-19 risk factors, as established by the Centers for Disease Control and Prevention ("CDC").[2] FCC Butner officials have fully and expediently implemented these Plans and directives, and have taken additional preventative steps in an attempt to mitigate the risks of the COVID-19 virus. See generally, Declaration of Phil Clark ("Clark Decl.") Respondents' Appendix ("R.A.") [D.E. 37] 010-044; Declaration of Andrew Stock ("Stock Decl.") R.A. 085-129; Declaration of Mary Strassel ("Strassel Decl.") R.A. 130-156.

While FCC Butner's extraordinary efforts have not prevented the spread of COVID-19 or deaths resulting from it, which has proven impossible even outside the prison walls, these efforts cannot reasonably be characterized as "inhumane," "dangerous," "deadly," or deliberately indifferent. [D.E. 25, at 15, 16, 17, 21].[3] In

[1] "Federal Bureau of Prisons Covid-19 Action Plan," March 13, 2020, https://www.bop.gov/resources/news/20200313_covid_19.jsp (last visited June 1, 2020).
[2] Attorney General Memorandum for Director of Bureau of Prisons, Re: Increasing use of Home Confinement at Institutions Most Affected by COVID-19 (Apr. 3, 2020), https://www.justice.gov/file/1266661/download (last visited June 1, 2020).
[3] Respondents' references to the page numbers in Petitioners' filings are cited using the page numbers on this Court's docket stamp.

fact, contrary to what Petitioners' sensationalized allegations would suggest, the mortality rate at FCC Butner is actually **lower** than that in the general population.

As of June 1, 2020, the CDC reports that the COVID-19 mortality rate in the United States is approximately 5.8% (104,396 deaths out of 1,787,680 cases), and that the mortality rate in North Carolina is approximately 3.1%. (886 deaths out of 28,589 cases). See Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19), "Cases in the U.S." (last updated June 1, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last visited June 2, 2020). As of June 2, 2020, FCC Butner has a total population of 4,360 inmates. Clark Decl., R.A. 012 ¶ 5. Of those inmates tested, 702 have tested positive for the COVID-19 virus, 286 have recovered and/or been released, and 15 have died. Declaration of Kellie Harden ("Harden Decl."), R.A. 353–54 ¶ 6. Fourteen inmates died as a result of the virus and its interaction with their other co-morbid medical conditions, and one died of non-COVID-19-related conditions although he tested positive for the virus at the time of his death. Stock Decl. R.A. 121 ¶ 149. All 15 of these inmates had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19-related symptoms.[4] Thus, although the FCC Butner infection rate may be higher than that of the general population, the FCC Butner mortality rate of approximately 2.1% is lower than the rates for the general population. Contrary to Petitioners' claims, then, FCC Butner's efforts have been effective in managing infections and treating inmates. FCC

[4] See https://www.bop.gov/resources/press_releases.jsp.

Butner's conditions and responses to the crisis therefore cannot possibly be deemed constitutionally deficient.

Nevertheless, Petitioners demand that this Court grant them extraordinary and emergency injunctive relief, claiming (wrongly) that BOP's response to the COVID-19 pandemic is so woefully deficient—so deliberately indifferent—as to rise to the level of a constitutional, Eighth Amendment violation, thereby entitling them, and other inmates present and future, to release from prison. Their claims rest on unfounded allegations from a handful of inmates and unsupported theories relating to infection control espoused by their purported experts whose theories are not grounded in science, the standard of care in the community, or evolving CDC guidelines. Ultimately, Petitioners cannot meet any of the requirements for the preliminary injunctive relief they seek. Their claimed constitutional violations should be rejected as meritless, and their motion for temporary restraining order ("TRO") and preliminary injunction should be denied.

First, Petitioners fail to demonstrate a likelihood of success on the merits. As an initial matter, Petitioners' challenge to their conditions of confinement is not appropriate under 28 U.S.C. § 2241. Wilborn v. Mansukhani, 795 F. App'x 157, 162–64 (per curiam) (4th Cir. Nov. 8, 2019) (unpublished) (collecting cases); Hunt v. Johns, No. 5:10-HC-2176-FL, 2011 WL 3664553, at *2 (E.D.N.C. Aug 18, 2011) (unpublished).[5] Even if it were, it would fail on the merits. Respondents, three high-

[5] The Court should not convert Petitioners' petition into a Bivens action for multiple reasons. First, Petitioners are represented by 13 lawyers from two nationwide organizations and one nationwide law firm, who presumably considered the available

level BOP officials, have efficiently implemented at FCC Butner policies and guidelines recommended by the CDC, the Department of Justice, and the BOP. While these policies may not be precisely what the Petitioners want, they in no way violate the Eighth Amendment or demonstrate deliberate indifference to Petitioners' medical needs. Quite the contrary. That BOP has expediently implemented such significant measures demonstrates that prison officials take seriously the COVID-19 pandemic and the medical needs of the inmates entrusted to their custody. Petitioners' complaints about BOP policies fall exceedingly short of demonstrating that BOP's efforts are "repugnant to the conscience of mankind." Estelle v. Gamble, 429 U.S. 97 105–06 (1976). Instead, BOP must be "accorded wide-ranging deference in the adoption and execution of policies and practices that in [its] judgment are needed to preserve internal order and discipline and to maintain institutional security." Bell v. Wolfish, 441 U.S. 520, 547 (1979); Sandin v. Conner, 515 U.S. 472, 482 (1995) ("federal courts ought to afford appropriate deference and flexibility to [prison] officials trying to manage a volatile environment."); Livas v. Myers, No. 20-CV-422, 2020 WL 1939583, at *8 (W.D. La. Apr. 22, 2020) (denying petitioners' motion for release of purportedly vulnerable inmates from a BOP facility and dismissing action

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remedies for relief and intentionally rejected pursuing a Bivens claim despite the clear state of the law. The Court should not liberally construe the petition as it may if Petitioners were acting pro se. Cf. [D.E. 15, at 2] (refusing to "act on petitioners' request in their petition for immediate injunctive relief in the absence of a properly supported motion"). Even if the Court were to liberally construe the petition as a Bivens action, it would still fail. Respondents are expressly named in their official capacity, not their individual capacity, and the allegations do not support the personal involvement by Respondents required to make a Bivens claim.

because, *inter alia*, court cannot serve as a "a de facto 'super' warden of [the BOP facility]").

Petitioners also fail to demonstrate irreparable harm. Petitioners, and any other at-risk inmate who is truly vulnerable to contracting COVID-19, already have statutorily-based opportunities to present their individual case for a careful, fair, and individualized assessment by either the BOP or the appropriate district court. Therefore, they simply cannot show that they will suffer irreparable harm in the absence of a TRO or preliminary injunction. Instead, the sweeping relief Petitioners request here would undermine BOP's systemic response to the COVID-19 pandemic, inappropriately insert the Judicial Branch into policy decisions that have been assigned to expert prison administrators, and require BOP to defy the CDC's guidance to restrict prisoner movements during the pandemic to avoid unnecessary risk of spreading the virus.

Finally, Petitioners cannot show that an injunction is in the public interest or that the balance of the equities favors it. There are considerable risks associated with a large-scale release or transfer of inmates, and these risks will directly affect the safety and security of other BOP facilities, half-way houses, and the communities to which the inmates would be released. Moreover, Petitioners fail to demonstrate that their requested relief would make any difference — that is, that it would reduce the rate of infection at FCC Butner or the mortality rate (which is already lower than that in the general population), or that Petitioners would be better off in other facilities or the community (where, presumably, Petitioners would at minimum have

to work, shop for groceries and other essentials, and otherwise interact with the general public whose commitment to social distancing, sanitation, and hygiene may fall well short of FCC Butner's efforts). In that context, Petitioners' claim that "reducing the Butner population is the only way to halt the serious ongoing and irreparable harm of COVID-19" is, most charitably, merely speculative. [D.E. 25, at 19].

Accordingly, Petitioners cannot make their required showing for a TRO, Preliminary Injunction and Writ of Habeas Corpus, and their motion should be denied.

STATEMENT OF FACTS

For a full recitation of the facts regarding the BOP's and FCC Butner's Action Plans for COVID-19, Respondents respectfully refer the Court to their Material Statement of Facts [D.E. 36] and Respondents' Appendix ("R.A.") [D.E. 37], filed contemporaneously with their motion to dismiss the petition, or in the alternative, for summary judgment. Respondents respond to the factual assertions raised in Petitioners' Motion for Temporary Restraining Order, Preliminary Injunction, and Writ of Habeas Corpus and supporting memorandum ("Pet. Mot." or "Pet. Mem."), in the Argument section below.

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ARGUMENT

A. Applicable Standard for a Motion for Temporary Restraining Order or Preliminary Injunction.

Temporary restraining orders and preliminary injunctions[6] are extraordinary remedies, and should be granted only if the moving party clearly establishes entitlement to the relief sought and may never be awarded as of right. Winter v. Nat. Res. Def. Counsel, Inc., 555 U.S. 7, 24 (2008); Mountain Valley Pipeline, LLC v. W. Pocahontas Props., 918 F.3d 353, 366 (4th Cir. 2019). "Mandatory injunctive relief in any circumstance is disfavored, and warranted only in the most extraordinary circumstances." Taylor v. Freeman, 34 F.3d 266, 270 n.2 (4th Cir. 1994) (citations omitted).

The primary purpose of TROs and preliminary injunctions is to preserve the status quo pending a resolution of the merits. Wetzel v. Edwards, 635 F.2d 283, 286 (4th Cir. 1980) (citations omitted). As noted, the Fourth Circuit has repeatedly held that the authority of a district court judge to issue a preliminary injunction should be "sparingly exercised." Id. The standard for granting either a TRO or a preliminary injunction is the same. See, e.g., Sarsour v. Trump, 245 F. Supp. 3d 719 (E.D. Va. 2017). The party seeking a TRO or preliminary injunction bears the burden to establish a clear showing on **each of four elements**: the party "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

[6] Procedural requirements applicable to preliminary injunctions and TROs are governed by Rule 65 of the Federal Rules of Civil Procedure.

an injunction is in the public interest." Winter, 555 U.S. at 20 (emphasis added). To be sure, in order to obtain a preliminary injunction, all four of these requirements must be satisfied. Mountain Valley Pipeline, LLC, 918 F.3d at 366.

B. Petitioners' Motion is Procedurally Improper Because it Seeks the Equivalent of a Final Judgment on the Merits.

Petitioners' motion appears to seek the same relief as the Petition itself.[7] Thus, if the Court were to grant Petitioners' motion, there would effectively be nothing left for the Court to do. Petitioners' motion thus is more akin to a motion for summary judgment, rather than for emergency provisional relief designed to preserve the status quo until the Court can fully examine the merits of the claims on a complete record. The Court, however, may not grant a "preliminary" injunction that effectively gives Petitioners a final judgment on the merits. See, e.g., Wetzel v. Edwards, 635 F.2d 283, 286 (4th Cir. 1980) (preliminary injunction may not be used to secure a piecemeal trial, purpose is to preserve the status quo until the rights can be fairly and fully determined); Warner Vision Entm't Inc. v. Empire of Carolina, Inc., 101 F.3d 259, 261 (2d Cir. 1996) (purpose of a preliminary injunction not to give plaintiff ultimate relief it seeks).

Here, the extraordinary relief sought by Petitioners, (i.e., release or transfer of numerous inmates from prison), is neither temporary nor preliminary, but rather includes the same ultimate relief they seek in their underlying petition. Regardless, Respondents have now filed a motion to dismiss, or in the alternative for summary

[7] Compare Pet. Mot. [D.E. 24, at 2], with Petition [D.E. 1, "Request for Relief" at 66-70].

judgment. Therefore, the Court currently has everything necessary to rule on the dispositive legal issues in the underlying action, or otherwise rule on the merits. The requested TRO and preliminary injunction are, consequently, mooted and should be denied on this ground alone.

C. Petitioners Cannot Establish Any of the Four Elements Necessary to Justify Entry of a TRO or Preliminary Injunction.

1. Petitioners Fail to Demonstrate by a Clear Showing that They Are Likely to Succeed on the Merits.

Persons seeking a TRO or preliminary injunction must first demonstrate by "a clear showing" that, inter alia, they are likely to succeed on the merits at trial. Winter, 555 U.S. at 22. Here, Petitioners are not entitled to the extraordinary relief of a TRO or a preliminary injunction because they simply cannot establish by any showing, let alone the requisite "clear showing," that they are likely to succeed on the merits of their underlying habeas action.

First, as explained in Respondents' Memorandum in Support of their Motion to Dismiss, or in the Alternative, Motion for Summary Judgment, this Court lacks jurisdiction because Petitioners challenge the conditions of their confinement in a habeas petition. The settled rule in this Circuit provides that conditions-of-confinement cases are not cognizable under habeas corpus. See, e.g., Wilborn, 795 F. App'x at 162–64; Hunt, 2011 WL 3664553, at *2 (E.D.N.C. Aug 18, 2011).[8]

[8] Respondents hereby adopt by reference and fully incorporate the arguments set forth in full in their motion to dismiss, or in the alternative, for summary judgment, pursuant to Federal Rule of Civil Procedure 10(c).

Regardless, the conditions of Petitioners' incarceration simply do not violate the Eighth Amendment. To show such a violation, Petitioners must demonstrate that Respondents acted with "deliberate indifference" towards Petitioners' well-being by consciously disregarding an excessive risk of harm to their safety. Whitley v. Albers, 475 U.S. 312, 319 (1986) ("[O]nly the unnecessary and wanton infliction of pain . . . constitutes cruel and unusual punishment forbidden by the Eighth Amendment" (quotations omitted)). This entails proving two elements: first, Petitioners must show, objectively, that Respondents' actions "constitute an unnecessary and wanton infliction of pain or [are] repugnant to the conscience of mankind." Estelle, 429 U.S. at 105-06. In the context of exposing prisoners to risk of disease, a claim must be dismissed if it does not pose a threat that is so severe that it would be "contrary to current standards of decency for **anyone** to be so exposed." Helling v. McKinney, 509 U.S. 25, 35 (1993) (emphasis added); Farmer v. Brennan, 511 U.S. 825, 844–45 (1994) ("A prison official's duty under the Eighth Amendment is to ensure 'reasonable safety,' a standard that incorporates due regard for prison officials' unenviable task of keeping dangerous men in safe custody under humane conditions."). Second, Petitioners must show that Respondents "know[] of and disregard[] an excessive risk to inmate health and safety; the[y] must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and . . . must also draw the inference." Farmer, 511 U.S. at 837. Petitioners have not, and cannot, meet that high standard.

First, Petitioners mistakenly believe that the Eighth Amendment's objective requirement is met because they "are likely to show that confining Medically Vulnerable Subclass at Butner places them at substantial risk of harm from COVID-19". [D.E. 25 at 27]. They are wrong.

It is undisputed that COVID-19 poses significant health risks to both the world community at large, as well as to prison populations. However, while those general health risks may be relevant, they are not "repugnant to the conscience of mankind," Estelle, 429 U.S. at 105–06, or "contrary to current standards of decency," Helling, 509 U.S. at 35. This is particularly so in the context of a worldwide pandemic that led health officials to advise issuing stay-at-home orders and to issue guidance to correctional facilities to, among other things, **not** transfer prison inmates. See Centers for Disease Control and Prevention Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("CDC Interim Guidance"), 9.[9]

COVID-19 poses risks confronting not only prisoners but law-abiding citizens nationwide, including front-line workers and vulnerable nursing home patients. The CDC has issued guidance for appropriately mitigating the risks in correctional facilities, which includes detailed recommendations about proper hygiene and cleaning practices, social distancing, evaluating symptoms, and the use of medical isolation and quarantine. CDC Interim Guidance, 3. The CDC guidance explains

[9] CDC Interim Guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

that inmates may continue to be detained in "housing units" in which bunks "ideally" are separated by at least six feet, but that such separation and other "social distancing strategies" involving recreation, meals, and other activities "need to be tailored to the individual space in the facility." CDC Interim Guidance, 11 (emphasis omitted). That expert guidance contradicts Petitioners' contention that their perceived risks at FCC Butner are such that contemporary societal standards wholly forbid them.[10]

Since January 2020, in order to combat the spread of COVID-19 at its institutions, BOP has been coordinating with subject-matter experts at multiple organizations and agencies, including the CDC—a fact that, alone, undercuts Petitioner's unfounded claims of deliberate indifference.[11] As a result of these ongoing efforts, BOP implemented a multi-phased operational Action Plan seeking to "mitigate the spread of COVID-19" among inmates and staff, continue effective operations of the federal prison system, and ensure that staff remain healthy and available for duty. Id. Regarding implementation of the Action Plan, personnel at FCC Butner are using an entire team of medical professionals to diagnose, treat, and mitigate the spread of COVID-19. Stock Decl., R.A. 094 ¶¶ 23–24. BOP has

[10] CDC guidance provides a useful benchmark in determining whether the facility's policies and procedures are appropriate. Although Respondents have followed the guidelines recommended by the CDC, any alleged hypothetical failure to follow such guidelines simply does not, without more, state a constitutional violation. See e.g. Hickox v. Christie, 205 F. Supp. 3d 579 (D.N.J. Sept. 2, 2016).

[11] See Federal Bureau of Prisons COVID-19 Action Plan, https://www.bop.gov/resources/news/20200313_covid-19.jsp (last visited June 2, 2020).

established several quarantine and isolation units at FCC Butner, and has engaged in comprehensive testing and symptom checks, Stock Decl., R.A. 102–03 ¶¶ 54–59. FCC Butner has also purchased specialized cleaning products, distributed personal protective equipment, and disseminated information on how to protect both inmates and staff from infection. Declaration of Luis Martinez ("Martinez Decl."), R.A. 358 ¶¶ 8 – 9.

Under these circumstances, there is no legal basis to conclude that BOP is violating "current standards of decency" or that BOP is taking actions that "constitute an unnecessary and wanton infliction of pain or [are] repugnant to the conscience of mankind." Helling, 509 U.S. at 35; Estelle, 429 U.S. at 35. Petitioners appear to disagree with the BOP's Action Plan and how it is being implemented. However, the Action Plan is merely a policy determination for which the Court (unlike BOP administrators) is ill-equipped to resolve. See Wetzel, 635 F.2d at 288. Moreover, it is well-established that disagreements over the course and propriety of certain medical treatment do not rise to the level of an Eighth Amendment claim. See, Jackson v. Lightsey, 775 F.3d 170, 178 (4th Cir. 2014).

Additionally, Petitioners fail to show that Respondents (the Director of the BOP, the Medical Director of the BOP, and the Warden of FCC Butner) had the subjective "intent" to transform the living conditions at FCC Butner, specifically, into "punishment" that violates the Eighth Amendment. Where challenged conditions are "not formally meted out as punishment by the statute or the sentencing judge," officials will impose "punishment" only if they "act with a sufficiently culpable state

of mind," Wilson v. Seiter, 501 U.S. 294, 298, 300 (1991), which is demonstrated "only [by] the unnecessary and wanton infliction of pain," Farmer, 511 U.S. at 834 (quoting Wilson, 501 U.S. at 297); e.g., Estelle, 429 U.S. at 104.

Whether an official's conduct can be deemed "'wanton' depends upon the constraints facing the official." Wilson, 501 U.S. at 303 (emphasis omitted); see Whitley, 475 U.S. at 320. "[D]eliberate indifference" can constitute "wanton" intent in prison-conditions contexts because "as a general matter" the Government's responsibility to rectify dangerous conditions "'does not ordinarily clash with other equally important governmental responsibilities'" or implicate unusual "constraints" on its action. Wilson, 501 U.S. at 302 - 03 (quoting Whitley, 475 U.S. at 320). Like the criminal-law "mens rea requirement" for "subjective recklessness," that standard requires proof that officials "know[] of and disregard[] an excessive risk of inmate health or safety," Farmer, 511 U.S. at 836–837, 839 — 40, i.e., they must "'consciously disregard'" that risk by subjectively recognizing it while failing to "respond[] reasonably." Id. at 839, 844 (brackets and citation omitted). That subjective inquiry "incorporates due regard for [officials'] 'unenviable task of keeping dangerous men in safe custody under humane conditions,'" Farmer, 511 U.S. at 845 (citation omitted), by "leav[ing] ample room for professional judgment, constraints presented by the institutional setting, and the need to give latitude to administrators who have to make difficult trade-offs as to risks and resources," Battista v. Clarke, 645 F.3d 449, 453 (1st Cir. 2011). The Supreme Court has thus emphasized that courts must use "caution" in exercising their equitable power and warned that they may not

"'enmesh[]'" themselves "'in the minutiae of prison operations.'" Farmer, 511 U.S. at 846–47 (citation omitted).

Notably, a "lack of due care" or other "error in good faith" is insufficient to show wantonness. Wilson, 501 U.S. at 299 (citation and emphasis omitted). Petitioners claim that Respondents know of and have disregarded the risk facing prisoners. [D.E. 25 at 27]. Nothing could be further from the truth. BOP and FCC Butner officials have consciously confronted the risks posed by this public health crisis by modifying FCC Butner's operations to implement CDC Guidelines, the BOP Action Plans, and the Attorney General's direction for the BOP to immediately review all inmates who have COVID-19 risk factors, as established by the CDC. FCC Butner officials have fully implemented these Plans and directives, and have even taken additional preventive steps in an attempt to mitigate the risks of the COVID-19 virus.

Specifically, in January 2020, BOP implemented an Action Plan consistent with World Health Organization ("WHO") and CDC recommendations, to combat the spread of COVID-19 in individual facilities. Strassel Decl., R.A. 088 ¶ 10. Over the course of the crisis, BOP has updated that Plan on several occasions. Currently, BOP has implemented seven phases of the Plan. Strassel Decl., R.A. 132–33 ¶ 73. As a result of this Plan, FCC Butner has initiated screening tools for inmates and staff. Strassel Decl., R.A. 133–35 ¶¶ 8, 13. FCC Butner also modified operations to promote social distancing between inmates and staff, including altering inmate movement, so that smaller groups went to dining hall, education, recreation, chapel, and other activities at any given time. Each institution across the Complex had modified

movement schedules to increase social distancing and limit contact between inmates. Strassel Decl., R.A. 135 ¶ 14. Subsequently, FCC Butner began satellite feeding all inmates in their assigned units or cells, and small group gatherings were halted for education, chapel, recreation, and all other instances where inmates were previously permitted to meet. FCC Butner began providing those services in a modified manner in the individual cells and housing units. Strassel Decl., R.A. 137 ¶ 22.

FCC Butner also began quarantining all incoming inmates and established quarantine and isolation units at each institution. Strassel Decl., R.A. 135–36 ¶¶ 14, 18. FCC Butner has continually educated both staff and inmates on the procedures set up as well as the prevention, contraction, and transmission of the virus. Strassel Decl., R.A. 136–37 ¶¶ 19, 20. All staff have been provided with Personal Protection Equipment ("PPE") which includes surgical masks and N-95 masks. Strassel Decl., R.A. 140 ¶ 32. All inmates have been provided with cloth masks which are to be worn at all times. Strassel Decl., R.A. 148 ¶ 56. FCC Butner is conducting COVID-19 testing in accordance with CDC guidelines. Harden Decl. R.A. 353 ¶ 5. FCC Butner is also isolating inmates who present with COVID-19-like symptoms; and quarantining asymptomatic inmates who have contracted the virus. Stock Decl., R.A. 104–05 ¶¶ 60–66.

During the course of the crisis, FCC Butner also implemented enhanced sanitation plans including daily cleaning and sanitizing all common areas; and providing inmates with disinfectant cleaners, and continuous access to soap, water, and sanitizers. Martinez Decl., R.A. 358, 360 ¶ 8–9, 14.

Additionally, in accordance with the Attorney General's direction to maximize BOP's authority to place inmates on home confinement FCC Butner staff have evaluated at least 932 inmates under the CARES Act. Clark Decl., R.A. 021 ¶ 32. At least 87 inmates have been referred for placement on home confinement, 42 inmates have been transferred to home confinement, and 9 inmates have been transferred to Residential Re-entry Centers ("RRC"). Clark Decl., R.A. 021 ¶ 32. An additional 24 inmates are pending transfer to home confinement or an RRC. Clark Decl., R.A. 021 ¶ 32. Twenty-four more inmates are currently awaiting a final decision from the BOP's Residential Reentry Management Office, regarding their referral for home confinement. Clark Decl., R.A. 022 ¶ 33. Since late March 2020, 56 inmates have been released from FCC Butner via compassionate release granted by the individual's sentencing court based upon various issues, including COVID-19. Clark Decl., R.A. 022 ¶ 34.

Aside from generally alleging "knowledge" of the health risks presented by COVID-19, Petitioners have altogether failed to allege any specific facts that even remotely suggest that Respondents—three very high-level BOP officials—have decided to ignore conditions at FCC Butner, specifically, such that they have a subjective intent to punish the inmates housed there. Nor can Petitioners make that showing. To the contrary, as the proceeding discussion demonstrates, the three high-level BOP and FCC Butner officials (and others) have affirmatively sought to mitigate COVID-19's risks by adhering to, and going beyond, BOP and CDC guidelines and

recommendations. Their concerted efforts to mitigate the spread of COVID-19 are neither wanton nor punitive.

It is simply indisputable that BOP is taking significant measures to address the spread of coronavirus among the inmate population at FCC Butner. While Petitioners believe more or different actions should be taken, a disagreement about the measures being taken does not rise to the level of deliberate indifference. Indeed, numerous other courts have already rejected similar claims. See, e.g., Wragg v. Ortiz, No. 1:20-cv-05496-RMB, 2020 WL 2745247 (D.N.J. May 27, 2020) (petitioners' claims are not cognizable under 28 U.S.C. § 2241, and in any event petitioners cannot show that respondents were deliberately indifferent to the inmates' rights); Nellson, v. Barnhart, ___ F.Supp.3d ___, 2020 WL 1890670, at *6 (D. Colo. Apr. 16, 2020) ("Assuming that the objective component is met, and that prison officials know of the risk of COVID-19, plaintiff has not demonstrated that defendants have disregarded that risk."); see also, Lucero-Gonzalez v. Kline, No. 2:20-cv-901, [D.E. 29] (D. Ariz. June 2, 2020) (finding very fact that defendant correctional complex has enacted policies to address the risks posed by COVID-19 supports that they have not been subjectively indifferent to the Plaintiffs); Swain v. Junior, 2020 WL 216137, at *4 (11th Cir. May 12, 2020) (Florida corrections officials likely to succeed on appeal because the plaintiffs offered little evidence to suggest that defendants were deliberately indifferent. Indeed, the evidence supports that the defendants are taking the risk of COVID-19 seriously.); Valentine v. Collier, 956 F.3d 797, 802 (5th Cir. Apr. 22, 2020) (staying injunction against Texas Department of Criminal Justice, after

finding no evidence that defendants subjectively believe the measures they are taking are inadequate, and finding to the contrary, the evidence shows that the prison has taken and continues to take measures informed by guidance from the CDC and medical professionals to abate and control the spread of the virus).

At its core, Petitioners' Eighth Amendment claim is really that FCC Butner has failed to ensure social distancing among the inmate population. That is the pervasive theme of Petitioners case, and, according to Petitioners, "reducing the Butner population is the only way to halt the serious ongoing and irreparable harm of COVID-19." [D.E. 25, at 11, 19]. However, as the Supreme Court has cautioned, the inability of a defendant to take an action that a plaintiff seeks will likely not constitute a reckless state of mind. Wragg, 2020 WL 2745247, *22 (citing Farmer, 511 U.S. at 835). In other words, "[t]hat physical distancing is not possible in a prison setting, as Petitioners urge, does not an Eighth Amendment claim make." Id.

Simply put, Petitioners fail to make out a deliberate indifference claim. Instead, the overwhelming evidence clearly shows that officials within the BOP and at FCC Butner are taking the coronavirus very seriously and have taken critical steps in an effort to mitigate or prevent the spread of COVID-19 at FCC Butner. Those efforts have been successful. Although the FCC Butner infection rate may be higher than that of the general population, the FCC Butner mortality rate of approximately 2.1%, is lower than the rates for the general population nationally and in North Carolina, which suggests that FCC Butner's efforts have been effective in managing infections and treating inmates. Accordingly, Petitioners fail to demonstrate any

likelihood of succeeding on the merits of their claim, and their motion should be denied. Because Petitioner cannot meet the first Winter requirement, the Court's inquiry stops here.

2. Petitioners Have Not Demonstrated Irreparable Harm in the Absence of Injunctive Relief.

Even assuming arguendo that Petitioners could state a claim or establish clear likelihood of success on the merits, Petitioners cannot satisfy any of the other Winter requirements.

The ultimate relief sought by Petitioners (i.e., release) is available to individual federal inmates through several federal statutes. First, pursuant to 18 U.S.C. § 3624(c)(2), BOP has the exclusive authority to place a prisoner in home confinement for the shorter of 10 percent of the term of imprisonment of that prisoner or 6 months. Under this statute, BOP shall, to the extent practicable, place prisoners with lower risk levels and lower needs on home confinement for the maximum amount of time permitted under section 3624(c)(2). Second, under 34 U.S.C. § 60541, BOP may release some or all eligible elderly offenders and eligible terminally ill offenders from BOP facilities to home detention, upon written request from either BOP staff, or an eligible elderly offender or eligible terminally ill offender. Third, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), Pub. L. 116–136, § 12003(b)(2) (2020), authorizes the Attorney General to expand the cohort of inmates who can be considered for home confinement upon his finding of emergency conditions which are materially affecting the function of BOP. On April 3, 2020, the Attorney General made that finding and authorized the Director of BOP to immediately maximize

appropriate transfers to home confinement of all appropriate inmates held at facilities where COVID-19 is materially affecting operations.[12] This includes FCC Butner.

Contrary to Petitioners' suggestions, the Attorney General did not usurp the judgment and authority of BOP officials and somehow order a release of federal inmates en masse and irrespective of their individual circumstances. The Attorney General instead authorized the Director of BOP to maximize home-confinement transfers when appropriate.

FCC Butner has done exactly that. After reviewing at least 932 inmates for eligibility under these authorities, FCC Butner has referred 87 inmates for transfers to home confinement. Forty-two inmates have already been transferred to home confinement, 9 inmates have transferred to RRCs, and 24 more are pending transfer to home confinement or an RRC. Clark Decl. R.A. 021¶ 32. Twenty-four additional inmates are currently awaiting final decision from the BOP's Residential Reentry Management office regarding their referral for home confinement. Clark Decl. R.A. 022 ¶ 33.

In addition, pursuant to the First Step Act, 18 U.S.C. § 3582(c)(1)(A), an inmate may seek a reduction in sentence, commonly referred to as compassionate release. Specifically, an inmate may make a motion to his sentencing court to reduce his term of imprisonment for "extraordinary or compelling circumstances" that could not

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[12] Attorney General Memorandum for Director of Bureau of Prisons, Re: Increasing use of Home Confinement at Institutions Most Affected by COVID-19 (Apr. 3, 2020), https://www.justice.gov/file/1266661/download (last visited June 1, 2020).

reasonably have been foreseen by the court at the time of sentencing. Id. Since the First Step Act went into effect, numerous inmates have filed compassionate release motions, and many cite COVID-19 as a basis for their motion. While there is an administrative exhaustion requirement, an inmate can file a motion for compassionate release after the lapse of 30 days from submitting a request to the warden of the facility where the inmate is incarcerated. 18 U.S.C. § 3582(c)(1). Some courts have also relaxed the administrative exhaustion requirement. Since March 20, 2020, sentencing courts have released 56 inmates from FCC Butner on compassionate release. Clark Decl. R.A. 022 ¶ 34.

Consequently, in the absence of a TRO or preliminary injunction, any at-risk inmate who is truly vulnerable—based on an appropriate individualized assessment in accordance with applicable statutes—to contracting COVID-19 already has statutorily-based opportunities available to him to present his individual case for a careful, fair, and individualized assessment by either the BOP or a district court. See Wragg, 2020 WL 2745247, *23. As such, Petitioners cannot show that they would suffer irreparable harm if a TRO or a preliminary injunction does not issue. See Yarborough v. United States, No. 5:10-CT-3083-D, 2010 WL 3835120, at *6–7 (E.D.N.C. Sept. 30, 2010) (denying prisoner's motion for injunctive review where he failed to make clear showing he will suffer irreparable injury in the absence of a preliminary injunction).

3. The Balance of Equities Strongly Favors the BOP.

The third prong of the preliminary injunction standard requires a petitioner to demonstrate that the balance of equities tips in his favor. See Winter, 555 U.S. at

20. Petitioners have failed to show that the balance of equities weighs in favor of a TRO or mandatory injunction essentially compelling prison administrators to release inmates from lawful prison sentences, or to otherwise "enlarge" their custody. The sweeping relief requested here would undermine BOP's systemic response to the COVID-19 pandemic; inappropriately insert the Judicial Branch into policy decisions that have been assigned to expert prison administrators; and require BOP to defy the CDC's guidance to restrict prisoner movements during the pandemic to avoid unnecessary risk of spreading the virus.

The Fourth Circuit has long recognized the "wide ranging deference" that the judiciary shows prison administrators with regard to matters within their discretion. See Wetzel, 635 F.2d at 288 (discussing the complexities of running a penal institution and the reluctance of federal courts to interfere in the problems of prison administration). "[T]he Supreme Court has repeatedly warned that 'it is difficult to imagine an activity in which a State has a stronger interest, or one that is more intricately bound up with state laws, regulations, and procedures, than the administration of its prisons.'" Valentine, 956 F.3d at 803 (quoting Woodford v. Ngo, 548 U.S. 81, 94 (2006) (other quotation omitted)).

Further, Petitioners fail to demonstrate that their requested relief would make any difference — that is, that it would reduce the rate of infection at FCC Butner or the mortality rate (which is already lower than that in the general population), or that Petitioners would be better off in other facilities or the community (where, presumably, Petitioners would at minimum have to work, shop for groceries and

other essentials, and otherwise interact with the general public whose commitment to social distancing, sanitation, and hygiene may fall well short of FCC Butner's efforts). Moreover, as is evidenced by FCC Butner's relatively low mortality rate, released inmates may not have access to the level of medical care that they can receive at the Butner medical complex. Indeed, Petitioners fail to provide any evidentiary support for their claim that "reducing the Butner population is the only way to halt the serious ongoing and irreparable harm of COVID-19." [D.E. 25, at 19].

Even so, BOP's enormous good-faith efforts at FCC Butner have resulted in the implementation of policies and procedures to mitigate the spread and impact of COVID-19 well before Petitioners filed their petition, and there has been no showing that a preliminary injunction is necessary for Respondents to continue the current safety measures. Thus, Petitioners' motion should be denied. See, e.g., Nellson, 2020 WL 1890670 (denying injunction because COVID-19 protocols were implemented by BOP).

Further, while FCC Butner, like all communities, has not been able to prevent the spread of COVID-19 altogether, the extensive measures have clearly been effective as the mortality rate at FCC Butner is actually lower than that of the United States and the State of North Carolina. Here, the balance of the equities favors Respondents, and Petitioners' request for a preliminary injunction should be denied.

4. The Public Interest Is Not Served by the Injunctive Relief Sought.

Finally, Petitioners have not shown that an injunction is in the public interest.

Petitioners assert that "[t]he public interest is served by preventing the continuing violation of Petitioners' and the Class's constitutional rights." [D.E. 25, at 31]. However, as discussed fully above, this assertion fails on its premise because Petitioners' constitutional rights are not being violated. Indeed, Petitioners' claim that Respondents have been deliberately indifferent to the safety and welfare of inmates at FCC Butner is wholly without merit.

Moreover, conspicuously absent in Petitioners' discussion of the public interest prong is any acknowledgement of the obvious and considerable risks associated with a large-scale transfer or release of federal inmates. The Supreme Court has recognized that, even in normal times, an order requiring the release or transfer of "prisoners in large numbers . . . is a matter of undoubted, grave concern." Brown v. Plata, 563 U.S. 493, 501 (2011). Such orders carry a high risk of jeopardizing public safety and inappropriately interjecting the Judicial Branch into difficult decisions regarding prison security and administration (such as how and where to house inmates with gang affiliations, sex-offender status, substance-abuse-treatment needs, extensive records of institutional misconduct, and other considerations), despite the deference that is owed "to experienced and expert prison administrators faced with the difficult and dangerous task of housing large numbers of convicted criminals." Id. at 511; see also Turner v. Safley, 482 U.S. 78, 84-85 (1987) ("Running a prison is an inordinately difficult undertaking that requires expertise, planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government and separation of powers

counsels for a policy of judicial restraint."). That is all the more so when prison administrators must address the impact of a pandemic affecting the nation at large, and must do so across the entire prison system.

However, aside from the significant risks to the safety and security of the communities where the inmates would be released, there would be substantial burdens placed on United States Probation Offices around the country, which would be responsible for supervision of released inmates when the COVID-19 crisis is significantly impacting their work as well. Additionally, it is questionable whether immediate release of federal inmates, many of whom are serving lengthy prison sentences, is in their best interests. When inmates are released, they need to find work to pay for basic necessities and a place to live. Immediate re-entry into society without the typical release planning conducted by BOP for successful re-entry would not be in the best interest of many inmates or society at large. In sum, the public interest favors Respondents.

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CONCLUSION

For all of the foregoing reasons, the Court should deny Petitioners' motion for a TRO and preliminary injunction.

Respectfully submitted, this 3rd day of June, 2020.

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CERTIFICATE OF SERVICE

This is to certify that I have this 3rd day of June, 2020, served a copy of the foregoing upon Petitioners' counsel of record by electronically filing the same with the Clerk of Court via the CM/ECF Document Filing System.

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Exhibit 2

06/03/2020 - The BOP has **135,258** federal inmates in BOP-managed institutions and **12,589** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **1956 federal inmates** and **176 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3689** inmates and **450** staff have recovered. There have been **72** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	2	0	0	1	8	Butner	NC
Butner Low FCI	367	6	6	1	45	6	Butner	NC
Butner Medium I FCI	30	4	9	0	190	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC
Otero County Prison Facility (RRC)	2	0	0	0	0	0	Charparral	NM

Exhibit 3

06/10/2020 - The BOP has **134,112** federal inmates in BOP-managed institutions and **12,870** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **2134 federal inmates** and **190 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3972** inmates and **456** staff have recovered. There have been **79** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

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(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	3	0	0	1	8	Butner	NC
Butner Low FCI	642	9	9	1	45	6	Butner	NC
Butner Medium I FCI	28	5	9	0	189	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC

Exhibit 4

07/06/2020 - The BOP has **130,770** federal inmates in BOP-managed institutions and **13,455** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **1,992 federal inmates** and **160 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **5,137** inmates and **603** staff have recovered. There have been **94** federal inmate deaths and **1** BOP staff member death attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

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The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

Butner FMC	5	3	0	0	1	10	Butner	NC
Butner Low FCI	556	4	16	1	116	12	Butner	NC
Butner Medium I FCI	6	1	9	0	198	29	Butner	NC
Butner Medium II FCI	2	1	0	0	1	0	Butner	NC

Exhibit 5

U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
April 12, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Thursday, March 26, 2020, inmate Charles Richard Rootes, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. While at the local hospital, Mr. Rootes tested positive for COVID-19. On Friday, March 27, 2020, his condition declined and he was placed on a ventilator. On Saturday, April 11, 2020, Mr. Rootes, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Rootes was an 81 year-old male who was sentenced in the Eastern District of Tennessee to a 99-year sentence for Kidnapping, National Motor Vehicle Theft Act, and Rape. He had been in custody at FCI Butner I since October 22, 2019.

FCI Butner I is a Medium security facility that currently houses 641 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
April 13, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Sunday, March 29, 2020, inmate Gary Edward Nixon, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. While at the local hospital, Mr. Nixon tested positive for COVID-19. On Thursday, April 2, 2020, his condition declined and he was placed on a ventilator. On Sunday, April 12, 2020, Mr. Nixon, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Nixon was a 57 year-old male who was sentenced in the Eastern District of North Carolina to a 155-month Supervised Release Violation Term with new criminal conduct of Conspiracy to Distribute With Intent to Distribute More Than 5 Grams of Cocaine Base (Crack). The original offense conduct was Conspiracy to Possess With Intent to Distribute 100 Grams or More of Heroin and Possession With Intent to Distribute a Quantity of Heroin. He had been in custody at FCI Butner I since May 21, 2019.

FCI Butner I is a Medium security facility that currently houses 641 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
April 13, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Monday, March 30, 2020, inmate John Doe, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. While at the local hospital, Mr. Doe tested positive for COVID-19. On Monday, March 30, 2020, his condition declined and he was placed on a ventilator. On Monday, April 13, 2020, Mr. Doe, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Doe was a 46 year-old male who was sentenced in the Southern District of New York to a 57-month term for Making Materially False Statements. He had been in custody at FCI Butner I since October 22, 2019.

FCI Butner I is a Medium security facility that currently houses 641 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
April 13, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Monday, April 6, 2020, inmate Andre Williams was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina, and transported to a local hospital for further treatment and evaluation of pre-existing medical conditions. Mr. Williams previously tested positive for COVID-19 on April 5, 2020. On Sunday, April 12, 2020, Mr. Williams, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease was pronounced dead by hospital staff.

Mr. Williams was a 78 year-old male who was sentenced in the Northern District of Florida to a term of Life for Armed Bank Robbery and Possession of a Firearm by a Convicted Felon. He had been in custody at FCI Butner I since November 20, 2015.

FCI Butner I is a Medium security facility that currently houses 641 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
April 17, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On April 6, 2020, inmate Fabian Tinsley, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. While at the local hospital, Mr. Tinsley tested positive for COVID-19. On Monday, April 6, 2020, his condition declined and he was placed on a ventilator. On Thursday, April 16, 2020, Mr. Tinsley, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Tinsley was a 67 year-old male who was sentenced in the District of Columbia, Superior Court to a 23 year term for Kidnapping While Armed and Aggravated Assault While Armed. He had been in custody at FCI Butner I since November 15, 2018.

FCI Butner I is a Medium security facility that currently houses 652 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 7, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Tuesday, April 7, 2020, inmate William E. Miller went into respiratory failure at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. Mr. Miller tested positive for COVID-19 on April 5, 2020. On Wednesday, April 8, 2020, his condition declined and he was placed on a ventilator. On Wednesday, May 6, 2020, Mr. Miller, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Miller was a 58 year-old male who was sentenced in the Western District of New York to a 14-year sentence for Coercion and Enticement of a Minor. He had been in custody at FCI Butner I since May 20, 2019.

FCI Butner I is a Medium security facility that currently houses 671 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
April 28, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Wednesday, April 15, 2020, inmate William Walker Minto went into respiratory failure at the Federal Correctional Institution (FCI) Butner I adjacent minimum security satellite camp, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. While at the local hospital, Mr. Minto tested positive for COVID-19. On Tuesday, April 21, 2020, his condition declined and he was placed on a ventilator. On Tuesday, April 28, 2020, Mr. Minto, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Minto was a 73 year-old male who was sentenced in the Eastern District of Tennessee to a 240-month term for Conspiracy to Distribute and Possess With Intent to Distribute 1,000 Kilograms or More of Marijuana. He had been in custody at the FCI Butner I adjacent minimum security satellite camp since October 11, 2019.

The adjacent minimum security satellite camp at FCI Butner I currently houses 268 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 15, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I

WASHINGTON, D.C.: On Tuesday, April 21, 2020, inmate Jerry Lynn Dempsey, went into respiratory failure at the Federal Correctional Institution (FCI) Butner I, in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. Mr. Dempsey tested positive for COVID-19 on April 22, 2020. On Friday, April 24, 2020, his condition declined and he was placed on a ventilator. On Friday, May 15, 2020, Mr. Dempsey, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Dempsey was a 59 year-old male who was sentenced in the Southern District of California to a 130-month sentence for Conspiracy to Distribute Methamphetamine. He had been in custody at FCI Butner I since November 13, 2014.

FCI Butner I is a Medium security facility that currently houses 658 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 25, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Friday, May 22, 2020, inmate Eric Spiwak, went into respiratory failure at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. Mr. Spiwak tested positive for COVID-19 on May 22, 2020. On Monday, May 25, 2020, Mr. Spiwak, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Spiwak was a 73-year-old male who was sentenced in the Eastern District of North Carolina to a 188-month sentence for Possession of Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since June 22, 2009.

FCI Butner is a Low security facility that currently houses 1,201 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 26, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner I's Satellite Camp

WASHINGTON, D.C.: On Monday, April 23, 2020, Isaac Lamar Byers, an inmate at the Federal Correctional Institution (FCI) Butner I's Satellite Prison Camp (SPC), in Butner, North Carolina, tested positive for COVID-19. On April 27, 2020, Mr. Byers went into respiratory failure. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. On Sunday, May 10, 2020, his condition declined and he was placed on a ventilator. On Tuesday, May 26, 2020, Mr. Byers, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Byers was a 52-year-old male who was sentenced in the Western District of North Carolina to a 151-month sentence for Possession With Intent to Distribute at Least 28 Grams of Cocaine Base. He had been in custody at SPC Butner since November 5, 2019.

SPC Butner is a minimum security facility adjacent to FCI Butner I and currently houses 211 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 28, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, May 18, 2020, inmate Dongfan Greg Chung, went into respiratory failure at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. Mr. Chung tested positive for COVID-19 on May 18, 2020. On Thursday, May 28, 2020, Mr. Chung, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Chung was an 84-year-old male who was sentenced in the Central District of California to a 188-month sentence for Economic Espionage, Acting as an Agent of Foreign Government Without Prior Notification to the Attorney General, and False Statements. He had been in custody at the Federal Correctional Complex (FCC) Butner since June 28, 2012.

FCI Butner is a Low security facility that currently houses 1,197 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 29, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Sunday, May 10, 2020, inmate Bernardo Luis Olarta-Loaiza, tested positive for COVID-19 at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina and was immediately placed in isolation. On Thursday, May 21, 2020, Mr. Olarta-Loaiza, was evaluated by institutional medical staff for issues with his Automatic Implantable Cardiac Defibrillator (AICD). He was transported to a local hospital for treatment and further evaluation. On Thursday, May 28, 2020, Mr. Olarta-Loaiza, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Olarta-Loaiza was a 63-year-old male who was sentenced in the Middle District of Florida to a 144-month sentence for Maritime Drug and Conspiracy to Possess With Intent to Distribute Five Kilograms or More of Cocaine While on Board a Vessel Subject to the Jurisdiction of the United States. He had been in custody at the Federal Correctional Complex (FCC) Butner since May 22, 2018.

FCI Butner is a Low security facility that currently houses 1,197 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 31, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, May 25, 2020, inmate David Grant tested positive for COVID-19. On Tuesday, May 26, 2020, he went into respiratory failure at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. On Sunday, May 31, 2020, Mr. Grant, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19, was pronounced dead by hospital staff.

Mr. Grant was a 63-year-old male who was sentenced in the District of South Carolina to a 180-month sentence for Firearms, Gun Control, and Felon in Possession of a Firearm, Ammunition, and Possession With Intent to Distribute Heroin. He had been in custody at the Federal Correctional Complex (FCC) Butner since May 7, 2019.

FCI Butner is a Low security facility that currently houses 1,192 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
May 31, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, May 25, 2020, inmate Steve Arthur Robinette went into respiratory failure at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina. He was evaluated by institutional medical staff and transported to a local hospital for further treatment and evaluation. Mr. Robinette tested positive for COVID-19 on May 25, 2020. On Saturday, May 30, 2020, Mr. Robinette, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19, was pronounced dead by hospital staff.

Mr. Steve Arthur Robinette was a 79-year-old male who was sentenced in the Middle District of North Carolina to a 216-month sentence for Coercing a Minor to Engage in Sexually Explicit Conduct for the Purpose of Producing Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since September 11, 2012.

FCI Butner is a Low security facility that currently houses 1,192 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 2, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Sunday, May 10, 2020, inmate Juan Ledoux-Moreno, was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina, for issues relating to bacterial sepsis due to pelvic osteomyelitis. He was transported to a local hospital for treatment and further evaluation. Mr. Ledoux-Moreno tested positive for COVID-19 on Friday, May 19, 2020. On Monday, June 1, 2020, Mr. Ledoux-Moreno, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Ledoux-Moreno was a 74-year-old male who was sentenced in the District of Puerto Rico to a 12-month and 1-day sentence for Firearms, Gun Control, Aiding and Abetting Prohibited Person in Possession of a Firearm, and Aiding and Abetting Possession With Intent to Distribute Controlled Substance. He had been in custody at the Federal Correctional Complex (FCC) Butner since August 20, 2019.

FCI Butner (Low) is a Low security facility that currently houses 1,170 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 3, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Wednesday, May 20, 2020, inmate Bobby Lee Medford was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina for issues relating to hypoxia. He was transported to a local hospital for treatment and further evaluation. While at the outside hospital Mr. Medford tested positive for COVID-19. On Thursday, May 21, 2020, his condition declined and he was placed on a ventilator. On Wednesday, June 3, 2020, Mr. Medford, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Medford was a 74-year-old male who was sentenced in the Western District of North Carolina to a 180-month sentence for Racketeering, Violence, Conspiracy to Commit Extortion, Conspiracy to Commit Mail Fraud, Mail Fraud, Conspiracy to Commit Money Laundering, Obstruction of State and Local Law Enforcement, and Conspiracy to Conduct an Illegal Gambling Business. He had been in custody at the Federal Correctional Complex (FCC) Butner since December 9, 2008.

FCI Butner (Low) is a Low security facility that currently houses 1,184 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 4, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Thursday, May 21, 2020, inmate Andrew Charles Markovci was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina. He tested positive for COVID-19 and was immediately placed in isolation. On Thursday, May 28, 2020, Mr. Markovci was transported to a local hospital for treatment and further evaluation for issues relating to shortness of breath and hypoxia. On Thursday, June 4, 2020, Mr. Markovci, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Markovci was a 56-year-old male who was sentenced in the District of South Carolina to a 144-month sentence for Bank Robbery and Armed Bank Robbery, Unarmed Bank Robbery, Firearms Laws, and Possession of a Firearm in Furtherance of a Crime of Violence. He had been in custody at the Federal Correctional Complex (FCC) Butner since July 30, 2019.

FCI Butner (Low) is a Low security facility that currently houses 1,181 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 6, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Friday, May 22, 2020, inmate John A. Brust was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina. He tested positive for COVID-19 and was immediately placed in isolation. On Monday, May 25, 2020, Mr. Brust was transported to a local hospital for treatment and further evaluation for issues relating to pulmonary infection and hypoxia. He was placed on a ventilator that same day. On Friday, June 5, 2020, Mr. Brust, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Brust was a 77-year-old male who was sentenced in the Eastern District of Michigan to a 120-month sentence for Obscene Matter, Receipt of Child Pornography, and Possession of Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since December 17, 2014.

FCI Butner (Low) is a Low security facility that currently houses 1,181 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 14, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Wednesday, May 29, 2020, inmate John Marrone was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina for issues relating to shortness of breath, hypoxia and possible pneumonia. He was transported to a local hospital for treatment and further evaluation. On Thursday, May 30, 2020, Mr. Marrone tested positive for COVID-19. On Saturday, June 13, 2020, Mr. Marrone, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Marrone was an 85-year-old male who was sentenced in the Middle District of Florida to a 37-month sentence for Firearms, Gun Control, Felon in Possession of a Firearm and Ammunition, Racketeering, RICO Conspiracy, Illegal Gambling Business, and Use of Communication Facility in Aid of Racketeering. He had been in custody at the Federal Correctional Complex (FCC) Butner since January 30, 2018.

FCI Butner (Low) is a Low security facility that currently houses 1,157 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 14, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On June 8, 2020, Mark E. Hebert tested positive for COVID-19. On Friday, June 12, 2020, Mr. Hebert was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina for issues relating to ventricular tachycardia. He was transported to a local hospital for treatment and further evaluation. On Saturday, June 13, 2020, Mr. Hebert, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Hebert was a 61-year-old male who was sentenced in the Northern District of Illinois to a 151-month sentence for Obscene Material and Possession of Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since June 5, 2014.

FCI Butner is a Low security facility that currently houses 1,157 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 20, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, June 1, 2020, Wayne Delvin Littlecrow tested positive for COVID-19. On Wednesday, June 3, 2020, Mr. Littlecrow was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low) in Butner, North Carolina for issues related to Acute Respiratory Distress Syndrome (ARDS) due to COVID-19 pneumonia. He was transported to a local hospital for treatment and further evaluation. On Saturday, June 6, 2020, his condition declined and he was placed on a ventilator. On Saturday, June 20, 2020, Mr. Littlecrow, who had long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Littlecrow was a 55-year-old male who was sentenced in the District of Montana to a 140-month sentence for Sexual Abuse and Abusive Sexual Contact. He had been in custody at the Federal Correctional Complex (FCC) Butner since September 22, 2015.

FCI Butner is a Low security facility that currently houses 1,166 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 24, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Wednesday, May 27, 2020, Joe Tapia, III, tested positive for COVID-19. He was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina, for issues relating to shortness of breath, hypoxia, and fever. He was transported to a local hospital for treatment and further evaluation. On Friday, May 29, 2020, his condition declined and he was placed on a ventilator. On Tuesday, June 23, 2020, Mr. Tapia, who had long-term, pre-existing medical conditions, which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Tapia was a 55-year-old male who was sentenced in the Western District of Texas to a 360-month sentence for Soliciting Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since April 30, 2015.

FCI Butner is a Low security facility that currently houses 1,158 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
June 24, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Tuesday, June 2, 2020, Norman F. Grimm, Jr., tested positive for COVID-19. On Thursday, June 4, 2020, he was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina, for issues relating to worsening COVID-19 symptoms with hypoxia and possible pneumonia. He was transported the same day to a local hospital for treatment and further evaluation. On Sunday, June 7, 2020, his condition declined and he was placed on a ventilator. On Wednesday, June 24, 2020, Mr. Grimm, who had long-term, pre-existing medical conditions, which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Grimm was a 66-year-old male who was sentenced in the Western District of New York to a 300-month sentence for Obscene Matter and Production of Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since May 14, 2008.

FCI Butner is a Low security facility that currently houses 1,157 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
July 3, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, May 25, 2020, John Dailey, was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina, for issues relating to syncope and shortness of breath. He was transported to a local hospital for treatment and further evaluation where he tested positive for COVID-19. On Tuesday, May 26, 2020, Mr. Dailey's condition declined and he was placed on a ventilator. On Friday, July 3, 2020, Mr. Dailey, who had long-term, pre-existing medical conditions, which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Dailey was a 62-year-old male who was sentenced in the Eastern District of Missouri to a 27-month sentence for Fraud, Health Care Fraud, and False Statements Relating to Health Care Matters. He had been in custody at the Federal Correctional Complex (FCC) Butner since November 5, 2019.

FCI Butner is a Low security facility that currently houses 1,133 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
July 5, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, June 1, 2020, Jack Edward Talledo, tested positive for COVID-19. On Friday, June 19, 2020, he was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low), in Butner, North Carolina, for issues relating to progressive shortness of breath and fatigue. He was transported to a local hospital for treatment and further evaluation. On Saturday, July 4, 2020, his condition declined and he was placed on a ventilator. On Sunday, July 5, 2020, Mr. Talledo, who had long-term, pre-existing medical conditions, which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Talledo was a 61-year-old male who was sentenced in the Southern District of Florida to a 60-month sentence for Obscene Matter, and Receipt of Child Pornography. He had been in custody at the Federal Correctional Complex (FCC) Butner since February 11, 2020.

FCI Butner is a Low security facility that currently houses 1,130 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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U.S. Department of Justice
Federal Bureau of Prisons

FOR IMMEDIATE RELEASE
September 17, 2020

Contact: Office of Public Affairs
202-514-6551

Inmate Death at FCI Butner (Low)

WASHINGTON, D.C.: On Monday, June 1, 2020, inmate Ricky Lynn Miller tested positive for COVID-19. On Monday, July 6, 2020, Mr. Miller tested negative for COVID-19. Mr. Miller was evaluated by institutional medical staff at the Federal Correctional Institution (FCI) Butner (Low) in Butner, North Carolina on Wednesday, September 9, 2020 for issues relating to shortness of breath and leg edema. He was transferred to a local hospital for treatment and further evaluation. On Wednesday, September 16, 2020, Mr. Miller tested positive for COVID-19 at the outside hospital. On Thursday, September 17, 2020, Mr. Miller, who had long-term, pre-existing medical conditions, which the CDC lists as risk factors for developing more severe COVID-19 disease, was pronounced dead by hospital staff.

Mr. Miller was a 62-year-old male who was sentenced in the Northern District of Texas to a 210-month sentence for Receipt of a Visual Depiction of a Minor Engaging in Sexually Explicit Conduct. He had been in custody at the Federal Correctional Complex (FCC) Butner since July 11, 2018.

FCI Butner is a Low security facility that currently houses 1,050 male offenders.

The Bureau of Prisons will continue to provide daily updates and information on actions related to COVID-19 at www.bop.gov/coronavirus/index.jsp.

Additional information about the Bureau of Prisons can be found at www.bop.gov.

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Exhibit 6

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

How COVID-19 Spreads

COVID-19 is thought to spread mainly through close contact from person-to-person. Some people without symptoms may be able to spread the virus. We are still learning about how the virus spreads and the severity of illness it causes.

Person-to-person spread

The virus is thought to spread mainly from person-to-person.

- Between people who are in close contact with one another (within about 6 feet).
- Through respiratory droplets produced when an infected person coughs, sneezes, or talks.
- These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- COVID-19 may be spread by people who are not showing symptoms.

The virus spreads easily between people

How easily a virus spreads from person-to-person can vary. Some viruses are highly contagious, like measles, while other viruses do not spread as easily. Another factor is whether the spread is sustained, which means it goes from person-to-person without stopping.

The virus that causes COVID-19 is spreading very easily and sustainably between people. Information from the ongoing COVID-19 pandemic suggest that this virus is spreading more efficiently than influenza, but not as efficiently as measles, which is highly contagious.

The virus does not spread easily in other ways

COVID-19 is a new disease and we are still learning about how it spreads. It may be possible for COVID-19 to spread in other ways, but these are not thought to be the main ways the virus spreads.

- **From touching surfaces or objects**. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes. This is not thought to be the main way the virus spreads, but we are still learning more about this virus.
- **From animals to people**. At this time, the risk of COVID-19 spreading from animals to people is considered to be low. Learn about COVID-19 and pets and other animals.
- **From people to animals.** It appears that the virus that causes COVID-19 can spread from people to animals in some situations. CDC is aware of a small number of pets worldwide, including cats and dogs, reported to be infected with the virus that causes COVID-19, mostly after close contact with people with COVID-19. Learn what you should do if you have pets.

Protect yourself and others

The best way to prevent illness is to avoid being exposed to this virus. You can take steps to slow the spread.

- Maintain good social distance (about 6 feet). This is very important in preventing the spread of COVID-19.
- Wash your hands often with soap and water. If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.
- Routinely clean and disinfect frequently touched surfaces.

Learn more about what you can do to protect yourself and others.

More Information

ASL Video Series: How does COVID-19 Spread?

Page last reviewed: April 13, 2020

Exhibit 7

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Assessing Risk Factors for Severe COVID-19 Illness

Updated April 23, 2020

COVID-19 can affect anyone, and the disease can cause symptoms ranging from mild to very severe. For some other illnesses caused by respiratory viruses (such as influenza), some people may be more likely to have severe illness than others because they have characteristics or medical conditions that increase their risk. These are commonly called "risk factors." Examples include being 65 years of age or older or having serious underlying medical conditions.

CDC is conducting disease surveillance and field investigations to better understand why some people are more likely to develop severe COVID-19 illness. This is one of the top priorities in CDC's strategy to combat COVID-19. What we learn from these efforts will provide vital information to help CDC scientists and other public health officials make decisions to protect our most vulnerable populations.

CDC carries out these activities in collaboration with state, local, and territorial health departments; public health, commercial, and clinical laboratories; vital statistics offices; health care providers; emergency departments; and academic and private sector partners.

Why Risk Factors Matter

People with risk factors may be more likely to need hospitalization or intensive care if they have COVID-19, or they may be more likely to die of the infection.

It is important to learn about risk factors for severe COVID-19 illness because it can help you:

- Take extra precautions to avoid exposure to the virus that causes COVID-19.
- Better understand how a medical condition could affect your own health if you get sick with COVID-19.
- Anticipate medical treatment that you might need if you get sick.
- Reduce your risk for severe COVID-19 illness by managing any conditions you have that are risk factors.

How We Learn about Risk Factors for Severe Disease

Because COVID-19 is a new disease, more work is needed to better understand the risk factors for severe illness or complications. Potential risk factors that have been identified to date include:

- Age
- Race/ethnicity
- Gender
- Some medical conditions
- Use of certain medications
- Poverty and crowding
- Certain occupations
- Pregnancy

Additional research will help us confirm if these are risk factors for severe COVID-19 illness and determine if there are other factors that increase a person's risk.

Investigations

CDC is working to identify risk factors for severe COVID-19 illness through a variety of investigations, some of which are described below. These investigations include adults and children and examine severe illness resulting in hospitalizations and intensive care unit (ICU) admissions. As we continue to investigate risk factors for severe illness, we will update this webpage with new findings and new investigations.

Investigation of People with COVID-19 Who Have Symptoms (Symptomatic) vs. People with COVID-19 Who Do Not Have Symptoms (Asymptomatic or Pre-symptomatic)*

Assessment	Compare characteristics of people with COVID-19 who have symptoms with characteristics of people with COVID-19 who do not have symptoms.
What We Will Learn	How people with COVID-19 who have symptoms are different from those with COVID-19 who do not have symptoms. How people with COVID-19 who feel more sick (for example, sick enough to need to stay in bed or to seek medical care) are different from those with COVID-19 who feel less sick.

*Investigations used include: Ongoing household investigations

Investigation of People Hospitalized with COVID-19 vs. Other Groups*

Assessment	Compare characteristics of people with COVID-19 who are hospitalized with characteristics of: • People who have COVID-19 but do not need hospitalization, and • People who seek medical care for respiratory illness but are COVID-19-negative, and • The general U.S. population.
What We Will Learn	Characteristics associated with illness that is severe enough to require hospitalization among people with COVID-19.

*Surveillance networks and investigations used include: COVID-NET; The U.S. Flu Vaccine Effectiveness (VE) network, New Vaccine Surveillance Network (NVSN); Hospitalized Adult Influenza Vaccine Effectiveness Network (HAIVEN); and ongoing field investigations

Investigation of People with COVID-19 Requiring ICU Care vs. Other Groups*

Assessment	Compare characteristics of people with COVID-19 who are hospitalized in ICUs with characteristics of: • People hospitalized with COVID-19 who do not require ICU care, and • People with COVID-19 who are not hospitalized, and • The general U.S. population.
What We Will Learn	How people with COVID-19 who are sick enough to need ICU care are different from less sick people with COVID-19 who are hospitalized, people with COVID-19 who are not hospitalized, and the U.S. general population.

*Networks used include: Influenza Vaccine effectiveness in critically ill patients (IVY)

Resources

People Who Are at Higher Risk for Severe Illness

Frequently Asked Questions for People at Higher Risk

Clinical Questions about COVID-19: Questions and Answers

Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020

Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020

COVID-19 Cases, Data, and Surveillance

Page last reviewed: April 23, 2020

Exhibit 8

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Incidence, clinical characteristics and prognostic factor of patients with COVID-19: a systematic review and meta-analysis

Running title: Predictors of clinical prognosis of COVID-19

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Abstract

Background: Recently, Coronavirus Disease 2019 (COVID-19) outbreak started in Wuhan, China. Although the clinical features of COVID-19 have been reported previously, data regarding the risk factors associated with the clinical outcomes are lacking.

Objectives: To summary and analyze the clinical characteristics and identify the predictors of disease severity and mortality.

Methods: The PubMed, Web of Science Core Collection, Embase, Cochrane and MedRxiv databases were searched through February 25, 2020. Meta-analysis of Observational Studies in Epidemiology (MOOSE) recommendations were followed. We extracted and pooled data using random-e□ects meta-analysis to summary the clinical feature of the confirmed COVID-19 patients, and further identify risk factors for disease severity and death. Heterogeneity was evaluated using the I^2 method and explained with subgroup analysis and meta-regression.

Results: A total of 30 studies including 53000 patients with COVID-19 were included in this study, the mean age was 49.8 years (95% CI, 47.5-52.2 yrs) and 55.5% were male. The pooled incidence of severity and mortality were 20.2% (95% CI, 15.1-25.2%) and 3.1% (95% CI, 1.9-4.2%), respectively. The predictor for disease severity included old age (≥ 50 yrs, odds ratio [OR] = 2.61; 95% CI, 2.29-2.98), male (OR =1.348, 95% CI, 1.195-1.521), smoking (OR =1.734, 95% CI,

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1.146-2.626) and any comorbidity (OR = 2.635, 95% CI, 2.098-3.309), especially chronic kidney disease (CKD, OR = 6.017; 95% CI, 2.192-16.514), chronic obstructive pulmonary disease (COPD, OR = 5.323; 95% CI, 2.613-10.847) and cerebrovascular disease (OR = 3.219; 95% CI, 1.486-6.972). In terms of laboratory results, increased lactate dehydrogenase (LDH), C-reactive protein (CRP) and D-dimer and decreased blood platelet and lymphocytes count were highly associated with severe COVID-19 (all for $P < 0.001$). Meanwhile, old age (≥ 60 yrs, RR = 9.45; 95% CI, 8.09-11.04), followed by cardiovascular disease (RR = 6.75; 95% CI, 5.40-8.43) hypertension (RR = 4.48; 95% CI, 3.69-5.45) and diabetes (RR = 4.43; 95% CI, 3.49-5.61) were found to be independent prognostic factors for the COVID-19 related death.

Conclusions: To our knowledge, this is the first evidence-based medicine research to explore the risk factors of prognosis in patients with COVID-19, which is helpful to identify early-stage patients with poor prognosis and adapt effective treatment.

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Introduction

Coronaviruses are a family of viruses that widely exist in nature and can infect both humans and animals[1]. At present, there are six recognized types of coronavirus that can cause infection in humans, leading to pneumonia, injury in the digestive tracts, kidney failure and even death. Two of the coronavirus family have been reported to cause deadly infections including Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS)[2,3]. Recently, pneumonia caused by a novel coronavirus (SARS-CoV-2), also termed as Coronavirus Disease 2019 (COVID-19) was first reported in China's Wuhan City, Hubei Province in December 2019 and the disease spread rapidly in China and even around the world[4].

Compared with two other types of coronaviruses, the present new coronavirus is spreading far more quickly and has higher contagiousness[5]. As of March 17, 2020, a total of 187, 361 COVID-19 cases in 151 countries have been confirmed, which almost 22.2 times the number of people infected by the SARS in 2003. Although COVID-19 has a relatively low mortality rate, it can be highly deadly and lethal, especially in high-risk patients[6]. The reported incidence of COVID-19 accompanied with underlying comorbidities in the literature were up to 26.0%, and most of them (65.3%) had cardiovascular and cerebrovascular diseases. Patients infected with SARS-CoV-2 who already have

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underlying diseases were at increased the risk of severe illnesses and death[7].

And more worrying, there is no vaccine and specific treatment available for this novel coronavirus as of now[8]. Therefore, it is necessary to identify potential risk factors for predicting the disease progression and severity for COVID-19. Meanwhile, early monitoring the predictive indicators may also increase the efficiency of treatment and improve the prognosis of COVID-19. Thus, the aim of our study is to perform a systematic review and meta-analysis of clinical characteristics to explore the risk factors of COVID-19-associated severe illness and death, and first time to compare the differences of those predictors between COVID-19, SARS and MERS.

Methods

Our study was performed according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement and Meta-analysis of Observational Studies in Epidemiology (MOOSE) reporting guidelines[9,10]. In eMethods in the Supplement, we describe the detailed definitions of COVID-19 laboratory confirmed cases and severe illness.

Search strategy and study selection

PubMed, Embase, Cochrane, the Web of Science Core Collection

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(Clarivate Analytics), and MedRxiv databases were used for searching articles published until February 25, 2020 using the following keywords: “coronavirus”, “nCoV”, “HCoV”, “Wuhan”, “2019” “SARS-CoV-2”, “COVID*”, “NCP*”, “China”, “clinical”, “outcome”, “sever*”, “death”, “fatali*” and “mortalit*” alone and in combination. Detailed search strategies were presented in eMethods in the Supplement. After removing duplicates, three reviewers (C.M. & J.G. & P. H) were assigned to independently screen the titles and abstracts and then examine the full text, and any questions with conflict were resolved by the senior authors (P. L. and X. Z.). Inclusion criteria were as follows: (1) any study that gives information about the clinical characteristics or demographic or outcome of the infectious disease, (2) restriction language to English only, and (3) studies that allowed us to stratify the risk of severe or fatal COVID-19 by demographic or medical condition were preferred. Exclusion criteria were (1) data that could not be reliably extracted, (2) editorials, comments, expert opinions, case reports or articles with number of patients ≤ 10, (3) studies with special populations (eg, only focused on family clusters or severe or death cases).

Data extraction and quality assessment

Two authors (C.M. and J.G.) independently extracted the data using a predesigned spreadsheet, including author’s name, publication year, study period, geographical region, study design, epidemiological information,

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sample size, baseline and clinical characteristics, laboratory results, severity and outcomes. For the study cohort divided according to disease severity, data of all patients, severe and non-severe patients were collected, respectively. For further meta-analysis, categorical variables like sex, comorbidities, symptoms or endpoint events, number were dealt with as dichotomous variables, while for continuous variables such as age, laboratory results or timelines of illness, different types of measurement including median (range) or median (IQR, interquartile range) were transferred to the form of mean (SD, standard deviation)[10].

Along with data extraction, study quality was assessed using the Quality Assessment Forms recommended by Agency for Healthcare Research and Quality (AHRQ) for cross-sectional study (eMethods in supplement)[11]. Conflicts on the assessments were resolved either by consensus or by the adjudicator (P.L. and X. Z.).

Data analysis

Firstly, to obtain summary e□ect estimate for each clinical variable, including case severity rate (CSR), case fatality rate (CFR), male proportion, mean age, pooled value of lymphocyte count and timeline of COVID-19 confirmed patients, random e□ects meta-analysis was used because high variability between studies was expected. Heterogeneity was evaluated using the I^2 statistic. Cut-off values of 25%, 50%, and 75% indicated low, moderate, and high heterogeneity, respectively[12]. We

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visualized the results with forest plots. Secondly, to identify the risk factors for severity, pooled odds ratios (ORs) with 95% CIs were estimated with the dichotomous method, and mean difference (MD) with 95% CIs between severe and non-severe cases were calculated with continuous method, Fixed effects model was used when $I^2 < 50\%$, and random effects models otherwise. Regarding the COVID-19 related death, we conducted logistic regression model to calculate relative risks (RR) with 95% CIs using the data of Chinese Center for Disease Control, which included 44672 laboratory confirmed patients. Thirdly, to explore potential sources of heterogeneity, we conducted subgroup analysis and random-e ects meta-regression. Variables significant in univariable meta-regression ($P < 0.05$) were included in multivariable meta-regression. Next, sensitivity analyses were performed by systematically removing each study in turn to explore its effect on outcome[13].

Finally, to investigate the risk of publication bias, we applied the Begger test, Egger test and the test used by Peters et al and visually inspected the funnel plots[14]. All analyses were performed using Review Manager (version5.3), Stata (version 15) and R (version 3.5.3), RStudio (version 1.2.1335) and Comprehensive Meta-analysis (version 3.3).

Results

Literature Search and Study Characteristics

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We identified 854 studies, of which 30 were eligible for our analysis including 53,000 COVID-19 confirmed patients (Figure *1*)[1,7,15-38]. All of them were retrospective, observational studies (19 single-center and 11 multi-center studies), which were performed between December 2019 and February 19, 2020. The majority of studies were conducted in Wuhan (13, 43.3%) and other cities in China (11, 36.7%), 2 from nationwide and 3 from other countries including United States, Australia and Korea. To avoid any overlap of cases, the nationwide study of Chinese Centers for Disease Control (CDC) including 44672 confirmed cases was only used for identifying COVID-19 related death risk factors. The male to female sex ratio was 1.25, with an overall average age of 49.8 years (95% CI, 47.5-52.2). Five studies included the information of COVID-19 infected medical staff (Table *1*).

Case Severity Rate and Case Fatality Rate

18 studies listed the number of severe cases, with pooled CSR 20.2% (95% CI, 15.1-25.2%, n = 18, I^2 = 92%). The proportion of severe illness in Wuhan subgroup was higher than outside of Wuhan in China (36.9%; [95% CI, 26.7-47.0%]; n = 7 vs. 10.9%; [95% CI, 6.7-15.1%]; n = 7, P < 0.001]). Of note, the overall case fatality rate (CFR) was 3.1% (95% CI, 1.9-4.2%, n = 23, I^2 = 75%). Subgroup analysis showed a significantly higher CFR in Wuhan than outside Wuhan (9.5%; [95% CI, 5.2-13.8%]; n = 10 vs. 0.2%; [95% CI, 0-0.5%]; n = 8, P < 0.001) (Figure *1*).

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Univariate meta-regression showed that compared with Wuhan, CSR and CFR in other areas were significantly lower (all for $P < 0.0001$), which was consistent with the subgroup analysis. Although not statistically significant, CSR and CFR showed a decreasing trend over time. In addition, onset-to-admission time were identified closely correlation with CSR (4.99% per increase in days, $P = 0.0047$) and CFR (1.97% per increase in days, $P < 0.0001$), suggesting shortening the onset-to-admission time favored COVID-19 related outcomes. Multivariate meta-regression confirmed the close correlation between onset-to-admission time and CFR (1.27% per increase in days, $P = 0.0263$). (Table *2* and Figure *3*).

Clinical characteristics and laboratory results

Clinical and laboratory data from 26 studies, including 1374 severe and 4326 non-severe patients, were extracted for meta-analysis. Of this, 7.7% patients (95% CI, 3.6-11.8%) were medical staff. The pooled CFR of severe patients was significantly higher than non-severe patients (6.0%; [95% CI, 4.6-7.3%] vs. 0.1%; [95% CI, 0-0.2%], $P < 0.001$). The mean incubation period was 7.10 days (95% CI, 6.06-8.14 d), with no statistically difference between severe and non-severe cases. The mean time from symptom onset to hospital admission was 6.18 days (95% CI, 5.23-7.12 d), which is longer in severe cases than that in non-severe cases (6.56 d vs. 4.81d, P = 0.023) and in Wuhan than outside (7.23 d vs.4.86 d,

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P = 0.027).

Severe cases presented with older age (54.5 yrs; [95% CI, 55.5-61.4 yrs] vs. 44.5 yrs; [95% CI, 42.0-47.1 yrs], $P < 0.001$) and higher ratio of male (59.7%; [95% CI, 55.0-64.3%] vs. 51.9; [95% CI, 46.6-57.2%], $P < 0.001$), as compared with non-severe cases. Similarly, patients in Wuhan were older than those outside Wuhan (55.7 yrs vs. 41.6 yrs, $P < 0.001$). Fever (79.1%; 95% CI, 68.0-90.3%), cough (58.0%; 95% CI, 42.0-74.0%) and fatigue (29.3%; 95% CI, 23.4-35.3%) were the dominant symptoms, whereas digestive symptoms such as diarrhea (5.7%; 95%CI 3.9-7.5%), nausea or vomiting (2.0%; 95% CI, 1.0-2.9%) were relatively rare. The overall prevalence of any comorbidity was 37.1% (95% CI, 28.1-46.1%), with higher incidence rate in severe cases than non-severe cases (54.9% vs. 27.6%, P = 0.006), and higher in Wuhan than other areas (45.1% vs. 28.8%, $P = 0.01$). The most common comorbidities were hypertension (19.0%, 95% CI, 13.2-24.9%), followed by diabetes (8.2%, 95% CI, 6.3-10.0%) and cardiovascular diseases (CVD, 2.7%, 95% CI, 1.4-4.1%). Moreover, hypertension, diabetes, CVD, cerebrovascular diseases, chronic obstructive pulmonary disease (COPD) and chronic kidney disease (CKD) were significantly more common in severe cases as compared with non-severe cases (all for $P < 0.05$). The overall proportion of bilateral radiologic abnormalities was 87.2% (95% CI, 82.1-92.3%), with significant difference between inside and outside Wuhan (91.6% vs.

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82.6%, $P = 0.018$).

In terms of the laboratory index, several elevated indicators were observed as follows: C-reaction protein (CRP, 26.07 mg/L; 95% CI, 20.69-31.44 mg/L), erythrocyte sedimentation rate (ESR, 46.54 mm/h; 95% CI, 33.31-59.78 mm/h), lactate dehydrogenase (LDH, 287.48 U/L; 95% CI, 260.76-314.20 U/L), cardiac troponin I (cTnI, 4.54 pg/mL,; 95% CI, -1.17-10.24 pg/mL) and ferritin (724.44 ng/mL; 95%CI, 356.28-1092.60 ng/mL). In contrast, the level albumin (37.31 g/L; 95% CI, 34.33-40.28 g/L) and lymphocytes count (1.18 × 10□/L; 95% CI, 1.00-1.36 × 10□/L) were below normal level. Of note, obvious differences in laboratory index were identified between severe and non-severe cases, as well as between Wuhan and outside Wuhan. Elevated level of CRP, LDH and D-dimer, together with reduced level of lymphocytes count and PLT count were the prominent features of severe cases (all for $P < 0.001$). Likewise, more elevated CRP, myoglobin, aspartate aminotransferase (AST) and ferritin, followed by decreased lymphocyte count and hemoglobin were observed in Wuhan patients than outside (all for $P < 0.001$) (Table *2*).

Risk factors for severity of COVID-19

Among the baseline characteristics, disease severity was highly associated with old age (≥ 50 yrs, OR = 2.609; 95% CI, 2.288-2.976; n = 5; I^2 = 37%), male (OR =1.348; 95% CI, 1.195-1.521; n = 13; I^2 = 0%), smoking (OR =1.734; 95% CI, 1.146-2.626; n = 4; I^2 = 0%) and any

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comorbidity (OR = 2.635; 95% CI, 2.098-3.309; n = 7; I^2 = 12%). Comorbidities with pooled OR larger than 2 included CKD (6.02; 95% CI, 2.19-16.51; n = 4; I^2 = 0), COPD (5.32; 95% CI, 2.61-10.85; n = 6; I^2 = 0%), cerebrovascular diseases (3.19; 95% CI, 1.51-6.77; n = 6; I^2 = 0%), tumor (3.21; 95% CI, 1.42-7.24; n = 4; I^2 = 30%), diabetes (2.49; 95% CI, 1.82-3.4; n = 10; I^2 = 44%) and hypertension (2.06; 95% CI, 1.61-2.62; n = 10; I^2 = 36%) (Figure *4*, eFigure *5*).

In terms of laboratory results, there were obvious difference between severe and non-severe cases in PLT (MD = -30.654 × 10^9/L, 95% CI, -38.7 to -22.61, n = 8), lymphocyte count (MD = -0.376 × 10^9/L , 95% CI, -0.467 to -0.285, n = 11), LDH (MD = 150.702 U/L, 95% CI, 82.569 to 218.836, n = 5), D-dimer (MD = 0.715 mg/L, 95% CI, 0.562 to 0.868, n = 7) and CRP (MD = 30.395 mg/L, 95% CI, 20.006 to 40.784, n = 10). Meanwhile, the ORs were calculated for several index including lymphocytopenia (OR = 4.23; 95% CI, 3.03-6.03; I^2 = 33%), thrombocytopenia (OR = 2.84; 95% CI, 2.00-4.04; I^2 = 49%), elevated D-dimer (OR = 3.17; 95% CI, 1.86-5.41; I^2 = 69%) and elevated CRP (OR = 4.23; 95% CI, 2.94-6.08; I^2 = 25%). (Figure *5*, eFigure *6-7*).

Comparison of Clinical Characteristics and risk factors among COVID-19, SARS and MERS

The most common comorbidity was diabetes for both SARS (24.0%) and

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MERS (68.0%), while hypertension for COVID-19 (19.0%). Fever and cough were the dominant symptoms for all three viruses, whereas digestive symptoms and chill were relatively rare for COVID-19. Regarding laboratory index, elevated LDH was common for three coronaviruses; higher incidence of lymphopenia, elevated AST or ALT was observed in COVID-19 and SARS than MERS[39,40]. (Table 4).

Both old age and comorbidity proved the common risk factors for predicting death among three coronaviruses. In support, COVID-19 related death was associated with old age ($\geq$ 60 yrs, RR = 9.45; 95% CI, 8.09-11.04), male (RR = 1.67, 95% CI, 1.47-1.89) and any comorbidity (5.86; 95% CI, 4.77-7.19), most notably CVD (6.75; 95% CI, 5.40-8.43) followed by hypertension (4.48; 95% CI, 3.69-5.45) and diabetes (4.43; 95% CI, 3.49-5.61). Similar with COVID-19, male (RR = 1.6; 95% CI, 1.2-2.1) and CVD (OR = 3.5; 95% CI, 3.1-4.8) were also risk factors for MERS related death[41,42]. In contrast, the most predominant risk factor for SARS related death was CKD (9.02; 95% CI, 3.81-21.36), and the risk of male gender was not statistically significant[3,43,44]. In addition, medical staff had a lower fatality rate than non-clinical staff for COVID-19 (RR = 0.12; 95% CI, 0.05-0.30) and MERS (RR = 0.1; 95% CI, 0.02-0.20), whereas the difference was not significant for SARS (RR = 0.76; 95% CI, 0.52-1.15). (Table *5*).

Sensitivity Analysis and Publication Bias

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Leaving each trial out of the analysis one at a time revealed no meaningful differences in CSR and CFR (eFigure *8* in supplement). We observed no evidence of publication bias with inspection of the funnel plot or with the Begger test or the test used by Peters et al (eFigure *9* in supplement).

Discussion

The main findings of this present analysis are that: (1) Despite the high incidence rate, the distinctive feature of COVID-19 was low severity and mortality, showing a significant difference on the incidence of severity and mortality between Wuhan and outside of Wuhan; (2) The onset-to-admission time was closely related to mortality, which will be increased about 1.27% with every day of delay in admission; (3) Older age is a common risk factor for poor prognosis of the three coronavirus diseases; Hypertension and cardiovascular diseases are the most relevant clinical predictors for the death caused by both COVID-19 and MERS-CoV, while chronic kidney disease is for SARS; (4) The five main laboratory indicators of severe illness included lymphocytopenia, thrombocytopenia and the rise of LDH, CRP and D-dimer.

SARS-CoV-2 has been reported to be higher contagious than previously discovered human coronaviruses[45]. Until now, more than 187, 361 confirmed cases and caused 7, 485 deaths in 151 countries on six continents were identified. Despite its high prevalence of COVID-19, the

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pooled severe incidence and fatality rate is significantly lower compared with SARS and MERS, which may explain why the novel coronavirus has spread so widely[46]. Of note, there are regional and spatial differences in the incidence rate of COVID-19. In our research, the pooled severity rate and mortality caused by COVID-19 was found significantly higher in Wuhan than that of the infected outside of Wuhan (all for $P < 0.01$). On the other hand, disease incidence at the early stage of outbreak was higher than that at the late stage, which may be caused by the lack of recognitions and treatment experience for COVID-19. Moreover, the longer time from symptoms to hospitalization, the higher incidence rate of the mortality related to COVID-19, highlighting the importance of timely medical treatment[30]. In addition, among the patients with 2019-nCoV, the pooled infection rate of medical staff was 7.7%, which was lower than that of SARS (23%) and MERS (9.8%)[39].

SARS-CoV-2, SARS-CoV and MERS-CoV belong to high pathogenic coronaviruses, whereas each of which has its own clinical manifestation. In comparison to SARS-CoV (4.6 days) and MERS-CoV (5.2 days)[47], COVID-19 has a longer latent period (7.1 days) and the initial manifestations are non-specific, making it more difficult to prevent and control at early stage. Similar to SARS and MERS, persons with COVID-19 often present initially with lower respiratory signs, including fever, coughing and fatigue. In the late

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course of illnesses, infected persons are characterized by progressive breathing difficulty, tachypnea, acute respiratory distress syndrome, or life-threatening complications. In fact, SARS-CoV-2 has been isolated from respiratory secretions, feces, urine, blood, tears, and conjunctival secretions[48], indicating that SARS-CoV-2 infection is not confined to the respiratory tract. Indeed, in our analysis, the pooled incidences rate of respiratory symptom was present in 79.1% of patients, followed by 7.7% with gastrointestinal disorders and 6.1% with neurological symptoms. Therefore, the patients with COVID-19 whose initial symptom were out of the lung should also be paid more attention, especially for those with the contact history of COVID-19. It should be noted that the pooled incidence of diarrhea symptoms (5.7%) is lower than previous data of patients with MERS-CoV (25%) or SARS-CoV (26%) infection. In terms of laboratory tests, the most common hematological abnormalities in patients with COVID-19 were lymphopenia (54.7%), suggesting aggressive effect on lymphocytes by COVID-19, which is similar to those previously observed in patients with SARS (68-85%). In addition, elevated levels of liver enzymes, LDH, myocardial enzymes, and depressed platelet count concomitant with the rise of D-dimer was observed in our study. Compare with MERS (36%) and SARS (45%), thrombocytopenia was relatively less frequent in patients infected with SARS-CoV-2 (12.8%)[39,47].

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Given the fact that the rapid progression to end-organ failure and even death was occurred in some patients, it is therefore essential to paid more attention to susceptible population of COVID-19[49]. Our results showed the majority of the SARS-CoV-2 infection were male patients (55.5%) similarly to the gender distribution of MERS (64.5%), while the predominance of female patients (43.0%) was observed in SARS. It is believed that the sex difference is probably related to the higher expression of ACE2 receptor in male than that in female and the lack of the protection of estrogen and X chromosome[50]. COVID-19 has affected persons in all age groups; in particular, 53.5% patients were found after more than 50 years, suggesting that the elderly patients are more likely to have weak immune function. Moreover, 10-30% of patients in SARS and 37.1% of patients in COVID-19 had at least one underlying disorder; patients with comorbidities such as diabetes mellitus, cardiovascular diseases, renal failure and chronic respiratory diseases are especially vulnerable to SARS-CoV-2 infection[7]. Owning to the pro-inflammatory state and the reduced immune response, the chronic conditions were also noted to have similar effects in the other two coronaviruses. Although the comorbidities identified in our study has been described previously, their value to predict the severity of COVID-19 has not yet been evaluated.

A focus on risk factor affecting clinical outcome is critically important to identify high-risk patients and mitigate COVID-19

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complications. In the present study, people with old age, male, smoking, presence of comorbidity, CKD, COPD, cancer, hypertension, and diabetes were identified as predictors of severe disease from COVID-19 infection. Importantly, old age, male gender and presence of comorbidity, including hypertension, diabetes, cancer and respiratory disease, were identified predictor of disease severity as well as mortality related to COVID-19, suggesting that elderly patients with these underlying comorbidities should be given more attention and care. In line with previously published studies, the laboratory indicators including lymphocytes, CRP, LDL, PLT, D-dimer, ALT and CK levels were closely related to a poor prognosis, which provided key reference index of the prognosis of COVID-19. In particular, lymphopenia, thrombocytopenia and elevated D-dimer could act as effective predictors of the COVID-19 severity. However, it was worth noting that increased level of myoglobin and ferritin were observed in severe cases, but the predictive value could not be estimated limited by the number of related studies and further in-depth research is needed.

Limitation

Our meta-analysis has several potential limitations. Firstly, there was obvious heterogeneity among studies regarding CSR and its subgroups, because of differences in medical condition, study period, public

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awareness and others. Nevertheless, we conducted meta-regression based on the observation duration and symptom onset to hospital admission time, which explained a large percent of heterogeneity. Secondly, studies published before February 25, 2020 and articles published in English only were included in our study, therefore there was lack of data from other countries. However, our meta-analysis involved 53000 confirmed patients based on the data during the early-to-mid period of disease outbreak in China, which will provide great referential value for global epidemic control. Thirdly, meta-analysis was conducted on the level of the studies and the characteristics of individual patients could not be retrieved, thus it was hard to provide reference for individualized diagnosis and treatment of COVID-19. Finally, all included studies were retrospective, as no randomized control trials and prospective studies related to 2019-nCoV finish till now, thus our results require to be confirmed by more high-quality clinical researches.

Conclusions:

COVID-19 is emerging all over the world and spreading at an unprecedented rate, resulting in significant impacts on global economies and public health. The present study successfully and systematically evaluated the prognostic predictors of COVID-19 by collecting published information on risk factors of the outcomes related to SARS-CoV-2 infections. Nevertheless, more investigations are needed to further

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objectively confirm the clinical value of prognostic factors related to COVID-19.

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Figure legend

Figure 1. PRISMA Diagram of Study Selection.

N, the number of COVID-19 confirmed patients; ICU, intensive care unit.

a EndNote software (Clarivate Analytics) was used to remove duplicates.

Figure 2. Subgroup analysis of CSR (A) and CFR (B) by geographical region.

CSR, case severity rate; CFR, case fatality rate.

Figure 3. Meta-regression analysis for CSR and CFR. (A) meta-regression of Logit CSR on geographical region (Wuhan, outside Wuhan in China, nationwide). (B) meta-regression of Logit CSR on duration from Dec 1, 2019 to the middle time of study period. (C) meta-regression of Logit CSR on mean time from symptom onset to

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hospital admission (D) meta-regression of Logit CFR on geographical region (Wuhan, outside Wuhan in China, nationwide). (E) meta-regression of Logit CFR on duration from Dec 1, 2019 to the middle time of study period. (F) meta-regression of Logit CFR on mean time from symptom onset to hospital admission. The size of the circle represent the population size of each study. The red line in A&D represent the pooled incidence of CSR or CFR in each region, and the red line in B-C, E-F represent the regression equation from meta-analysis.

Figure 4. Clinical risk factors for severe cases. A, old age (> 50 yrs) ; B, male gender; C, any comorbidity; D, hypertension; E, diabetes; F, cerebrovascular diseases; G, chronic kidney diseases (CKD); H, chronic obstructive pulmonary diseases (COPD).All factors were dealt as dichotomous variables and odds ratios (ORs) were showed using fixed effect model (all for $I^2 < 50\%$).

Figure 5. Mean Difference (MD) in main laboratory index between severe and non-severe patients with COVID-19. A, blood platelet count (PLT, $\times 10^9$/L); B, lymphocyte count ($\times 10^9$/L); C, lactate dehydrogenase (LDH, U/L); D, D-dimer (mg/L); E, C-reaction protein (mg/L); F, aspartate aminotransferase (AST, U/L).

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Table 1. Study Characteristics

Study	Study period	Location	N	CSR, n (%)	CFR, n (%)	Mean age (SD)	Male, n (%)	Healthcare worker, n (%)	Quality score[a]
Chaolin Huang et al.	Dec 6, 2019 - Jan 2, 2020	Wuhan	41	NA	6 (15.0)	49.0 (5.2)	30 (73.0)	NA	9
Qun Li et al.	Dec 10, 2019 - Jan 04, 2020	Wuhan	425	NA	NA	59.0 (12.3)	238 (56.0)	15 (3.5)	6
Nanshan Chen et al.	Jan 1-20, 2020	Wuhan	99	NA	11 (11.0)	55.5 (13.1)	67 (68.0)	NA	8
Jing Liu et al.	Jan 5-24, 2020	Wuhan	40	13 (32.5)	2 (5.0)	48.7 (13.9)	15 (37.5)	NA	9
Guang Chen et al.	Dec 19, 2019 - Jan 27, 2020	Wuhan	21	11 (52.4)	4 (19.0)	56.3 (14.3)	17 (81.0)	NA	10
Dawei Wang et al.	Jan 1-28, 2020	Wuhan	138	NA	6 (4.3)	56.0 (11.7)	75 (54.3)	40 (29.0)	9
Yanli Liu et al.	Jan 2 - Feb 1, 2020	Wuhan	109	NA	31 (28.4)	54.7 (17.0)	59 (54.1)	NA	10
Jinjin Zhang et al.	Jan 16 - Feb 3, 2020	Wuhan	140	58 (41.4)	NA	56.5 (10.3)	71 (50.7)	3 (2.1)	9
Jiatao Lu et al.	Jan 21 - Feb 5, 2020	Wuhan	75	15/72 (20.8)	1 (1.3)	60.3 (17.0)	37 (49.3)	NA	9
Zhen Li et al.	Dec, 2019 - Feb 7, 2020[b]	Wuhan, Huangshi, Chongqing[c]	59	28 (47.5)	3 (5.1)	53.8 (13.8)	34 (57.6)	NA	6
Qilin Li et al.	Feb 3-7, 2020	Wuhan	52	NA	NA	58.3 (14.8)	26 (50.0)	NA	9

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Yichun Cheng et al.	Jan 28 - Feb 11, 2020	Wuhan	710	252 (35.5)	89 (12.5)	61.7 (14.8)	374 (52.7)	NA	8
Luwen Wang et al.	Jan 14 - Feb 13, 2020	Wuhan	116	46 (39.7)	7 (6.0)	53.7 (23.0)	67 (57.8)	NA	9
Xiaowei Xu et al.	Jan 10 - Jan 26, 2020	Zhejiang	62	NA	0	43.3 (14.8)	36 (58.1)	NA	9
De Chang et al.	Jan 16-29, 2020	Beijing	13	NA	0	35.3 (3.0)	10 (77.0)	NA	8
Jingyuan Liu et al.	Jan 13-31, 2020	Beijing	61	3 (4.9)	0	40.0 (14.2)	31 (50.8)	NA	10
Zhichao Feng et al.	Jan 17 - Feb 1, 2020	Hunan	141	15 (10.6)	NA	44.3 (15.6)	72 (51.1)	NA	10
Lei Liu at al.	Jan 20 - Feb 3, 2020	Chongqing	51	7 (13.7)	1 (2.0)	42.7 (12.6)	32 (62.7)	NA	9
Qingxian Cai et al.	Jan 11- Feb 6, 2020	Shenzhen	298	58 (19.4)	0	47.0 (20.7)	149 (50.0)	NA	8
Jinwei Ai et al.	Dec, 2019 - Feb 9, 2020[b]	Xiangyang, Hubei	102	NA	3 (2.9)	50.4 (16.9)	52 (51.0)	NA	6
Jingwen Ai et al.	Jan 22 - Feb 9, 2020	Shanghai	20	3 (15.0)	NA	40.4 (12.4)	10 (50.0)	NA	9
Jie Li et al.	Jan 22 - Feb 10, 2020	Dazhou, Sichuan	17	NA	0	45.1 (12.8)	9 (52.9)	NA	9
Hongzhou Lu et al.	Jan 20 - Feb 19, 2020	Shanghai	265	22 (8.3)	1 (0.4)	NA	NA	NA	10
Yishan Zheng et al.	NA	Nanjing	103	8 (7.8)	NA	44.4 (18.9)	55 (53.4)	NA	8
Yang Yang et al.	Dec, 2019 - Jan 26, 2020[b]	Nationwide	4021	935 (25.5)	58 (1.4)	48.0 (16.0)	2213 (55.04)	247 (6.14)	7

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Weijie Guan, et al.	Dec, 2019 - Jan 29, 2020[b]	Nationwide	1099	173 (15.7)	15 (1.4)	47.0 (3.8)	649 (59.1)	NA	10
Chinese CDC	Dec, 2019 - Feb 11, 2020 [b]	Nationwide	44672	8255 (18.6)	1023 (2.3)	NA	22981 (51.4)	1716 (3.8)	9
Moran Ki1, et al.	Jan 20 - Feb 8, 2020	South Korea	24	0	0	41.8 (10.3)	14 (58.3)	NA	7
Kristina L. Bajema, et al	Jan 17-31, 2020	America	11	0	0	NA	NA	NA	7
Liz J Walker, et al.	Jan 10 - Feb 8, 2020	Australia	15	NA	0	NA	NA	NA	5

N, number of COVID-19 confirmed patients; CSR, case severity rate; CFR, case fatality rate; CDC, centers for disease control; NA, data not available.

[a] Study quality was assessed using the Quality Assessment Forms recommended by Agency for Healthcare Research and Quality (AHRQ).

[b] Studies without specific beginning time mentioned, were taken as beginning since Dec, 2019.

[b] The study recruited patients at Tongji Hospital and Wuhan Pulmonary Hospital in Wuhan, Huangshi Central Hospital in Huangshi, and Southwest Hospital in Chongqing, China. The multi-center study was categorized into Wuhan subgroup after a discussion.

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Table 2. Meta-regression Analysis for CSR and CFR

	Univariate meta-regression			Multivariate meta-regression[a]		
	Coefficient (95% CI)	z value	p value	Coefficient (95% CI)	z value	p value
CSR						
Geographic region						
Wuhan	Reference	10.1055	Reference	Reference	3.3328	Reference
Outside Wuhan in China	-0.2472 (-0.3417 to -0.1528)	-5.1316	**<0.0001**	-0.1317 (-0.3150 to 0.0517)	-1.4074	0.1593
Nationwide	-0.1516 (-0.2813 to -0.0219)	-2.2909	**0.0220**	-0.0122 (-0.2162 to 0.2405)	0.1044	0.9169
Outside China	-0.3581 (-0.5004 to -0.2159)	-4.9355	**<0.0001**			
Observation duration[b]	-0.0048 (-0.0102 to 0.0006)	-1.7499	0.0801	-	-	-
Onset-to-admission time[c]	0.0499 (0.0153 to 0.0845)	2.8289	**0.0047**	0.0275 (-0.0189 to 0.0739)	1.1606	0.2458
CFR						
Geographic region						
Wuhan	Reference	8.5225	Reference	Reference	1.0729	Reference
Outside Wuhan in China	-0.0712 (-0.0935 to -0.0488)	-6.2345	**<0.0001**	-0.0450 (-0.0922 to 0.0022)	-1.8686	0.0617
Nationwide	-0.0627 (-0.0894 to -0.0359)	-4.5955	**<0.0001**	-0.0381 (-0.0949 to 0.0187)	-1.3156	0.1883

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Outside China	-0.0767 (-0.1264 to -0.0269)	-3.0214	**0.0025**			
Observation duration[b]	-0.0002 (-0.0013 to 0.0009)	-0.3710	0.7106	-	-	-
Onset-to-admission time[c]	0.0197 (0.0133 to 0.0260)	6.0555	**<0.0001**	0.0127 (0.0015 to 0.0239)	2.2217	**0.0263**

[a]Multivariate meta-regression was performed when the univariate meta-regression P value was < 0.05.

[b]Duration from December 1, 2019 to the middle time of study period.

[c]Mean time from symptom onset to hospital admission.

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Table 3. Clinical and laboratory data of the included COVID-19 patients.

	Overall	Severity			Region		
		Severe	Non-severe	P value	Wuhan	Outside Wuhan in China	P value
CSR, % (95%CI)	20.2 (15.1-25.2)	-	-	-	36.9 (26.7-47.0)	10.9 (6.7-15.1)	**<0.001**
CFR, % (95%CI)	3.1 (1.9-4.2)	6.0 (4.6-7.3)	0.1 (0-0.2)	**<0.001**	9.5 (5.2-13.8)	0.2 (0.0-0.5)	**<0.001**
Healthcare worker, % (95%CI)	7.7 (3.6-11.8)	0 (0-2.3)	3.7 (0-7.7)	0.101	10.1 (2.2-18.0)	NA	NA
Timeline of illness, d							
Incubation time	7.10 (6.06-8.14)`	7.00 (6.40-7.60)	7.50 (7.24-7.76)	0.133	NA	NA	NA
Days from symptom onset to hospital admission	6.18 (5.23-7.12)	6.56 (5.35-7.77)	4.81 (3.90-5.72)	**0.023**	7.23 (5.80-8.65)	4.86 (3.32-6.40)	**0.027**
Mean age, y (95% CI)	49.8 (47.5-52.2)	54.5 (55.5-61.4)	44.5 (42.0-47.1)	**<0.001**	55.7 (53.2-58.2)	41.6 (38.8-44.4)	**<0.001**
Male, % (95% CI)	55.5 (53.2-57.7)	59.7 (55.0-64.3)	51.9 (46.6-57.2)	**<0.001**	56.3 (52.2-60.4)	52.7 (49.4-56.0)	0.197
Current smoking, % (95% CI)	6.4 (0.0-12.9)	7.8 (0-16.5)	5.5 (0-12.5)	0.663	1.4 (0.0-3.4)	5.4 (2.3-8.5)	**0.027**
Sign & Symptom, % (95% CI)							
Fever	79.1 (68.0-90.3)	88.4 (73.1-100.0)	81.4 (62.6-100.0)	0.552	81.0 (63.4-98.5)	81.2 (72.4-90.0)	0.984
Cough	58.0 (42.0-74.0)	71.1 (59.6-82.7)	65.7 (57.8-73.5)	0.449	57.6 (38.2-77.0)	57.2 (41.5-72.9)	0.975
Fatigue	29.3 (23.4-35.3)	60.3 (39.9-80.8)	44.2 (32.6-55.9)	0.181	36.1 (27.3-44.9)	21.2 (13.0-29.5)	**0.016**

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Expectoration	11.5 (9.2-13.9)	37.6 (22.7-52.6)	28.0 (19.0-37.0)	0.281	2.7 (0.8-4.6)	20.6 (10.6-30.6)	**0.001**
Headache	6.0 (4.0-7.9)	11.3 (7.4-15.2)	13.5 (7.6-19.4)	0.542	2.0 (0.5-3.5)	8.8 (4.8-12.7)	**0.002**
Diarrhea	5.7 (3.9-7.5)	5.7 (3.1-8.4)	5.8 (3.3-8.3)	0.957	5.6 (2.6-8.6)	6.6 (3.8-9.3)	0.63
Myalgia	3.8 (2.4-5.2)	26.0 (11.1-40.9)	13.1 (8.4-17.8)	0.107	4.7 (2.1-7.3)	1.9 (0.2-3.5)	0.075
Shortness of breath	3.5 (2.2-4.9)	35.7 (17.8-53.7)	12.8 (4.7-20.9)	**0.023**	2.2 (0.4-3.9)	1.9 (0.2-3.7)	0.812
Sore throat/Pharyngalgia	3.2 (1.7-4.6)	7.8 (0-16.1)	9.7 (4.0-15.4)	0.706	1.5 (0.1-2.9)	2.1 (0.4-3.7)	0.587
Nausea or vomiting	2.0 (1.0-2.9)	5.9 (3.1-8.7)	5.7 (2.3-9.0)	0.928	2.5 (0.7-4.2)	1.3 (0.1-2.6)	0.274
Chill	1.1 (0.3-1.9)	26.0 (8.9-43.1)	10.9 (9.0-12.9)	0.087	0.1 (0.0-0.8)	0.4 (0.0-1.4)	0.466
Nasal congestion/Rhinorrhoea	1.1 (0.3-1.9)	2.8 (0.4-5.2)	5.1 (3.8-6.3)	0.097	0.0 (0.0-0.2)	1.6 (0.0-3.3)	0.058
Dyspnea	1.0 (0.3-1.7)	44.2 (7.8-80.6)	5.7 (0-10.7)	**0.042**	7.5 (4.6-10.5)	0.6 (0.0-1.6)	**<0.001**
Anorexia	1.0 (0.4-1.7)	14.9 (8.3-21.5)	8.2 (2.4-13.9)	0.135	2.5 (0.5-4.5)	3.5 (0.9-6.1)	0.55
Dizziness	0.1 (0.0-0.5)	16.1 (3.5-28.8)	12.1 (5.0-19.2)	0.591	0.9 (0.0-2.1)	0.0 (0.0-2.4)	0.269
Any comorbidity, % (95% CI)	37.1 (28.1-46.1)	54.9 (37.2-72.6)	27.6 (19.4-35.8)	**0.006**	45.1 (36.2-53.9)	28.8 (20.2-37.5)	**0.01**
Specific comorbidity, % (95% CI)							
Hypertension	19.0 (13.2-24.9)	29.4 (24.8-34.1)	16.1 (11.5-20.7)	**<0.001**	25.3 (11.3-39.3)	13.1 (9.4-16.9)	0.099
Diabetes	8.2 (6.3-10.0)	17.2 (13.4-20.9)	5.8 (3.4-8.1)	**<0.001**	11.8 (9.5-14.1)	5.4 (3.9-6.9)	**<0.001**
CVD	2.7 (1.4-4.1)	6.9 (3.9-9.8)	2.1 (1.4-2.9)	**0.002**	4.4 (1.7-7.1)	2.0 (0.4-3.6)	0.134
Cerebrovascular disease	1.0 (0.3-1.6)	3.0 (1.2-4.9)	0.9 (0.4-1.3)	**0.031**	2.2 (0.5-3.9)	0.2 (0.0-0.6)	**0.023**
COPD	0.6 (0.3-0.9)	4.1 (1.8-6.3)	0.7 (0.2-1.1)	**0.004**	0.8 (0.1-1.6)	1.2 (0.0-2.4)	0.58

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CKD	0.4 (0.1-0.7)	2.5 (0.8-4.2)	0.6 (0.1-1.0)	**0.035**	1.5 (0.1-2.9)	0.1 (0.0-0.5)	0.054
CLD	1.1 (0.3-1.8)	0.8 (0-1.9)	1.6 (0-3.7)	0.451	0.2 (0.0-0.7)	1.8 (0.3-3.4)	**0.049**
Cancer	0.8 (0.1-1.5)	5.6 (0-12.6)	2.3 (1.5-3.1)	0.309	1.7 (0.1-3.2)	0.6 (0.0-1.2)	0.195
Radiologic findings, % (95% CI)							
Bilateral lung involvement	87.2 (82.1-92.3)	87.5 (81.3-93.8)	72.6 (50.9-94.2)	0.195	91.6 (88.5-94.6)	82.6 (75.9-89.4)	**0.018**
Laboratory findings, mean (95% CI)							
WBC, × 10□/L	5.33 (5.03-5.62)	5.52 (4.79-6.24)	4.74 (4.55-4.92)	**0.041**	5.81 (5.13-6.50)	4.87 (4.61-5.13)	**0.012**
N, × 10□/L	3.43 (2.96-3.90)	4.23 (3.33-5.13)	3.03 (2.73-3.32)	**0.013**	3.87 (2.15-5.25)	3.16 (2.25-4.07)	0.439
L, × 10□/L	1.18 (1.00-1.36)	0.74 (0.67-0.82)	1.14 (1.05-1.23)	**<0.001**	0.87 (0.83-0.91)	1.39 (0.98-1.83)	**0.017**
M, ×□10□/L	0.39 (0.34-0.43)	0.31 (0.26-0.36)	0.55 (0.38-0.72)	**0.007**	0.39 (0.37-0.42)	0.40 (0.32-0.48)	0.815
NLR	NA	4.25 (3.42-5.08)	2.61 (1.85-3.48)	**0.007**	NA	NA	NA
Hb, g/L	133.16 (129.72-136.60)	132.81 (126.82-138.80)	134.81 (132.01-137.60)	0.554	125.30 (119.67-130.92)	139.51 (136.74-142.29)	**<0.001**
PLT, × 10□/L	185.56 (175.13-195.98)	147.14 (39.88-154.40)	176.58 (173.66-179.49)	**<0.001**	188.50 (165.34-211.66)	180.76 (175.74-185.78)	0.522
CRP, mg/L	26.07 (20.69-31.44)	54.37 (41.12-67.62)	16.74 (12.00-21.48)	**<0.001**	35.87 (28.75-43.00)	18.63 (14.26-23.01)	**<0.001**
ESR, mm/h	46.54 (33.31-59.78)	48.51 (36.50-60.51)	32.07 (11.72-52.43)	0.173	49.90 (45.29-54.51)	44.87 (22.14-67.61)	0.671
PCT, ng/mL	0.07 (0.05-0.08)	0.11 (0.07-0.16)	0.05 (0.03-0.06)	**0.007**	0.13 (0.07-0.19)	0.04 (0.04-0.05)	**0.004**

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LDH, U/L	287.48 (260.76-314.20)	378.47 (307.86-449.07)	228.68 (222.62-234.75)	**<0.001**	322.26 (276.49-368.04)	238.30 (225.61-250.99)	**0.001**
cTnI, pg/mL	4.54 (-1.17-10.24)	0.05 (0.03-0.07)	0.02 (0.02-0.03)	**0.026**	6.87 (2.26-11.48)	0.02 (0.02-0.03)	**0.004**
CK, U/L	101.13 (87.22-115.03)	109.80 (72.67-146.92)	110.50 (80.69-140.31)	0.977	109.56 (88.27-130.85)	91.08 (71.51-110.65)	0.211
CKMB, U/L	13.23 (10.83-15.63)	NA	NA	NA	12.00 (8.05-15.51)	14.65 (13.3-15.97)	0.191
Mb, ng/mL	35.99 (5.36-66.61)	76.0 (27.99-124.01)	6.98 (6.08-7.87)	**0.01**	60.83 (51.12-70.55)	23.84 (-6.77-54.46)	**<0.001**
NT-proBNP, pg/mL	NA	269.27 (66.12-472.41)	38.77 (35.17-42.36)	**0.037**	NA	NA	NA
ALT, U/L	26.78 (24.17-29.38)	29.12 (225.57-32.67)	22.02 (20.17-23.87)	**0.001**	29.54 (25.53-33.54)	23.37 (22.20-24.54)	**0.004**
AST, U/L	31.61 (28.10-35.11)	39.91 (31.02-48.43)	24.23 (23.38-25.08)	**0.001**	36.48 (33.93-39.04)	25.41 (23.13-27.68)	**<0.001**
Albumin, g/L	37.31 (34.33-40.28)	35.53 (33.08-37.98)	40.11 (37.16-43.06)	**0.019**	32.70 (31.45-33.95)	40.76 (38.35-43.16)	**<0.001**
TBil, μmol/L	10.51 (9.25-11.76)	10.95 (9.06-12.84)	9.25 (8.03-10.46)	0.138	11.04 (9.86-12.23)	8.16 (6.55-9.77)	**0.005**
Scr, μmol/L	69.99 (67.22-72.75)	68.48	66.05	0.297	72.71	66.95	**0.048**

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		(65.58-71.38)	(62.53-69.58)		(68.85-76.57)	(62.75-71.14)	
BUN, mmol/L	4.94 (4.20-5.68)	5.02 (3.41-6.63)	4.00 (3.58-4.43)	0.237	5.04 (4.19-5.90)	4.37 (3.88-4.86)	0.183
eGFR, ml/min/1.73m^2	98.48 (73.98-122.98)	97.09 (89.89-104.29)	113.98 (111.69-116.28)	**<0.001**	86.00 (84.24-87.77)	111.00 (108.24-113.77)	**<0.001**
Potassium, mmol/L	3.90 (3.78-4.03)	3.80 (3.75-3.86)	3.85 (3.77-3.93)	0.316	4.09 (3.81-4.36)	3.77 (3.70-3.84)	**0.027**
Sodium, mmol/L	135.53 (138.03-139.03)	137.28 (136.43-138.13)	139.21 (138.58-139.85)	**<0.001**	138.69 (138.01-139.36)	138.61 (137.85-139.37)	0.878
PT, s	12.67 (12.19-13.15)	13.43 (12.68-14.18)	13.21 (12.76-13.66)	0.628	12.83 (12.09-13.57)	12.34 (11.43-13.25)	0.413
APTT, s	33.89 (30.00-37.79)	39.37 (36.19-42.54)	40.91 (38.2-43.62)	0.47	33.31 (28.90-37.71)	35.30 (27.10-43.50)	0.675
D-dimer, mg/L	1.00 (0.42-.1.52)	1.07 (0.92-1.22)	0.35 (0.27-0.44)	**<0.001**	1.43 (0.51-2.35)	0.40 (0.20-0.57)	**0.032**
SF, ng/mL	724.44 (356.28-1092.60)	1370.94 (654.26-2087.63)	524.49 (43.01-1005.97)	0.061	845.05 (623.56-1066.54)	269.86 (202.01-337.77)	**<0.001**

CVD, cardiovascular disease; COPD, chronic obstructive pulmonary disease; CKD, chronic kidney disease; CLD, chronic liver disease; WBC, white blood cell count; N, neutrophil count; L, lymphocyte count; M, monocyte count; NLR, The ratio of neutrophils to lymphocytes; Hb, hemoglobin; PLT, platelet count; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; PCT, procalcitonin; LDH, lactate dehydrogenase; cTnI, hypersensitive troponin I; CK, creatine kinase; Mb, myoglobin; ALT,

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alanine aminotransferase; AST, aspartate aminotransferase; Tbil, total bilirubin; Scr, serum creatinine; BUN, blood urea nitrogen; PT, prothrombin time; APTT, activated partial thromboplastin time; SF, serum ferritin.

P <0.05 was considered as statistically significant.

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Table 4. Comparison of clinical characteristics among COVID-19, SARS and MERS.

Clinical Characteristics	COVID-19	SARS	MERS
CFR, %	3.1	9.6	40
Mean age, y	49.8	39.9	50
Male, %	55.5	43	64.5
Health care worker, %	7.7	23	9.8
Current smoking, %	6.4	17	23
Any comorbidity, %	37.1	10-30	76
Diabetes	8.2	24	68
Chronic renal disease	0.4	2-6	49
Chronic heart disease	2.7	10	28
Cancer	0.8	3	2
Hypertension	19	19	34
Presenting symptoms, %			
Fever	79.1	99-100	98
Cough	58	62-100	83
Diarrhea	5.7	20-25	26
Myalgia	3.8	45-61	32
Shortness of breath	3.5	40-42	72
Chill	1.1	15-73	87
Laboratory results, %			
Leucopenia ($<4.0 \times 10^9$ /L)	22.2	25-35	14
Lymphopenia ($<1.5 \times 10^9$ /L)	54.7	68-85	32
Thrombocytopenia ($<140 \times 10^9$ /L)	12.8	40-45	36
High LDH (>245 U/L)	42.9	50-71	48

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High ALT (>40 U/L)	20	20-30	11
High AST (>40 U/L)	23.8	20-30	14

Table 5. Comparison of risk factors for death among COVID-19, SARS and MERS.

		COVID-19			SARS			MERS		
Predictive factors		N	CFR, n (%)	RR (95%CI)	N	CFR, n (%)	RR (95%CI)	N	CFR, n (%)	RR (95%CI)
Age	≥ 60 y	13909	829 (6.0)	9.45 (8.09-11.04)	548	135 (24.6)	7.18 (5.66-9.12)			
	< 60 y	30763	194 (0.6)		4777	208 (4.4)				
Sex	Male	22981	653 (2.8)	1.67 (1.47-1.89)	2720	196 (7.2)	0.81 (0.64-1.02)	888	203 (22.9)	1.6 (1.2-2.1)
	Female	21691	370 (1.7)		2607	147 (5.6)		359	52 (14.5)	
Any comorbidity	Present	5446	273 (5.0)	5.86 (4.77-7.19)	359	164 (45.5)	7.61 (5.80-9.98)	796	201 (25.3)	3.0 (2.2-3.9)
	Absent	15536	133 (0.9)		1396	139 (10.0)		271	23 (8.5)	
Health care worker	Yes	1716	5 (0.3)	0.12 (0.05-0.30)	1021	34 (3.3)	0.76 (0.52-1.15)	150	2 (1.3)	0.1 (0.02-0.2)
	No	42956	1018 (2.4)		4306	309 (7.2)		1064	236 (22.2)	
Hypertension	Yes	2683	161 (6.0)	4.48 (3.69-5.45)						2.6 (2.2-3.5)[a]
	No	18299	245 (1.3)							
Diabetes	Yes	1102	80 (7.3)	4.43 (3.49-5.61)	72	25	6.48 (3.82-10.99)			1.8 (1.5-2.1)[a]
	No	19880	326 (1.6)		1239	94				

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CVD	Yes	873	92 (10.5)	6.75 (5.40-8.43)	47	18	7.15 (3.84-13.32)	3.5 (3.1-4.8)[a]
	No	20109	314 (1.6)		1264	101		
Cancer	Yes	107	6 (5.6)	2.93 (1.34-6.41)	14	3	2.78 (0.76-10.1)	
	No	20875	400 (1.9)		1297	116		
Other factors		Respiratory disease 3.43 (2.42-4.86)			Cerebrovascular disease 5.34 (2.34-12.16); CKD 9.02 (3.81-21.36)			Respiratory disease 3.1 (2.6-4.2)[a]; CKD 2.2 (1.7-2.9)[a]

RR, relative risk

[a] Odds ratio (OR) retrieved from published meta-analysis of MERS.

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Search

618 Records identified through database searching

- **331** PubMed
- **147** Embase
- **132** Web of science
- **8** Cochrane

236 Records identified through MedRxiv

147 Duplicate records excluded[a]

Identification

707 Records induced for title and abstract screening

649 Excluded for the following reasons:

- Basic research or molecular research
- Comments, editorials or expert opinions
- Case reports or case series
- Unrelated topic/not relevant
- Studies with N ≤ 10
- Studies not in English

58 Full-text atricles selected

28 Excluded for the following reasons:

- **13** Epidemiological studies
- **6** Lacking enough clinical information for meta-analysis
- **3** Did not meet inclusion criteria
- **3** Studies with special but not random populations (including only severe or death cases)
- **2** Publication with overlapping data
- **1** Family clusters

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30 Studies included for meta-analysis

- **19** Single-center studies
- **11** Multi-center studies

Analysis

22 Studies divided the patients cohort according to

- **13** the severity of the illness
- **3** the result of nucleic acid test
- **2** whether admitted to ICU or not
- **2** the serum creatine level or renal function
- **1** time since symptom onset
- **1** whether discharged or not

8 Studies without cohort division

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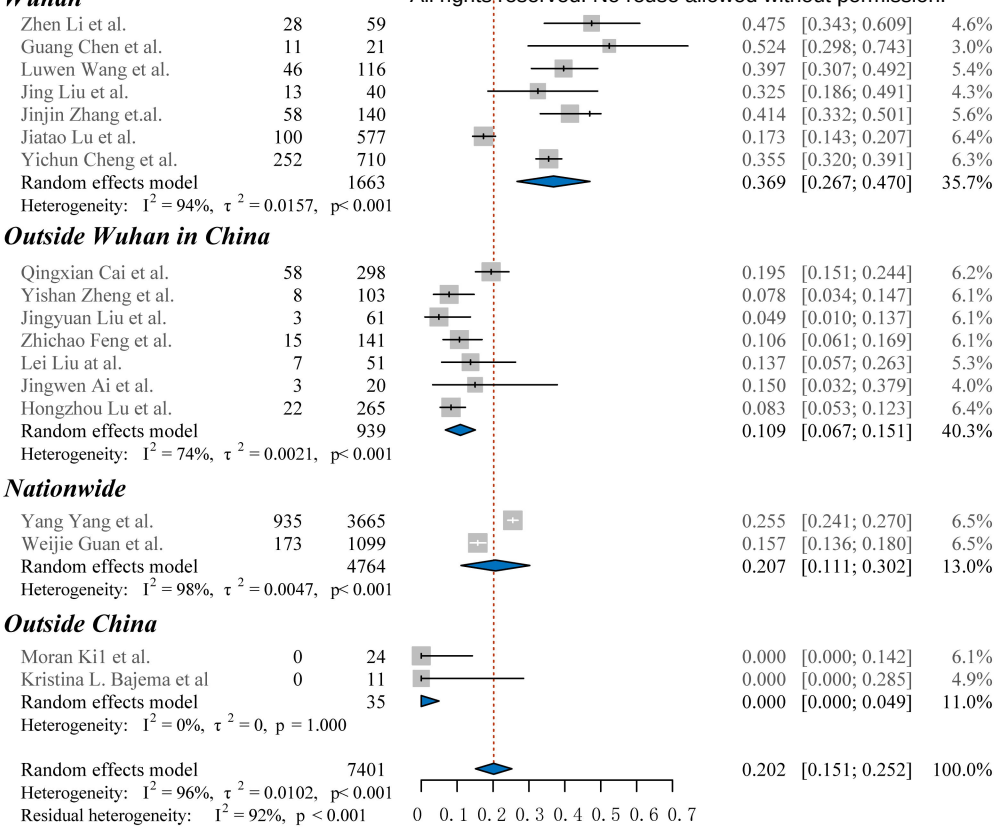
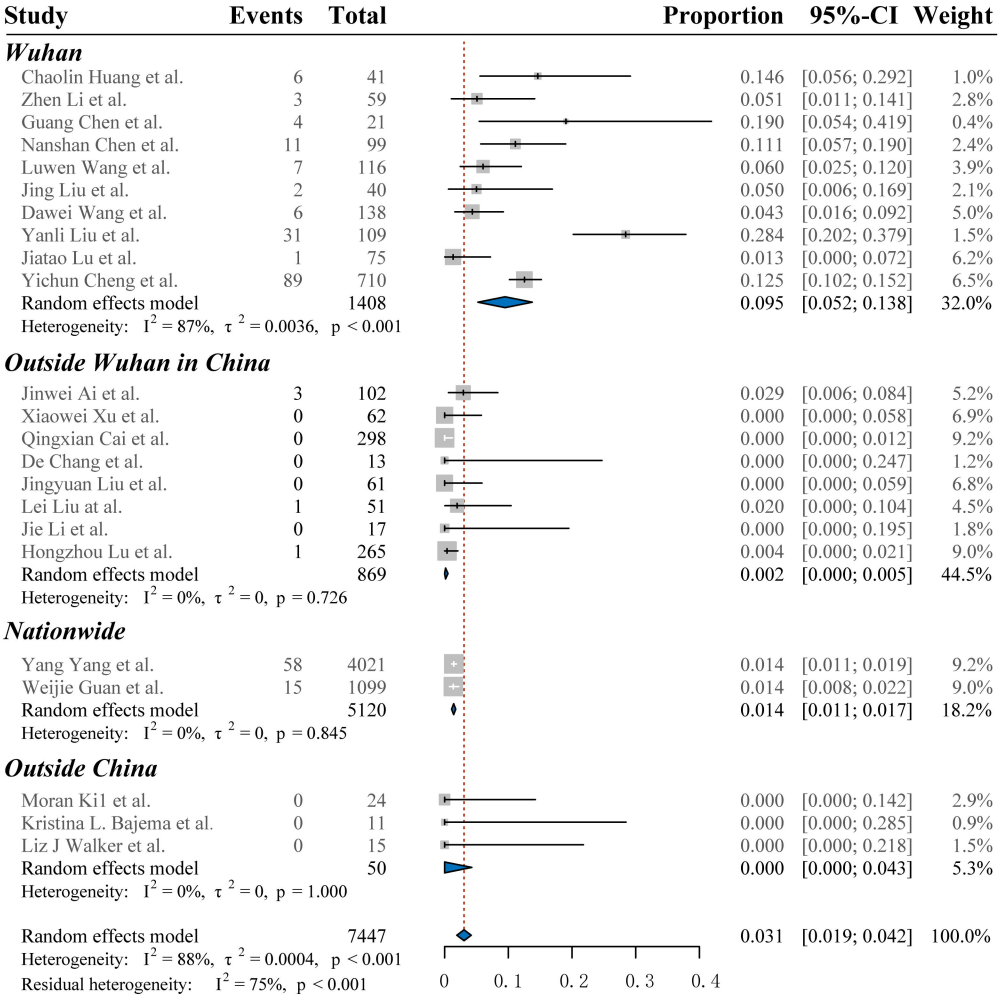
A CSR



B CFR



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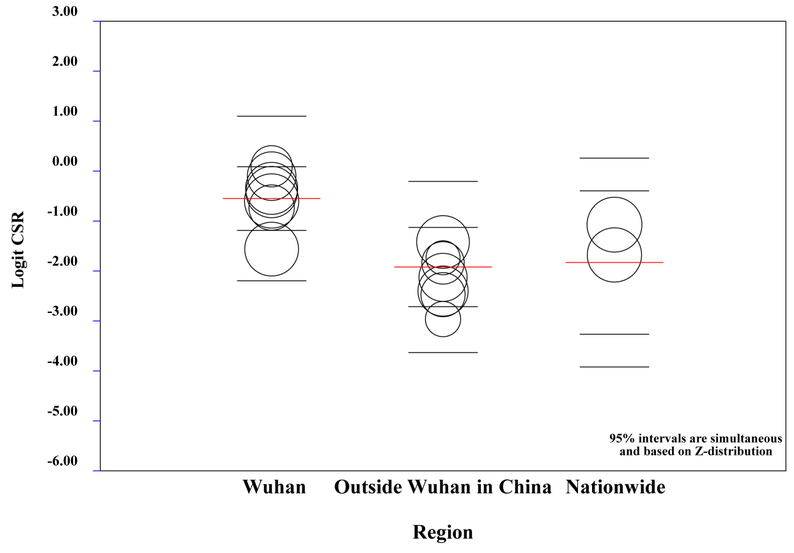
A



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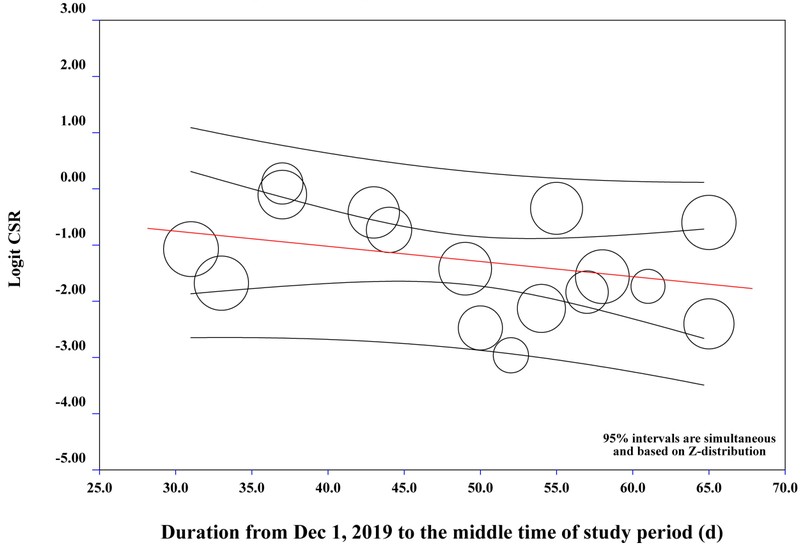

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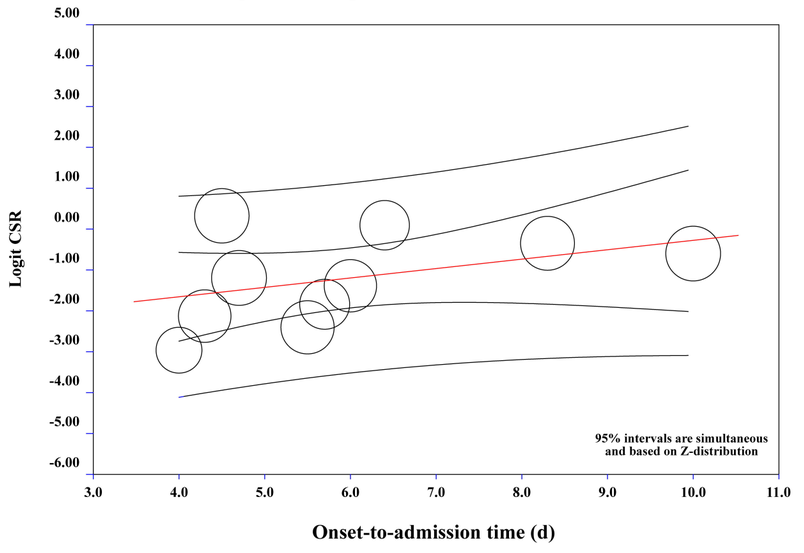

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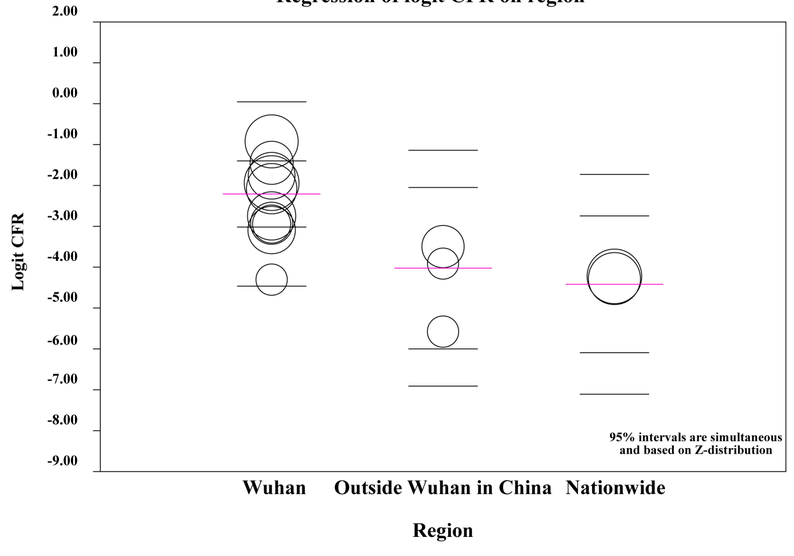

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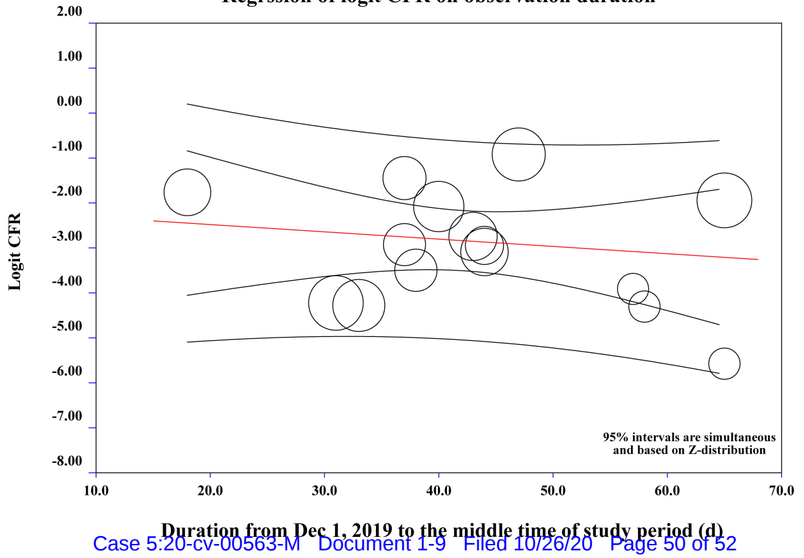
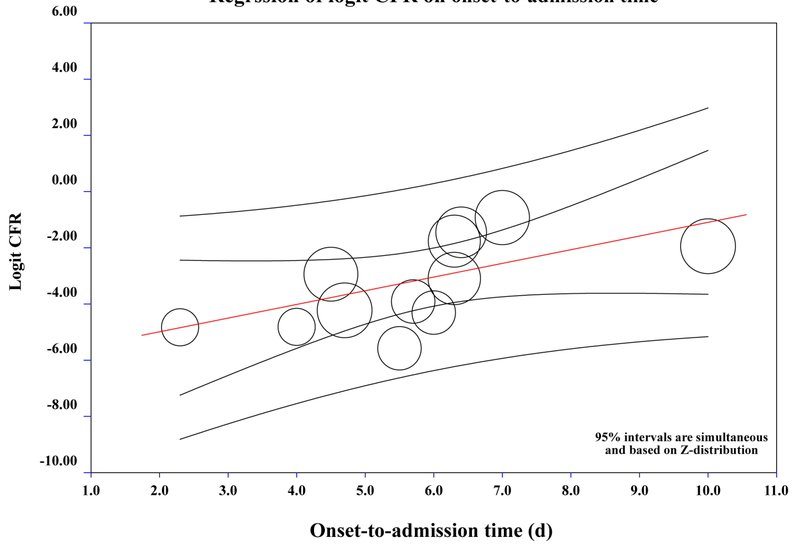


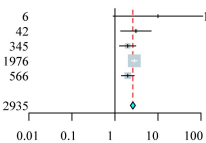
F



A Age

Study	> 50 y Events	> 50 y Total	≤ 50 y Events	≤ 50 y Total	OR	95%-CI	Weight
Guang Chen et al.	10	15	1	6	10.000	[0.907; 110.282]	0.2%
Jing Liu et al.	48	98	10	42	3.072	[1.362; 6.927]	2.6%
Luwen Wang et al.	54	232	46	345	1.972	[1.277; 3.046]	10.3%
Jinjin Zhang et al.	607	1689	328	1976	2.819	[2.415; 3.290]	70.0%
Jiatao Lu et al.	95	445	68	566	1.988	[1.415; 2.793]	17.0%
Fixed effect model		2479		2935	2.609	[2.288; 2.976]	100.0%

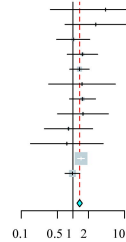
Heterogeneity: $I^2 = 37\%$, $\tau^2 = 0.0245$, $p = 0.173$



B Sex

Study	Male Events	Male Total	Female Events	Female Total	OR	95%-CI	Weight
Guang Chen et al.	10	17	1	4	4.286	[0.366; 50.197]	0.1%
Jing Liu et al.	7	15	6	25	2.771	[0.706; 10.882]	0.5%
Luwen Wang et al.	33	67	24	49	1.011	[0.484; 2.113]	3.1%
Jinjin Zhang et al.	33	71	25	69	1.528	[0.777; 3.008]	3.0%
Jiatao Lu et al.	50	254	50	323	1.338	[0.869; 2.061]	7.7%
Yishan Zheng at al.	5	55	3	48	1.500	[0.339; 6.635]	0.6%
Qingxian Cai et al.	33	144	25	154	1.534	[0.860; 2.735]	4.1%
Jingyuan Liu et al.	10	31	7	30	1.565	[0.504; 4.856]	1.1%
Zhichao Feng et al.	7	72	8	69	0.821	[0.281; 2.401]	1.6%
Lei Liu at al.	4	32	3	19	0.762	[0.151; 3.843]	0.7%
Yang Yang et al.	575	2013	360	1652	1.435	[1.233; 1.670]	61.8%
Weijie Guan et al.	100	640	73	459	0.979	[0.705; 1.360]	15.7%
Fixed effect model		3411		2901	1.348	[1.195; 1.521]	100.0%

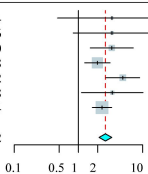
Heterogeneity: $I^2 = 0\%$, $\tau^2 = 0$, $p = 0.668$



C Any comorbidity

Study	Yes Events	Yes Total	No Events	No Total	Mean Difference	OR	95%-CI	Weight
Guang Chen et al.	5	7	6	14		3.333	[0.473; 23.471]	1.3%
Jing Liu et al.	7	14	6	26		3.333	[0.831; 13.372]	2.4%
Jinjin Zhang et al.	46	90	12	50		3.311	[1.534; 7.146]	8.6%
Jiatao Lu et al.	67	309	33	268		1.972	[1.252; 3.104]	31.6%
Qingxian Cai et al.	36	96	22	202		4.909	[2.679; 8.995]	10.1%
Zhichao Feng et al.	7	33	8	108		3.365	[1.118; 10.134]	3.4%
Weijie Guan et al.	65	255	108	844		2.331	[1.649; 3.297]	42.6%
Fixed effect model		804		1512		2.635	[2.098; 3.309]	100.0%

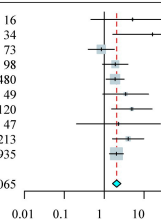
Heterogeneity: $I^2 = 12\%$, $\tau^2 = 0.0151$, $p = 0.340$



D Hypertension

Study	Yes Events	Yes Total	No Events	No Total	Mean Difference	OR	95%-CI	Weight
Guang Chen et al.	4	5	7	16		5.143	[0.465; 56.897]	0.8%
Jing Liu et al.	5	6	8	34		16.250	[1.648; 160.243]	0.5%
Luwen Wang et al.	20	43	37	73		0.846	[0.398; 1.800]	17.7%
Jinjin Zhang et al.	22	42	36	98		1.894	[0.911; 3.938]	12.4%
Jiatao Lu et al.	25	97	75	480		1.875	[1.118; 3.146]	22.6%
Jingyuan Liu et al.	6	12	11	49		3.455	[0.927; 12.875]	2.6%
Zhichao Feng et al.	6	21	9	120		4.933	[1.538; 15.820]	2.3%
Lei Liu at al.	1	4	6	47		2.278	[0.203; 25.613]	0.9%
Hongzhou Lu et al.	10	52	12	213		3.988	[1.617; 9.836]	4.6%
Weijie Guan et al.	41	164	132	935		2.028	[1.361; 3.021]	35.7%
Fixed effect model		446		2065		2.058	[1.614; 2.623]	100.0%

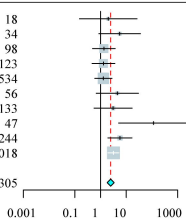
Heterogeneity: $I^2 = 36\%$, $\tau^2 = 0.1007$, $p = 0.121$



E Diabetes

Study	Yes Events	Yes Total	No Events	No Total	Mean Difference	OR	95%-CI	Weight
Guang Chen et al.	2	3	9	18		2.000	[0.153; 26.187]	2.0%
Jing Liu et al.	4	6	9	34		5.556	[0.864; 35.706]	2.1%
Luwen Wang et al.	10	18	47	98		1.356	[0.494; 3.726]	15.0%
Jinjin Zhang et al.	8	17	50	123		1.298	[0.469; 3.592]	14.9%
Jiatao Lu et al.	9	43	91	534		1.289	[0.598; 2.779]	24.8%
Jingyuan Liu et al.	3	5	14	56		4.500	[0.681; 29.748]	2.1%
Zhichao Feng et al.	2	8	13	133		3.077	[0.562; 16.835]	2.6%
Lei Liu at al.	4	4	3	47		114.429	[5.064; 2585.608]	0.2%
Hongzhou Lu et al.	6	21	16	244		5.700	[1.948; 16.683]	4.2%
Weijie Guan et al.	28	81	145	1018		3.181	[1.948; 5.194]	32.3%
Fixed effect model		206		2305		2.485	[1.818; 3.399]	100.0%

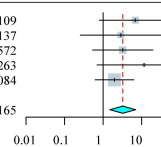
Heterogeneity: $I^2 = 44\%$, $\tau^2 = 0.2435$, $p = 0.067$



F Cerebrovascular disease

Study	Yes Events	Yes Total	No Events	No Total	Mean Difference	OR	95%-CI	Weight
Luwen Wang et al.	6	7	51	109		6.824	[0.795; 58.589]	14.1%
Jinjin Zhang et al.	2	3	56	137		2.893	[0.256; 32.679]	12.8%
Jiatao Lu et al.	2	5	98	572		3.224	[0.532; 19.553]	16.3%
Hongzhou Lu et al.	1	2	21	263		11.524	[0.696; 190.920]	2.5%
Weijie Guan et al.	4	15	169	1084		1.969	[0.620; 6.256]	54.2%
Fixed effect model		32		2165		3.219	[1.486; 6.972]	100.0%

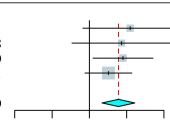
Heterogeneity: $I^2 = 0\%$, $\tau^2 = 0$, $p = 0.742$



G CKD

Study	Yes Events	Yes Total	No Events	No Total	Mean Difference	OR	95%-CI	Weight
Luwen Wang et al.	5	5	52	111		12.467	[0.673; 230.859]	15.7%
Jinjin Zhang et al.	2	2	56	138		7.301	[0.344; 154.960]	14.0%
Hongzhou Lu et al.	2	5	20	260		8.000	[1.262; 50.697]	15.9%
Weijie Guan et al.	3	8	170	1091		3.251	[0.770; 13.729]	54.4%
Fixed effect model		20		1600		6.017	[2.192; 16.514]	100.0%

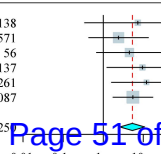
Heterogeneity: $I^2 = 0\%$, $\tau^2 = 0$, $p = 0.790$



H COPD

Study	Yes Events	Yes Total	No Events	No Total	Mean Difference	OR	95%-CI	Weight
Jinjin Zhang et al.	2	2	56	138		7.301	[0.344; 154.960]	7.7%
Jiatao Lu et al.	2	6	98	571		2.413	[0.436; 13.360]	26.3%
Jingyuan Liu et al.	3	5	14	56		4.500	[0.681; 29.748]	17.8%
Zhichao Feng et al.	2	4	13	137		9.538	[1.238; 73.471]	7.1%
Hongzhou Lu et al.	2	4	20	261		12.050	[1.611; 90.143]	5.8%
Weijie Guan et al.	6	12	167	1087		5.509	[1.756; 17.286]	35.3%
Fixed effect model				225		6.323	[2.613; 10.847]	100.0%

Heterogeneity: $I^2 = 0\%$, $\tau^2 = 0$, $p = 0.$



A PLT

Study	Severe Total	Mean	SD	Non-severe Total	Mean	SD	MD	95%-CI	Weight
Jingyuan Liu et al.	17	163.167	70.7407	44	179.433	50.9630	-16.267	[-53.112; 20.578]	4.8%
Weijie Guan et al.	173	138.667	59.6296	926	174.333	54.0741	-35.667	[-45.210; -26.123]	71.1%
Guang Chen et al.	11	164.200	45.8000	10	161.000	44.2000	3.200	[-35.310; 41.710]	4.4%
Zhichao Feng et al.	15	162.433	78.3704	126	188.767	77.1852	-26.333	[-68.221; 15.554]	3.7%
Lei Liu et al.	7	163.667	80.7407	44	189.333	72.5926	-25.667	[-89.209; 37.876]	1.6%
Jing Liu et al.	13	186.600	68.1000	27	181.400	70.7000	5.200	[-40.424; 50.824]	3.1%
Hongzhou Lu et al.	22	163.000	65.9259	243	179.333	57.0370	-16.333	[-44.800; 12.133]	8.0%
Yishan Zheng et al.	8	152.375	43.4710	95	216.053	160.0936	-63.678	[-107.767; -19.589]	3.3%
Fixed effect model	266			1515			-30.654	[-38.703; -22.605]	100.0%

Heterogeneity: $I^2 = 31\%$, $\tau^2 = 111.7039$, $p = 0.179$

Mean Difference: -100 -50 0 50 100

B Lymphocyte

Study	Severe Total	Mean	SD	Non-severe Total	Mean	SD	MD	95%-CI	Weight
Qingxian Cai et al.	58	0.937	0.4000	240	1.367	0.5926	-0.430	[-0.557; -0.303]	11.1%
Jinjin Zhang et al.	58	0.733	0.3704	82	0.867	0.4444	-0.133	[-0.269; 0.002]	10.8%
Jingyuan Liu et al.	17	0.900	0.2963	44	1.133	0.3704	-0.233	[-0.412; -0.055]	9.2%
Weijie Guan et al.	173	0.800	0.2963	926	1.067	0.4444	-0.267	[-0.319; -0.214]	13.6%
Guang Chen et al.	11	0.700	0.3000	10	1.100	0.3000	-0.400	[-0.657; -0.143]	6.7%
Zhichao Feng et al.	15	0.767	0.2963	126	1.200	0.5926	-0.433	[-0.616; -0.251]	9.1%
Lei Liu et al.	7	0.423	0.2222	44	1.300	0.5926	-0.877	[-1.117; -0.636]	7.1%
Jing Liu et al.	13	0.667	0.1481	27	1.100	0.4444	-0.433	[-0.619; -0.247]	8.9%
Hongzhou Lu et al.	22	0.733	0.3704	243	1.200	0.4444	-0.467	[-0.631; -0.302]	9.7%
Jiatao Lu et al.	100	0.633	0.3704	338	0.933	0.5185	-0.300	[-0.391; -0.209]	12.4%
Yishan Zheng et al.	8	1.220	0.8070	95	1.688	2.3820	-0.468	[-1.204; 0.268]	1.4%
Random effects model	482			2175			-0.376	[-0.467; -0.285]	100.0%

Heterogeneity: $I^2 = 76\%$, $\tau^2 = 0.0151$, $p < 0.001$

Mean Difference: -1 -0.5 0 0.5 1

C LDH

Study	Severe Total	Mean	SD	Non-severe Total	Mean	SD	MD	95%-CI	Weight
Guang Chen et al.	11	567.200	217.1000	10	234.400	46.7000	332.800	[201.280; 464.320]	13.3%
Lei Liu et al.	7	295.333	30.3704	44	221.667	60.7407	73.667	[44.887; 102.447]	25.2%
Jing Liu et al.	13	462.400	190.6000	27	221.500	71.2000	240.900	[133.866; 347.934]	16.0%
Hongzhou Lu et al.	22	374.667	120.0000	243	232.167	61.8519	142.500	[91.757; 193.243]	23.0%
Yishan Zheng et al.	8	295.375	78.4250	95	222.082	70.6071	73.293	[17.124; 129.462]	22.4%
Random effects model	61			419			150.702	[82.569; 218.836]	100.0%

Heterogeneity: $I^2 = 84\%$, $\tau^2 = 4572.7399$, $p < 0.001$

Mean Difference: -400 -200 0 200 400

D D-dimer

Study	Severe Total	Mean	SD	Non-severe Total	Mean	SD	MD	95%-CI	Weight
Qingxian Cai et al.	58	1.142	1.0259	240	0.373	0.2000	0.768	[0.503; 1.034]	33.2%
Jinjin Zhang et al.	58	1.000	1.6296	82	0.200	0.1481	0.800	[0.379; 1.221]	13.2%
Guang Chen et al.	11	8.200	9.0000	10	0.400	0.3000	7.800	[2.478; 13.122]	0.1%
Lei Liu et al.	7	0.760	0.8296	44	0.307	0.2074	0.453	[-0.164; 1.071]	6.1%
Jing Liu et al.	13	1.033	0.5926	27	0.467	0.4444	0.567	[0.204; 0.930]	17.7%
Hongzhou Lu et al.	22	1.600	2.2222	243	0.463	0.3259	1.137	[0.207; 2.066]	2.7%
Jiatao Lu et al.	100	1.033	1.4815	338	0.333	0.4444	0.700	[0.406; 0.994]	27.0%
Fixed effect model	269			984			0.715	[0.562; 0.868]	100.0%

Heterogeneity: $I^2 = 35\%$, $\tau^2 = 0.0259$, $p = 0.160$

Mean Difference: -10 -5 0 5 10

E CRP

Study	Severe Total	Mean	SD	Non-severe Total	Mean	SD	MD	95%-CI	Weight
Qingxian Cai et al.	58	68.853	57.5407	240	17.537	22.5037	51.317	[36.237; 66.396]	11.7%
Jinjin Zhang	58	51.767	49.2593	82	30.100	31.5556	21.667	[7.267; 36.067]	11.9%
Jingyuan Liu et al.	17	32.467	50.7407	44	11.933	13.5556	20.533	[-3.917; 44.984]	8.3%
Guang Chen et al.	11	135.200	52.4000	10	51.400	50.8000	83.800	[39.639; 127.961]	4.1%
Zhichao Feng et al.	15	40.200	19.7037	126	17.633	11.7778	22.567	[12.386; 32.748]	13.5%
Lei Liu et al.	7	133.500	71.8519	44	11.233	15.8519	122.267	[68.833; 175.700]	3.0%
Jing Liu et al.	13	63.967	32.7407	27	22.667	40.1481	41.300	[17.931; 64.669]	8.7%
Hongzhou Lu et al.	22	56.700	56.0000	243	11.333	16.0000	45.367	[21.880; 68.853]	8.6%
Jiatao Lu et al.	100	32.967	9.4074	338	23.600	20.8148	9.367	[6.482; 12.252]	15.3%
Yishan Zheng et al.	8	10.798	5.5660	95	3.914	13.7848	6.884	[2.134; 11.634]	15.0%
Random effects model	309			1249			30.395	[20.006; 40.784]	100.0%

Heterogeneity: $I^2 = 89\%$, $\tau^2 = 181.8541$, $p < 0.001$

Mean Difference: -150 -100 -50 0 50 100 150

F AST

Study	Severe Total	Mean	SD	Non-severe Total	Mean	SD	MD	95%-CI	Weight
Guang Chen et al.	11	51.000	28.3000	10	24.200	4.1000	26.800	[9.884; 43.716]	12.7%
Lei Liu et al.	7	25.667	14.8148	44	22.000	9.6296	3.667	[-7.671; 15.004]	19.4%
Jing Liu et al.	13	51.200	18.7000	27	25.900	9.5000	25.300	[14.522; 36.078]	20.2%
Hongzhou Lu et al.	22	40.900	17.6296	243	24.667	8.8889	16.233	[8.782; 23.684]	25.7%
Yishan Zheng et al.	8	33.813	13.5470	95	23.344	10.4107	10.469	[0.851; 20.087]	22.1%
Random effects model	61			419			15.697	[8.117; 23.278]	100.0%

Heterogeneity: $I^2 = 61\%$, $\tau^2 = 43.7502$, $p = 0.038$

Mean Difference: -40 -20 0 20 40

Age, Sex, Existing Conditions of COVID-19 Cases and Deaths

Last updated: May 13, 18:00 GMT

Current Statistics

Age of Coronavirus Deaths

We are collecting and analyzing the data from all US States. In the meantime, below we show the data provided by New York City Health as of May 13, 2020:

AGE	Number of Deaths	Share of deaths	With underlying conditions	Without underlying conditions	Unknown if with underlying cond.	Share of deaths of unknown + w/o cond.
0 - 17 years old	9	**0.06%**	6	3	0	0.02%
18 - 44 years old	601	**3.9%**	476	17	108	0.8%
45 - 64 years old	3,413	**22.4%**	2,851	72	490	3.7%
65 - 74 years old	3,788	**24.9%**	2,801	5	982	6.5%
75+ years old	7,419	**48.7%**	5,236	2	2,181	14.3%
TOTAL	**15,230**	100%	11,370 (75%)	99 (0.7%)	1,551 (24.7%)	25.3%

April 14 Data

For comparison, below is the data provided by **New York City Health** as of April 14. It can be noted that the absolute number of deaths of patients without underlying conditions was actually higher in this earlier report compared to the May 13 one, signaling the data has been since corrected and revised downward.

AGE	Number of Deaths	Share of deaths	With underlying conditions	Without underlying conditions	Unknown if with underlying cond.	Share of deaths of unknown + w/o cond.
0 - 17 years old	3	**0.04%**	3	0	0	0%
18 - 44 years old	309	**4.5%**	244	25	40	1.0%
45 - 64 years old	1,581	**23.1%**	1,343	59	179	3.5%
65 - 74 years old	1,683	**24.6%**	1,272	26	385	6.0%
75+ years old	3,263	**47.7%**	2,289	27	947	14.2%

TOTAL	**6,839**	100%	5,151	137 (2.0%)	1,551	24.68%

[1] Underlying illnesses include Diabetes, Lung Disease, Cancer, Immunodeficiency, Heart Disease, Hypertension, Asthma, Kidney Disease, and GI/Liver Disease. [source]

Sex ratio

Data provided by **New York City Health** as of April 14, for known sex of deceased:

SEX	Deaths	Share of Deaths	With underlying conditions	Share within this category	Without underlying conditions	Share within this category	Unknown if with cond.	Share within this category
Male	4,095	**61,8%**	3,087	62,2%	96	72.2%	912	59.5%
Female	2,530	**38.2%**	1.873	37.8%	37	27.8%	620	40.5%

Older Statistics

Data from initial studies in China

At the end of February, there were two sources that provided age, sex, and comorbidity statistics:

- The *Report of the WHO-China Joint Mission* published on Feb. 28 by WHO, [2] which is based on **55,924 laboratory confirmed cases**. The report notes that "*The Joint Mission acknowledges the known **challenges and biases of reporting crude CFR early in an epidem**ic*" (see also our discussion on: How to calculate the mortality rate during an outbreak)
- A paper by the Chinese CCDC released on Feb. 17, which is based on **72,314 confirmed, suspected, and asymptomatic cases** of COVID-19 in China as of Feb. 11, and was published in the Chinese Journal of Epidemiology [1]

We will list data from both, labeling them as "**confirmed cases**" and "**all cases**" respectively in the tables.

Age of Coronavirus Deaths

COVID-19 Fatality Rate by AGE:

*__Death Rat__e = (number of deaths / number of cases) = **probability of dying if infected by the virus** (%). This probability differs depending on the age group. The percentages shown below **do not have to add up to 100%**, as they **do NOT represent share of deaths by age** group. Rather, it represents, for a person in a given age group, the **risk of dying** if infected with COVID-19.

AGE	DEATH RATE confirmed cases	DEATH RATE all cases
80+ years old	**21.9%**	**14.8%**
70-79 years old		**8.0%**
60-69 years old		**3.6%**
50-59 years old		**1.3%**
40-49 years old		**0.4%**
30-39 years old		**0.2%**

20-29 years old		**0.2%**
10-19 years old		**0.2%**
0-9 years old		**no fatalities**

*__Death Rat__e = (number of deaths / number of cases) = **probability of dying if infected by the virus** (%). The percentages **do not have to add up to 100%**, as they **do NOT represent share of deaths by age** group.

In general, relatively few cases are seen among children.

Sex ratio

COVID-19 Fatality Rate by SEX:

*__Death Rate__ = (number of deaths / number of cases) = **probability of dying if infected by the virus** (%). This probability differs depending on sex. When reading these numbers, it must be taken into account that **smoking** in China is much more prevalent among males. Smoking increases the risks of respiratory complications.

SEX	DEATH RATE confirmed cases	DEATH RATE all cases
Male	**4.7%**	**2.8%**
Female	**2.8%**	**1.7%**

*__Death Rat__e = (number of deaths / number of cases) = **probability of dying if infected by the virus** (%). The percentages **do not have to add up to 100%**, as they **do NOT represent share of deaths by sex.**

Pre-existing medical conditions (comorbidities)

Patients who reported no pre-existing ("comorbid") medical conditions had a case fatality rate of 0.9%. Pre-existing illnesses that put patients at higher risk of dying from a COVID-19 infection are:

COVID-19 Fatality Rate by COMORBIDITY:

*__Death Rat__e = (number of deaths / number of cases) = **probability of dying if infected by the virus** (%). This probability differs depending on pre-existing condition. The percentage shown below does **NOT represent in any way the share of deaths by pre-existing condition**. Rather, it represents, for a patient with a given pre-existing condition, the **risk of dying** if infected by COVID-19.

PRE-EXISTING CONDITION	DEATH RATE confirmed cases	DEATH RATE all cases
Cardiovascular disease	**13.2%**	**10.5%**
Diabetes	**9.2%**	**7.3%**
Chronic respiratory disease	**8.0%**	**6.3%**
Hypertension	**8.4%**	**6.0%**
Cancer	**7.6%**	**5.6%**
no pre-existing conditions		**0.9%**

*__Death Rate__ = (number of deaths / number of cases) = **probability of dying if infected by the virus** (%). The percentages **do not have to add up to 100%**, as they **do NOT represent share of deaths by condition.**

Coronavirus Worldometer Sections:

- **Coronavirus Update**
- **Case statistics and graphs**
- **Death statistics and graphs**
- **Mortality Rate**
- **Incubation Period**
- **Age, Sex, Existing Condition**
- **Symptoms**
- **Countries with cases: basic list - detailed list**

Sources

1. The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) - China CCDC, February 17 2020
2. Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19) [Pdf] - World Health Organization, Feb. 28, 2020

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Exhibit 10

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Older Adults

Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness.

Steps to Reduce Risk of Getting Sick

There are things you can do to reduce your risk of getting sick.

- Stay home if possible.
- Wash your hands often.
- Keep space between yourself and others (stay 6 feet away, which is about two arm lengths).
- What You Can Do
- How to Protect Yourself

Stress & Coping

You may feel increased stress during this pandemic. Fear and anxiety can be overwhelming and cause strong emotions. Learn about stress and coping.

Symptoms

Symptoms of COVID-19 can range from mild symptoms to severe illness and death. Symptoms may appear 2-14 days after exposure. Watch for fever, cough, and shortness of breath. Watch for symptoms.

Develop a Care Plan

A care plan summarizes your health conditions, medications, healthcare providers, emergency contacts, and end-of-life care options (for example, advance directives). Complete your care plan in consultation with your doctor, and if needed, with help from a family member or home nurse aide.

A care plan can have benefits beyond the current pandemic. You can update your care plan every year, or any time you have a change in your health or medications. Care plans can help reduce emergency room visits and hospitalizations, and improve overall medical management for people with a chronic health condition, resulting in better quality of life.

During the COVID-19 pandemic, having a care plan is an important part of emergency preparedness.

- Guidance on how to develop your emergency preparedness care plan.
- Download a fillable care plan form [5 pages]
- Serious Illness Care Program COVID-19 Response Toolkit

Senior Living Facilities

People with loved ones in nursing homes, assisted living facilities, and other types of senior living facilities may be understandably concerned about their loved one's risk of illness from COVID-19.

To protect these vulnerable friends and family members, CDC has advised that long-term care facilities

- restrict visitors,
- regularly check healthcare workers and residents for fevers and symptoms, and
- limit activities within the facility to keep residents safe.

Older Adults are at Higher Risk

8 out of 10 deaths reported in the U.S. have been in adults 65 years old and older. See below for estimated percent of adults with confirmed COVID-19 reported in the U.S:

	Adults 65 – 84	Adults 85+
Hospitalizations	31-59%	31-70%
Admission to intensive care	11-31%	6-29%
Deaths	4-11%	10-27%

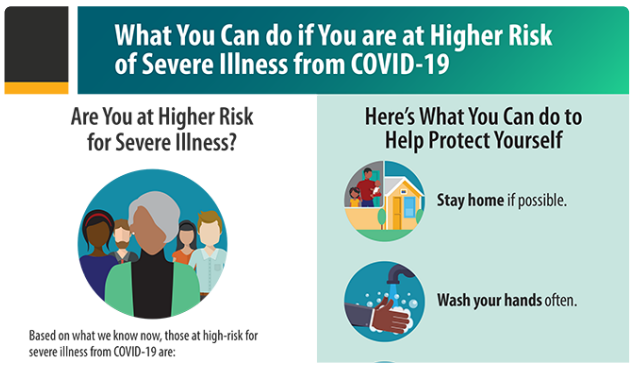
Digital Resources

What Older Adults Need to Know

Preventative actions to help protect older adults.

AARP Live Question & Answer Events

Experts share information about how to protect yourself



What You Can do if You Are at a Higher Risk (PDF)

Learn what you can do to protect yourself.

More Information

- People at Higher Risk
- Prevent Getting Sick
- If You Are Sick
- Symptoms & Testing
- Cases & Latest Updates
- Guidance for Caregivers of People Living with Dementia in Community Settings

Page last reviewed: April 30, 2020

Exhibit 11

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

MENU >

COVID-19 Hospitalization and Death by Age

Hospitalization and Death by Age

Updated Aug. 18, 2020 Print

Rate ratios compared to 18-29 year olds

	Hospitalization[1]	Death[2]
0-4 years	4x lower	9x lower
5-17 years	9x lower	16x lower
18-29 years	Comparison Group	Comparison Group
30-39 years	2x higher	4x higher
40-49 years	3x higher	10x higher
50-64 years	4x higher	30x higher
65-74 years	5x higher	90x higher
75-84 years	8x higher	220x higher
85+ years	13x higher	630x higher

Factors that increase community spread and individual risk

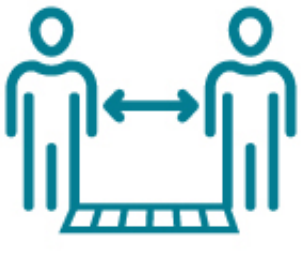
Crowded Situations

Close/physical contact

Enclosed space

Duration of exposure

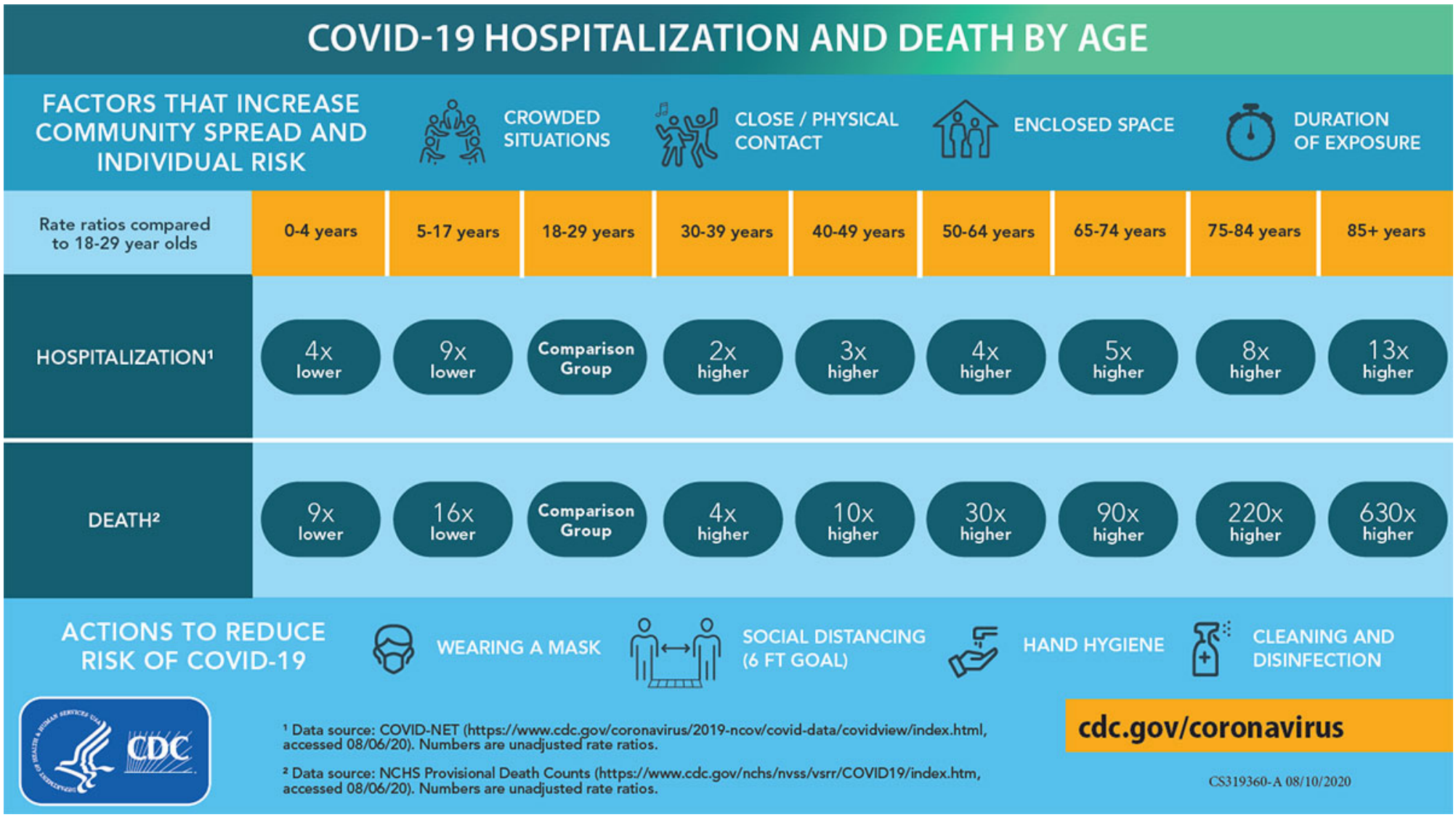
Actions to reduce risk of COVID-19



Wearing a mask	Social distancing (6 ft goal)	Hand hygiene	Cleaning and disinfecting

[1] Data source: COVID-NET (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, accessed 08/06/20). Numbers are unadjusted rate ratios.

[2] Data source: NCHS Provisional Death Counts (https://www.cdc.gov/nchs/nvss/vsrr/COVID19/index.htm, accessed 08/06/20). Numbers are unadjusted rate ratios.



Last Updated Aug. 18, 2020

Exhibit 12

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

MENU >

Social Distancing

Keep a Safe Distance to Slow the Spread.

Updated July 15, 2020 Print

Limiting close face-to-face contact with others is the best way to reduce the spread of coronavirus disease 2019 (COVID-19).

What is social distancing?

Social distancing, also called “physical distancing,” means keeping a safe space between yourself and other people who are not from your household.

To practice social or physical distancing, stay at least 6 feet (about 2 arms’ length) from other people who are not from your household in both indoor and outdoor spaces.

Social distancing should be practiced in combination with other everyday preventive actions to reduce the spread of COVID-19, including wearing masks, avoiding touching your face with unwashed hands, and frequently washing your hands with soap and water for at least 20 seconds.

Why practice social distancing?

COVID-19 spreads mainly among people who are in close contact (within about 6 feet) for a prolonged period. Spread happens when an infected person coughs, sneezes, or talks, and droplets from their mouth or nose are launched into the air and land in the mouths or noses of people nearby. The droplets can also be inhaled into the lungs. Recent studies indicate that people who are infected but do not have symptoms likely also play a role in the spread of COVID-19. Since people can spread the virus before they know they are sick, it is important to stay at least 6 feet away from others when possible, even if you—or they—do not have any symptoms. Social distancing is especially important for people who are at higher risk for severe illness from COVID-19.

If you are sick with COVID-19, have symptoms consistent with COVID-19, or have been in close contact with someone who has COVID-19, it is important to stay home and away from other people until it is safe to be around others.

COVID-19 can live for hours or days on a surface, depending on factors such as sunlight, humidity, and the type of surface. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or eyes. However, this is not thought to be the main way the virus spreads. Social distancing helps limit opportunities to come in contact with contaminated surfaces and infected people outside the home.

Although the risk of severe illness may be different for everyone, anyone can get and spread COVID-19. Everyone has a role to play in slowing the spread and protecting themselves, their family, and their community. In addition to practicing everyday steps to prevent COVID-19, keeping space between you and others is one of the best tools we have to avoid being exposed to this virus and slowing its spread in communities.

Tips for Social Distancing

When going out in public, it is important to stay at least 6 feet away from other people and wear a mask to slow the spread of COVID-19. Consider the following tips for practicing social distancing when you decide to go out.

- **Know Before You Go:** Before going out, know and follow the guidance from local public health authorities where you live.
- **Prepare for Transportation:** Consider social distancing options to travel safely when running errands or commuting to and from work, whether walking, bicycling, wheelchair rolling, or using public transit, rideshares, or taxis. When using public transit, try to keep at least 6 feet from other passengers or transit operators – for example, when you are waiting at a bus station or selecting seats on a bus or train. When using rideshares or taxis, avoid pooled rides where multiple passengers are picked up, and sit in the back seat in larger vehicles so you can remain at least 6 feet away from the driver. Follow these additional tips to protect yourself while using transportation.
- **Limit Contact When Running Errands:** Only visit stores selling household essentials in person when you absolutely need to, and stay at least 6 feet away from others who are not from your household while shopping and in lines. If possible, use drive-thru, curbside pick-up, or delivery services to limit face-to-face contact with others. Maintain physical distance between yourself and delivery service providers during exchanges and wear a mask.
- **Choose Safe Social Activities:**It is possible to stay socially connected with friends and family who don't live in your home by calling, using video chat, or staying connected through social media. If meeting others in person (e.g., at small outdoor gatherings, yard or driveway gathering with a small group of friends or family members), stay at least 6 feet from others who are not from your household. Follow these steps to stay safe if you will be participating in personal and social activities outside of your home.
- **Keep Distance at Events and Gatherings**: It is safest to avoid crowded places and gatherings where it may be difficult to stay at least 6 feet away from others who are not from your household. If you are in a crowded space, try to keep 6 feet of space between yourself and others at all times, and wear a mask. Masks are especially important in times when physical distancing is difficult. Pay attention to any physical guides, such as tape markings on floors or signs on walls, directing attendees to remain at least 6 feet apart from each other in lines or at other times. Allow other people 6 feet of space when you pass by them in both indoor and outdoor settings.
- **Stay Distanced While Being Active**: Consider going for a walk, bike ride, or wheelchair roll in your neighborhood or in another safe location where you can maintain at least 6 feet of distance between yourself and other pedestrians and cyclists. If you decide to visit a nearby park, trail, or recreational facility, first check for closures or restrictions. If open, consider how many other people might be there and choose a location where it will be possible to keep at least 6 feet of space between yourself and other people who are not from your household.

Many people have personal circumstances or situations that present challenges with practicing social distancing to prevent the spread of COVID-19. Please see the following guidance for additional recommendations and considerations:

- Households Living in Close Quarters: How to Protect Those Who Are Most Vulnerable
- Living in Shared Housing
- People with Disabilities
- People Experiencing Homelessness

More Information

- How to Protect Yourself
- Cleaning and Disinfecting Your Home
- Gatherings and Community Events

Last Updated July 15, 2020

Exhibit 13

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

MENU >

How to Protect Yourself & Others

Updated Sept. 11, 2020 Print

Older adults and people who have certain underlying conditions like heart or lung disease or diabetes are at increased risk of severe illness from COVID-19 illness. More information on Are you at higher risk for serious illness.

Know how it spreads

- There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19).
- **The best way to prevent illness is to avoid being exposed to this virus.**
- The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person coughs, sneezes or talks.
  - These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
  - Some recent studies have suggested that COVID-19 may be spread by people who are not showing symptoms.

Everyone Should

Wash your hands often

- Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.
- It's especially important to wash:
  - Before eating or preparing food
  - Before touching your face
  - After using the restroom
  - After leaving a public place
  - After blowing your nose, coughing, or sneezing
  - After handling your mask
  - After changing a diaper
  - After caring for someone sick
  - After touching animals or pets
- If soap and water are not readily available, **use a hand sanitizer that contains at least 60% alcohol**. Cover all surfaces of your hands and rub them together until they feel dry.

all surfaces of your hands and rub them together until they feel dry.

- **Avoid touching your eyes, nose, and mouth** with unwashed hands.

Avoid close contact

- **Inside your home:** Avoid close contact with people who are sick.
  - If possible, maintain 6 feet between the person who is sick and other household members.
- **Outside your home:** Put 6 feet of distance between yourself and people who don't live in your household.
  - Remember that some people without symptoms may be able to spread virus.
  - Stay at least 6 feet (about 2 arms' length) from other people.
  - Keeping distance from others is especially important for people who are at higher risk of getting very sick.

Cover your mouth and nose with a mask when around others

- You could spread COVID-19 to others even if you do not feel sick.
- The mask is meant to protect other people in case you are infected.
- Everyone should wear a mask in public settings and when around people who don't live in your household, especially when other social distancing measures are difficult to maintain.
  - Masks should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- Do NOT use a mask meant for a healthcare worker. Currently, surgical masks and N95 respirators are critical supplies that should be reserved for healthcare workers and other first responders.
- Continue to keep about 6 feet between yourself and others. The mask is not a substitute for social distancing.

Cover coughs and sneezes

- **Always cover your mouth and nose** with a tissue when you cough or sneeze or use the inside of your elbow and do not spit.
- **Throw used tissues** in the trash.
- Immediately **wash your hands** with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

Clean and disinfect

- **Clean AND disinfect** frequently touched surfaces **daily**. This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- **If surfaces are dirty, clean them.** Use detergent or soap and water prior to disinfection.
- **Then, use a household disinfectant.** Most common EPA-registered household disinfectants will work.

Monitor Your Health Daily

- **Be alert for symptoms.** Watch for fever, cough, shortness of breath, or other symptoms **of COVID-19.**
  - Especially important if you are running essential errands, going into the office or workplace, and in settings where it may be difficult to keep a physical distance of 6 feet.
- **Take your temperature** if symptoms develop.

- Don't take your temperature within 30 minutes of exercising or after taking medications that could lower your temperature, like acetaminophen.

- Follow CDC guidance if symptoms develop.

Protect Your Health This Flu Season

It's likely that flu viruses and the virus that causes COVID-19 will **both** spread this fall and winter. Healthcare systems could be overwhelmed treating both patients with flu and patients with COVID-19. This means getting a flu vaccine during 2020-2021 is more important than ever.

While getting a flu vaccine will not protect against COVID-19 there are many important benefits, such as:

1. Flu vaccines have been shown to reduce the risk of flu illness, hospitalization, and death.
2. Getting a flu vaccine can also save healthcare resources for the care of patients with COVID-19.

Stop the Spread of Germs

Robert R. Redfield, MD | #COVIDStopsWithMe

CDC Director Robert R. Redfield, MD discusses how we can slow the spread of COVID-19.

COVID-19 Stop the Spread of Germs

Help stop the spread of COVID-19 and other respiratory illnesses by following these steps.

Handwashing Resources

View handwashing video in Spanish

View handwashing video in French

Handwashing tips

Hand Hygiene in Healthcare Settings

More information

Symptoms

What to do if you are sick

If someone in your house gets sick

Frequently asked questions

Travelers

Individuals, schools, events, businesses and more

Healthcare Professionals

10 Things You Can Do to Manage COVID-19 at Home

Frequently asked questions

10 Things You Can Do to Manage COVID-19 at Home

10 Things You Can Do to Manage COVID-19 at Home (ASL Version)

ASL Video Series: What You Need to Know About Handwashing

Social Distancing (ASL Video)

Last Updated Sept. 11, 2020

Exhibit 14

COVID-19 in Correctional and Detention Facilities — United States, February–April 2020

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On May 6, 2020, this report was posted as an MMWR *Early Release on the* MMWR *website (https://www.cdc.gov/mmwr).*

An estimated 2.1 million U.S. adults are housed within approximately 5,000 correctional and detention facilities† on any given day (*1*). Many facilities face significant challenges in controlling the spread of highly infectious pathogens such as SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19). Such challenges include crowded dormitories, shared lavatories, limited medical and isolation resources, daily entry and exit of staff members and visitors, continual introduction of newly incarcerated or detained persons, and transport of incarcerated or detained persons in multiperson vehicles for court-related, medical, or security reasons (*2*,*3*). During April 22–28, 2020, aggregate data on COVID-19 cases were reported to CDC by 37 of 54 state and territorial health department jurisdictions. Thirty-two (86%) jurisdictions reported at least one laboratory-confirmed case from a total of 420 correctional and detention facilities. Among these facilities, COVID-19 was diagnosed in 4,893 incarcerated or detained persons and 2,778 facility staff members, resulting in 88 deaths in incarcerated or detained persons and 15 deaths among staff members. Prompt identification of COVID-19 cases and consistent application of prevention measures, such as symptom screening and quarantine, are critical to protecting incarcerated and detained persons and staff members.

To estimate the prevalence of COVID-19 in U.S. correctional and detention facilities, CDC requested aggregate surveillance data from 54 state and territorial health department jurisdictions. Data were provided to CDC during April 22–28, 2020 and included laboratory-confirmed cases identified and reported to jurisdictions during January 21–April 21, 2020. Requested data elements included 1) the number of facilities that had reported at least one laboratory-confirmed COVID-19 case; 2) the cumulative number of incarcerated or detained persons and staff members with laboratory-confirmed COVID-19; and 3) the cumulative number of COVID-19–associated hospitalizations and deaths among incarcerated or detained persons and staff members. Jurisdictions were asked to include data for persons in the custody of or working for state and local corrections, U.S. Immigration and Customs Enforcement, U.S. Marshals Service, and Federal Bureau of Prisons. Data on the number tested or persons with negative test results were not requested.

Thirty-seven (69%) jurisdictions provided aggregate surveillance data; 32 (86%) of those reported at least one laboratory-confirmed COVID-19 case among incarcerated or detained persons or staff members. In those 32 jurisdictions, 420 facilities reported 4,893 COVID-19 cases among incarcerated or detained persons and 2,778 cases among staff members (Table). More than half (221; 53%) of the affected facilities reported cases only among staff members. Among COVID-19 cases in incarcerated or detained persons, 491 (10%) COVID-19–associated hospitalizations and 88 (2%) deaths were reported; among staff member cases, 79 (3%) hospitalizations and 15 (1%) deaths were reported. Among the 32 jurisdictions reporting cases, the median number of affected facilities was 10 (range = 1–59), the median number of cases in incarcerated or detained persons was 34 (range = 0–858), and the median number of cases in staff members was 26 (range = 1–756).

Discussion

This analysis provides the first documentation of the number of reported laboratory-confirmed cases of COVID-19 in correctional and detention facilities in the United States, although information on the proportion of incarcerated and detained persons and staff members tested was not available. Approximately one half of facilities with COVID-19 cases reported them among staff members but not among incarcerated persons. Because staff members move between correctional facilities and their communities daily, they might be an important source of virus introduction into facilities. Regular symptom screening can help to reduce introduction of the virus from symptomatic persons, whether through staff members,

* These authors contributed equally.
† Correctional facilities refer to state and federal prisons, which incarcerate persons who have been tried for a crime, convicted, and sentenced for a duration >1 year. Those convicted of federal crimes are incarcerated in federal prisons; those convicted of state crimes are held in state prisons. Detention facilities refer to jails or detention centers, which temporarily detain persons awaiting sentencing or deportation, usually for a duration of <1 year.

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Summary

What is already known about this topic?

Correctional and detention facilities face challenges in controlling the spread of infectious diseases because of crowded, shared environments and potential introductions by staff members and new intakes.

What is added by this report?

Among 37 jurisdictions reporting, 32 (86%) reported at least one confirmed COVID-19 case among incarcerated or detained persons or staff members, across 420 correctional and detention facilities. As of April 21, 2020, 4,893 cases and 88 deaths among incarcerated and detained persons and 2,778 cases and 15 deaths among staff members have been reported.

What are the implications for public health practice?

Prompt identification of persons with COVID-19 and consistent application of prevention measures within correctional and detention facilities are critical to protecting incarcerated or detained persons, staff members, and the communities to which they return.

new intakes, or incarcerated or detained persons who attend court-related or medical appointments in the community. Screening all incarcerated or detained persons quarantined as close contacts of a case twice daily and promptly isolating persons with symptoms can help identify persons infected as a result of transmission that occurred within the facility and control spread of disease.

Although symptom screening is important, an investigation of a COVID-19 outbreak in a skilled nursing facility found that approximately one half of cases identified through facility-wide testing were among asymptomatic and presymptomatic persons, who likely contributed to transmission (*4*). These data indicate that symptom screening alone is inadequate to promptly identify and isolate infected persons in congregate settings such as correctional and detention facilities. Additional strategies, including physical distancing, movement restrictions, use of cloth face coverings, intensified cleaning, infection control training for staff members, and disinfection of high-touch surfaces in shared spaces are recommended to prevent and manage spread within correctional and detention facilities (Box). Some jurisdictions have implemented decompression strategies to reduce crowding, such as reducing or eliminating bail and releasing persons to home confinement or community supervision. Testing might become an important strategy to include when it is more widely available and when facilities have developed plans for how the results can be used to inform operational strategies to reduce transmission risk.

The findings in this report are subject to at least six limitations, each of which could result in an underestimation of the number of COVID-19 cases in correctional facilities. First, only 69% of jurisdictions reported data; therefore, these results are not representative of the entire United States. Second, many facilities do not provide testing to staff members, making data completeness dependent on staff members self-reporting their diagnosis to their employer after being tested by their personal health care providers. Third, some jurisdictions received data only from state prisons and were missing data from local jails and federal or privately operated facilities. Fourth, data on the total number of facilities, the total number of incarcerated and detained persons, and the total number staff members were not available; thus, proportions of facilities and persons affected could not be determined. Fifth, one jurisdiction reported only collecting data on facility outbreaks (defined by the jurisdiction as >1 COVID-19 case per facility). Finally, data are not available to determine the extent to which variations in testing availability and testing practices across states influenced the number of COVID-19 cases reported among staff and incarcerated and detained persons.

Prompt identification of COVID-19 cases and consistent application of prevention measures are critical to protecting incarcerated and detained persons, correctional and detention facility staff members, and the communities to which they return (*3*). Additional data on COVID-19 in correctional and detention settings, particularly from facilities that have conducted broad-based testing, is needed to identify differences in disease risk based on demographic characteristics, underlying medical conditions, and type of correctional and detention setting, and to evaluate the effectiveness of mitigation measures. CDC recommends that facility administrators, with the support of local health departments and partners, prepare for potential SARS-CoV-2 transmission, implement prevention measures, and follow guidance for the management of suspected and confirmed COVID-19 cases to prevent further transmission, which is available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (*3*).

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TABLE. COVID-19 among incarcerated and detained persons and correctional and detention facility staff members — 32 U.S. state and territorial health department reporting jurisdictions,* January 21–April 21, 2020†

Characteristic	No. (%) of cases among reporting jurisdictions
Facilities reporting at least one confirmed COVID-19 case among incarcerated or detained persons or staff members	420
Facilities reporting COVID-19 cases only among staff members	221 (53)
COVID-19 cases among incarcerated or detained persons	4,893
COVID-19–associated hospitalizations among incarcerated or detained persons	491 (10)
COVID-19–associated deaths among incarcerated or detained persons	88 (2)
COVID-19 cases among facility staff members	2,778
COVID-19–associated hospitalizations among facility staff members	79 (3)
COVID-19–associated deaths among facility staff members	15 (1)

Abbreviation: COVID-19 = coronavirus disease 2019.
* Jurisdictions reporting at least one laboratory-confirmed COVID-19 case among incarcerated or detained persons or staff members.
† Data provided to CDC during April 22–28, 2020.

BOX. COVID-19 guidance for correctional and detention facilities

Prepare for COVID-19
- Update an emergency plan for COVID-19 response
- Coordinate with local public health department and other correctional and detention facilities
- Require that staff members and visitors stay home if ill, and consider suspending in-person visitation
- Ensure access to soap at no cost to encourage frequent handwashing
- Plan for how space will be used to medically isolate and care for ill persons and to quarantine close contacts
- Plan for potential staff member shortages
- Train staff members to safely use personal protective equipment
- Enhance facility cleaning and disinfection

Prevent introduction of COVID-19 into facilities from the community
- Limit nonmedical transfers into and out of the facility
- Screen all new entrants, staff members, and visitors for symptoms before they enter the facility
- Assign staff members to consistent locations to limit movement between facility areas
- Encourage daily use of cloth face coverings by incarcerated or detained persons and staff members
- Use multiple physical distancing strategies (e.g., sleep head to foot, stagger meals and showers, reduce the number of persons allowed in a common area at one time, suspend group gatherings*)
- Regularly communicate with staff members and incarcerated or detained persons about COVID-19 and how they can protect themselves and others

Manage COVID-19 in facilities
- Activate emergency plan and notify public health officials
- Medically isolate ill persons and quarantine close contacts
- Evaluate ill persons for underlying medical conditions that would increase their risk for severe illness from COVID-19,† and provide necessary care on-site or transfer to a health care facility
- Incorporate screening for COVID-19 symptoms into release planning§
- Continue activities from preparation and prevention phases

Abbreviation: COVID-19 = coronavirus disease 2019.
* Other suggestions available in full corrections guidance. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.
† Asthma, chronic lung disease, diabetes, serious heart conditions, chronic kidney disease being treated with dialysis, severe obesity, age ≥65 years, immunocompromising conditions, and liver disease. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html.
§ Additional guidance on SARS-CoV-2 testing in correctional and detention facilities will be provided as testing becomes more widely available and strategies are developed to assist facilities in using test results to inform their operational efforts to reduce transmission risk.

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[1]CDC COVID-19 Emergency Response; [2]Epidemic Intelligence Service, CDC; [3]Alabama Department of Public Health; [4]State of Alaska Department of Corrections; [5]Alaska Division of Public Health; [6]Arizona Department of Health Services; [7]Arkansas Department of Health; [8]California Department of Public Health; [9]Connecticut Department of Public Health; [10]Georgia Department of Public Health; [11]Kansas Department of Health and Environment; [12]Office of Public Health, Louisiana Department of Health; [13]Massachusetts Department of Public Health; [14]Michigan Department of Corrections; [15]Michigan Department of Health and Human Services; [16]Minnesota Department of Health; [17]North Dakota Department of Health; [18]Nebraska Department of Health and Human Services; [19]New Jersey Department of Corrections; [20]New Mexico Association of Counties; [21]New Mexico Department of Health; [22]New York State Department of Corrections and Community Supervision; [23]Oklahoma State Department of Health; [24]Oregon Health Authority; [25]Physician Correctional, San Juan, Puerto Rico; [26]South Carolina Department of Health and Environmental Control; [27]South Dakota Department of Health; [28]Texas Department of State Health Services; [29]U.S. Virgin Islands Department of Health; [30]Utah Department of Health; [31]Virginia Department of Health; [32]Vermont Department of Health; [33]Washington Department of Corrections; [34]Wisconsin Department of Corrections; [35]Wyoming Department of Health; [36]Florida Department of Health.

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Exhibit 15

Coronavirus Disease 2019 (COVID-19)

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

Updated July 22, 2020

Languages

Print

This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of the date of posting, July 14, 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 CDC website periodically for updated interim guidance.

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.

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., U.S. Immigration and Customs Enforcement and U.S. Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of SARS-CoV-2 (the virus that causes Coronavirus Disease 2019, or 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 SARS-CoV-2 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of 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 participate in activities within congregate environments, heightening the potential for SARS-CoV-2 to spread once introduced.
- In most cases, incarcerated/detained persons are not permitted to leave the facility.
- Many opportunities exist for SARS-CoV-2 to be introduced into a correctional or detention facility, including daily staff movements; 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 SARS-CoV-2 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 SARS-CoV-2 from different geographic areas.
- The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent hand washing) may be limited and is determined by the supplies provided in the

https://web.archive.org/...https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html[10/26/2020 2:36:12 PM]

facility and by security considerations. Many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants.

- Social distancing options within correctional and detention settings may be limited due to crowded living conditions.
- Incarcerated/detained persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements, stigma and fear of isolation.
- Incarcerated/detained persons and staff may have underlying medical conditions that increase their risk of severe illness from COVID-19.
- Options for medical isolation for people with COVID-19 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 settings that may include both government and private employers. Each employer 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.
- Because limited outside information is available to many incarcerated/detained persons, unease and misinformation regarding the potential for SARS-CoV-2 to spread may be high, potentially creating security and morale challenges.

CDC has issued separate COVID-19 guidance addressing healthcare infection control and clinical care for individuals with COVID-19 as well as their close contacts 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?

https://web.archive.org/...https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html[10/26/2020 2:36:12 PM]

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
- Strategies 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
- Testing considerations for SARS-CoV-2
- Medical isolation of individuals with confirmed and suspected COVID-19 and quarantine of close contacts, including considerations for cohorting when individual spaces are limited
- Healthcare evaluation for individuals with suspected COVID-19
- Clinical care for individuals with confirmed and suspected COVID-19
- Considerations for people who are at increased risk for severe illness from COVID-19

Definitions of Commonly Used Terms

Close contact of someone with COVID-19 – 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). The definition of close contact does not change if the infected individual is wearing a mask or cloth face covering.

Cloth face covering – Cloth face coverings cover the nose and mouth and are intended to help prevent people who have the virus from transmitting it to others, even if they do not have symptoms. CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain. Cloth face coverings prevent the person wearing the covering from spreading respiratory droplets when talking, sneezing, or coughing. If everyone wears a cloth face covering in congregate settings, the risk of exposure to SARS-CoV-2 can be reduced. Anyone who has trouble breathing, or is unconscious, incapacitated, younger than 2 years of age or otherwise unable to remove the mask without assistance should not wear a cloth face covering (for more details see Guidelines on how to safely wear cloth face coverings). **Cloth face coverings are**

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a type of "source control," intended to help slow the spread of COVID-19 and are not personal protective equipment (PPE). Individuals working under conditions that require PPE should not use a cloth face covering when a surgical mask or N95 is indicated (see Table 1). Surgical masks and N95 respirators should be reserved for situations where the wearer needs PPE. Detailed recommendations for wearing cloth face coverings can be found here.

Cohorting – In this guidance, cohorting refers to the practice of isolating multiple individuals with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells. While cohorting those with confirmed COVID-19 is acceptable, cohorting individuals with suspected COVID-19 is not recommended due to high risk of transmission from infected to uninfected individuals. See Quarantine and Medical Isolation sections below for specific details about ways to implement cohorting as a harm reduction strategy to minimize the risk of disease spread and adverse health outcomes.

Community transmission of COVID-19 – Community transmission of SARS-CoV-2 occurs when individuals are exposed to the virus 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 infections inside their walls. Facilities should consult with local public health departments if assistance is needed to determine how to define "local community" in the context of SARS-CoV-2's spread. However, because all states have reported cases, all facilities should be vigilant for the virus's introduction into their populations.

Confirmed vs. suspected COVID-19 – A person has **confirmed COVID-19** when they have received a positive result from a COVID-19 viral test, but they may or may not have symptoms. A person has **suspected COVID-19** if they show symptoms of COVID-19 but either have not been tested via a viral test or are awaiting test results. If their test result is positive, suspected COVID-19 is reclassified as confirmed COVID-19.

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. 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 separating someone with confirmed or suspected COVID-19 infection to prevent their contact with others and to reduce the risk of transmission.

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Medical isolation ends when the individual meets pre-established clinical, time-based, and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials. 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, and should ensure that the conditions in medical isolation spaces are distinct from those in punitive isolation.

Quarantine – Quarantine refers to the practice of separating individuals who have had close contact with someone with COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine also reduce the risk of transmission if an individual is later found to have COVID-19. Quarantine for COVID-19 should last for a period of 14 days after the exposure has ended. Ideally, each quarantined individual should be quarantined in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, and/or a quarantined individual receives a positive viral test result for SARS-CoV-2, the individual should be placed under medical isolation and evaluated by a healthcare professional. If symptoms do not develop during the 14-day period and the individual does not receive a positive viral test result for SARS-CoV-2, quarantine restrictions can be lifted. (NOTE: Some facilities may also choose to implement a "routine intake quarantine," in which individuals newly incarcerated/detained ("new intakes") are housed separately or as a group for 14 days before being integrated into general housing. This type of quarantine is conducted to prevent introduction of SARS-CoV-2 from incoming individuals whose exposure status is unknown, rather than in response to a known exposure to someone infected with SARS-CoV-2.)

Social distancing – Social distancing is the practice of increasing the space between individuals and decreasing their 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. People who have been infected with SARS-CoV-2 but do not have symptoms can still spread the infection, making social distancing even more important. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication . Examples of potential social distancing strategies for correctional and detention facilities are detailed in the guidance below.

Staff – In this document, "staff" refers to all public or private-sector employees working within a correctional facility (e.g., including private healthcare or food service workers). 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 cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, and new loss of taste or smell. This list is not exhaustive. Other less common symptoms have been reported, including nausea and vomiting. Like other respiratory infections, COVID-19 can vary in severity from mild to severe, and 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 at increased risk for severe illness are not yet fully understood. Monitor the CDC website for updates on symptoms.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails 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 persons with confirmed and suspected COVID-19 infection 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 identify incarcerated/detained persons or staff with confirmed or suspected COVID-19, 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 persons with confirmed and suspected COVID-19 infection.

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 should 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 SARS-CoV-2 transmission in the facility. Strategies focus on operational and communications planning, training, and personnel practices.
- **Prevention**. This guidance is intended to help facilities prevent spread of SARS-CoV-2 within the facility and between the community and the facility. Strategies focus on reinforcing hygiene practices; intensifying cleaning and disinfection of the facility; regular symptom screening for new intakes, visitors, and staff; continued communication with incarcerated/detained persons and staff; social distancing measures; as well as, testing symptomatic and asymptomatic individuals in correctional and detention facilities.(refer to the Interim Guidance on Testing for SARS-CoV-2 in Correctional and Detention Facilities for more information on how to implement testing in correctional and detention settings).
- **Management**. This guidance is intended to help facilities clinically manage persons with confirmed and suspected COVID-19 inside the facility and prevent further transmission of SARS-CoV-2. Strategies include medical isolation and care of incarcerated/detained persons with COVID-19 (including considerations for cohorting), quarantine and testing of close contacts, restricting movement in and out of the facility, infection control practices for interactions with persons with COVID-19 and their quarantined close contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas where infected persons spend time.

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 the importance of reporting those symptoms if they develop. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, training staff on proper use of personal protective equipment (PPE) that may be needed in the course of their duties, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication and Coordination

- **Develop information-sharing systems with partners.**
  - Identify points of contact in relevant state, local, tribal, and/or territorial public health

departments before SARS-CoV-2 infections 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 individuals with confirmed and suspected COVID-19 and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release, or to prevent overcrowding.
- Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

- **Review existing influenza, all-hazards, and disaster plans, and revise for COVID-19.**
  - Train staff on the facility's COVID-19 plan. All personnel should have a basic understanding of COVID-19, how the disease is thought to spread, what the symptoms of the disease are, and what measures are being implemented and can be taken by individuals to prevent or minimize the transmission of SARS-CoV-2.
  - Ensure that **separate** physical locations (dedicated housing areas and bathrooms) have been identified to 1) isolate individuals with confirmed COVID-19 (individually or cohorted), 2) isolate individuals with suspected COVID-19 (individually – do not cohort), and 3) quarantine close contacts of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary). The plan should include contingencies for multiple locations if numerous infected individuals and/or close contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for more detailed cohorting considerations.
  - Facilities without onsite healthcare capacity should make a plan for how they will ensure that individuals with suspected COVID-19 will be isolated, evaluated, tested, 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 disease transmission patterns change.
- **Coordinate with local law enforcement and court officials.**

  - Identify legally acceptable alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of SARS-CoV-2 transmission.
  - Consider options to prevent overcrowding (e.g., diverting new intakes to other facilities with available capacity, and encouraging alternatives to incarceration and other decompression strategies where allowable).
- **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signs 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 have low-vision.
  - **For all:**
    - Practice good cough and sneeze 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; before and after preparing food; before taking medication; and after touching garbage.
    - Wear face coverings, unless PPE is indicated.
    - Avoid touching your eyes, nose, or mouth without cleaning your hands first.
    - Avoid sharing eating utensils, dishes, and cups.
    - Avoid non-essential physical contact.
  - **For incarcerated/detained persons**: the importance of reporting symptoms to staff; social distancing and its importance for preventing COVID-19; the purpose of quarantine and medical isolation
  - **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.

Personnel Practices

- **Review the sick leave policies of each employer that operates within the facility.**

  - Review policies to ensure that they are flexible, non-punitive, and actively encourage staff not to report to work when sick.
  - Determine which officials will have the authority to send symptomatic staff home.
- **Identify duties that can be performed remotely.** Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of SARS-CoV-2 transmission.
- **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.
  - Identify critical job functions and plan for alternative coverage.
  - 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.
  - Review CDC guidance on safety practices for critical infrastructure workers (including correctional officers, law enforcement officers, and healthcare workers) who continue to work after a potential exposure to SARS-CoV-2.
  - 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 increased risk for severe illness from COVID-19.** Persons at increased risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, moderate to severe asthma, heart disease, chronic kidney disease, severe obesity, and diabetes. See CDC's website for a complete list and check regularly for updates as more data become available.
  - Consult with occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to SARS-CoV-2.
- **Make plans in advance for how to change staff duty assignments to prevent unnecessary movement between housing units during a COVID-19 outbreak.**
  - If there are persons with COVID-19 inside the facility, it is **essential** for staff members to maintain a consistent duty assignment in the same area of the facility across shifts to prevent transmission across different facility areas.
  - Where feasible, consider the use of telemedicine to evaluate persons with COVID-19 symptoms and other health conditions to limit the movement of healthcare staff across housing units.
- **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of

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COVID-19 are similar to those of influenza. Preventing influenza in a facility can speed the detection of COVID-19 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, or share with others.

Operations, Supplies, and PPE Preparations

- **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.**
  - Standard medical supplies for daily clinic needs
  - Tissues
  - Liquid or foam soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing
  - Ensure a sufficient supply of soap for each individual
  - Hand drying supplies
  - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
  - Cleaning supplies, including EPA-registered disinfectants effective against SARS-CoV-2 , the virus that causes COVID-19
  - Recommended PPE (surgical masks, 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 surgical masks are acceptable alternatives to N95s. Visit CDC's website for a calculator to help determine rate of PPE usage.
  - Cloth face coverings
  - SARS-CoV-2 specimen collection and testing supplies
- **Make contingency plans for possible 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, and placing dispensers at facility entrances/exits and in PPE donning/doffing stations.

- **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 or foam soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing, and ensure that individuals do not share bars of soap.
- **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 persons with COVID-19 or their close contacts.
    - Visit CDC's website for PPE donning and doffing training videos and job aids .
- **Prepare to set up designated PPE donning and doffing areas outside all spaces where PPE will be used. These spaces should include:**
    - A dedicated trash can for disposal of used PPE
    - A hand washing station or access to alcohol-based hand sanitizer
    - A poster demonstrating correct PPE donning and doffing procedures
- Review CDC and EPA guidance for cleaning and disinfecting of the facility.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of SARS-CoV-2 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 SARS-CoV-2 do not display symptoms, the virus could be present in facilities before infections are identified. Good hygiene practices, vigilant symptom screening, wearing cloth face coverings (if able), and social distancing are critical in preventing

further transmission.

Testing symptomatic and asymptomatic individuals and initiating medical isolation for suspected and confirmed cases and quarantine for close contacts, can help prevent spread of SARS-CoV-2.

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.**
- **Limit 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, release, or to prevent overcrowding.**
  - Consider postponing non-urgent outside medical visits. Use telehealth to the extent possible as a social distancing measure within the facility and to help minimize movement between the facility and the community.
  - 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 suspected COVID-19 infection – including giving the individual a cloth face covering (unless contraindicated), if not already wearing one, immediately placing them under medical isolation, and evaluating them for SARS-CoV-2 testing.
  - Ensure that the receiving facility has capacity to properly quarantine or isolate the individual upon arrival.
  - See Transportation section below on precautions to use when transporting an individual with confirmed or suspected COVID-19.
- **Make every possible effort to modify staff assignments to minimize movement across housing units and other areas of the facility.** For example, ensure that the same staff are assigned to the same housing unit across shifts to prevent cross-contamination from units where infected individuals have been identified to units with no infections.
- **Consider suspending work release and other programs that involve movement of incarcerated/detained individuals in and out of the facility, especially if the work release assignment is in another congregate setting, such as a food processing plant**
- **Implement lawful alternatives to in-person court appearances where permissible.**

- **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for possible COVID-19 symptoms.**
- **Limit the number of operational entrances and exits to the facility.**

Where feasible, consider establishing an on-site laundry option for staff so that they can change out of their uniforms, launder them at the facility, and wear street clothes and shoes home. If on-site laundry for staff is not feasible, encourage them to change clothes before they leave the work site, and provide a location for them to do so. This practice may help minimize the risk of transmitting SARS-CoV-2 between the facility and the community.

Cleaning and Disinfecting Practices

- **Even if COVID-19 has not yet been identified inside the facility or in the surrounding community, implement intensified cleaning and disinfecting procedures according to the recommendations below. These measures can help prevent spread of SARS-CoV-2 if introduced, and if already present through asymptomatic infections.**
- **Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.** Monitor these recommendations for updates.
  - Visit the CDC website for a tool to help implement cleaning and disinfection.
  - 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, telephones, and computer equipment).
  - Staff should clean shared equipment (e.g., radios, service weapons, keys, handcuffs) several times per day and when the use of the equipment has concluded.
  - Use household cleaners and EPA-registered disinfectants effective against SARS-CoV-2, the virus that causes COVID-19 as appropriate for the surface.
    - Follow label instructions for safe and effective use of the product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use, and around people.
    - Clean according to label instructions, including for pre-cleaning steps, product dilution, contact time, and potable water rinse directions, if applicable, in order to ensure the product is effective and does not present an undue risk to users and others. The contact time is the amount of time the surface needs be treated for the product to work. Many product labels recommend keeping the surface wet for a specific amount of time.
- **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

- **Encourage all staff and incarcerated/detained persons to wear a cloth face covering as much as safely possible, to prevent transmission of SARS-CoV-2 through respiratory droplets that are created when a person talks, coughs, or sneezes ("source control").**
  - Provide cloth face coverings at no cost to incarcerated/detained individuals and launder them routinely.
  - Clearly explain the purpose of cloth face coverings and when their use may be contraindicated. Because many individuals with COVID-19 do not have symptoms, it is important for everyone to wear cloth face coverings in order to protect each other: "My mask protects you, your mask protects me."
  - Ensure staff know that cloth face coverings should not be used as a substitute for surgical masks or N95 respirators that may be required based on an individual's scope of duties. Cloth face coverings are not PPE, but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer.
  - Surgical masks may also be used as source control but should be conserved for situations requiring PPE.
- **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).**
- **Provide incarcerated/detained persons and staff no-cost access to:**
  - **Soap** – Provide liquid or foam soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing, and ensure that individuals are not sharing bars of soap.
  - **Running water, and hand drying machines or disposable paper towels** for hand washing
  - **Tissues** and (where possible) no-touch trash receptacles for disposal
  - **Cloth face coverings**
- **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 SARS-CoV-2 due to potential contamination of shared items and close contact between individuals.**

Testing for SARS-CoV-2

Correctional and detention facilities are high-density congregate settings that present unique challenges to implementing testing for SARS-CoV-2, the virus that causes COVID-19. Refer to Testing guidance for details regarding testing strategies in correctional settings.

Prevention Practices for Incarcerated/Detained Persons

- **Provide cloth face coverings (unless contraindicated) and perform pre-intake symptom screening and temperature checks for all new entrants in order to identify and immediately place individuals with symptoms under medical isolation. Screening should take place in an outdoor space prior to entry, in the sally port, or at the point of entry into the facility immediately upon entry, before beginning the intake process.** 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**:
    - Require the individual to wear a cloth face covering (as much as possible, use cloth face coverings in order to reserve surgical masks for situations requiring PPE). Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a cloth face covering.
    - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
    - Place the individual under medical isolation 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. See Transport section and coordinate with the receiving facility.
  - **If an individual is an asymptomatic close contact of someone with COVID-19:**
    - Quarantine the individual and monitor for symptoms at least once per day (ideally

twice 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 symptoms), and to minimize mixing of individuals from different housing units.** 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 in the dining hall (one housing unit at a time)
    - 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 their faces
    - Minimize the number of individuals housed in the same room as much as possible
    - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
  - **Work details:**
    - Modify work detail assignments so that each detail includes only individuals from a single housing unit.
  - **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 individuals' sick call visits.
    - Stagger pill line, or stage pill line within individual housing units.
    - Identify opportunities to implement telemedicine to minimize the movement of healthcare staff across multiple housing units and to minimize the movement of ill individuals through the facility.
    - Designate a room near the intake area to evaluate new entrants who are flagged by the intake symptom screening process before they move to other parts of the facility.
- **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.**
- **Provide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis.** As much as possible, provide this information in person and allow opportunities for incarcerated/detained individuals to ask questions (e.g., town hall format if social distancing is feasible, or informal peer-to-peer education). Updates should address:
  - Symptoms of COVID-19 and its health risks
  - Reminders to report COVID-19 symptoms to staff at the first sign of illness
    - Address concerns related to reporting symptoms (e.g., being sent to medical isolation), explain the need to report symptoms immediately to protect everyone, and explain the differences between medical isolation and solitary confinement.
  - Reminders to use cloth face coverings as much as possible
  - Changes to the daily routine and how they can contribute to risk reduction

Prevention Practices for Staff

Remind staff to stay at home if they are sick. Ensure 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.

- See strategies for testing of asymptomatic incarcerated or detained individuals and staff without known SARS-CoV-2 exposure for early identification of SARS-CoV-2 in correctional and detention facilities.
- **Perform verbal screening 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.
    - In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
    - 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:**
    - Symptoms of COVID-19 and its health risks
    - Employers' sick leave policy
- **If staff develop a fever or other symptoms of COVID-19 while at work**, they should immediately put on a cloth face covering (if not already wearing one), inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

If a staff member has a confirmed SARS-CoV-2 infection, the relevant employers should inform other staff about their possible exposure in the workplace but should maintain the infected employee's confidentiality as required by the Americans with Disabilities Act .

Follow guidance from the Equal Employment Opportunity Commission when offering testing to staff. Any time a positive test result is identified, ensure that the individual is rapidly notified, connected to appropriate medical care, and advised how to self-isolate.

- **Staff identified as close contacts of someone with COVID-19 should self-quarantine at home for 14 days, unless a shortage of critical staff precludes quarantine.**
    - Staff identified as close contacts should self-monitor for symptoms and consider seeking testing.
    - Refer to CDC guidelines for further recommendations regarding home quarantine.
    - **To ensure continuity of operations, critical infrastructure workers (including corrections officers, law enforcement officers, and healthcare staff) may be permitted to continue work following potential exposure to SARS-CoV-2 , provided**

that they remain asymptomatic and additional precautions are implemented to protect them and the community.

- **Screening:** The facility should ensure that temperature and symptom screening takes place daily before the staff member enters the facility.
- **Regular Monitoring:** The staff member should self-monitor under the supervision of their employer's occupational health program. If symptoms develop, they should follow CDC guidance on isolation with COVID-19 symptoms.
- **Wear a Cloth Face Covering:** The staff member should wear a cloth face covering (unless contraindicated) at all times while in the workplace for 14 days after the last exposure (if not already wearing one due to universal use of cloth face coverings).
- **Social Distance:** The staff member should maintain 6 feet between themselves and others and practice social distancing as work duties permit.
- **Disinfect and Clean Workspaces:** The facility should continue enhanced cleaning and disinfecting practices in all areas including offices, bathrooms, common areas, and shared equipment.

- **Staff with confirmed or suspected COVID-19 should inform workplace and personal contacts immediately. These staff should be required to meet CDC criteria for ending home isolation before returning to work.** Monitor CDC guidance on discontinuing home isolation regularly, as circumstances evolve rapidly.
- **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with COVID-19 symptoms while interviewing, escorting, or interacting in other ways, and to wear recommended PPE if closer contact is necessary.**
- **Ask staff to keep interactions with individuals with COVID-19 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.**
- **Require visitors to wear cloth face coverings (unless contraindicated), and perform verbal screening 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 COVID-19 symptoms.
    - 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 symptom 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 in-person 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 after each use. (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 should only be done in the interest of incarcerated/detained persons' physical health and the health of the general public. 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.

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

Management

If there is an individual with suspected COVID-19 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 individuals with suspected or confirmed COVID-19 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.

Testing symptomatic and asymptomatic individuals (incarcerated or detained individuals and staff) and initiating medical isolation for suspected and confirmed cases and quarantine for close contacts, can help prevent spread of SARS-CoV-2 in correctional and detention facilities. Continue following recommendations outlined in the Preparedness and Prevention sections above.

Operations

- **Coordinate with state, local, tribal, and/or territorial health departments.** When an individual has suspected or confirmed COVID-19, notify public health authorities and request any necessary assistance with medical isolation, evaluation, and clinical care, and contact tracing and quarantine of close contacts. See Medical Isolation, Quarantine and Clinical Care sections below.
- **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), unless necessary for medical evaluation, medical isolation/quarantine, health care, extenuating security concerns, release, or to prevent overcrowding.**
- **Set up PPE donning/doffing stations as described in the Preparation section.**
- **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 someone who has COVID-19).** This practice is referred to as **routine intake quarantine**.
- **Consider testing all newly incarcerated/detained persons before they join the rest of**

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the population in the correctional or detention facility.

- **Minimize interactions between incarcerated/detained persons living in different housing units, to prevent transmission from one unit to another.** For example, stagger mealtimes and recreation times, and consider implementing broad movement restrictions.
- **Ensure that work details include only incarcerated/detained persons from a single housing unit, supervised by staff who are normally assigned to the same housing unit.**
    - If a work detail provides goods or services for other housing units (e.g., food service or laundry), ensure that deliveries are made with extreme caution. For example, have a staff member from the work detail deliver prepared food to a set location, leave, and have a staff member from the delivery location pick it up. Clean and disinfect all coolers, carts, and other objects involved in the delivery.
- **Incorporate COVID-19 prevention practices into release planning.**
    - Consider implementing a release quarantine (ideally in single cells) for 14 days prior to individuals' projected release date.
    - Consider testing individuals for SARS-CoV-2 before release, particularly if they will be released to a congregate setting or to a household with persons at increased risk for severe illness from COVID-19.
    - 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 suspected COVID-19 – including giving the individual a cloth face covering, if not already wearing one, immediately placing them under medical isolation, and evaluating them for SARS-CoV-2 testing.
        - If the individual is released from the facility 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 who has confirmed or suspected COVID-19, or is a close contact of someone with COVID-19, contact local public health officials to ensure they are aware of the individual's release and anticipated location. If the individual will be released 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 quarantine as needed.
- **Incorporate COVID-19 prevention practices into re-entry programming.**
    - Ensure that facility re-entry programs include information on accessing housing, social

services, mental health services, and medical care within the context of social distancing restrictions and limited community business operations related to COVID-19.

- Provide individual about to be released with COVID-19 prevention information, hand hygiene supplies, and cloth face coverings.
- Link individuals who need medication-assisted treatment for opioid use disorder to substance use, harm reduction, and/or recovery support systems . If the surrounding community is under movement restrictions due to COVID-19, ensure that referrals direct releasing individuals to programs that are continuing operations.
- Link releasing individuals to Medicaid enrollment and healthcare resources , including continuity of care for chronic conditions that may place an individual at increased risk for severe illness from COVID-19.
- When possible, encourage releasing individuals to seek housing options among their family or friends in the community, to prevent crowding in other congregate settings such as homeless shelters. When linking individuals to shared housing, link preferentially to accommodations with the greatest capacity for social distancing.

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 individuals with COVID-19 spend time** (see below).

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 individuals with

suspected COVID-19 will be effectively isolated, evaluated, tested (if indicated), and given care.

- **Staff interacting with incarcerated/detained individuals with COVID-19 symptoms should wear recommended PPE** (see Table 1).
- **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having symptomatic individuals walk through the facility to be evaluated in the medical unit.**
- **Incarcerated/detained individuals with COVID-19 symptoms should wear a cloth face covering (unless contraindicated) and should be placed under medical isolation immediately. See Medical Isolation section below.**
- **Medical staff should evaluate symptomatic individuals to determine whether SARS-CoV-2 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing See Infection Control and Clinical Care sections below as well. Incarcerated/detained persons with symptoms are included in the high-priority group for testing in CDC's recommendations due to the high risk of transmission within congregate settings.
    - If the individual's SARS-CoV-2 test is positive, continue medical isolation. (See Medical Isolation section below.)
    - If the SARS-CoV-2 test is negative, the individual can be returned to their prior housing assignment unless they require further medical assessment or care or if they need to be quarantined as a close contact of someone with COVID-19.
- **Work with public health or private labs, as available, to access testing supplies or services.**

Medical Isolation of Individuals with Confirmed or Suspected COVID-19

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that individuals with confirmed or suspected COVID-19 will be appropriately isolated, evaluated, tested, and given care.

- **As soon as an individual develops symptoms of COVID-19 or tests positive for SARS-CoV-2 they should be given a cloth face covering (if not already wearing one and if it can be worn safely), immediately placed under medical isolation in a separate environment from other individuals, and medically evaluated.**

    - **Ensure that medical isolation for COVID-19 is distinct from punitive solitary confinement of incarcerated/detained individuals, both in name and in practice.** Because of limited individual housing spaces within many correctional and detention facilities, infected individuals are often placed in the same housing spaces that are used for solitary confinement. To avoid being placed in these conditions, incarcerated/detained individuals may be hesitant to report COVID-19 symptoms, leading to continued transmission within shared housing spaces and, potentially, lack of health care and adverse health outcomes for infected individuals who delay reporting symptoms. Ensure that medical isolation is *operationally* distinct from solitary confinement, even if the same housing spaces are used for both. For example:
        - Ensure that individuals under medical isolation receive regular visits from medical staff and have access to mental health services.
        - Make efforts to provide similar access to radio, TV, reading materials, personal property, and commissary as would be available in individuals' regular housing units.
        - Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.
        - Communicate regularly with isolated individuals about the duration and purpose of their medical isolation period.

- **Keep the individual's movement outside the medical isolation space to an absolute minimum.**
    - Provide medical care to isolated individuals inside the medical isolation space, unless they need to be transferred to a healthcare facility. See Infection Control and Clinical Care sections for additional details.
    - Serve meals inside the medical isolation space.
    - Exclude the individual from all group activities.
    - Assign the isolated individual(s) a dedicated bathroom when possible. When a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result. Clean and disinfect areas used by infected individuals frequently on an ongoing basis during medical isolation.
- **Ensure that the individual is wearing a cloth face covering if they must leave the medical isolation space for any reason, and whenever another individual enters.** Provide clean masks as needed. Masks should be washed routinely and changed when visibly soiled or wet.
- **If the facility is housing individuals with confirmed COVID-19 as a cohort:**
    - **Only individuals with laboratory-confirmed COVID-19 should be placed under**

medical isolation as a cohort. Do not cohort those with confirmed COVID-19 with those with suspected COVID-19, or with close contacts of individuals with confirmed or suspected COVID-19.

- Do not house individuals with undiagnosed respiratory infection (who do not meet the criteria of suspected COVID-19) with individuals with suspected COVID-19.
- Ensure that cohorted groups of people with confirmed COVID-19 wear cloth face coverings whenever anyone (including staff) enters the isolation space. (Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a cloth face covering.)
- Use one large space for cohorted medical isolation rather than several smaller spaces. This practice will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.

- **If the facility is housing individuals with confirmed COVID-19 as a cohort, use a well-ventilated room with solid walls and a solid door that closes fully.**
- **If possible, avoid transferring infected individual(s) to another facility unless necessary for medical care. If transfer is necessary, see Transport section for safe transport guidance.**
- **Staff assignments to isolation spaces should remain as consistent as possible, and these staff should limit their movements to other parts of the facility as much as 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.
  - If staff must serve multiple areas of the facility, ensure that they change PPE when leaving the isolation space. If PPE supplies necessitate reuse, ensure that staff move only from areas of low to high exposure risk while wearing the same PPE, to prevent cross-contamination. For example, start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in an isolation unit. Ensure that staff are highly trained in infection control practices, including use of recommended PPE.
- **Minimize transfer of individuals with confirmed or suspected COVID-19 between spaces within the facility.**
- **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:
  - **Cover** their mouth and nose with a tissue when they cough or sneeze
  - **Dispose** of used tissues immediately in the lined trash receptacle
  - **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water

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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 at least until CDC criteria for discontinuing home-based isolation have been met. These criteria have changed since CDC corrections guidance was originally issued and may continue to change as new data become available. Monitor the sites linked below regularly for updates.** This content will not be outlined explicitly in this document due to rapid pace of change.
  - CDC's recommended strategy for release from isolation can be found here.
  - Detailed information about the data informing the symptom-based strategy, and considerations for extended isolation periods for persons in congregate settings including corrections, can be found here.
  - If persons will require ongoing care by medical providers, discontinuation of transmission-based precautions (PPE) should be based on similar criteria found here.

Cleaning Spaces where Individuals with COVID-19 Spend Time

- **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)
- **Thoroughly and frequently clean and disinfect all areas where individuals with confirmed or suspected COVID-19 spend time.**
  - After an individual has been medically isolated for COVID-19 close off areas that they have used prior to isolation. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions) before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
  - Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).
  - Clean and disinfect areas used by infected individuals frequently on an ongoing basis during medical isolation.
- **Hard (non-porous) surface cleaning and disinfection**
  - If surfaces are soiled, they should be cleaned using a detergent or soap and water prior to disinfection.

Consult the 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.).

- If EPA-approved disinfectants are not available, diluted household bleach solutions can be used if appropriate for the surface. Unexpired household bleach will be effective against coronaviruses when properly diluted.
  - Use bleach containing 5.25%–8.25% sodium hypochlorite. Do not use a bleach product if the percentage is not in this range or is not specified.
  - Follow the manufacturer's application instructions for the surface, ensuring a contact time of at least 1 minute.
  - Ensure proper ventilation during and after application.
  - Check to ensure the product is not past its expiration date.
  - Never mix household bleach with ammonia or any other cleanser. This can cause fumes that may be very dangerous to breathe in.
- Prepare a bleach solution by mixing:
  - 5 tablespoons (1/3rd cup) of 5.25%–8.25% bleach per gallon of room temperature water

    OR
  - 4 teaspoons of 5.25%–8.25% bleach per quart of room temperature water
- Bleach solutions will be effective for disinfection up to 24 hours.
- Alcohol solutions with at least 70% alcohol may also be used.

- **Soft (porous) surface cleaning and disinfection**
  - For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
    - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
    - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.
- **Electronics cleaning and disinfection**
  - For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
    - Follow the manufacturer's instructions for all cleaning and disinfection products.
    - Consider use of wipeable covers for electronics.

    - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

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

- **Food service items.** Individuals 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 following food safety requirements. Individuals handling used food service items should clean their hands immediately after removing gloves.
- **Laundry from individuals with COVID-19 can be washed with other's laundry.**
    - Individuals handling laundry from those with COVID-19 should wear disposable gloves and gown, discard after each use, and clean their hands immediately after.
    - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air. Ensure that individuals performing cleaning wear recommended PPE (see PPE section below).
    - 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.

Transporting Individuals with Confirmed and Suspected COVID-19 and Quarantined Close Contacts

- **Refer to CDC guidance for Emergency Medical Services (EMS) on safely transporting individuals with confirmed or suspected COVID-19.** This guidance includes considerations for vehicle type, air circulation, communication with the receiving facility, and cleaning the vehicle after transport.
    - If the transport vehicle is not equipped with the features described in the EMS guidance, at minimum drive with the windows down and ensure that the fan is set to high, in non-recirculating mode. If the vehicle has a ceiling hatch, keep it open.
- **Use the same precautions when transporting individuals under quarantine as close contacts of someone with COVID-19.**
- **See Table 1 for the recommended PPE for staff transporting someone with COVID-19.**

Quarantining Close Contacts of Individuals with COVID-19

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 individuals with COVID-19 will be effectively quarantined and medically monitored.

- **To determine who is considered a close contact of an individual with COVID-19, see definition of close contact above and the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan for more information.**
- **Contact tracing can be a useful tool to help contain disease outbreaks. When deciding whether to perform contact tracing, consider the following:**
  - Have a plan in place for how close contacts of individuals with COVID-19 will be managed, including quarantine logistics.
  - Contact tracing can be especially impactful when:
    - There is a small number of infected individuals in the facility or in a particular housing unit. Aggressively tracing close contacts can help curb transmission before many other individuals are exposed.
    - The infected individual is a staff member or an incarcerated/detained individual who has had close contact with individuals from other housing units or with other staff. Identifying those close contacts can help prevent spread to other parts of the facility.
    - The infected individual is a staff member or an incarcerated/detained individual who has recently visited a community setting. In this situation, identifying close contacts can help reduce transmission from the facility into the community.
  - Contact tracing may be more feasible and effective in settings where incarcerated/detained individuals have limited contact with others (e.g., celled housing units), compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
  - If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage. Under such conditions, consider broad-based testing in order to identify infections and prevent further transmission.
- **Incarcerated/detained persons who are close contacts of someone with confirmed or suspected COVID-19 (whether the infected individual is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (Refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact**

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Tracing Plan for more information):

- If the close contact is tested for SARS-CoV-2 and tests positive for SARS-CoV-2, the individual should be medically isolated rather than quarantined.
- If quarantined individual is tested during quarantine and they test negative, they should continue to quarantine for a full 14 days after last exposure and follow all recommendations of public health authorities.
- If an individual is quarantined due to contact with someone with suspected COVID-19 who is subsequently tested and receives a negative result, they can be released from quarantine and retesting should be considered. See Interim Guidance on Testing for SARS-CoV-2 in Correctional and Detention Facilities for more information about testing strategies in correctional and detention settings.
- **Testing is recommended for all close contacts of persons with SARS-CoV-2 infection, regardless of whether the close contacts have symptoms.**
  - Medically isolate those who test positive to prevent further transmission.
  - Asymptomatic close contacts testing negative should still quarantine for 14 days from their last exposure
- **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. When a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result.

- **Staff assignments to quarantine spaces should remain as consistent as possible, and these staff should limit their movements to other parts of the facility.** These staff should wear recommended PPE as appropriate for their level of contact with the individuals under quarantine (see PPE section below) and should limit their own movement between different parts of the facility.
  - If staff must serve multiple areas of the facility, ensure that they change PPE when leaving the quarantine space. If PPE supplies necessitate reuse, ensure that staff move only from areas of low to high exposure risk while wearing the same PPE, to prevent cross-contamination.
- **Facilities should make every possible effort to individually quarantine cases of confirmed COVID-19, and close contacts of individuals with confirmed, or suspected**

COVID-19. Cohorting multiple quarantined close contacts could transmit SARS-CoV-2 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 or who test positive for SARS-CoV-2 should be placed under medical isolation immediately. If an individual is removed from the cohort due to COVID-19 symptoms and tests positive (or is not tested), the 14-day quarantine clock should restart for the remainder of the quarantined cohort.
- If an entire housing unit is under quarantine due to contact with an individual from the same housing unit who has COVID-19, 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 someone with COVID-19). **Under this scenario, avoid mixing individuals quarantined due to exposure someone with COVID-19 with individuals undergoing routine intake quarantine.**
- Do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.

- **If cohorting close contacts is absolutely necessary, be especially mindful of those who are at increased risk for 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 increased-risk individuals. (For example, intensify social distancing strategies for increased-risk individuals.)
- **If single cells for isolation (of those with suspected COVID-19) and quarantine (of close contacts) are limited, prioritize them in rank order as follows to reduce the risk of further SARS-CoV-2 transmission and adverse health outcomes:**
  - Individuals with suspected COVID-19 who are at increased risk for severe illness from COVID-19
  - Others with suspected COVID-19
  - Quarantined close contacts of someone with COVID-19 who are themselves at increased risk for severe illness from COVID-19
  - Other quarantined close contacts
- **In order of preference, multiple quarantined individuals should be housed:**
  - **IDEAL:** Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully

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- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements. (See Transport section.)
  (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 as a harm reduction approach.

- **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 immediately after removing gloves.
- **If quarantined individuals leave the quarantine space for any reason, they should wear cloth face coverings (unless contraindicated) as source control, if not already wearing them.**
  - Quarantined individuals housed as a cohort should wear cloth face coverings at all times.
  - Quarantined individuals housed alone should wear cloth face coverings whenever another individual enters the quarantine space.
  - Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable

to remove the mask without assistance should not wear a cloth face covering.

- **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).
    - Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to someone with COVID-19) do not need to wear PPE but should still wear a cloth face covering as source control.
- **Quarantined individuals should be monitored for COVID-19 symptoms at least once per day (ideally twice per day) including temperature checks.**
    - If an individual develops symptoms or tests positive for SARS-CoV-2, they should be moved to medical isolation (individually, and separately from those with confirmed COVID-19 and others with suspected COVID-19) immediately and further evaluated. (See Medical Isolation section above.)
    - See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of someone with COVID-19.
- **If an individual who is part of a quarantined cohort becomes symptomatic:**
    - **If the individual is tested for SARS-CoV-2 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
    - **If the individual is tested for SARS-CoV-2 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 as their symptoms and diagnosis allow.
    - **If the individual is not tested for SARS-CoV-2:** 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 COVID-19 symptoms during the 14-day quarantine period.**
    - Place any individuals testing positive under medical isolation, and if the individual testing positive was part of a quarantine cohort, restart the 14-day quarantine clock for the remainder of the cohort.
    - Consider re-testing individuals in quarantine cohort every 3-7 days to identify and isolate infected individuals and to minimize the amount of time infected individuals spend with the rest of the cohort.

https://web.archive.org/...https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html[10/26/2020 2:36:12 PM]

- **Laundry from quarantined individuals can be washed with other's laundry.**
  - Individuals handling laundry from quarantined persons should wear disposable gloves and gown, discard after each use, and clean their hands immediately after.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

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

- **Provide clear information to incarcerated/detained persons about the presence of COVID-19 within the facility, and the need to increase social distancing and maintain hygiene precautions.**
  - As much as possible, provide this information in person and allow opportunities for incarcerated/detained individuals to ask questions (e.g., town hall format if social distancing is feasible, or informal peer-to-peer education).
  - 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 have low-vision.
- **If individuals with COVID-19 have been identified among staff or incarcerated/detained persons anywhere in a facility, consider implementing regular symptom screening and temperature checks in housing units that have *not* yet identified infections, until no additional infections have been identified in the facility for 14 days.** Because some incarcerated/detained persons are hesitant to report symptoms, it is very important to monitor for symptoms closely even though doing so is resource intensive. 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 within the facility,**

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and the need to enforce use of universal cloth face coverings (unless contraindicated) and social distancing and to encourage hygiene precautions.
    - As much as possible, provide this information in person (if social distancing is feasible) and allow opportunities for staff to ask questions.
- **Staff identified as close contacts of someone with COVID-19 should be tested for SARS-CoV-2 and self-quarantine at home for 14 days, unless a shortage of critical staff precludes quarantine of those who are asymptomatic (**see considerations for critical infrastructure workers). Refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan for more information about close contact tracing.
    - Close contacts should self-monitor for symptoms and consider seeking testing.
    - Refer to CDC guidelines for further recommendations regarding home quarantine.
- **Staff who have confirmed or suspected COVID-19 should meet CDC criteria for ending home isolation before returning to work.** Monitor CDC guidance on discontinuing home isolation regularly, as circumstances evolve rapidly.

Infection Control

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

- **All individuals who have the potential for direct or indirect exposure to someone with COVID-19 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 and wear recommended PPE when in contact with individuals showing COVID-19 symptoms.** Contact should be minimized to the extent possible until the infected individual is wearing a cloth face covering (if not already wearing one and if not contraindicated) and staff are wearing PPE.
- **Refer to PPE section to determine recommended PPE for individuals in contact with individuals with COVID-19, their close contacts, and potentially contaminated items.**
- **Remind staff about the importance of limiting unnecessary movements between housing units and through multiple areas of the facility, to prevent cross-contamination.**
- **Ensure that staff and incarcerated/detained persons are trained to doff PPE after they leave a space where PPE is required, as needed within the scope of their duties and work details. Ideally, staff should don clean PPE before entering a different space within the facility that also requires PPE.**
    - If PPE shortages make it impossible for staff to change PPE when they move between different spaces within the facility, ensure that they are trained to move from areas of low exposure risk ("clean") to areas of higher exposure risk ("dirty") while wearing the same PPE, to minimize the risk of contamination across different parts of the facility.

Clinical Care for Individuals with COVID-19

- **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 (including notifying the facility/hospital in advance). See Transport section. The initial medical evaluation should determine whether a symptomatic individual is at increased risk for severe illness from COVID-19. Persons at increased risk may include older adults and persons of any age with serious underlying medical conditions, including chronic kidney disease, serious heart conditions, and Type-2 diabetes. See CDC's website for a complete list and check regularly for updates as more data become available to inform this issue.
    - Based on available information, **pregnant people seem to have the same risk of COVID-19 as adults who are not pregnant.** However, much remains unknown about the risks of COVID-19 to the pregnant person, the pregnancy, and the unborn child. Prenatal and postnatal care is important for all pregnant people, including those who are incarcerated/detained. Visit the CDC website for more information on pregnancy and breastfeeding in the context of COVID-19.
- **Staff evaluating and providing care for individuals with confirmed or suspected COVID-**

19 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 COVID-19 symptoms and those who are close contacts of someone with COVID-19 in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the individual being evaluated is wearing a cloth face covering.**
    - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having symptomatic individuals 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).** However, presence of another illness such as influenza does not rule out COVID-19.
- **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, use 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 individuals with confirmed and suspected COVID-19. Ensure strict adherence to OSHA PPE requirements.**
    - Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95 respirator) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program. If individuals wearing N95s have facial hair, it should not protrude under the respirator seal, or extend far enough to interfere with the device's valve function (see OSHA regulations □).
    - For PPE training materials and posters, visit the CDC website on Protecting Healthcare Personnel.
- **Ensure that all staff are trained to perform hand hygiene after removing PPE.**
- **Ensure that PPE is readily available where and when needed, and that PPE donning/doffing/disposal stations have been set up as described in the Preparation section.**

- **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with someone with COVID-19 and their close 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 surgical masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols or droplets from someone with COVID-19.
    - **Surgical mask**
      Worn to protect the wearer from splashes, sprays, and respiratory droplets generated by others. (NOTE: Surgical masks are distinct from cloth face coverings, which are not PPE but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer.)
    - **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 an individual with confirmed or suspected COVID-19, and that clothing is changed as soon as possible and laundered. 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, activities where splashes and sprays are anticipated, and high-contact activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.
- **Note that shortages of all PPE categories have been seen during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category (including strategies to reuse PPE safely) can be found on CDC's website:**
    - Strategies for optimizing the supply of N95 respirators
        - Based on local and regional situational analysis of PPE supplies, **surgical 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.

- Strategies for optimizing the supply of surgical masks
  - Reserve surgical masks for individuals who need PPE. Issue cloth face coverings to incarcerated/detained persons and staff as source control, in order to preserve surgical mask supply (see recommended PPE).
- Strategies for optimizing the supply of eye protection
- Strategies for optimizing the supply of gowns/coveralls
- Strategies for optimizing the supply of disposable medical gloves

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

Classification of Individual Wearing PPE	N95 respirator	Surgical mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of someone with COVID-19*)	Use surgical masks or cloth face coverings as source control (NOTE: cloth face coverings are NOT PPE and may not protect the wearer. Prioritize cloth face coverings for source control among all persons who do not meet criteria for N95 or surgical masks, and to conserve surgical masks for situations that require PPE.)				
Incarcerated/detained persons who have confirmed or suspected COVID-19, or showing symptoms of COVID-19					
Incarcerated/detained persons handling laundry or used food service items from someone with				X	X

COVID-19 or their close contacts					
Incarcerated/detained persons cleaning an area where someone with COVID-19 spends time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of someone with COVID-19* (but not performing temperature checks or providing medical care)		Surgical 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		X	X	X	
Staff having direct contact with (including transport) or offering medical care to individuals with confirmed or suspected COVID-19 (See CDC infection control guidelines). For recommended PPE for staff performing collection	X**		X	X	X

of specimens for SARS-CoV-2 testing see the Standardized procedure for SARS-CoV-2 testing in congregate settings.					
Staff present during a procedure on someone with confirmed or suspected COVID-19 that may generate infectious aerosols (See CDC infection control guidelines)	X		X	X	X
Incarcerated/detained persons handling laundry or used food service items from someone with COVID-19 or their close contacts				X	X
Staff cleaning an area where someone with COVID-19 spends time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X

Classification of Individual Wearing PPE

* If a facility chooses to routinely quarantine all newly incarcerated/detained intakes (without symptoms or known exposure to someone with COVID-19) before integrating into the general population, surgical masks are not necessary. Cloth face coverings are recommended.
**A NIOSH-approved N95 respirator is preferred. However, based on local and regional situational analysis of PPE supplies, surgical 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 close 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 surgical 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 with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
  - Remove and discard PPE

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Last Updated July 22, 2020

Community Mitigation Framework

Cleaning & Disinfecting

Businesses & Workplaces

Worker Safety & Support

Schools & Child Care

Colleges & Universities

Parks, Sports & Recreation

Gatherings & Community Events

Community & Faith-Based Organizations

First Responders, Law Enforcement & Public Services

Shared & Congregate Housing

Retirement Communities

Homeless Populations

Correctional & Detention Facilities

Tribal Communities

Guidance Documents

Communication Resources

What's New

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Português

Italiano

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English

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Exhibit 16

https://www.bop.gov/coronavirus/ Go FEB MAR APR
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22 Mar 2020 - 15 Apr 2020 2019 2020 2021
About this capture

The Bureau of Prisons (BOP) is carefully monitoring the spread of the COVID-19 virus. As with any type of emergency situation, we carefully assess how to best ensure the safety of staff, inmates and the public.

BOP COVID-19 Modified Operations Plan

BOP's Emergency Response

Every institution is like a small city and to cope with major emergencies or other significant interruptions of normal operations, they each have continuity of operations (COOP) plans that provide guidance to staff.

BOP's COVID-19 Response

In February 2020, the BOP's Public Health Service (PHS) staff were placed in operational dress uniforms to be ready to respond to COVID-19 incidents by the Assistant Secretary for Health.

BOP's COVID-19 Collaboration Efforts

BOP PHS Officers have been deployed for national travel-related screening at airports and NIC has been asked to share BOP-related guidance with state and local corrections.

Coronavirus.gov

The primary lane of information for the public regarding Coronavirus (COVID-19) is a portal for public information published by the Coronavirus (COVID-19) Task Force at the White House, working in conjunction with CDC, HHS and other agency stakeholders.

CDC.gov

The Centers for Disease Control and Prevention (CDC) has established a resource portal on CDC.gov with the latest information from CDC and the overarching medical community on COVID-19.

USA.gov

To learn about international travel restrictions, how you can prepare for coronavirus, and what the U.S. government is doing in response to the virus, visit https://www.usa.gov/coronavirus

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22 Mar 2020 - 15 Apr 2020 2019 2020 2021
About this capture

COVID-19 Tested Positive Cases

Inmates

28

(Inmate) 3/30/2020 - MDC Brooklyn; FCC Oakdale (7); USP Atlanta (2); MCC New York (3); FMC Butner (2); FCI Otisville; FCI Danbury; FCC Lompoc (3); FCI Elkton (2); RRC Phoenix, AZ, RRC Brooklyn, NY (4); RRC Janesville, WI

(Staff) 3/30/2020 - Grand Prairie, TX; Leavenworth, KS (no inmate contact); Yazoo, MS (2); Atlanta, GA (2); Danbury, CT; Butner, NC; Ray Brook, NY; New York, NY (2); Chicago, IL (2); Brooklyn, NY (4); Oakdale, LA (3); Lompoc, CA; Otisville, NY; Fort Dix, NJ; Talladega AL.

Staff

24

Note: *Due to the rapidly evolving nature of this public health crisis, the BOP will update this dashboard daily at 3:00 p.m. based on the most recently available data from across the agency as reported by the BOP's Office of Occupational Health and Safety.*

Resources

- COVID-19 Visitor/Volunteer/Contractor Screening Tool
- COVID-19 Inmate Screening Tool
- COVID-19 Staff Screening Tool
- Coronavirus (COVID-19) Precautions/Modified Operations for Residential Reentry Centers.
- Coronavirus (COVID-19) Religious Accommodations

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Exhibit 17

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About this capture

COVID-19 Tested Positive Cases

Inmates

57

Staff

(Inmate) 4/1/2020 - MDC Brooklyn; FCC Oakdale (11); USP Atlanta (4); MCC New York (4); FMC Butner (9); FCI Otisville; FCI Danbury (9); FCC Lompoc (6); FCI Elkton (2); USP Canaan, PA; Forrest City, AK (2); Yazoo City, MS; RRC Phoenix, AZ; RRC Brooklyn, NY (4); RRC Janesville, WI.

(Staff) 4/1/2020 - Grand Prairie, TX; Leavenworth, KS (no inmate contact); Yazoo, MS (3); Atlanta, GA (3); Danbury, CT (4); Butner, NC; Ray Brook, NY (2); New York, NY (5); Chicago, IL (2); Brooklyn, NY (4); Oakdale, LA (4); Lompoc, CA; Otisville, NY; Talladega, AL; Tucson, AZ; Milan, MI; Southeast Regional Office Atlanta, GA; Central Office, Washington, DC

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- Coronavirus (COVID-19) Religious Accommodations

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Exhibit 18

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About this capture

Open COVID-19 Tested Positive Cases

Inmates

138

(Inmate) 04/05/2020 - USP Atlanta (9); FCI Bennettsville; MDC Brooklyn; FCI Butner Low (7); FMC Butner; FCI Butner Medium I (3); USP Canaan; FMC Carswell; FCI Cumberland; FCI Danbury (21); FCI Elkton (7); FCI Forrest City Low (2); FCI Forrest City Medium (8); USP Lompoc (17); FCI Milan (3); MCC New York (4); FCI Oakdale I (22); FCI Otisville; FCI Yazoo City Low (2); FCI Yazoo City Medium (5); USP Yazoo City (11); RRC Baltimore, MD; RRC Brooklyn, NY (4); RRC Chicago, IL; RRC Dallas, TX; RRC Phoenix, AZ; RRC St Louis, MO; FLM Guam.

Staff

(Staff) 04/05/2020 - Atlanta, GA (3); Brooklyn, NY (5); Butner, NC; Waymart (Canaan), PA; Chicago, IL (3); Danbury, CT (7); Lisbon (Elkton), OH; Forrest City, AR Low (2); Forrest City, AR Medium (2); Fort Dix, NJ; Leavenworth, KS; Lompoc, CA (2); Milan, MI; New York, NY (6); Oakdale, LA (4); Otisville, NY (2); Ray Brook, NY (7); Talladega, AL (3); Tucson, AZ; Yazoo, MS Low (2); Yazoo, MS Medium; Central Office, Washington, DC; Grand Prairie Office Complex, Grand Prairie, TX; Southeast Regional Office, Atlanta, GA.

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- Coronavirus (COVID-19) Religious Accommodations

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Exhibit 19

The BOP has **141,610** federal inmates in BOP-managed institutions and **10,880** in community-based facilities. The BOP staff complement is approximately **36,000**. As of 05/01/2020, there are **1842 federal inmates** and **343 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **509** inmates and **146** staff have recovered. There have been **36** federal inmate deaths and **0** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving open cases from across the agency as reported by the BOP's Office of Occupational Health and Safety. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

0	1	0	0	Beaumont Medium FCI	Beaumont	TX
2	2	0	0	Bennettsville FCI	Bennettsville	SC
6	0	0	0	Community Resources for Justice, Inc. (RRC)	Boston	MA
0	0	1	0	GEO Care, Inc. (RRC)	Bronx	NY
0	28	0	0	Brooklyn MDC	Brooklyn	NY
2	0	0	0	CORE Services Group, Inc. (RRC)	Brooklyn	NY
5	4	0	0	Butner FMC	Butner	NC
27	3	0	0	Butner Low FCI	Butner	NC
208	13	6	0	Butner Medium I FCI	Butner	NC

Exhibit 20

05/31/2020 - The BOP has **135,745** federal inmates in BOP-managed institutions and **12,520** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **1629 federal inmates** and **177 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3605** inmates and **435** staff have recovered. There have been **67** federal inmate deaths and **0** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	2	0	0	1	8	Butner	NC
Butner Low FCI	137	6	4	0	39	6	Butner	NC
Butner Medium I FCI	27	4	9	0	191	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC
Otero County Prison Facility (RRC)	2	0	0	0	0	0	Charparral	NM

Exhibit 21

06/03/2020 - The BOP has **135,258** federal inmates in BOP-managed institutions and **12,589** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **1956 federal inmates** and **176 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3689** inmates and **450** staff have recovered. There have been **72** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	2	0	0	1	8	Butner	NC
Butner Low FCI	367	6	6	1	45	6	Butner	NC
Butner Medium I FCI	30	4	9	0	190	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC
Otero County Prison Facility (RRC)	2	0	0	0	0	0	Charparral	NM

Exhibit 22

06/07/2020 - The BOP has **134,505** federal inmates in BOP-managed institutions and **12,784** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **1999 federal inmates** and **184 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3936** inmates and **452** staff have recovered. There have been **78** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	2	0	0	1	8	Butner	NC
Butner Low FCI	534	7	9	1	44	6	Butner	NC
Butner Medium I FCI	31	4	9	0	190	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC
Otero County Prison Facility (RRC)	1	0	0	0	1	0	Charparral	NM

Exhibit 23

06/08/2020 - The BOP has **134,522** federal inmates in BOP-managed institutions and **12,788** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **2068 federal inmates** and **185 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3957** inmates and **452** staff have recovered. There have been **78** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	2	0	0	1	8	Butner	NC
Butner Low FCI	617	7	9	1	44	6	Butner	NC
Butner Medium I FCI	27	5	9	0	194	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC

Exhibit 24

06/09/2020 - The BOP has **134,351** federal inmates in BOP-managed institutions and **12,774** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **2125 federal inmates** and **190 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3975** inmates and **453** staff have recovered. There have been **78** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	3	0	0	1	8	Butner	NC
Butner Low FCI	622	9	9	1	45	6	Butner	NC
Butner Medium I FCI	28	5	9	0	194	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC

Exhibit 25

06/10/2020 - The BOP has **134,112** federal inmates in BOP-managed institutions and **12,870** in community-based facilities. The BOP staff complement is approximately **36,000**. There are **2134 federal inmates** and **190 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **3972** inmates and **456** staff have recovered. There have been **79** federal inmate deaths and **1** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers, recoveries, and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving **open cases** from across the agency as reported by the BOP's Office of Occupational Health and Safety at 11:00 a.m. each day. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The BOP has begun additional testing of asymptomatic inmates to assist in slowing transmissions within a correctional setting. As such, our data reflects an increase in the number of COVID-19 positive tests reflected in the table below. The BOP is able to better utilize this information for the management of an outbreak at the relevant, affected facility.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program, inmates supervised under the USPO, or being held in privately managed prisons. Additionally, the reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

(RRC)								
Hazelton USP	0	1	0	0	0	0	Bruceton Mills	WV
Butner FMC	4	3	0	0	1	8	Butner	NC
Butner Low FCI	642	9	9	1	45	6	Butner	NC
Butner Medium I FCI	28	5	9	0	189	24	Butner	NC
Butner Medium II FCI	2	0	0	0	0	0	Butner	NC

Exhibit 26

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

April 3, 2020

MEMORANDUM FOR DIRECTOR OF BUREAU OF PRISONS

FROM: THE ATTORNEY GENERAL

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

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

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

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

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

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

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

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

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

II. PROTECTING THE PUBLIC

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

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

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

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

Exhibit 27

Washington, D.C. 20534

April 13, 2020

MEMORANDUM FOR ALL CHIEF EXECUTIVE OFFICERS

FROM: **ANDRE MATEVOUSIAN, ACTING ASSISTANT DIRECTOR**
CORRECTIONAL PROGRAMS DIVISION

L. CRISTINA GRIFFITH, ASSISTANT DIRECTOR
HUMAN RESOURCE MANAGEMENT DIVISION

SUBJECT: **CORONAVIRUS (COVID-19) PHASE SIX ACTION PLAN**

To ensure comprehensive understanding of the BOP's COVID-19 Phase Six Action Plan, we reiterate herein previously disseminated guidance along with new measures for implementation in managing the evolving pandemic. Effective immediately, the following preventative measures are mandated for all Bureau locations.

EXTENSION OF PHASE FIVE ACTION PLAN:

Effective, Monday, April 13, 2020, the Bureau will continue its nationwide action as described in the Phase 5 Action Plan, to minimize movement and decrease the spread of the virus. This extension - which applies to medical screening, limited inmate gathering, daily rounds, limited external movement, and fit testing - will remain in place until May 18, 2020, at which time the action will be reevaluated.

HIRING:

Hiring initiatives are paramount to the Bureau's mission to address shortages in key positions and locations. Emphasis must be placed in prioritizing the hiring of Correctional Officers. Wardens will ensure Human Resource Departments are fully engaged in processing new applicants into the agency. As a reminder, all applicants who enter the institution should undergo the same COVID-19 screening and temperature check as staff, contractors, and visitors.

TRAINING:

All staff training is suspended through May 31, 2020, with the exception of "*Introduction to Correctional Techniques - Phase I*", and any training that can be conducted remotely to fulfill ongoing mandatory

credentialing requirements that cannot be waived during this pandemic. Any other exceptions to this suspension must be routed through the appropriate Assistant Director or Regional Director, and submitted to the Deputy Director for final approval.

OFFICIAL STAFF TRAVEL:

Official staff travel, with the exception of the deployment of staff to institutions to assist with the COVID-19 pandemic, is suspended through May 31, 2020. Any exceptions to this suspension must be routed through the appropriate Assistant Director or Regional Director.

SECONDARY LAW ENFORCEMENT STAFF:

Secondary Law Enforcement Officers located throughout the agency will be deployed to assist with staffing shortages in field locations. Wardens requiring supplemental staff to cover vacancies will submit a written request to their Regional Emergency Operations Center (EOC). Once approved by the Regional Director, the request will be forwarded to the National EOC for scheduling, notifications, and travel arrangements.

LOGISTICS:

Wardens must continually assess and account for their supply and equipment inventories and plan for an extended crisis period by increasing normal supply inventories to the greatest extent possible. Emphasis for assessment should be placed on Personal Protective Equipment (PPE), food, medicine, cleaning supplies, and emergency-related equipment. PPE supplies may be requested first through the region and then from the National EOC.

SOCIAL VISITS:

Social visits will continue to be suspended until May 18, 2020, at which time the suspension will be reevaluated.

LEGAL VISITS:

Legal visits will continue to be suspended until May 18, 2020, at which time the suspension will be reevaluated.

Wardens are reminded that access to legal counsel remains a paramount requirement and must be accommodated to the maximum extent practicable. Although legal visits are suspended until May 18, 2020, case-by-case accommodations for in-person visits should be made at the local level. Attorneys should be encouraged to make requests through each facility's main email address found at www.bop.gov, telephonically, or by contacting the appropriate Consolidated Legal Center.

If approved for an in-person visit, the attorney must undergo a COVID-19 screening and temperature check, consistent with the procedures in place for staff, contractors, and visitors. Anyone with COVID-19 symptoms or a temperature ≥ 100.4°F will not be allowed to enter the facility. When performing screening activities, staff or contractors will wear PPE according to Bureau and CDC guidance.

The authority to approve and/or deny legal visits will not be delegated below the Warden and/or his/her designee.

Facilities should offer as an alternative a legal visit via video conferencing. The BOP's VTC infrastructure can support a connected call through the Administrative Office of the US Courts bridge and can connect to external callers using WebEx or Jabber. If your field site has questions about how to do so, the local IT staff may contact the Computer Services and Administration Branch in Central Office.

CONTRACTORS:

Contractors performing essential services or necessary maintenance on essential systems will continue to be allowed to enter the facility, and must undergo a COVID-19 screening and temperature check prior to entry. Anyone with COVID-19 symptoms or a temperature ≥ 100.4°F will not be allowed to enter the facility. When performing screening activities, staff or contractors will wear PPE according to Bureau and CDC guidance.

VOLUNTEERS:

Volunteer visits will be suspended until May 18, 2020, at which time the suspension will be reevaluated. Alternate means of communication, to include telephone calls and video conferences, may be considered for inmates who request to speak with a religious advisor.

QUARANTINE AND ISOLATION:

Quarantine will be used for the following reasons for inmates who are asymptomatic for COVID-19:

1) All new admissions to a Bureau facility and all returns to a Bureau facility.
    - This includes all new intakes, detainees and commitments, writ returns, parole violators, and hospital returns, regardless of their mode of arrival (e.g., voluntary surrender, U.S. Marshals Service / Justice Prisoner and Alien Transportation Service, Customs and Border Patrol, and Immigration and Customs Enforcement).
    - Bureau intra-system transfers who have already been in Bureau population more than 14 days should be screened and temperature checked for COVID-19 before departure. They ordinarily do not require quarantine at their gaining facility if there are no active or suspected COVID-19 cases at the sending facility, and they did not come in contact with any other inmates from another facility during transfer to the gaining facility.
2) All close contacts of a confirmed or suspected case of COVID-19.
3) All inmates releasing to a Residential Reentry Center (RRC), Home Confinement (HC), or Good Conduct Time/3621e/Full Term release.

At the time of placement in Quarantine, inmates will have a COVID-19 symptom screening and a temperature check. Those with COVID-19 symptoms or a temperature ≥ 100.4°F will be placed in Isolation. ***All inmates in Isolation will be placed in a single cell. Any deviations from this housing will be immediately reported to the Regional and National EOCs.*** All inmates in Quarantine or Isolation will be monitored and managed according to Bureau and Centers for Disease Control and

Prevention (CDC) guidance. PPE will be worn by staff when in contact with quarantined or isolated inmates as recommended in this same guidance.

Quarantine is ordinarily continued for 14 days unless the quarantined inmate becomes symptomatic or is cohorted with someone who becomes symptomatic.

Criteria for release from isolation for COVID-19 may be determined using a test-based or a symptom-based strategy. Using a test-based strategy, an inmate may be released from isolation when:

- Fever has resolved without the use of fever-reducing medications, *and*
- Respiratory symptoms have improved, *and*
- A molecular test for Sars-CoV-2 is negative on two occasions at least 24 hours apart.

Using a symptom-based strategy, an inmate may be released from isolation when:

- Fever has resolved for 72 hours without the use of fever-reducing medications, *and*
- Respiratory symptoms have improved for at least 72 hours, *and*
- Seven days or more have passed since the onset of symptoms.

EXIT SCREENING OF INMATES:

All inmates will be screened for COVID-19 symptoms and undergo a temperature check prior to leaving the facility. Inmates with COVID-19 symptoms or a temperature ≥ 100.4°F will be placed in isolation. All staff or contractors who perform screening activities will wear PPE according to Bureau and CDC guidance.

OUTSIDE TRIPS FOR HEALTH CARE:

Outside trips for health care should be limited to urgent and emergent health conditions. All routine outside health care should be postponed when clinically appropriate to do so.

PERSONAL PROTECTIVE EQUIPMENT:

Appropriate PPE for COVID-19 must be worn by staff or contractors according to Bureau and CDC guidance and may include gown, gloves, surgical mask or N-95 respirator, and face shield or goggles, depending on the situation. Recommended PPE guidance may be found at http://sallyport.bop.gov/co/hsd/infectious_disease/covid19/covid19_guidance.jsp#1_5

FACE COVERINGS:

All staff and inmates will be issued and strongly encouraged to wear an appropriate face covering when in public areas when social distancing cannot be achieved.

FOOD SERVICE:

Institutions with active COVID-19 transmission (especially Care Level 3 and 4 Institutions) should satellite feed all inmates in their units. Meals, eating utensils, and drink-ware should only be served by staff

wearing proper PPE. When meals are being distributed, a distance of six feet between inmates should be observed.

INFECTION PREVENTION AND CONTROL PRACTICES:

Rigorous infection prevention and control practices are essential to contain and mitigate the spread of COVID-19. These practices include identifying symptomatic inmates as early as possible by assessing for COVID-19 symptoms and conducting a temperature check at intake screening, exit screening, during a contact investigation, and broader screening initiatives, (e.g., daily screening or other methods of enhanced surveillance at institutions affected by COVID-19, in consultation with the Regional Quality Improvement/ Infection Prevention and Control Consultant). Institutions should also encourage early reporting of symptoms by inmates and provide them opportunities for medical evaluations. When indicated, a contact investigation should be performed for cases of COVID-like symptoms, in consultation with the Regional Quality Improvement/ Infection Prevention and Control Consultant. Isolation is mandatory for any inmate with COVID-like symptoms. PPE must be worn in accordance with CDC guidance. Recommended guidance can be found at http://sallyport.bop.gov/co/hsd/infectious_disease/covid19/covid19_guidance.jsp#1_5

Good hand and health hygiene practices are strongly encouraged and include washing hands regularly with soap and water for at least 20 seconds, covering a cough or a sneeze, avoiding touching the face or shaking hands, limiting contact with high touch surfaces, and staying home when sick.

Social distancing should be practiced whenever possible. Strategies for accomplishing this should be evaluated, especially in open bay / barracks-style living quarters.

At all institutions, compartmentalization of staff and inmate movement will continue to help slow the cross-contamination of work spaces and housing units. This restriction includes limiting supervisor and manager movements for rounds to specific locations. During this period, staff post assignments shall not be changed unless to fill behind a vacant post. Changes in shift hours is permitted provided the shift location remains the same.

Regular cleaning and disinfection of units and high touch surfaces should be emphasized to the inmate population. Wardens must ensure cleaning supplies are readily available for all inmates. Institutions without any known COVID-19 cases should take proactive infection prevention and control measures, while institutions with COVID-19 cases will need to modify delivery of health care services in accordance with guidance from the Bureau Medical Director.

PANDEMIC PREPAREDNESS:

All institutions should continue to review and update pandemic plans to include identifying locations for quarantine and isolation of potentially large numbers of inmates, purchasing appropriate supplies, and planning for potentially severe staffing shortages and moderate-to-severe disruptions of normal operations. All institutions should make contact with local health authorities and community health resources to plan for limited or widespread institution transmission of COVID-19.

FIT TESTING:

In the March 31, 2020 Phase Five memo, all positions within the agency were mandated to comply and participate in the respiratory protection program as stated in Program Statement 1600.11, Chapter 3 Section 2, Respiratory Protection. It is mandatory that all staff complete the training to ensure maximum numbers of staff are available on each shift to meet the anticipated needs throughout this public health emergency.

This participation includes the completion of the "OSHA Medical Questionnaire" for medical review and clearance followed by training and proper fit-testing for the following respirators:

- N-95.
- Scott M-120 full face respirator (Gas Mask).
- Scott AV-3000 sure seal face piece (Scott Air-Pak 75 SCBA).

Upon completion of the initial training and fit-testing, staff must maintain a state of readiness to use a respirator at all times, to include absence of facial hair that would interfere with the seal of the respirator. Failure to do so may result in disciplinary action. This requirement will remain in effect throughout the duration of the public health emergency.

Individuals who are unable to obtain medical clearance must request accommodation, in accordance with Program Statement 3720.03, Reasonable Accommodation Program.

LIMITED MOVEMENT:

The Bureau will continue to coordinate with the U.S. Marshals Service to significantly decrease incoming movement. Strategic institutions have been identified for mandatory movement needs; these locations will include all detention centers and key locations located throughout the country to accommodate population increases. These areas will serve as quarantine sites until such time inmates can be moved to their final destination.

Internal movement will continue to be suspended. Exceptions to this restriction are legally-required transfers related to forensic studies, writs, Interstate Agreements on Detainers, medical or mental health reasons, and RRC/HC placements. Medical trips for treatment will still continue, as necessary (see Outside Trips for Health Care section above).

Any exceptions must be routed through your Regional Director for approval by the Assistant Director, Correctional Programs Division.

QUESTIONS:

If staff have questions about COVID-19, they may reach out to the agency at the following email box: COVID19Questions@bop.gov.

We appreciate your assistance in this significant phase of our COVID-19 response.

Exhibit 28

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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UNITED STATES OF AMERICA

v.

WESAM EL-HANAFI,

Defendant.
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DOC #: _____
DATE FILED: May 19, 2020

10-CR-162 (KMW)
OPINION AND ORDER

KIMBA M. WOOD, District Judge:

Defendant Wesam El-Hanafi has moved to reduce his term of imprisonment under the federal compassionate release statute, 18 U.S.C. § 3582(c)(1)(A). He argues that if he were to contract COVID-19 while incarcerated, he would face a heightened risk of suffering life-threatening illness because of his many serious underlying health conditions. (ECF No. 242.) The Government opposes his motion. (ECF No. 247.) For the reasons set forth below, the Court GRANTS Defendant's motion and orders his immediate release from prison. Defendant's sentence is reduced to time served. He shall abide by all the terms and conditions of supervised release that were imposed at his original sentencing and that are memorialized in his judgment of conviction. (ECF No. 211.)

BACKGROUND

On June 18, 2012, Defendant pleaded guilty to an Information charging two counts: (1) providing, and attempting to provide, material support and resources to a designated foreign terrorist organization, namely, Al Qaeda, in violation of Title 18, United States Code, Section

2339B; and (2) conspiring to provide material support and resources to a designated foreign terrorist organization, namely, Al Qaeda, in violation of Title 18, United States Code, Section 371.

In advance of sentencing, the Court received two expert medical reports and, on January 7, 2015, conducted a one-day hearing focused on Mr. El-Hanafi's medical condition. (*See* Hearing Tr., ECF No. 203.) The Court heard testimony from the authors of the medical reports: Dr. Jeffery Weitz, who testified for the defense, and Dr. James F. McKinsey, who testified for the Government. (*Id.*) Although the doctors assessed the cause and extent of Defendant's disability differently, they agreed that he suffers from deep vein thrombosis. (*Id.*)

The Court sentenced Defendant on January 20, 2015. (Sentencing Tr., ECF No. 209.) The Court cited "a number of factors" that "counsel[ed] for a degree of leniency," including that Defendant's deep vein thrombosis had made the prior four years of incarceration "significantly harsher for the defendant than they would have been for the average inmate." (*Id.* at 33–34.) The Court also explained that Defendant had developed anti-phospholipid syndrome, which put him "at high risk for further damage to his kidneys as well as a fatal pulmonary embolism." (*Id.* at 34–35.) The Court sentenced Defendant to a non-guidelines term of 15 years' incarceration, to be followed by three years of supervised release. (*Id.* at 35.)

Defendant is currently serving his sentence at FCI Butner Low. Over the course of 10 years of incarceration, he has incurred no incident reports. (Def. Mot. at 1, ECF No. 242.) According to Bureau of Prisons ("BOP") records, his projected release date is February 9, 2023.

On April 8, 2020, Defendant submitted a request to the BOP pursuant to 18 U.S.C. § 3624 to serve the remainder of his sentence under home confinement in light of his poor health and the dangers that he faces from COVID-19. (Def. Mot. at Ex. I.) The BOP denied this

request on April 20, 2020, principally because Defendant is incarcerated for a terrorism offense. (Gov. Opp'n at 5–6, ECF No. 247.)

On April 24, 2020, Defendant submitted a request to the BOP pursuant to 18 U.S.C. § 3582 for compassionate release. (Def. Mot. at 19.) Defense counsel wrote to the Warden of FCI Butner Low three days later in support of Defendant's compassionate release application. Counsel also requested that the BOP reconsider Defendant as a candidate for home confinement under Section 12003(b)(2) of the CARES Act. (Def. Mot. at 19, Ex. K.) The Warden denied Defendant's compassionate release application on May 6, 2020. (Gov. Opp'n at 7.)

Defendant filed the present motion on April 30, 2020. The Government submitted its opposition on May 13, 2020, and Defendant replied on May 15, 2020.

LEGAL STANDARD

Under 18 U.S.C. § 3582(c)(1)(A), as modified by the First Step Act, Pub. L. No. 115–391, 132 Stat. 5194 (Dec. 21, 2018), a court may reduce a defendant's sentence upon motion of the Director of the Bureau of Prisons ("BOP"), or upon motion of the defendant. A defendant may move under Section 3582(c)(1)(A) only after the defendant has "fully exhausted all administrative rights to appeal a failure of the Bureau of Prisons to bring a motion on the defendant's behalf or the lapse of 30 days from the receipt of such a request by the warden of the defendant's facility, whichever is earlier." *Id.*

I. Exhaustion

Defendant has not satisfied the exhaustion requirements of Section 3582(c)(1)(A). Thirty days have not yet expired since Defendant submitted his compassionate release request to the Warden of FCI Butner Low. And although the Warden has already declined to bring a motion for compassionate release on Defendant's behalf, Defendant has not fully exhausted his

administrative rights to appeal that decision.

The Court has authority to waive Section 3582(c)(1)(A)'s exhaustion requirement. Other judges in this district have ably explained why, and this Court will not belabor an issue that has been cogently and comprehensively examined elsewhere. *See, e.g.*, *United States v. Scparta*, No. 18-CR-578, 2020 U.S. Dist. LEXIS 68935, at *31 (S.D.N.Y. Apr. 19, 2020) (Nathan, J.); *United States v. Russo*, No. 16-CR-44, 2020 U.S. Dist. LEXIS 65390 (S.D.N.Y. Apr. 14, 2020) (Liman, J.); *United States v. Haney*, No. 19-CR-541, 2020 WL 1821988, at *2 (S.D.N.Y. Apr. 13, 2020) (Rakoff, J.). Rather, it suffices to review briefly some of the principal reasons that Section 3582(c)(1)(A)'s exhaustion requirement is amenable to equitable exceptions.

To begin, the language of Section 3582(c)(1)(A) is not jurisdictional. Unless Congress has clearly stated that a rule is jurisdictional, courts must treat it as non-jurisdictional. *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 153 (2013). Section 3582(c)(1)(A) makes no mention of jurisdictional elements and is not contained within the jurisdictional portion of the United States Code. *Russo*, 2020 U.S. Dist. LEXIS 65390 at *9 (citing *United States v. Taylor*, 778 F.3d 667, 671 (7th Cir. 2015)). Furthermore, the Second Circuit has deemed a related provision, Section 3582(c)(2), non-jurisdictional. *See United States v. Johnson*, 732 F.3d 109, 116 n.11 (2d Cir. 2013)); *Haney*, 2020 U.S. Dist. LEXIS 63971, No. 19-CR-541, at 5–7.

The exhaustion requirement in Section 3582(c) is therefore properly understood as a claim-processing rule, a non-jurisdictional directive that "seek[s] to promote the orderly progress of litigation by requiring that the parties take certain procedural steps at certain specified times." *Henderson v. Shinseki*, 562 U.S. 428, 435 (2011). "[T]he exhaustion requirement in Section 3582(c)(1)(A) merely controls who—the BOP or defendant—may move for compassionate release and when such a motion may be made. It simply delineates the process for a party to

obtain judicial review, not referring to the adjudicatory capacity of the courts." *Haney*, 2020 U.S. Dist. LEXIS 63971 at *6. Claim-processing rules may be, but are not always, mandatory.

"Of paramount importance" to this question "is congressional intent." *McCarthy v. Madigan*, 503 U.S. 140, 144 (1992) (citation and quotation marks omitted). Generally, Congress imposes exhaustion requirements in order to "serve[] the twin purposes of protecting administrative agency authority and promoting judicial efficiency." *Id.* at 145. Here, "the statute does not necessarily require the moving defendant to fully litigate his claim before the agency (i.e., the BOP) before bringing his petition to court. Rather, it requires the defendant either to exhaust administrative remedies or simply to wait 30 days after serving his petition on the warden of his facility before filing a motion in court." *Haney*, 2020 U.S. Dist. LEXIS 63971, at *8. Moreover, only a judge—not the BOP—may order a person's compassionate release. Even if Defendant followed the statute's exhaustion requirements, he could, at best, expect the BOP to bring a motion on his behalf, to be adjudicated in court. Thus, the "hybrid" nature of the exhaustion requirement "substantially reduces the importance of the first purpose [of protecting administrative agency authority]." *Id.* at *8–9. And because the exhaustion requirement "unquestionably reflects congressional intent for the defendant to have the right to a meaningful and prompt *judicial* determination of whether he should be released," it would undermine the goal of judicial efficiency and "pervert congressional intent" to treat the requirement "as a substantial obstacle to effective judicial review." *Russo*, 2020 U.S. Dist. LEXIS 65390 at *7.

In sum, Section 3582(c)(1)(A)'s text and purpose counsel in favor of concluding that its exhaustion requirement is subject to equitable exceptions. Here, waiting for Defendant to exhaust his administrative appeal rights would both be futile and cause him irreparable harm.

See Scparta, 2020 U.S. Dist. LEXIS 68935, at *12. Thus, the Court waives exhaustion and turns to the merits of Defendant's motion.

II. Extraordinary and Compelling Reasons for Release

A court may reduce a defendant's sentence if the court finds that "extraordinary and compelling reasons warrant such a reduction," and "such a reduction is consistent with the applicable policy statements issued by the Sentencing Commission." *Id.* § 3582(c)(1)(A)(i). In making this determination, the court must consider the "the factors set forth in [18 U.S.C. § 3553(a)] to the extent that they are applicable." *Id.* § 3582(c)(1)(A).

Congress delegated responsibility to the Sentencing Commission to "describe what should be considered extraordinary and compelling reasons for sentence reduction." 28 U.S.C. § 994(t)). The Sentencing Commission has determined that a defendant's circumstances meet this standard when, *inter alia*, the defendant is "suffering from a terminal illness" or a "serious physical or medical condition . . . that substantially diminishes the ability of the defendant to provide self-care within the environment of a correctional facility," or if, in the judgment of the BOP, the defendant's circumstances are extraordinary and compelling for "other reasons." U.S.S.G. § 1B1.13(1)(A) & cmt. n.1(A), (D). Following the passage of the First Step Act, courts may independently determine whether such "other reasons" are present in a given case, without deference to the BOP's judgment. *See United States v. Lisi*, No. 15-CR-457, 2020 WL 881994, at *3 (S.D.N.Y. Feb. 24, 2020) (Failla, J.). In addition, the Sentencing Commission has resolved that a court should reduce a defendant's sentence only after determining that "[t]he defendant is not a danger to the safety of any other person or to the community." U.S.S.G. § 1B1.13(2).

Here, the mutually reinforcing risks of Defendant's living environment and his severe underlying health conditions give rise to extraordinary and compelling reasons for his release.

COVID-19 presents increased dangers in prison settings, where it is difficult to practice consistent social distancing, to maintain strict hygiene, and to take other preventative cautions. As of May 18, 2020, the top three clusters of COVID-19 cases in the United States—and ten of the top fifteen—were connected to prisons and jails.[1] And the problem of COVID-19 infection in jails and prisons likely runs deeper than we know. Tellingly, mass testing, in the few correctional facilities that have undertaken it, revealed vast hidden asymptomatic outbreaks.[2]

The Butner complex is one of the hardest-hit facilities. According to the Government, 318 inmates at the Butner complex have tested positive for COVID-19. (Gov. Opp'n at 17.) The Butner complex has the third highest number of confirmed cases of any BOP facility. (Def. Mot. at 6.)[3] The pace of infection shows no signs of abating. On May 18, 2020, the BOP website listed 32 currently infected inmates at FCI Butner Low, the low-security facility within the Butner complex where Defendant resides. This number represents an increase of nearly 50% in five days.[4] At least two staff members are also currently infected at FCI Butner Low,[5] although, remarkably, the Government concedes that no staff have been tested by the BOP; the number of positive cases among staff is self-reported. (Gov. Opp'n at 17.)

Defendant has no ability to avoid contact with infected areas or people. The Government acknowledges that at least one inmate and two staff members who tested positive "may have had exposure to the unit where Mr. El-Hanafi is assigned before they tested positive." (Gov. Opp. at 16.) Defendant is housed in a dormitory with 150-160 inmates. (Def. Motion at 6.) The space is

[1] *See Coronavirus in the U.S.: Latest Map and Case Count*, NEW YORK TIMES, at https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last accessed May 18, 2020).
[2] Linda So & Grant Smith, *In Four U.S. State Prisons, Nearly 3,300 Inmates Test Positive for Coronavirus -- 96% Without Symptoms*, REUTERS (April 25, 2020), available at https://www.reuters.com/article/us-health-coronavirus-prisons-testing-in/in-four-u-s-state-prisons-nearly-3300-inmates-test-positive-for-coronavirus-96-without-symptoms-idUSKCN2270RX.
[3] *See* Covid-19 Cases, BUREAU OF PRISONS, https://www.bop.gov/coronavirus/ (last accessed May 18, 2020)
[4] *Id.*; Def. Supplemental Letter, ECF No 251.
[5] *Id.*

divided into two- and three-person cubicles, with four-foot high walls. (*Id.*) Two aisles run the length of the cubicles, so that 75-80 inmates regularly stream past to access restrooms, to converse with one another, and to go to work. (*Id.*) Every day, approximately 48 inmates leave Defendant's unit to work throughout the facility. (Def. Reply at 6, ECF No. 250.) Two of those inmates are tasked with cleaning the medical isolation unit. (*Id.*) Defendant states that telephones and computers shared by 150 inmates are not cleaned or disinfected between uses. (*Id.* at 7.) The BOP provided the inmates at FCI Butner with three masks each, but Defendant states that his fellow inmates do not always wear them. (Def. Mot. at 11.) According to Defendant, one sick inmate was housed in his unit from April 27 through April 29, and spent time, unmasked, playing cards with other unmasked inmates at tables in the unit's common area. (Def. Reply at. 6.) It is difficult to conceive of an environment more conducive to the rapid spread of infection than the type of prison dormitory where Defendant resides.

For Defendant, infection from COVID-19 could well be fatal. He suffers from hypertension, stage 3 kidney failure, and severe anti-phospholipid syndrome with recurrent deep vein thrombosis. These chronic health problems place him firmly in the category of high-risk individuals.[6] The BOP has classified him at "Care Level 3," the second highest care level, for "outpatients who have complex, and usually chronic, medical or mental health conditions and who require frequent clinical contacts to maintain control or stability of their condition, or to prevent hospitalization or complications." (See Def. Mot. at 6, Exhibit C.)

In support of his motion for compassionate release, Defendant submits the informative report of Dr. Thomas T. Ward. (Def. Reply at Ex. M.) Dr. Ward is a Professor Emeritus in the Infectious Diseases Division in the Department of Medicine for Oregon Health Services

[6] *See* CDC: COVID-19: What if You are High Risk, available at https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html (last accessed May 15, 2020)

University. (*Id.*) He has practiced infectious disease and internal medicine for 45 years, and serves on the COVID-19 Advisory Task Force for the Oregon Health Authority. Dr. Ward states that "Both Mr. El-Hanafi's underlying hypertension, and likely more important, his underlying anti-phospholipid syndrome, poses risks for severe complications following a COVID-19 infection." (*Id.*)

Dr. Ward elaborates that anti-phospholipid syndrome is too uncommon to be identified in observational studies as a known risk factor, but it "much more likely than not" to contribute to severe illness and complications from COVID-19. It "shares with other recognized risk factors for severe COVID-19 disease the fact that it is a chronic inflammatory condition," even when controlled with medication. (*Id.*) Dr. Ward concludes that Defendant is "at very high risk for severe illness and death while residing in a large congregate setting and during ongoing significant prevalence of coronavirus disease." (*Id.*)

The Court finds that the COVID-19 pandemic, the conditions of incarceration that diminish Defendant's ability to protect himself from exposure, and Defendant's serious underlying health challenges, in combination, give rise to "extraordinary and compelling reasons" for reducing his sentence.

III. The Section 3553(a) Factors

The sentencing factors set forth in 18 U.S.C. § 3553(a) do not "outweigh the 'extraordinary and compelling reasons' warranting compassionate release" in Defendant's case. *United States v. Ebbers*, No. 02-cr-1144-3, 2020 U.S. Dist. LEXIS 3746, at *20 (S.D.N.Y. Jan. 8, 2020) (Caproni, J.)

Defendant's offense was exceptionally serious, but the considerations that counseled leniency at the time of sentencing are even more salient today. First, the Court recognized at

sentencing that Defendant's "childhood was marked by abuse and poverty, but he nonetheless became a pillar of strength and supportive love to his relatives." (Sentencing Tr. at 33.) Defendant remains "exceptionally close" to his family, in spite of his long incarceration, and he will return to the caring home of his wife and three children. (Def. Mot. at 21.)

The Court also remarked at sentencing that "[a]part from his very serious offense in this case, his record is unblemished," and that Defendant had demonstrated "signs of remorse and rehabilitation" during his four years of pre-sentence incarceration. (Sentencing Tr. at 33–34.) Defendant has maintained a spotless institutional record throughout ten years of incarceration and has participated in a long list of educational, rehabilitative, and job-readiness programs. (Def. Mot. at 20, Ex. C.) In a "Risk and Needs Assessment" conducted pursuant to the First Step Act, employing the Prisoner Assessment Tool Targeting Estimated Risk and Needs ("PATTERN"), Defendant's "Recidivism Risk Level" was determined to be "minimum." (*See id.* at 4, Ex. D.) The Court is convinced that Defendant is a rehabilitated offender who poses no danger to the community. His continued incarceration is not necessary to effectuate specific deterrence.

Finally, at sentencing, the Court found that Defendant's health problems caused significant suffering and magnified the ordinary challenges and hazards of incarceration. (Sentencing Tr. at 34–35.) Plainly, that concern is now more relevant and pressing than ever.

In light of Defendant's extensive health challenges and the other considerations addressed here, the Court concludes that the COVID-19 pandemic renders the previously imposed term of incarceration greater than necessary to achieve the goals of sentencing. Releasing Defendant 33 months early from a 180-month sentence in order to protect his life and health during an unprecedented global pandemic will not undermine general deterrence.

Defendant's previously imposed sentence is no longer just punishment where there is a real risk that it could be transformed into a death sentence. *See United States v. Field*, No. 18-cr-426, 2020 U.S. Dist. LEXIS 78112, at *6 (S.D.N.Y. May 4, 2020) (Oetken, J.).

CONCLUSION

For the foregoing reasons, Defendant's motion for a compassionate release under § 3582(c)(1)(A) is GRANTED. Defendant shall be resentenced to time served, and shall be released from the custody of the Bureau of Prisons immediately. Upon release, Defendant shall be placed on supervised release status and shall be for three years subject to all the mandatory conditions, standard conditions, and special conditions of supervised release stated in the original judgment and sentence in this case.

SO ORDERED.

Dated: New York, New York
May 19, 2020

/s/ Kimba M. Wood
KIMBA M. WOOD
United States District Judge

Exhibit 29

Declaration of Dr. Chris Beyrer

I, Chris Beyrer, declare as follows:

1. I am a professor of Epidemiology, International Health, and Medicine at the Johns Hopkins Bloomberg School of Public Health, where I regularly teach courses in the epidemiology of infectious diseases. This semester, I am teaching the epidemiology course on emerging infections at Hopkins. I am a member of the National Academy of Medicine, a former President of the International AIDS Society, and a past winner of the Lowell E. Bellin Award for Excellence in Preventive Medicine and Community Health. I have been active in infectious diseases epidemiology since completing my training in Preventive Medicine and Public Health at Johns Hopkins in 1992. Over the course of my career, I have at various times studied and published on the spread of infectious diseases within prisons. A copy of my curriculum vitae is attached as an exhibit.

2. I am currently actively at work on the COVID-19 pandemic in the United States. Among other activities, I am the Director of the Center for Public Health and Human Rights at Johns Hopkins, which is active in disease prevention and health promotion among vulnerable populations—including prisoners and detainees—in the U.S., Africa, Asia, and Latin America.

The Nature of COVID-19

3. The SARS-CoV-2 virus, and the human infection it causes—COVID-19—is a global pandemic and has been termed a global health emergency by the World Health Organization (WHO). Cases first began appearing sometime between December 1, 2019 and December 31, 2019 in Hubei Province, China. Most of the initial cases were associated with a wet seafood market in Wuhan City.

4. On January 7, 2020, the virus was isolated and identified. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus that caused the 2002–2003 SARS epidemic.[1]

5. On March 11, 2020, the WHO announced that the outbreak of COVID-19 is a pandemic. On March 13, President Trump declared a national emergency.

6. As of October 17, 2020, there have been 8,333,013 confirmed cases of coronavirus in the United States and 224,732 deaths.[2] The United States reports thousands of new cases of COVID-19 daily, with 47,153 cases and 369 deaths reported on August 30, 2020.[3] On September 22, 2020, the CDC reported that more than 200,000 people had died from COVID-19.[4]

7. COVID-19 is a serious disease. There is no vaccine or known cure. The overall case fatality rate has been estimated to range from 0.3 to 3.5% in most countries. The case fatality rate in the U.S. is estimated to be 2.9% as of September 27, 2020.[5] The U.S. currently has one of the highest deaths per 100,000 population in the world.[6] The estimated case fatality of COVID-19 is at least 5 times the fatality associated with influenza infection, and may even be as high as 50 times.[7]

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[1] Jiabao Xu, et al., *Systematic comparison of two animal-to-human transmitted human coronaviruses: SARS-CoV-2 and SARS-CoV*, 12 Viruses 244 (2020).

[2] *COVID-19 Map*, Johns Hopkins Coronavirus Resource Center, https://coronavirus.jhu.edu/map.html (last visited Oct. 2, 2020).

[3] *New Cases of COVID-19 in World Countries*, Johns Hopkins Coronavirus Resource Center, https://coronavirus.jhu.edu/data/new-cases (last visited Oct. 2, 2020).

[4] Bill Chappell, "*Enormous And Tragic": U.S. Has Lost More Than 200,000 People To COVID-19*, npr.com (Sept. 22, 2020 11:39 AM), https://www.npr.org/sections/coronavirus-live-updates/2020/09/22/911934489/enormous-and-tragic-u-s-has-lost-more-than-200-000-people-to-covid-19.

[5] *Mortality Analyses*, Johns Hopkins Coronavirus Resource Center, https://coronavirus.jhu.edu/data/mortality (last visited Oct. 2, 2020).

[6] *Id*.

[7] *Q&A: Influenza and COVID-19 –similarities and differences,* World Health Organization (Mar. 17, 2020), https://www.who.int/westernpacific/news/q-a-detail/q-a-similarities-and-differences-covid-19-and-influenza.

8. The case fatality rate can be significantly higher depending on the presence of certain demographic and health factors. The case fatality rate is higher in men, and varies significantly with advancing age, rising after age 50,[8] and the case fatality rate is above 10% (1 in 10 cases) for those with pre-existing medical conditions such as cardio-vascular disease.

9. Overall, some 20% of cases will have more severe disease requiring medical intervention and support. Among patients who have more serious disease, some will progress to Acute Respiratory Distress Syndrome (ARDS), which requires mechanical ventilation. The mortality rate among COVID-19 patients on mechanical ventilation is estimated between 30 and 50%.[9] According to a CDC report published in May 2020, 30% of all hospitalized COVID-19 patients required this mechanical ventilation,[10] which is why intensive care beds and ventilators have been in insufficient supply.

10. COVID-19 can severely damage lung tissue, which requires an extensive period of rehabilitation, and in some cases, may cause permanent loss of breathing capacity. COVID-19 may also target the heart, causing an inflammation of the heart muscle called myocarditis. Myocarditis can reduce the heart's ability to pump.

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[8] Graziano Onder, et al., *Case-Fatality Rate and Characteristics of Patients Dying in Relation to COVID-19 in Italy*, 323 JAMA 1775-1776 (2020), https://jamanetwork.com/journals/jama/fullarticle/2763667.

[9] Pipetius Quah, et al., *Mortality rates of patients with COVID-19 in the intensive care unit: a systematic review of the emerging literature*, Critical Care (June 4, 2020), https://ccforum.biomedcentral.com/articles/10.1186/s13054-020-03006-1.

[10] Jeremy A. W. Gold, et al., *Characteristics and Clinical Outcomes of Adult Patients Hospitalized with COVID-19 — Georgia, March 2020*, 69 Morbidity and Mortality Weekly Report 545-550 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6918e1-H.pdf?deliveryName=USCDC_921-DM26922.

11. Patients with COVID-19 can progress quickly to serious complications. Studies have found that the median time from disease onset to the development of dyspnea (difficulty breathing) is just 5–8 days.[11]

12. Risk of re-infection with COVID-19 within a few months of first infection appears to be low, based on available evidence; however, it is unclear how durable the immune response to COVID-19 is. Some studies have found that more severe infections are more likely to produce neutralizing antibodies,[12] meaning that those with mild illness may remain susceptible to re-infection. Potential re-infection has been difficult to document, based on testing delays between when symptoms first occur and seem to abate or lessen in severity, and when testing actually occurs. Given that COVID-19 can lead to symptoms, including cycles of symptoms, for weeks or months following initial infection,[13] it has not always been clear in suspected re-infection cases whether another, new infection occurred or whether the tests capture an ongoing infection that the immune system did not clear the first time. In places with consistent and high-quality testing strategies, though, there have been rare documented cases in which true re-infection with COVID-19 likely occurred.[14]

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[11] Dawei Wang, et al., *Clinical Characteristics of 138 Hospitalized Patients with 2019 Novel Coronavirus-Infected Pneumonia in Wuhan*, China, 323 JAMA 1061-1069 (2020), https://jamanetwork.com/journals/jama/fullarticle/2761044; Chaolin Huang, et al., Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China, 395 Lancet 497-506 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7159299/.

[12] Ger Rijkers , et al., *Differences in Antibody Kinetics and Functionality Between Severe and Mild Severe Acute Respiratory Syndrome Coronavirus 2 Infections*, 222 J. Infectious Diseases 1265-1269 (2020); Kara L. Lynch, et al., Magnitude and Kinetics of Anti-SARS-CoV-2 Antibody Responses and Their Relationship to Disease Severity Clinical Infectious Diseases (July 14, 2020), https://doi.org/10.1093/cid/ciaa979.

[13] Rita Rubin, *As Their Numbers Grow, COVID-19 "Long-Haulers" Stump Experts*, JAMA Medical News & Perspectives (Sept. 23, 2020), https://jamanetwork.com/journals/jama/fullarticle/2771111.

[14] Kelvin Kai-Wang To, et al., *COVID-19 re-infection by phylogenetically distinct SARS-coronavirus-2 strain confirmed by whole genome sequencing*, Clinical Infectious Diseases (Aug. 25, 2020), https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1275/5897019.

13. The U.S. CDC estimates that the reproduction rate of the virus (referred to as the R_0) is 2.2–5.7,[15] meaning that each newly infected person is estimated to infect on average 4 additional persons. This is highly infectious, and only the influenza pandemic of 1918, (which killed between 17 and 50 million people worldwide) is thought to have had higher infectivity. This again is likely a function of all human populations not having pre-existing immunity and currently being highly susceptible. In congregate facilities, defined as places where people live, eat, and sleep in close proximity, such as FCC Butner, this reproduction rate may be as high as 11.[16]

14. The attack rate—the proportion of people exposed who contract the disease—is also high. The attack rate is estimated at 20–30% depending on community conditions but may be as high as 80% in some settings and populations, including in closed settings such as nursing homes, ships, prisons, jails, and detention centers. It can take up to 14 days for COVID-19 symptoms to appear. Individuals who are asymptomatic or pre-symptomatic (in other words, they currently do not exhibit symptoms but will go on to become symptomatic), can be infectious before exhibiting symptoms.[17]

15. Absent a vaccine or an effective treatment, the best way to slow and prevent spread of the virus is through "social distancing." Social distancing involves avoiding human contact and staying at least six feet away from other people, and it is a helpful heuristic for public health practice. This recommendation is based on studies conducted in the 1930s[18] that

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[15] Steve Sanche, et al., *High Contagiousness and Rapid Spread of Severe Acute Respiratory Syndrome Coronavirus 2*, 26 Emerging Infectious Diseases 1470-1477 (2020), https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article.

[16] Kenji Mizumoto & Gerardo Chowell, *Transmission potential of the novel coronavirus (COVID-19) onboard the diamond Princess Cruises Ship*, 2020, 5 Infectious Disease Modelling 264-270 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7068636.

[17] Stephen A. Lauer, et al., *The Incubation Period of Coronavirus Disease 2019 (COVID-19) From Publicly Reported Confirmed Cases: Estimation and Application*, 172 Annals of Internal Medicine577-582 (2020).

[18] W.F. Wells, *On Air-Borne Infection: Study II. Droplets and Droplet Nuclei*, 20 Am. J. Epidemiology 611 (1934), https://academic.oup.com/aje/article-abstract/20/3/611/280025?redirectedFrom=PDF.

analyzed large droplets expelled during coughs and sneezes, and where those droplets settled due to gravity. However, evidence from the SARS 2003 pandemic showed droplet exposure and potential infection was possible from 7.5 feet away.[19] In addition, evidence specifically for the SARS-CoV-2 virus (which causes COVID-19) suggests that smaller droplets can be expelled from sneezes and coughs for 23 to 26 feet.[20] Force of exhalation, ventilation of enclosed environments, and exposure time are all important factors in transmission.[21] Thus, the current recommendations should be considered a *minimum guide*, rather than a strict threshold of exposure. Even vigilant efforts to improve personal hygiene are not enough to slow the spread of COVID-19. Consequently, nearly every American institution outside of correctional settings has either dramatically reduced the number of people in close quarters or closed entirely at some point during the pandemic.

The Risks of COVID-19 in the Federal Correctional Complex (FCC) Butner

16. People in congregate environments face increased danger of contracting COVID-19. Correctional facilities, including prisons and jails, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.[22] Infections that are transmitted through droplets, like influenza and the SARS-

[19] Sonja J. Olsen, et al., *Transmission of Severe Acute Respiratory Syndrome on Aircraft*, 349 New England J. Med. 2416-2422 (2003), https://www.nejm.org/doi/full/10.1056/nejmoa031349.

[20] Lydia Bourouiba, *Turbulent Gas Clouds and Respiratory Pathogen Emission: Potential Implications for Reducing Transmission of COVID-19*, 323 JAMA 1837 (2020), https://jamanetwork.com/journals/jama/fullarticle/2763852.

[21] Nicholas R. Jones, et al., *Two metres or one: what is the evidence for physical distancing in covid-19?*, 370 BMJ 3223 (2020), https://www.bmj.com/content/370/bmj.m3223.

[22] Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 Clinical Infectious Diseases 1047-1055 (2007), available at *https://academic.oup.com/cid/article/45/8/1047/344842.*

CoV-2 virus, are particularly difficult to control in correctional facilities, as 6-foot distancing and proper decontamination of surfaces is difficult.

17. The evidence concerning COVID-19 indicates that once it enters a correctional center like FCC Butner, it spreads significantly faster inside the correctional center than outside. In the United States, this is demonstrated by dramatic outbreaks in the Cook County jail in Illinois[23] and Rikers Island in New York City.[24] At a federal prison in Lompoc, California, nearly 70% of inmates have tested positive for COVID-19,[25] and at San Quentin State Prison in California, more than 2,200 people have become infected.[26]

18. In Federal Bureau of Prisons (BOP) facilities specifically, incarcerated individuals are being infected with COVID-19 at a rate more than 4.8 times higher than that of the general U.S. population.[27] COVID-19 has already entered FCC Butner, where it has rapidly spread. FCC Butner has experienced one of the worst COVID-19 outbreaks of any BOP facility, with at least 1,000 confirmed infections and 27 deaths, including one staff member.[28] In the United States as a whole, there have been approximately 65 deaths

[23] Sam Kelly, *134 inmates at Cook County Jail confirmed positive for COVID-19*, Chicago Sun-Times (Mar. 30, 2020, 8:11 PM), https://cutt.ly/6tYTqi5.
[24] *Analysis of COVID-19 Infection Rate in NYC Jails*, The Legal Aid Society, https://legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/ (last visited March 30, 2020).
[25] Richard Winton, *70% of inmates test positive for Coronavirus at Lompoc federal prison*, Los Angeles Times (May 9, 2020, 9:32 AM), https://www.latimes.com/california/story/2020-05-09/coronavirus-cases-lompoc-federal-prison-inmates.
[26] Sara Al-Arshani, *COVID-19 is engulfing prisons like San Quentin and it shows how letting the virus spread unchecked may only accelerate the death count and prolong the illness for those who manage to survive it*, Business Insider (Aug. 11, 2020, 11:23 PM), https://www.businessinsider.com/covid-19-engulfing-prisons-shows-herd-immunity-may-be-messy-2020-8.
[27] *BOP-Reported Positive Tests for COVID-19 Nationwide,* Federal Defenders of New York, https://federaldefendersny.org/assets/uploads/BOP_COVID-19_Charts_and_Graphs.8.28.pdf (last visited Sept. 27, 2020).
[28] *COVID-19 Coronavirus*, Federal Bureau of Prisons, https://www.bop.gov/coronavirus/ (last visited Oct. 2, 2020).

due to COVID-19 for every 100,000 people. At FCC Butner, in comparison, the figure is approximately ten times higher—650 deaths per every 100,000 people.[29]

The Proposed Disability Subclass Is Far More Vulnerable to COVID-19 than the Population at Large

19. People over the age of 50 face a greater risk of serious illness or death from COVID-19. According to the CDC provisional death counts, individuals aged 50 to 64 had an overall mortality rate 30 times higher than that of 18 to 29-year-olds; 65 to 74-year-olds had a mortality rate 90 times that; and those 75 and above had a mortality rate between 220 and 630 times that.[30]

20. People of any age who suffer from certain underlying medical conditions are at higher risk for severe illness from COVID-19, including people with cancer, COPD (chronic obstructive pulmonary disease), serious heart conditions, chronic kidney disease, Type 2 diabetes mellitus, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), and obesity.[31] The CDC estimates that increased risk of hospitalization for those with certain underlying conditions is as follows[32]:

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[29] *Mortality Analyses*, Johns Hopkins Coronavirus Resource Center, https://coronavirus.jhu.edu/data/mortality (last visited Oct. 2, 2020).

[30] *Coronavirus Disease 2019 (COVID-19): COVID-19 Hospitalizations and Death by Age,* Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html (last updated Aug. 18, 2020).

[31] *Coronavirus Disease 2019 (COVID-19): People with Certain Medical Conditions*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html (last updated Sept. 11, 2020).

[32] *Coronavirus Disease 2019 (COVID-19): COVID-19 Associated Hospitalization Related to Underlying Medical Conditions*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-underlying-medical-conditions.html (last updated Aug. 10, 2020).

Condition	Risk of Hospitalization vs. No Underlying Conditions
Hypertension	3 times the risk
Diabetes	3 times the risk
Chronic kidney disease	4 times the risk
Two or more conditions	4.5 times the risk
Three or more conditions	5 times the risk

21. These underlying conditions also put patients at increased risk of death if they become infected: death due to COVID-19 is 12 times more likely in patients with underlying health conditions such as diabetes, cardiovascular disease, and chronic lung disease as compared to patients without these conditions.[33]

22. Aging and chronically ill populations are uniquely vulnerable to more-severe illnesses and death after having COVID-19. Prison and jail populations are at additional risk due to the high rates of chronic health conditions among these people, estimated at more than 38% of people in correctional custody nationally.[34]

23. According to BOP and declarations from prisoners, FCC Butner houses medically vulnerable people in its medical center (FMC Butner) and its other three facilities. These conditions at each facility increase the risk of infection for all prisoners, including medically vulnerable prisoners who are at higher risk for severe illness or death from COVID-19.[35]

24. I have not seen evidence that BOP and FCC Butner have taken sufficient, proactive measures to plan for and establish special protections for high-risk people to help prevent

[33] Erin K. Stokes, et al., *Coronavirus Disease 2019 Case Surveillance—United States, January 22–May 30, 2020*, 69 Morbidity and Mortality Weekly Report 759-765 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm.

[34] Andrew P. Wilper, et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 Am. J. Public Health 666-672 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661478/.

[35] *FMC Butner*, Federal Bureau of Prisons, https://www.bop.gov/locations/institutions/buh/ (last visited Oct. 2, 2020).

illness and mortality, including an inpatient facility that can meet their needs, release from the facility to home confinement, or other release options. Instead, BOP staff continue to house incarcerated people in conditions that put them at risk of experiencing serious illness or death while remaining in FCC Butner, as described below.

25. First, FCC Butner continues to house people in facilities that are at almost full capacity. According to declarations previously submitted by the Defendants, the total rated capacity for the Complex is 4,095 inmates. The current population is 3,924. FMC Butner has a rated capacity of 868 inmates and an approximate current population of 835. Physical distancing is challenging in facilities at or nearly at capacity, and statistical modeling has shown that meaningful reduction of risk requires facilities having at least 50% capacity available.[36]

26. Second, correctional staff are not adequately screened and tested for COVID-19 and may expose people who are incarcerated. To my knowledge, staff registering a temperature of 100.4 degrees Fahrenheit or higher are barred from the facility,[37] but if staff have other symptoms (such as a runny nose), it is at the discretion of a medical officer as to whether they are barred from attending work. Given that fever is present in only 43% of COVID-19 cases with known symptom status, this strategy is likely to miss staff members with COVID-19.[38]

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[36] Udi Ofer & Lucia Tian, *New Model Shows Reducing Jail Population Will Lower COVID-19 Death Toll for All of Us*, aclu.org (Apr. 22, 2020), https://www.aclu.org/news/smart-justice/new-model-shows-reducing-jail-population-will-lower-covid-19-death-toll-for-all-of-us/.

[37] *COVID-19 Update*, fd.org (Apr. 30, 2020), https://www.fd.org/sites/default/files/covid19/federal_court_orders/eleventh_circuit/work_group_covid-19_update_fdc_miami_043020.pdf.

[38] Erin K. Stokes, et al., *Coronavirus Disease 2019 Case Surveillance—United States, January 22–May 30, 2020*, 69 Morbidity and Mortality Weekly Report 759-765 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm.

27. Third, the in-house testing equipment that FCC Butner is using is not reliable enough to protect people who are incarcerated from COVID-19. The facility has two Abbott ID NOW COVID-19 Point-of-Care testing machines that yield rapid results. However, in May 2020 the FDA issued a warning about the accuracy of this particular test, and there have been several instances in which people received negative test results while being infected with COVID-19.[39] If correctional staff or people incarcerated receive a false negative test from this device with questionable reliability, they could spread COVID-19 throughout the facility.

28. The Defendants' failures put Butner's staff, local health care workers, family members, and the broader community at serious risk of further COVID-19 transmission, especially with the expected surge in cases in the fall and winter. As restrictions are expected to abate in the coming months, schools and universities attempt to return to in-person learning, and prior outdoor events are held indoors due to the cold weather (such as indoor restaurant dining), I and other epidemiologists and researchers expect a surge in cases.[40]

29. This is of particular concern, given that it remains unclear to what extent, if any, people become immune after COVID-19 infection. People who once recovered may undertake riskier behaviors and unknowingly increase transmission if they become infected again.

[39] Press Release, U.S. Food and Drug Administration, Coronavirus (COVID-19) Update: FDA Informs Public About Possible Accuracy Concerns with Abbott ID NOW Point-of-Care Test (May 14, 2020), https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-informs-public-about-possible-accuracy-concerns-abbott-id-now-point.

[40] Joel Achenbach & Rachel Weiner, *Experts project autumn surge in coronavirus cases, with a peak after Election Day*, Washington Post (Sept. 5, 2020, 9:00 AM), https://www.washingtonpost.com/health/coronavirus-fall-projections-second-wave/2020/09/04/6edb3392-ed61-11ea-99a1-71343d03bc29_story.html.

30. I understand that many incarcerated individuals in custody at FCC Butner, particularly those at FMC Butner, have complex and chronic medical conditions and may have served long sentences and grown significantly older while incarcerated. All Declarations from prisoners that I reviewed reported that there are many people who are elderly or have serious medical conditions at all four facilities within FCC Butner. While everyone is vulnerable to serious illness or death if they contract COVID-19, people with medical conditions or who are older are at greater risk.

31. The most reasonable and effective strategy to mitigate further COVID-19 spread is to begin immediately releasing Butner residents based on defined categories—including but not limited to those who are medically vulnerable or with disabilities—and to develop and implement a plan to (1) provide for adequate physical distancing; (2) effectively test, quarantine, and isolate people at Butner; and (3) effectively clean and disinfect the areas used by the population housed at Butner. These are described in detail as follows.

Reducing the Population as an Infection Control Measure

32. Numerous public health experts agree that expediting release from custody of people most vulnerable to COVID-19, such as the disability subclass, is critical to controlling the spread of the disease.[41]

[41] Andre G. Montoya-Barthelemy, et al., *COVID-19 and the Correctional Environment: The American Prison as a Focal Point for Public Health*, 58 Am. J. Preventive Med. 888-891 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7164863/; Laura Hawks, *COVID-19 in Prisons and Jails in the United States*, 180 JAMA Internal Med.1041-1042 (2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2765271; Matthew J. Akiyama, et al., *Flattening the Curve for Incarcerated Populations—Covid-19 in Jails and Prisons*, 382 New England J. Med. 2075-2077 (2020), https://www.nejm.org/doi/full/10.1056/NEJMp2005687; Talha Burki, *Prisons are "in no way equipped" to deal with COVID-19*, 395 Lancet 1411-1412 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7252088/; Paul L. Simpson, *Covid-19, prison crowding, and release policies*, 369 BMJ 1551 (2020), https://www.bmj.com/content/369/bmj.m1551; Kathryn Nowotny, *COVID-19 Exposes Need for Progressive Criminal Justice Reform*, 110 Am. J. Public Health 967-968 (2020), https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.305707; Hong Yang & Julian R. Thompson, *Fighting covid-19 outbreaks in prisons*, 369 BMJ 1362 (2020); Karthik Sivashanker, et al., *Covid-19 and decarceration*, 369

33. Releasing as many incarcerated people as possible from FCC Butner is important to protect the health of people who are incarcerated, the health of correctional facility staff, the health of health care staff, and the health of the community as a whole. Reducing the incarcerated population by releasing the most vulnerable people from custody minimizes strain on the region's health care infrastructure by decreasing the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.

34. Federal correctional officials have not provided assurances that FCC Butner has implemented or can implement key recommendations to prevent the spread of COVID-19 in its facilities, or from its facilities to the community. In particular, BOP officials have not indicated that the BOP has implemented or plans to implement the measures necessary to achieve physical distancing, screening, medical isolation or quarantine, or enhanced hygienic practices that have been deemed essential to prevent the spread of coronavirus.

35. While every effort should be made to reduce exposure at FCC Butner, this will be extremely difficult to achieve and sustain due to the population density and physical constraints of these facilities (such as small corridors, shared common areas, etc.). Under these conditions, the social distancing measures must be consistently implemented throughout each area of the prison, including bathrooms, laundry facilities, and places of work, and at all times of the day, regardless of which correctional staff are on duty for a shift.

BMJ 1865(2020); Brandy F. Henry, *Social Distancing and Incarceration: Policy and Management Strategies to Reduce COVID-19 Transmission and Promote Health Equity Through Decarceration*, 47 Health Educ. Behav. 536-539 (2020), https://journals.sagepub.com/doi/full/10.1177/1090198120927318.

36. Similarly, when these facilities are used, proper cleaning must occur between uses in order to minimize exposure to inanimate objects contaminated with infectious material.

37. It is particularly vital to reduce the population at FCC Butner given the projected surge in COVID-19 cases and deaths in the fall and winter months. The Institute of Health Metrics and Evaluation estimates that the daily death rate due to COVID-19 in the general population will increase to 2,200 per day in mid-January, more than triple the current 680 daily deaths.[42] It is therefore an urgent priority in this time of public health emergency to significantly reduce the number of persons at FCC Butner as quickly as possible.

38. To effectively control the spread of COVID-19, BOP should move people generally, including those who are vulnerable, to home confinement or other release options within the BOP system. The number of releases to date and the failure to significantly reduce populations has been inadequate to reduce density sufficiently to allow for physical distancing. Reducing the population that is incarcerated is an important step, otherwise all of the other infection control methods will be undermined because of the sheer amount of exposure to potential infection that people will have in the facility.

The Need for Consistent Provision and Usage of Masks.

39. Masks should be cleaned after each use in order to reduce transmission. Additionally, incarcerated people should have thorough training in how best to remove, store, and put masks back on to reduce contamination during the process. Masks should be washed

[42] Institute for Health Metrics and Evaluation, *Model updates for September 11, 2020–United States* (Oct. 15, 2020), http://www.healthdata.org/sites/default/files/files/Projects/COVID/briefing_US_10152020.pdf

daily, which means that soap and space to do so must be provided. Alternatively, if daily washing is not possible, a new mask should be distributed each day.

40. This speaks also to the quality of masks that must be provided. Ill-fitting masks or those that degrade quickly due to too-thin material must be replaced. To illustrate this point, in an ideal setting where N95 masks are available, staff undergo yearly fittings of their masks to ensure a proper seal around the mouth and nose is maintained for those working in a healthcare setting to avoid transmission. Therefore, while evidence suggests that cloth masks do offer some protection, it remains dependent on the fit and material. Research has shown that additional layers of cloth fabric provide greater levels of protection, and having only one layer of material that is too thin will likely be insufficient. The WHO recommends a minimum of three layers of synthetic nonwoven materials configured to have a filtration layer in the middle.[43]

41. Mask use must also be consistent for it to have an effect at such a large scale. The Statement of Facts describes that people incarcerated at Butner are "strongly encouraged to wear the face covering when in public areas when social distancing cannot be achieved," but it does not describe face coverings being required. The lack of a mask requirement decreases the efficacy of face coverings at stopping COVID-19 transmission and makes it much more likely that SARS-CoV-2 will propagate throughout the incarcerated population and staff at Butner.

[43] *Q&A: Masks and COVID-19*, World Health Organization (June 7, 2020), https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-and-masks.

The Necessity for Further Cleaning Efforts

42. Surfaces must be cleaned consistently throughout the day in order to minimize lingering droplets and infectious material on high-touch areas. The CDC currently recommends that such surfaces be cleaned after every individual use if a person in the household tests positive for COVID-19.[44] It is not feasible that cleaning staff are able to clean after each individual comes into contact with a communal object, given the number of individuals housed in FCC Butner. So supplies should be provided to incarcerated people in the bathroom and other common areas to wipe down any surfaces after their individual use.

43. Recent research has shown that the virus that causes COVID-19 remains on a number of surfaces for up to 72 hours.[45] Therefore, cleaning every 24 hours will leave incarcerated people at risk throughout the entire day. Additionally, if cleaners are not used as recommended by their manufacturers and either are wiped away too early or not used on all parts of a surface (such as cleaning just a doorknob rather than the whole surface of the door someone may reasonably touch), their effectiveness is reduced. Virex, for example, requires that it be left on for 10 minutes to kill pathogens like that which causes COVID-19,[46] and removing it too early may leave live virus on the surface.

44. Additionally, it is my understanding that no ventilation or other aerosol mitigation efforts have been taken by BOP and FCC Butner.[47] It is now acknowledged that the virus is

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[44] *Coronavirus Disease 2019 (COVID-19): Cleaning and Disinfection for Households: Interim Recommendations for U.S. Households with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19)*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html (last updated July 10, 2020).

[45] *Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1*, The New England Journal of Medicine (Mar. 17, 2020), https://www.nejm.org/doi/10.1056/NEJMc2004973.

[46] Pesticide Product Label, VIREX II/256, Environmental Protection Agency (Oct. 21, 2004), https://www3.epa.gov/pesticides/chem_search/ppls/070627-00024-20041021.pdf.

[47] *Notice of Alleged Safety or Health Hazards*, AFGE (Mar. 31, 2020), https://www.afge.org/globalassets/documents/generalreports/coronavirus/4/osha-7-form-national-complaint.pdf.

airborne. This means, as opposed to being spread only by larger droplets that fall and linger on surfaces, the virus can exist in smaller particles that linger in the air. Someone entering a room recently after an infected person has, for example, coughed or sneezed and spread the aerosolized virus, can then become infected without having touched any other surfaces. In a confined environment with stagnant air, the virus can likely remain in the air longer than if there was regular ventilation or air filtration. However, BOP and FCC Butner have not addressed airborne transmission in any of their cleaning efforts.

Testing Protocols Are Insufficient to Identify All Cases.

45. I have been advised that the testing program generally has included symptomatic individuals only. This strategy is inadequate to control the infection. While this type of confirmatory testing can be used when an infection has already been contained within a facility, it is inappropriate at this point because the baseline prevalence of infection is not known. The CDC estimates that 40% of COVID-19 infections are asymptomatic, and that half of all transmission occurs prior to symptom onset.[48] Due to asymptomatic transmission—i.e., people who do not go on to show any symptoms, and presymptomatic people who will later go on to show symptoms but do not at the time they are identified as infected—a count of infected people using BOP's current protocol will likely be a *severe undercount*. Additionally, a CDC study described the number of cases identified before mass testing and following, implementing a universal testing protocol in 16 prison

[48] *Coronavirus Disease 2019 (COVID-19): COVID-19 Pandemic Planning Scenarios*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html (last updated Sept. 10, 2020).

facilities, including 3 BOP facilities, and found *thousands* of additional cases that would not have otherwise been identified through confirmatory testing alone.[49]

46. An initial program of universal testing will also allow BOP and FCC Butner to assess whether the current protocols are working. One would hope that most of the COVID-19 cases found by this strategy would only be found in individuals already quarantined or medically isolated; however, there is no way of knowing, because testing only occurs in symptomatic cases.

47. Even when a universal testing strategy is employed, it is important that the protocol is strictly followed to maximize the likelihood for valid results, and that these results are turned around quickly to act fast. I have been advised BOP has not been consistently swabbing the nasopharyngeal passage for a specimen, with some staff reaching the proper depth to get a sample, while others simply swab just inside the nostril. The latter method is not proper protocol and, should it occur, can result in invalid samples and false negatives.

48. Of those people who receive accurate results, allowing people who test positive and those who test negative to continue to be housed in the same units will render testing inaccurate. People who initially tested negative will later begin testing positive due to spread within the cohort. I have been informed that this exact scenario is what the Declarants claim has occurred. It is against CDC protocols to continue to house people in the same units, and the CDC instead recommends that those testing positive immediately be placed in medical isolation apart from the general population or be placed in a separate

[49] Liesl M. Hagan, et al., *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails—Six Jurisdictions, United States, April–May 2020*,69 Morbidity and Mortality Weekly Report 1139-1143 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm.

cohort of individuals who have confirmed COVID-19 infection and tested positive at roughly the same time.[50]

49. Holding individuals in quarantine together before they receive their results runs the risk of an infection spreading within the quarantined cohort while they wait. Anyone who begins showing symptoms or tests positive should be removed from the cohort as soon as possible; any delay may result in people who were previously uninfected being exposed in the cohort. This may result in them developing COVID-19 despite testing negative in the days before. Such a scenario will lead to widespread inaccuracies as to the current state of transmission in the facility.

50. Additionally, even if those testing negative and positive are separated, protocols must be in place to double-check their results and their placement to ensure they are accurately housed according to their infection status. Following a negative test, regardless of their housing unit, if a person goes on to develop symptoms, then they should receive another test to reassess whether they have been subsequently infected. Ideally, under a universal testing strategy, they could be tested even if they are asymptomatic, including a retest within a reasonable amount of time in case they were exposed while awaiting their initial test results or if they received a false negative at their first time. If individuals who initially tested negative go on to display symptoms for whatever reason, they should be retested as soon as possible and should not be presumed to be negative based on the initial test results.

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

51. Similarly, testing should be provided to correctional staff as a matter of ensuring occupational health. Many BOP facilities assume that correctional staff will receive tests in the community, but that is not always the case.[51] The lack of universal testing available for staff will result in undercounts of the actual number of infections because approximately 4 in 10 infections are asymptomatic.[52]

52. In fact, a CDC study found that between 21 and 27% of incarcerated people who had contact with a confirmed case in a BOP facility went on to test positive for the virus when retested 7 days later.[53] If these secondary cases had not been identified, it would likely lead to further tertiary cases as they transmit the virus to their close contacts, in turn.

53. Even despite the lack of widespread testing, at least 1,000 people have tested positive for the virus at FCC Butner, as reported by BOP.[54] The positivity rate for tests (that is, of the tests administered, how many individuals are positive) remains high across all facilities. For instance, at FCC Butner Medium I, 314 tests were conducted, and 64.0% were positive. Even at FMC Butner, which houses more medically vulnerable people due to being a medical facility, the positivity rate is 6.5%, which is above the recommended <5% cutoff.[55] These statistics represent unchecked transmission that will continue to spread among the medically vulnerable and broader population.

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[51] Jessie Bur, *BOP pushes staff COVID testing responsibility onto outside programs*, Federal Times (June 5, 2020), https://www.federaltimes.com/management/2020/06/05/bop-pushes-staff-covid-testing-responsibility-onto-outside-programs/.

[52] *Coronavirus Disease 2019 (COVID-19): COVID-19 Pandemic Planning Scenarios*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html (last updated Sept. 10, 2020).

[53] Liesl M. Hagan, et al., *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails—Six Jurisdictions, United States, April–May 2020*, 69 Morbidity and Mortality Weekly Report 1139-1143 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm.

[54] *COVID-19 Coronavirus*, Federal Bureau of Prisons, https://www.bop.gov/coronavirus/ (last visited Oct. 2, 2020).

[55] *Id*.

54. Under the current CDC testing regimen, individuals with signs or symptoms of COVID-19 should be referred to a healthcare provider for evaluation and testing. Individuals who are in close contact with an infected person (such as cell mates, coworkers, etc.) are recommended to be tested for infection as well. If contact tracing to identify these close contacts is not possible, or if there are other concerns of wide transmission, the CDC recommends considering a broader testing strategy to identify cases and control the infection. In facilities with a higher likelihood of community transmission, asymptomatic individuals should also be considered for testing.[56] At FCC Butner, reportedly one such incarcerated person tested positive June 1, negative July 6, and then positive again in September.[57] This person went on to die from COVID-19. While it is not clear whether the negative test was a false negative—the standard of care is two consecutive negative tests before an infection is considered over, which he is not reported to have received—or a case of true reinfection, this case highlights the insufficiencies in the FCC Butner testing strategy to identify and confirm cases or recovered cases in a timely manner, and the continued risk this poses to inmates.

55. Testing individuals with signs and symptoms of COVID-19 is a critical strategy to identify employees and incarcerated individuals who should not come to work and quarantine. However, as asymptomatic spread is possible,[58] testing for surveillance should also be employed. Surveillance testing means routine universal testing of

[56] *Coronavirus Disease 2019 (COVID-19): Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html#when-test (last updated Aug. 10, 2020).
[57] *See* Press Release, *Inmate Death at FCI Butner (Low)*, U.S. Dep't of Justice Federal Bureau of Prisons (Sept. 17, 2020), https://www.bop.gov/resources/news/pdfs/20200917_press_release_bux.pdf.
[58] Pan X, Chen D, Xia Y, Wu X, Li T, Ou X, et al., Asymptomatic cases in a family cluster with SARS-CoV-2 infection. Lancet Infect Dis. 2020;20(4):410-1. Epub 2020/02/23.

incarcerated individuals and employees. The CDC recommends testing for surveillance in order to assess the burden of SARS-CoV-2 and to evaluate the effectiveness of infection control programs.[59]

56. Based on these recommendations, FCC Butner should consider a widespread testing strategy, including testing of asymptomatic individuals. Universal testing at this point is the only way to understand how many active infections are present and the extent to which community transmission in the facility is occurring. Without this information, the extent of restrictions necessary to control the infection cannot be ascertained. In other words, if we do not have an accurate estimate of how many people are ill, we cannot make informed decisions about containing transmission.

Isolation through the Special Housing Unit.

57. Medical isolation is necessary to monitor people who are exposed to someone with COVID-19 or who display symptoms. While individuals are waiting for test results, they should be isolated from the rest of the population, under medical supervision. However, due to many facilities lacking dedicated isolation facilities (like one would find in a medical facility), many BOP facilities have resorted to using Special Housing Units (SHUs) in order to isolate. This is inappropriate due to material differences between medical isolation and punitive isolation.

58. Medical isolation is used to maintain the public's health in the face of a terrifying and debilitating disease, and when properly implemented, is an important tool to curb infectious disease transmission. However, additional consideration should be paid to the

[59] *Coronavirus Disease 2019 (COVID-19): SARS-CoV-2 Testing Strategy: Considerations for Non-Healthcare Workplaces*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/testing-non-healthcare-workplaces.html#testing-5.

psychological and physical health of incarcerated people. To maintain physical health during such isolation, there should be increased access to medical personnel who consistently check on individuals for symptoms. COVID-19 infections can quickly become severe and lead to complications and even death. The level of care required for a person with COVID-19 depends on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and the ability of the patient to self-isolate.[60] Some incarcerated people with COVID-19 will have severe disease requiring hospitalization for management.

59. Typically, those under medical isolation should also have increased ventilation and filtration of the air, and ideally a negative pressure environment whereby air and potential droplets are pulled by airflow into the room, to reduce the likelihood of them spreading into the hallway. If they develop new or worsening symptoms, either of COVID-19 or other diseases and conditions they may have, they should receive timely and comprehensive care for these conditions as well.

60. To maintain psychological health in a time of extreme stress and uncertainty, more access to connection, such as via televisions, tablets, phone calls, etc. should be available.[61] For example, additional sanitary facilities, such as a well-maintained bathroom in the event of gastrointestinal symptoms should be made available to only the medically isolated person (to reduce spread of disease to those unexposed). The SHU is often incapable of

[60] *Coronavirus Disease 2019 (COVID-19): Interim Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html (last updated Sept. 10, 2020).

[61] David H. Cloud, et al., *Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19*, 35 J. Gen. Internal Med. 2738-2742 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7338113/.

providing such necessary amenities due to infrastructure, architecture, and even prison policies. All of this makes it an inappropriate place to medically isolate people.

61. Additionally, anecdotal reports throughout the U.S. state that individuals are so concerned with being placed in medical isolation in the SHU that they hide their symptoms.[62] I have also been notified that people incarcerated at Butner share this fear. Because testing is often only administered when individuals report their symptoms, this will likely lead to an underreporting of cases and continued transmission among those who avoid medical isolation and monitoring.

Isolation in Other Housing Units and Facilities.

62. While the SHU poses its own challenges, it is also inappropriate to hold people in medical isolation in other facilities that lack consistent access to bathrooms and water. Offices, chapels, and similar facilities that lack beds and proper living space lead to unnecessary distress and discomfort and do not provide a hygienic space for incarcerated people to live and rest while they undergo isolation. Not having access to water and sinks to consistently wash their hands, bodies, and clothes will lead to increased transmission. Medical isolation is intended to control infection and follow strict contamination protocols that are impossible to enact in spaces lacking easy access to soap, water, and restrooms.[63]

[62] Gus Burns, *Michigan inmates hide coronavirus symptoms to avoid prison quarantine*, mLIVE (Apr. 15, 2020), https://www.mlive.com/public-interest/2020/04/michigan-inmates-hide-coronavirus-symptoms-to-avoid-prison-quarantine.html.

[63] *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)*, Centers for Disease Control and Prevention, https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html (last updated July 22, 2019).

Recent Facility Changes.

63. I have been advised that other major facility changes, such as separation by positive and negative test results, have been inconsistently implemented. This leads to heightened risk for incarcerated people. For instance, testing individuals but allowing delays in separating people may result in people who tested negative being exposed. They are then placed in the "negative" housing facility where they may or may not begin to display symptoms and can infect others.

64. Allowing for people to move between units may also increase the spread. Mixing of units must be limited as much as possible to prevent the transmission of infection, for both incarcerated people and for correctional staff. Correctional staff assigned to one area of the facility must remain there for, at least, that day. Ideally, they would be considered, for the goal of infection control, as part of the cohort with the incarcerated people. The virus does not discriminate based on uniform, and if they are placed in a unit with COVID-19 infections, they should also be considered exposed.

65. To allow for physical distancing, the CDC specifically recommends the following: sleep head to foot, stagger meals and showers, reduce the number of persons allowed in a common area at one time, and suspend group gatherings. The report also highlighted efforts of some jurisdictions to "implement decompression strategies to reduce crowding" in prisons such as releasing persons to home confinement or community supervision.[64]

[64] Megan Wallace, et al., *COVID-19 in Correctional and Detention Facilities—United States, February–April 2020*, 69 Morbidity and Mortality Weekly Report 587-590 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.html.

Conclusions

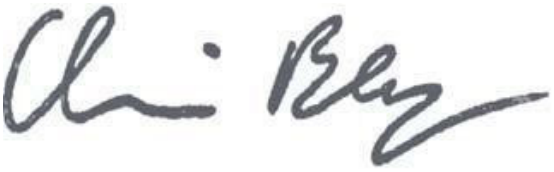
66. While COVID-19 has had a substantial negative impact on all people in the U.S., the pandemic has had a disproportionate impact on people who are incarcerated. I have seen no indication that FCC Butner has implemented an effective strategy to curb the spread of COVID-19, both within its walls and between the community and the incarcerated population.

67. As of October 20, 2020, the U.S. is experiencing a surge in COVID-19 cases that is projected to continue to increase throughout the winter. Thus, taking measures to mitigate the impact of COVID-19 on people in prisons, including FCC Butner, is as important as ever.

68. The BOP has not protected, and has not shown that it can protect, the people at FCC Butner from the pandemic and the resulting unreasonable risk of harm to the prisoners and BOP staff. Significant reduction of the population at FCC Butner, including release of all individuals in the proposed disability subclass, therefore, is essential and the only way to mitigate the unreasonable risk of harm at FCC Butner during this continuing national public health emergency. For the people who remain in custody there, proactive disease control measures must be implemented, including but not limited to: frequent universal testing, providing adequate space for physical distancing, and provision of disinfectant supplies/PPE.

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

Executed this 22nd day of October, 2020.



_____
Professor Chris Beyrer, MD

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Charles Hallinan, Josean Kinard, George Riddick, et al., on behalf of themselves and similarly situated individuals

(b) County of Residence of First Listed Plaintiff Granville
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Jeffrey S. Wilkerson; Gretchen Vetter Scavo
Winston & Strawn LLP, 300 S. Tryon St., Charlotte, NC 28202 Tel. (704) 350-7700

DEFENDANTS

Thomas Scarantino, Warden, FCC Butner; et al., in their official capacities and the Federal Bureau of Prisons

County of Residence of First Listed Defendant Granville
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

U.S. Attorney's Office

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☒ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- ☒ 1 Original Proceeding
- ☐ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from Another District *(specify)*
- ☐ 6 Multidistrict Litigation - Transfer
- ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
29 U.S.C. § 794 et seq.

Brief description of cause:
Violation of Rehabilitation Act of 1973; Unconstitutional Confinement & Conditions of Confinement in Violation of Eighth Amend.to the U.S. Const.

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE Louise Wood Flanagan; Terrance W. Boyle DOCKET NUMBER 5:20-HC-02088; 5:11-CR-247

DATE
10/26/2020

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

UNITED STATES DISTRICT COURT

for the

Eastern District of North Carolina

CHARLES HALLINAN, JOSEAN KINARD, GEORGE B. RIDDICK, JORGE L. MALDONADO, et al., on behalf of themselves and similarly-situated individuals, *Plaintiff(s)* v. THOMAS SCARANTINO, Warden, FCC Butner; MICHAEL CARVAJAL, FBOP Director; et al., in their official capacities, and the FEDERAL BUREAU OF PRISONS *Defendant(s)*	)	Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Civil Process Clerk
United States District Court for the Eastern District of N.C.
150 Fayetteville St., Suite 2100
Raleigh, NC 27601

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Jeffrey S. Wilkerson
Gretchen Vetter Scavo
Winston & Strawn LLP
300 S. Tryon St., 16th Floor
Charlotte, NC 28202

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: 10/26/2020

Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

UNITED STATES DISTRICT COURT

for the

Eastern District of North Carolina

CHARLES HALLINAN, JOSEAN KINARD, GEORGE B. RIDDICK, JORGE L. MALDONADO, et al., on behalf of themselves and similarly-situated individuals, *Plaintiff(s)* v. THOMAS SCARANTINO, Warden, FCC Butner; MICHAEL CARVAJAL, FBOP Director; et al., in their official capacities, and the FEDERAL BUREAU OF PRISONS *Defendant(s)*	)	Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Federal Bureau of Prisons
c/o William Barr
U.S. Attorney General
U.S. Department of Justice 950 Pennsylvania Ave., NW
Washington, DC 20530-0001

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Jeffrey S. Wilkerson
Gretchen Vetter Scavo
Winston & Strawn LLP
300 S. Tryon St., 16th Floor
Charlotte, NC 28202

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: 10/26/2020

Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

UNITED STATES DISTRICT COURT

for the

Eastern District of North Carolina

CHARLES HALLINAN, JOSEAN KINARD, GEORGE B. RIDDICK, JORGE L. MALDONADO, et al., on behalf of themselves and similarly-situated individuals, *Plaintiff(s)* v. THOMAS SCARANTINO, Warden, FCC Butner; MICHAEL CARVAJAL, FBOP Director; et al., in their official capacities, and the FEDERAL BUREAU OF PRISONS *Defendant(s)*	)	Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Federal Bureau of Prisons
c/o Robert J. Higdon, U.S. Attorney for the Eastern District of N.C.
150 Fayetteville St., Suite 2100
Raleigh, NC 27601

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Jeffrey S. Wilkerson
Gretchen Vetter Scavo
Winston & Strawn LLP
300 S. Tryon St., 16th Floor
Charlotte, NC 28202

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: 10/26/2020

Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

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❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

UNITED STATES DISTRICT COURT

for the

Eastern District of North Carolina

CHARLES HALLINAN, JOSEAN KINARD, GEORGE B. RIDDICK, JORGE L. MALDONADO, et al., on behalf of themselves and similarly-situated individuals, *Plaintiff(s)* v. THOMAS SCARANTINO, Warden, FCC Butner; MICHAEL CARVAJAL, FBOP Director; et al., in their official capacities, and the FEDERAL BUREAU OF PRISONS *Defendant(s)*	)	Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Jeffery Allen
Bureau of Prisons
Health Services Division
320 First St., NW
Washington, DC 20534

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Jeffrey S. Wilkerson
Gretchen Vetter Scavo
Winston & Strawn LLP
300 S. Tryon St., 16th Floor
Charlotte, NC 28202

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: 10/26/2020

Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

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This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

UNITED STATES DISTRICT COURT

for the

Eastern District of North Carolina

CHARLES HALLINAN, JOSEAN KINARD, GEORGE B. RIDDICK, JORGE L. MALDONADO, et al., on behalf of themselves and similarly-situated individuals, *Plaintiff(s)* v. THOMAS SCARANTINO, Warden, FCC Butner; MICHAEL CARVAJAL, FBOP Director; et al., in their official capacities, and the FEDERAL BUREAU OF PRISONS *Defendant(s)*	)	Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Michael Carvajal, Director, Federal BOP
320 First St., NW
Washington, DC 20534

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Jeffrey S. Wilkerson
Gretchen Vetter Scavo
Winston & Strawn LLP
300 S. Tryon St., 16th Floor
Charlotte, NC 28202

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: 10/26/2020

Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

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Date: _____

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UNITED STATES DISTRICT COURT

for the

Eastern District of North Carolina

CHARLES HALLINAN, JOSEAN KINARD, GEORGE B. RIDDICK, JORGE L. MALDONADO, et al., on behalf of themselves and similarly-situated individuals, *Plaintiff(s)* v. THOMAS SCARANTINO, Warden, FCC Butner; MICHAEL CARVAJAL, FBOP Director; et al., in their official capacities, and the FEDERAL BUREAU OF PRISONS *Defendant(s)*	)	Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Thomas Scarantino
Complex Warden
Federal Correctional Complex-Butner
Old NC Highway 75
Butner, NC 27509

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Jeffrey S. Wilkerson
Gretchen Vetter Scavo
Winston & Strawn LLP
300 S. Tryon St., 16th Floor
Charlotte, NC 28202

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

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