UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.,* Plaintiffs, v. QUINCY BOOTH, in his official capacity as Director of the District of Columbia Department of Corrections, *et al.,* Defendants.	No. 1:20-cv-849 (CKK)

REPORT SUBMITTED BY *AMICUS CURIAE* PURSUANT TO APRIL 9, 2020 CONSENT ORDER*

Pursuant to the April 9, 2020 Consent Order issued in the above-captioned matter, *Amici*, Grace M. Lopes and Mark Jordan, submit the following report for the Court's consideration.

I. INTRODUCTION

On April 9, 2020 *amici* were appointed to provide specific information to the Court regarding medical services and environmental health and hygiene at two detention facilities operated by the District of Columbia Department of Corrections ("DOC"), the Central Detention Facility ("CDF") and the Correctional Treatment Facility ("CTF"). In the wake of the order, *amici* collected and analyzed data obtained from site visits at both facilities; conducted structured interviews with DOC managers, line staff, inmates, and contractors; reviewed electronic health records; and analyzed multiple electronic datasets extracted from information management

* This filing corrects two typographical errors that appear in the version of this report that was submitted to the Court and the parties on April 18, 2020 by deleting the word "not" in line three on page 25 and substituting the word "secure" for "non-secure" in line eight on page 33.

systems maintained by the DOC or its contract services providers. On April 15, 2020, *amici* participated in a teleconference with the Court and the parties and provided a preliminary summary of their findings, which are explained in greater detail below. At the conclusion of the teleconference, the Court directed *amici* to include in this report recommendations regarding issues that *amici* have identified.

This report describes the methodology *amici* relied upon to conduct their assessment, the facilities subject to the assessment, and *amici's* findings and recommendations related to the questions delineated in the April 9, 2020 order. Throughout this one-week investigation, the defendants have fully cooperated with *amici's* requests for information and actively facilitated *amici's* work. DOC and contract staff at every level, as well as representatives from the Office of the Attorney General, have made themselves available on short notice, on every day of the week, and well after traditional officer hours. Data reports and other records were produced on abbreviated timelines. *Amici* acknowledge and appreciate the efforts the defendants have made to cooperate with and expedite their review.

II. METHODOLOGY

Following the issuance of the April 9, 2020 order, *amici* reviewed the documents identified in the order and conducted unannounced and unescorted site visits on multiple shifts at both the CDF and CTF on April 10, 11, and 12, 2020. During the site visits, at both facilities *amici* visited general population, maximum and medium security housing units, including housing units on isolation or quarantine status, as well as intake, special management, and mental health units. Seven housing units at the CDF (S1, NW1, S2, NE2, N3, NE3, and N2) and five housing units at the CTF (D2A, D1B, C2A, C2B, and C4B) were visited. Observations in housing units included cells, dayrooms, restrooms, and shower facilities. At both facilities,

medical units (including the CTF infirmary), visitor entry areas, Command Centers, and the Culinary Unit at the CDF,[1] were visited.

Structured in-person interviews were conducted with the DOC Medical Director, the Medical Director and Deputy Medical Director for Correctional Health at Unity Health Care, Inc. ("Unity"),[2] the CDF/CTF Warden and his deputies, and dozens of correctional officers assigned to various posts throughout the facilities, including housing unit, environmental, and culinary posts. In-person interviews were also conducted, in groups and individually, with over 100 inmates on isolation and quarantine status as well as in the general population at both facilities.

In addition, *amici* conducted informal in-person or telephone discussions with Unity staff, including infection control staff and managerial clinical health care providers, to obtain and/or verify information. A range of DOC managers and staff with responsibility for administrative matters, including cleaning, hygiene and medical supplies, data management and analysis, warehouse functions, contractual cleaning services and human resources were also contacted and provided information that is reflected in this report.

In addition to the information collected during site visits and from interviews, *amici* requested and received access from the DOC to the electronic health records of inmates confined at the CDF and CTF.[3] Review and analysis of samples from these records has been conducted

[1] The Culinary Unit at the CTF was not operational at the time of the site visits and as a result the Culinary Unit at the CDF has been servicing both facilities.

[2] Unity provides medical services on a contractual basis to inmates at the CDF and CTF.

[3] Case record reviews were conducted by Janet Maher, an additional member of the team *amici* assembled. Ms. Maher is an attorney who has extensive experience in working in institutional and health-care settings. Ms. Maher headed the Office of Corporation Counsel's Mental Health Division from 1992 to 2000, worked as Deputy General Counsel and Chief of Staff for the District's Child and Family Services Agency from 2000 to 2007 and as DOJ Compliance Officer at Saint Elizabeths Hospital from 2007 to 2014. From 2013 to her retirement in 2016, she headed the Hospital's Performance Improvement Department. She also has provided consultative services to the Maryland and Pennsylvania behavioral health systems and to the Special Arbiter appointed by the Superior Court in *Jerry M. v. District of Columbia*, Superior Court of the District of Columbia, C.A. No. 1519-85.

and the results are described below. The following data were also obtained from the DOC and analyzed:

- Admissions data for both facilities for the period February 15, 2020 to April 10, 2020;
- Daily census data, including inmate housing assignments, for the period February 15, 2020 to April 13, 2020;
- Data related to sick call requests for the period February 5, 2020 to April 12, 2020;
- Data related to all COVID-19 tests conducted on inmates housed at both facilities through April 10, 2020;
- Data related to all urgent care encounters for the period February 15, 2020 through April 15, 2020;
- Inventory data for cleaning supplies as of April 13, 2020;
- Inventory data for personnel protective equipment as of April 17, 2020; and
- Data related to cleaning supplies and soap deliveries to both facilities for the period December 31, 2019 to April 13, 2020.

Aggregated data related to DOC correctional staffing levels was also reviewed and is addressed below.

III. BACKGROUND

The CDF is a multi-story, secure detention center. Recent population levels have hovered near 1020 inmates. The facility has 18 housing units, which are both single and double celled. Analysis of DOC housing data shows that as of April 13, 2020, 43 percent of the inmates housed at the CDF were housed in single cells and 56 percent were housed in cells with another inmate.[4] At the time of *amici's* site visits, 16 housing units were open and two were closed. Of the 16 open housing units, two were quarantine units and one was an isolation unit.[5] Cellblocks are divided into two sides, and for most of the facility's housing units, each side contains two tiers with 20 cells per tier.[6] All cells at the CDF are "wet" cells, *i.e.,* they have toilets and sinks.

[4] Ex. 1, Table, Number of Cells Housing One Inmate and Two Inmates at the Central Detention Facility, March 15 – April 13, 2020. Two inmates did not have a recorded cell assignment.

[5] The number of quarantine and isolation units is, of course, variable. It is *amici's* understanding that since the time of their site visits additional quarantine units have opened.

[6] There are two exceptions: N1 is a restrictive housing unit with 72 cells and NE3 is a mental health step down unit with 36 cells.

Each cellblock tier of 20 cells has two showers, which are shared by inmates housed in the unit and located in a common area. The CDF Culinary Unit, which is operated by a contractor and up until April 11, 2020 employed inmate workers, currently supports the food service program for both the CDF and the CTF.[7]

The CTF, which had a population of approximately 400 inmates at the time of *amici's* site visits, has 25 housing units.[8] Eighteen have a capacity of 50 beds, four have a capacity of 96 beds, and one has a capacity of 65 beds. There are two additional medical housing units and two special management units that have varying capacities and are not intended for general population housing. As of April 13, 2020, 95 percent of the inmates at the CTF were housed in single cells.[9] With the exception of eight housing units,[10] all of the CTF's housing units have wet cells. At the time of *amici's* site visits, nine housing units were closed and there were eight quarantine units and three isolation units. The isolation units and seven of the eight quarantine units operating at the time of *amici's* site visits have wet cells. The CTF also has a 30-room infirmary with 40 beds. The infirmary serves both facilities.

As of April 16, 2020, the DOC reported that 130 inmates have been tested for COVID-19 and a total of 65 inmates have been confirmed positive, 57 at the CTF and eight at the CDF. Forty-three have tested negative, 22 are currently on isolation units and forty-three have recovered. One inmate died while hospitalized and none are currently hospitalized. Data

[7] The CTF has a separate Culinary Unit that is responsible for that facility's food service program. At the time of *amici's* site visits, DOC staff reported that the Culinary Unit at the CTF was closed due to a COVID-19 issue. *Amici* have confirmed that the food service program at the CTF is not operational and that the CDF Culinary Unit is now supporting the food service program at the CTF. *Amici* have not had an opportunity to confirm the date the CTF Culinary Unit closed, but staff reported it had been up to several weeks before the site visit. The closure of the CTF Culinary Unit has put evident strain on the food service program at the CDF.

[8] This total includes two special management units. Inmates are also housed in a limited mobility medical unit and the infirmary.

[9] Ex. 2, Table, Number of Cells Housing One Inmate and Two Inmates at the Correctional Treatment Facility, March 15 – April 13, 2020.

[10] Three of the eight housings units that do not have toilets and sinks were open during the site visits.

regarding the number of DOC staff who have tested positive for COVID-19 have not been provided. One member of the DOC correctional staff died earlier this week. Not surprisingly, as evidenced by the findings set out below, the COVID-19 pandemic has presented formidable challenges for the defendants and had a significant impact on operations at both the CDF and the CTF.

IV. FINDINGS AND RECOMMENDATIONS

Amici's findings and recommendations related to the questions delineated in the April 9, 2020 order are set forth below.

A. MEDICAL

Question One: When residents display COVID-19 symptoms, as defined by the CDC, are they seen by medical staff?

Question Two: When residents display COVID-19 symptoms are they tested for COVID-19?

Question Three: Are there requests for a sick call based on suspected COVID-19 symptoms where there is no response?

Question Four: Is the response time for sick call requests of suspected COVID-19 symptoms for a resident to be seen by medical staff reasonable (assuming time of request and response time are recorded)?

Questions One through Four address the identification of inmates who display symptoms or who are suspected of having contracted COVID-19 and whether those inmates have access to timely health assessments, services, and COVID-19 testing, as indicated. As discussed below, *amici* were not able to address Questions One through Four directly because the available healthcare datasets did not enable identification of either the universe or representative samples of inmates displaying symptoms or suspected of having contracted COVID-19. *Amici* therefore attempted to identify the mechanisms by which inmates with COVID-19 symptoms are identified

by medical staff and reviewed a sample of the electronic health records of inmates who had been tested for COVID-19 to assess timeliness and scope of service delivery in those cases.

In order to evaluate DOC performance relative to these questions, *amici* relied on multiple sources of information including the following: interviews with DOC and contract medical staff, including executive staff; interviews with inmates; interviews with correctional officers; custom data reports from Unity's electronic health record system, including data regarding sick call requests and encounters and urgent care encounters; data regarding all COVID-19 testing conducted on inmates at the CDF and CTF through April 10, 2020; data regarding all sick call requests and encounters between February 5, 2020 and April 12, 2020; [11] data regarding all urgent care encounters between February 15, 2020 and April 15, 2020; and, two random samples of individual inmate health records, one drawn from the population of inmates tested for COVID-19 through April 10, 2020, and the second from a dataset of all sick call requests submitted between March 1, 2020 and April 12, 2020.[12]

According to medical staff, the two primary methods by which inmates access health care are through a sick call process, in which inmates complete a written sick call form and insert it into a locked box on their housing units and an urgent care process, whereby an inmate can inform a correctional officer that s/he would like to see medical staff.[13] According to medical staff, in these circumstances the correctional officer contacts the medical unit and a nurse, in consultation with a medical provider,[14] triages the telephone call and either instructs the

[11] In some cases, clinical encounters are recorded as sick call visits, but they do not have an associated written sick call request. Medical staff have explained that when they visit housing units to conduct sick call, they allow inmates who did not submit sick call requests to access services.

[12] Records of 28 of the 83 inmates who were tested as of April 10, 2020 were reviewed. In addition, records of 40 inmates who submitted sick call requests during the review period were reviewed. There were no overlapping cases in the two samples.

[13] There are also chronic care clinics operating Monday through Friday at both the CDF and CTF for inmates with chronic health conditions.

[14] Advanced medical providers are considered to be MDs, DOs, nurse practitioners, and physician assistants.

correctional officer to have the inmate escorted to the medical suite or schedules the inmate for sick call on the next day.[15]

Amici initially analyzed sick call request data for the period between February 5, 2020 and April 12, 2020 to assess whether the data could be used to identify sick call requests for CDC-defined COVID-19 symptoms (*i.e.*, fever, cough, and shortness of breath) and thereafter to assess the time from the request to the time of any responsive medical evaluation. The data included a total of 6,840 records.

For two principal reasons, *amici* determined that these data could not be used as the basis for findings related to identification of inmates with COVID-19 symptoms and assessment of the timeliness of their access to medical services. First, nearly 5,000 of the records did not include a description of the symptoms for which the inmate requested medical care, making it impossible to identify either the universe of or a representative sample of inmates with COVID-19 symptoms.[16] Second, *amici* reviewed data regarding all 83 COVID-19 tests administered to inmates through April 10, 2020 and cross referenced the names of the tested inmates against sick call request records. Of the 83 inmates tested, 69 did not submit a sick call request at any point between February 5, 2020 and the date of their test. Based on a review of a sample of electronic health records of the 13 inmates who tested positive for COVID-19 for whom there was a record of a sick call request between February 5, 2020 and the date of their test, *amici* found that the sick call request was not associated with COVID-19 symptoms in any of the cases.

[15] Triage decisions require symptomatic information from the patient. Medical staff stated that at times the correctional officer will allow an inmate requesting urgent care to speak directly with the nurse and at times the inmate informs the correctional officer of their symptoms and the correctional officer reports that information to the nurse. It is not appropriate to require inmates to disclose health information to correctional staff in order to access medical services. The possibility of doing so could deter inmates from seeking necessary medical care.

[16] For example, the relevant data field in many cases recorded "initial visit," "follow-up visit," or "SC [sick call] slip."

However, based on *amici's* review of data related to inmates tested for COVID-19, it appeared that most inmates displaying symptoms or suspected of having contracted COVID-19 were presenting to medical staff by a method other than through the submission of a sick call request. Managers of the DOC medical program confirmed this impression. One manager stated that the first positive COVID-19 cases were identified after inmates presented to health care staff through the urgent care process. Once they were confirmed positive for COVID-19, the DOC began to quarantine housing units in which the COVID-19 positive inmates were housed as a containment precaution. Medical staff implemented a practice of monitoring quarantined inmates' temperatures twice daily and reported that this daily surveillance process identified multiple subsequent positive COVID-19 cases, principally at the CTF.

Medical staff members stated that inmates who are not subject to daily monitoring in a quarantine unit also are most likely to be identified as having symptoms of COVID-19 through the urgent care process. Accordingly, *amici* obtained and analyzed data regarding urgent care encounters at the CDF and CTF for the period February 15, 2020 through April 15, 2020. The data indicate that during that period there were a total of 3,439 urgent care encounters, 2,488 at the CDF and 951 at the CTF.[17] In comparison, over approximately the same time period there were a total of 5,244 sick call requests and encounters, 4,360 at the CDF, 525 at the CTF, and 359 at locations that could not be determined from the available data.[18] Based on these totals, it appears that during the period reviewed urgent care represented 40 percent of the combined volume of sick call and urgent care encounters, and sick call represented 60 percent of the total.

[17] Ex. 3, Chart, Urgent Care Visits at Central Detention Facility and Correctional Treatment Facility, by Day, February 15 – April 15, 2020.
[18] Ex. 4, Chart, Sick Call Requests and Encounters, by Day, February 15 – April 12, 2020.

To assess whether inmates with symptoms of COVID-19 utilize the urgent care process, *amici* analyzed the urgent care dataset for any references to the term "COVID." The data indicate that the first reference to COVID-19 in the data was on March 15, 2020 at the CDF (for an inmate who was later ruled out for COVID-19), and March 21, 2020 at the CTF. Beginning on March 26, 2020, there were nearly daily and steadily increasing references to COVID-19 in the urgent care encounter data.[19] Thus, it appears that inmates who are not housed in quarantine units are using the urgent care system to present with COVID-19 symptoms to medical staff at the CDF and CTF.

Given time constraints, it was not possible for *amici* to assess how accessible the urgent care system is to inmates. Available data sources included only records of completed visits and do not reflect attempts to access the system. Numerous factors could impact inmate access to the urgent care system, including the availability of escort staff, willingness of correctional officers to facilitate calls to medical staff while they perform other duties on the unit, and the willingness of inmates to disclose confidential health information when they are within earshot of non-medical staff.

Notwithstanding the evidence that most inmates with symptoms or who are suspected of having contracted COVID-19 appear to present to medical staff by a method other than sick call, in order to evaluate and to assess the responsiveness of the sick call process more generally, in the instances in which inmates submit sick call requests, *amici* assessed whether those requests are collected and the inmate is seen by medical staff on a timely basis. *Amici* selected a random sample of 41 sick call requests submitted by inmates between March 1, 2020 and April 12, 2020

[19] Ex. 5, Chart, Urgent Care Medical Encounters With Clinical Summary Descriptions Including the Word "COVID," by Day, February 15 – April 15, 2020. The data appear to include daily follow-up assessments of isolated inmates, which explains in part the dramatic increase in volume over time.

and reviewed the individual health records associated with each request. One sick call request was excluded from the analysis.[20] Of the 40 requests reviewed, 31 included a date of request recorded by the inmate. Of those 31 requests, 26 included a time stamp reflecting when medical staff collected the form. The time stamp was used to analyze the time that elapsed between the date recorded by the inmate on the sick call request form and the date of pick up. Of those 26 requests, 23 requests, 89 percent, were collected within one day. The remaining three were collected within two, four, and 14 days respectively.

Among the 31 requests that included a date of request recorded by the inmate, review of the corresponding electronic health records indicate that 23 inmates were seen within three days of submitting their request, 74 percent.[21] One inmate was seen six days after the request was made.[22] In two instances involving the same inmate, the inmate was seen every day for ten days for adult preventative care relating to COVID-19 exposure, but the notes in the electronic health records documenting these encounters do not specifically address the issue reflected in the inmate's sick call request. The other three requests were scheduled for appointments, but the inmates were not seen.[23] Two requests that were recorded as scheduled for appointments were cancelled.[24]

Amici also assessed whether the issue raised by the inmate in his or her sick call request was addressed by the medical provider. In the 33 cases in which the inmate was seen by a medical provider, the medical provider addressed the specific request made by the inmate in 28

[20] One of the cases sampled was excluded because the corresponding written request form was not available for review.
[21] In 22 of the 23 cases the inmates were seen within two days and in one case the inmate was seen within three days.
[22] The inmate requested treatment for tooth pain.
[23] In the three cases, the health record noted that the sick call appointment was cancelled because the inmate was in court, was "unavailable" or was a no show.
[24] In one case an inmate indicated he had a "possible" broken finger and in the second the inmate requested fungal cream.

cases, 85 percent. In some cases the inmate was referred to specialty providers, but in most cases the inmate received interventions intended to provide immediate relief. In a minority of cases the specific intervention requested by the inmate was not provided but the clinical basis for the decision was reflected in the record.

Recommendation: In light of the medical surveillance and monitoring that is occurring currently in the quarantine units, defendants should ensure that the triage process associated with sick call requests on the non-quarantine units is expedited and reflects appropriate sensitivity to the wide variety of symptoms associated with COVID-19 disease. Correctional officers and other staff who are in contact with inmates should ensure that the medical staff are promptly informed about inmates who present with symptoms of COVID-19 and medical staff should respond to the housing unit on an expedited basis. Any inmate grievances that include allegations of delay in medical assessment should be prioritized and submitted to the DOC medical director immediately.

Question Five: Are residents suspected of COVID-19 isolated from other people?

Health care staff reported that if an inmate is suspected by a medical provider of having contracted COVID-19, a request for testing is made to the D.C. Department of Health. As of April 10, 2020, all requests for testing made on behalf of DOC inmates had been approved. Heath care staff report that pending the testing results, the inmate is placed on cell restriction in their housing unit.

There is evidence that cell restriction practices are being implemented. The sample of electronic health records of inmates who tested positive for COVID-19 that *amici* reviewed document cell restriction orders entered by medical staff at the time COVID-19 testing was ordered by the provider. Inmates on isolation status at both facilities reported being placed on

cell restriction prior to testing and before being moved to an isolation unit. During site visits *amici* noted that there were inmates on cell restriction status in some housing units. Correctional officers assigned to housing unit posts who were interviewed by *amici* reported that inmates who are on cell restriction are not permitted to leave their cells for any reason.

Moreover, health care and facility management staff report that in instances in which an inmate tests positive for COVID-19, the inmate is moved to an isolation unit. According to those staff, only inmates who have tested positive for COVID-19 are housed in isolation units. DOC records indicate that as of April 10, 2020, 82 inmates were tested for COVID-19. Of the 82 inmates, 52 were COVID-19 positive, 26 were negative, and the balance were pending results. *Amici* reviewed a sample of 28 health records reflecting positives, negatives and pending test results. There were 16 COVID-19 positives in the sample. *Amici's* review of DOC housing records for this cohort indicates that all of the 16 inmates in the sample who tested positive were moved from their housing unit to another housing unit within no more than two days, and most within one day of the positive test result. Based on what *amici* have learned about current DOC business practices, it is likely this cohort was on cell restriction status at the time of testing before being moved to an isolation unit.

Accordingly, although *amici* have not had an opportunity to conduct a systematic review related to the implementation of cell restriction orders, it appears that inmates suspected of having COVID-19 are placed on cell restriction and isolated from other inmates.

Recommendation: If the defendants are not already doing so, they should that ensure that cell restrictions are appropriately monitored, tracked, and corrective action is undertaken on an expedited basis if warranted.

Question Six: Are new residents who enter DOC quarantined for 14 days?

DOC facility executives and medical staff reported a practice of quarantining newly admitted inmates for a 14-day period prior to moving them to another housing unit. To assess whether this practice was being implemented *amici* analyzed intake and housing data for the period from March 15, 2020 to April 10, 2020. The data indicate that starting March 25, 2020 the defendants implemented a practice of housing new admissions on SO2, the intake unit at the CDF, for 14 days, or until the inmate was released from custody, if the release occurred prior to the expiration of the 14-day period.

Amici identified six instances after March 25, 2020 in which an inmate was moved out of the intake unit prior to the end of the 14-day period. Five of the six cases involved inmates who were placed on a specialized mental health housing unit before the 14-day quarantine period was completed.[25] *Amici* were not able to determine whether these six inmates were placed on cell restriction after being moved to a non-intake housing unit. *Amici* alerted Unity's medical director of these six transfers so that a determination can be made about the propriety of the transfers and any special precautions that should be implemented on the receiving housing units.

Recommendation: In instances in which inmates are transferred from the intake unit to a different unit before the 14-day quarantine period expires, defendants should ensure that appropriate housing, surveillance and monitoring is afforded to the inmate in the receiving unit.

[25] The sixth case involved an inmate who was moved to a special management housing unit and subsequently to a less restrictive mental health housing unit.

Question Seven: How frequently do DOC medical staff and/or Unity Health Care staff meet with DOC staff and residents to inform them about COVID-19 symptoms and precautions, and what information is conveyed?

Unity providers and the DOC Medical Director report that they have conducted multiple education sessions on the housing units and during roll call at both facilities. They indicate that these sessions focus on COVID-19 symptoms and infection-control precautions. More extensive individualized education and counseling is provided on the quarantine and isolation units, which are visited at least twice daily by health care providers. Signage explaining COVID-19 symptoms and precautions is displayed in many common areas throughout both facilities. Nevertheless, the need for more intensified education of staff and inmates is apparent. Most, albeit not all, of the correctional staff and supervisors interviewed expressed substantial concerns about working in the facility in light of what they perceive as their increased risk of contracting COVID-19. Virtually all of the inmates interviewed outside of isolation units expressed fear that they would contract the virus and many of those who tested positive expressed fear that they would relapse or become infected again.

Recommendation: The defendants should consult with public health professionals regarding strategies that can be implemented to strengthen the COVID-19-related education program for both staff and inmates. Moreover, the defendants should explore appropriate supports that can be provided on an expedited basis to both staff and inmates who are living and working in an extremely stressful and high-risk environment and are at substantial risk of exposure.

Question Eight: What visitor screening is conducted? Do the thermometers used for visitor screening work and are they used properly?

Upon entry to the two facilities, all staff and visitors are required to have their temperature checked and to complete a written questionnaire with three questions. The three questions correspond to the CDC-defined symptoms of COVID-19 (*i.e.,* fever, cough, and

shortness of breath). An earlier version of the screening questionnaire included questions pertaining to recent travel to areas of the world with known COVID-19 outbreaks and known contacts with individuals with COVID-19. The DOC has updated its visitor and staff screening questionnaire in response to evolving knowledge about COVID-19.

The defendants use non-contact, infrared thermometers at the entrances of both the CDF and the CTF. According to the manufacturer's instructions the device is calibrated at the factory and calibration by a user is not necessary. One *amicus* recorded eight temperature readings at the two facilities, five at the CDF and three at the CTF and observed that two of the readings, both on the same night at the CDF, appeared to be inaccurate.[26] In both cases, the temperature reading was taken immediately adjacent to an external door and the ambient temperature outside the facility was substantially colder than the temperature inside the facility.

The manufacturer's instructions for the thermometer indicate that users should "avoid drafts."[27] It seems probable that user error may be resulting in some false temperature readings by the staff who are screening visitors. Medical staff report that they also use non-touch, infrared thermometers in their medical practice at both facilities. *Amici* have not had an opportunity to determine whether the thermometers used at visitor entry points are the same model of thermometers that are used by the medical staff. However, review of electronic health records also identified a number of questionably low temperature readings.[28]

Recommendation: *Amici* recommend that defendants conduct additional staff training on the use of the non-touch, infrared thermometers consistent with manufacturer Guidelines and provide

[26] In both instances the temperature registered in the low 90 degrees. After the second apparently incorrect reading, *amicus* requested that another reading be taken approximately 30 seconds later, and the thermometer registered what appeared to be an accurate temperature reading.

[27] The instructions also state that "if there is a significant change in the surrounding temperature, allow the thermometer to adjust to the 'new' temperature for at least 15 minutes before use in order to obtain a reliable result."

[28] In reviewing health records, *amici* also noted several instances of unusually low temperatures recorded on flow sheets or on assessments, with some as low as 93 or 94 degrees.

guidance to staff regarding what to do when thermometers produce results that appear on their face to be inaccurate.

Nine: How do the conditions of the quarantine housing compare to conditions in nonquarantine housing, and are residents deterred from reporting symptoms?

As explained in detail below, except for the isolation units, quarantine housing units are intended to operate like all other types of housing units except for twice daily monitoring of inmates by medical staff and the use of specified PPE.

A. <u>Daily Monitoring and Specified PPE</u>

While both facilities have different types of specialized housing,[29] three broad categories of housing are implicated by Question Nine:

- Quarantine housing;
- Isolation housing; and
- Non-Quarantine/Non-Isolation housing (*i.e.,* general population or some type of special housing unit)

The DOC began operating quarantine housing units in March 2020. These units are designated for the following inmates: inmates suspected of having COVID-19 and inmates who are asymptomatic but determined to have been exposed to someone who has tested positive. Health care staff report that when one inmate on a housing unit tests positive, every inmate in the housing is quarantined on the unit. Moreover, staff who have been assigned to the unit are released from duty for a 14-day self-quarantine period. There is a reported practice of maintaining each discrete cohort of quarantined inmates separately. The anecdotal evidence suggests that there may be deviations from this practice; however, *amici* have not had an

[29] For example, both the CDF and CTF have special management units and the CDF has mental health and mental health step down units.

opportunity to explore this issue. Additionally, *amici* have not had an opportunity to confirm the quarantine procedures that are implemented when DOC staff who are assigned to posts with inmate contact test positive for COVID-19 (*i.e.*, whether inmates are quarantined after exposure to a staff member who is known to have contracted COVID-19).

According to the current DOC policy guidance, quarantine housing units should operate like all other housing units except for the isolation units, in all respects except two: 1) inmates housed in quarantine units have their temperatures monitored by medical staff twice daily; and 2) except for inmates -- who are required to have masks -- anyone entering a quarantine housing unit is required to wear gloves and a mask at all times.[30] During the site visits *amici* conducted at multiple quarantine units in both facilities, for the most part the correctional staff wore a variety of masks that they had purchased for themselves. In some instances, the masks were ill-fitting and in poor condition. As a general matter, the correctional staff were not wearing gloves.

DOC policy requires inmates housed in a quarantine unit to wear masks whenever they are outside of their cells. Many inmates housed in the quarantine units that *amici* visited had masks, but they were not consistently wearing them nor were they required by the correctional staff to do so. In some instances, the masks were ill-fitting, visibly soiled, and ripped.

In contrast to the quarantine units, inmates and staff on non-quarantine units did not have masks during the site visits *amici* conducted.[31] The defendants did not have sufficient quantities of masks for staff or inmates during March; however, as explained in the next section of this report, the DOC received a shipment on April 10, 2020, and on the next day began issuing masks to staff at roll call. The defendants report that earlier this week, subsequent to *amici's* site visits,

[30] *See* §VII. Medical Restrictive Housing Unit (Quarantine), Post Order, dated March 28, 2020.
[31] A small number of inmates who indicated that they had serious medical conditions had masks that were obtained from health care providers.

they began to replace masks for inmates on a daily basis and are now providing masks to all inmates on all housing units. On April 14, 2020, the defendants reported that they are now requiring all staff and all inmates to wear masks. *Amici* have not had an opportunity to confirm these representations.

B. Conditions in Quarantine and Other Units Except Isolation

1. Cell Restriction

The defendants implemented a Medical Stay in Place policy directive on April 4, 2020.[32] Pursuant to the directive, as of April 4, 2020, inmates housed in quarantine and other housing units, except for isolation units, have been restricted to their cells except for 30 minutes each day for phone calls, showers and cleaning their cells. The directive provides contradictory information regarding out-of-cell time. In relevant part it states that inmates "will largely be restricted to their cells with the exception of a modified recreation schedule, where groups no larger than five are out at any one time."[33] However, the directive also requires staff to "[s]top all group activities and minimize the number of residents participating in recreation on tier (no more than 10 at a time)."[34] It also states that inmates are required to "practice social distancing of six feet to the fullest extent possible."[35] According to facility management, at some point after the policy was issued, it was modified to require one hour of out-of-cell time; however, during site visits many correctional staff and inmates *amici* interviewed were unaware of this change. Indeed, inmates consistently commented that it is not really possible to shower, make one phone call and clean a cell in 30 minutes.

[32] Ex.6, Medical Stay in Place, effective April 4, 2020.
[33] *Id.* at 1.
[34] *Id.* at 2.
[35] *Id.* at 1.

During site visits to quarantine and non-quarantine units, *amici* observed the following:

- More than five inmates were consistently out of their cells at one time, and sometimes between 10 and 20 inmates were out of their cells at one time; and
- Social distancing practices were not enforced and there were no attempts by the correctional staff to enforce social distancing even when numerous inmates crowded into a contained area (*e.g.,* to watch television).

The failure to enforce social distancing requirements is a supervision deficit. This appears at least in part to be attributable to significant understaffing of correctional officers and their supervisors at both facilities. According to data obtained from managers at the CDF and CTF, as of April 10, 2020, the CDF had a total staffing complement of 675 correctional staff (493 correctional officers and 182 supervisory staff) and the CTF had a total staffing complement of 283 correctional staff (259 correctional officers and 24 supervisory staff). In response to inquiries from *amici*, the DOC Human Resources Unit was unable to provide a breakdown of current correctional officer and supervisory staffing levels at the CDF and the CTF, including, for each facility, the number of funded positions that are vacant and the number of staff assigned to the complement who are unavailable for duty for quarantine or some other COVID-19 related status.[36] However, management staff in the DOC Human Resources Unit were able to provide aggregate data regarding the agency's total correctional workforce that provides insight into current staffing level at both facilities. According to these data, the DOC has a current workforce of 994 funded correctional positions, 45 of which are vacant. Of the remaining 949 positions, 281 correctional staff were unavailable for duty as of April 16, 2020.

[36] Many categories of leave render staff unavailable for duty, including workers compensation, administrative leave, AWOL status, military leave, leave without pay, and family and medical leave.

Thus, approximately one third of the total funded correctional work force is unavailable to work.[37]

According to DOC managers, the reduction in the size of the workforce that is available for duty has fueled excessive reliance on overtime in order to cover a minimum number of essential posts at both facilities. In response, both facilities converted recently from staffing three eight-hour shifts per day to two, 12-hour shifts per day during weekdays. During this period when the workforce is already stretched thin, there is also an enhanced need for active, direct supervision of inmates to enforce social distancing to mitigate the risk of transmission of the highly infectious novel coronavirus. With fewer available correctional staff and supervisors available to fill essential posts, the DOC has less flexibility to adopt strategies involving increased staff levels to achieve social distancing policies on housing units.

Telephone calls in settings that allow for confidentiality are arranged at both the CDF and CTF by DOC case management staff. DOC staff report that most of the case managers assigned to provide services for inmates at both facilities are either on quarantine status or working remotely. Thus, as a general matter, there has been no access to confidential legal calls for inmates confined on quarantine and non-quarantine housing units. There is some evidence that the defendants recently began to allow scheduled legal calls using the telephones in the housing unit day rooms. These telephones are used by inmates to make monitored telephone calls. *Amici* have not had an opportunity to determine whether the scheduled legal calls are monitored; however, even if they are not monitored, the telephones in the housing unit day rooms do not afford the confidentiality required to communicate with counsel.

[37] In addition to the CDF and CTF, the data the defendants provided indicate that the total workforce includes correctional staff assigned to a transportation unit and to the Central Cell Block.

2. Conditions in Isolation Relative to Other Units

Inmates housed in isolation units at both the CDF and CTF are restricted to their cells. Inmates in isolation at the CTF are not permitted to use the telephone for any reason, including legal calls. During the site visits *amici* conducted, inmates in isolation at the CDF were able to make monitored telephone calls from their cells. *Amici* were recently informed this may no longer be the case; however, we have not had an opportunity to follow up. Medical staff visit inmates in isolation at least twice per day to check temperatures, vital signs, and conduct assessments if indicated.

The first cohort of inmates who were isolated for COVID-19 were housed in a special management unit at the CTF. Several inmates in this cohort report that they were handcuffed when escorted to and from the showers. Showers are no longer afforded to inmates in the isolation housing units. To the extent they can bathe, inmates on isolation status must use the sinks in their cells to do so. The supply of towels does not appear adequate. In lieu of showers, the defendants planned to provide inmates on isolation status with body wipes, which were not available until April 14, 2020.

The evidence indicates that inmates have spent up to and even over two weeks on isolation status. Analysis of housing assignment data associated with the first 15 inmates who tested positive for COVID-19 shows that the inmates in this sample were housed on isolation status for a minimum of five days. Three inmates in the sample had already spent 12, 14, and 15 days, respectively, in isolation status and remained in isolation as of the date of this analysis.

Laundry services for inmates in isolation has been limited. Many inmates reported wearing the same clothes throughout their stays in the isolation units, and in fact most of the inmates *amici* met wore visibly soiled clothing and reported substantial delays in receiving fresh linens. Most of the inmates *amici* interviewed in the isolation units stated the conditions are far

too punitive, noting that if they had it to do over again, they would not have reported their symptoms. Deprivation of showers, the absence of any ability to contact family members, the lack of access to legal calls, clean clothing and clean linens are plainly a disincentive and are likely to deter inmates from reporting symptoms of COVID-19.

Recommendation: *Amici* recommend that the defendants take immediate steps to provide consistent and reliable access to legal calls, personal telephone calls, daily showers, and clean clothing and clean linens to all inmates on isolation status. The defendants should ensure appropriate and consistent implementation of social distancing policies by addressing limitations in current staffing levels, supervisory oversight of line staff, and provide enhanced education related to the importance of social distancing.

B. ENVIRONMENTAL HEALTH & HYGIENE

Question One: What are the quantities of personal protective equipment and cleaning products in the DOC stockpile?

As of April 17, 2020, the DOC reported to *amici* the following inventory of PPE:

Personal Protective Equipment:

- Surgical Mask: 71,680
- N95 Respirators: 12,774
- Face Shields: 190
- Goggles: 200
- Gowns: 2,400
- Gloves: Total Not Available[38]
- Small PPE Kits: 400

[38] DOC representatives provided data indicating that between March 28, 2020 and April 15, 2020, 39,237 pairs of gloves were used.

According to the DOC estimates, based on current usage rates, as of April 17, 2020, the defendants had approximately a 32-day supply of masks on hand. The DOC Compliance Officer informed *amici* that the processing of additional procurement orders was underway.

As of April 13, 2020, the DOC reported to *amici* that the following inventory of cleaning products was stored on site.

Cleaning Products:

- Ecolab Disinfectant: 144, 2.5-gallon cases;[39]
- Ecolab Peroxide Multi Surface Cleaner/Disinfectant: 32, 2-gallon cases;
- Ecolab Multi-Quat Sanitizer: 139, 2.5-gallon cases;[40]
- Ecolab Orange Force: 129, 2.5-gallon cases; and
- Ecolab Glass Cleaner: 30, 2.5-gallon cases.

Question Two: Are residents provided with a weekly bar of soap?

Many inmates *amici i*nterviewed reported that they purchase soap through the commissary. Most explained they had access to soap through the housing unit officers and everyone interviewed at their cells was able to show *amici* their bars of soap. There were limited supplies of soap available for distribution in a number of the housing units. Inmates housed in special management units are provided with small packets of liquid soap; they are not provided with bars of soap.

Question Three: Do staff who interact with visitors and residents have access to, and wear, sufficient personal protective equipment?

Staff who interact with visitors have access to and wear sufficient PPE. *Amici* observed screening staff posted at the entrances of both the CDF and the CTF wearing PPE consistent with CDC Guidelines.[41] Additionally, staff assigned to units housing inmates who are COVID-19

[39] This product is dilutable to make larger volumes of solution.
[40] This product is dilutable to make larger volumes of solution.
[41] CDC Guidelines recommend that staff performing temperature checks on any group of people wear a mask, eye protection, gloves, and a gown or coveralls. *See* Ex. 7, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, March 23, 2020 at 25.

positive wore PPE consistent with CDC Guidelines, including N95 respirators, eye protection, gloves, and a gown. None of the correctional staff interviewed who were wearing N95 respirators reported that they had been fitted for them as required by the Occupational Health and Safety Administration.

The defendants issued post orders for quarantine and isolation housing units on March 28, 2020 that included minimum PPE requirements.[42] Nevertheless, as of April 10, 2020, the day of the first unannounced site visit, *amici* observed that the post orders were not being adhered to and there was no clear, common understanding among the staff *amici* interviewed regarding what PPE they should wear. Most staff expressed considerable anxiety about not having access to appropriate PPE. Some staff were observed wearing masks that they purchased and brought to the facility themselves, few staff wore gloves, and other staff wore no PPE at all. Multiple staff stated that prior to April 10, 2020, PPE was not widely distributed to correctional officers.

Amici were informed that beginning on April 10, 2020, masks and gloves were being distributed to correctional officers at the start of each shift. Over the course of the three days of site visits, *amici* observed that PPE was more consistently worn by staff throughout the facilities and staff stated that there was an abrupt increase in the PPE that was distributed to correctional officers. As noted above, the defendants reported that earlier this week, subsequent to *amici's* site visits, they began to replace masks for inmates on a daily basis and are now providing masks to all inmates on all housing units. On April 14, 2020, the defendants reported that they are now

[42] *See supra* note 30 regarding the March 28, 2020 DOC policy applicable to quarantine housing units. On the same day the defendants issued a post order for isolation housing units. The PPE requirements in the post order related to the isolation units includes only a mask and gloves, less than the PPE recommended in the CDC Guidelines. As previously noted, however, in practice, in contrast to the observations *amici* made in the quarantine units, *amici* observed correctional officers on the isolation units wearing PPE consistent with CDC Guidelines.

requiring all staff and all inmates to wear masks at all times. *Amici* have not had an opportunity to confirm these representations.

Recommendation: *Amici* recommend that the defendants communicate clear expectations, in writing, to correctional staff about the types of PPE required to perform the various supervision and operational functions that are conducted throughout the facility, including the PPE they should expect to be given on each shift for each specific category of post assignment; the proper donning, doffing and disposal of the PPE; and an explanation of the related rationale. Clear communication to staff regarding differences in risk exposures and providing consistent PPE over time could help lower anxiety levels among staff.

In addition, the defendants should also ensure that all PPE issued is properly fitted. For example, N95 respirators must be properly fitted to ensure that they provide the intended protection. As noted above, during the site visits that *amici* conducted, none of the correctional staff who were wearing N95 respirators in isolation units reported that they had been fitted for the respirators.

Finally, defendants must ensure that all DOC staff receive instruction on the proper disposal of PPE, and appropriate and accessible receptables for immediate disposal must be readily available. During the site visits, *amici* observed that receptables for disposal of PPE were not accessible on a consistent basis, including to staff assigned to isolation units at the CTF.

Question Four: Are staff and prisoner-workers given masks and gloves, particularly in food service, and are they instructed to wear that equipment?

A*mici* toured the Culinary Unit at the CDF on April 11, 2020. At that time, all correctional staff and contractors were wearing masks, hairnets, and gloves. There were no inmate workers in the Culinary Unit during the site visit. They had been replaced by correctional officers. *Amici* learned that the inmate work detail in the Culinary Unit was suspended because

an inmate housed at the CDF, who had been assigned to the detail for at least several months, tested positive for COVID-19 on April 10, 2020. *Amici* have not had an opportunity to confirm the instructions regarding the use of masks and gloves that DOC staff, contractors, and inmates working in the Culinary Unit receive; however, during the site visit *amici* observed the consistent use of masks, gloves, and hairnets by the numerous contractors and DOC staff who were working in the food service area.

An interview conducted by *amici* with a supervisor for the food service contractor, (who reported working in the CDF Culinary Unit since the latter part of 2019), revealed that the contract staff assigned to the CDF did not know why the inmate detail workers were no longer working and had been replaced by correctional officers. In light of the fact that it appeared the detail inmate who tested positive prepared and served food along with the contractor's staff for at least several months, *amici* sought to ascertain whether the DOC made any attempt to determine whether the contract staff who worked alongside the detail inmate who tested positive were "close contacts" as defined by the applicable CDC Guidelines.[43] According to the Guidelines, "an individual is considered a close contact of a COVID-19 case if they a) have been within approximately 6 feet of a COVID-19 case for a prolonged period of time or b) have had direct contact with infectious secretions from a COVID-19 case (*e.g.*, have been coughed on)."[44] The Guidelines further provide that all staff who were a close contact of the inmate, whether employed by DOC or by the contractor,[45] should have been placed on self-quarantine status. Specifically, the Guidelines provide that if a staff member or contractor is identified as a close contact of a

[43] *See* Ex. 7 at 3.
[44] *Id.*
[45] The CDC Guidelines define staff as "all public sector employees as well as those working for a private contractor within a correctional facility (e.g. private healthcare or food service). Except where noted, "staff" does not distinguish between healthcare, custody, and other types of staff including private facility operators." *Id*. at 4.

COVID-19 case (whether in the facility or in the community) that staff member should self-quarantine at home for 14 days and may return to work if symptoms do not develop after the 14-day period.[46] It appears that these Guidelines have not been implemented with respect to any contractors who were in close contact with the detail inmate who tested positive for COVID-19.

According to the DOC administrator and staff responsible for the food service contract, on the morning of April 11, 2020, the DOC food contractor was informed that a detail inmate had tested positive and that the contractor's workers should self-quarantine if they did not feel well. It appears that no effort was made to determine whether any of the contract food service workers were a "close contact" of the detail inmate who tested positive. Indeed, *amici* contacted the DOC Medical Director, the Unity Medical Director, the Unity Infection Control Specialist, the DOC Deputy Director responsible for the food service contract, the DOC General Counsel, and lead counsel for the defendants in this litigation to inquire about this matter. Based on the responses they provided to *amici's* inquiries, it appears that any contact tracing that may have been conducted did not include consideration of whether the food service contractors who worked alongside the detail inmate who tested positive might be deemed a close contact who *should* have been quarantined for 14 days. *Amici's* understanding is that the detail inmate who tested positive was not contacted about any individuals with whom he had close contact. Moreover, it does not appear that any effort was made to contact public health experts at the D.C. Department of Health to receive guidance about this matter. In light of the implications attendant to having a close contact continue to work in the CDF Culinary Unit, promptly after learning about this matter a*mici* alerted counsel for both parties about their concerns.

[46] *Id.* at 12.

Amici's inquiries regarding the contact tracing conducted in the wake of the detail inmate's positive COVID-19 test results revealed that at least in this instance the defendants employed a fractured contact tracing effort that was not centralized nor informed by public health experts.[47]

Recommendation: If they have not done so in the wake of *amici's* inquiries, the defendants should seek immediate guidance from public health professionals about identification of the detail inmate's close contacts. Moreover, it is important to recognize that the defendants are working in an extremely challenging environment that requires a well-coordinated response to the range of infection control issues that are presented throughout the course of each daily shift. Any individuals who are tasked with conducting contact tracing after a confirmed positive COVID-19 test should have appropriate training and be closely supervised.

Question Five: Do residents have access to cleaning supplies in sufficient quantity and concentration, including rags, to clean their cells?

Amici reviewed records of cleaning supply deliveries to the CDF and CTF to assess whether supplies were made available to the facilities. Department of Corrections records indicate that there have been regular deliveries of cleaning supplies to both facilities since December 31, 2019, the start of the dataset reviewed.[48] Delivery records reflect that historically

[47] The DOC Medical Director informed *amici* that she had seen email correspondence regarding the issue but had not been involved in advising staff about how to handle this matter. The Medical Director referred *amici* to the DOC Deputy Director for Administration to determine whether contact tracing related to the contractor's staff had been conducted. The Deputy Director was contacted and informed *amici* that the contractor was notified that the contractor's workers should self-quarantine if they did not feel well. There was no recognition of the fact that food service contract workers may have potentially been close contacts of the detail inmate who tested positive and should have been quarantined regardless of how they felt. Moreover, in response to amici's inquiries, the manager of Unity's infection control program at the CDF advised *amici* that Unity's involvement was limited to determining the identity of the inmates and health care providers who may have had contact with the detail inmate while he was in the medical unit.

[48] Ex. 8, Table, Dates and Quantities of Cleaning Supplies and Soap Delivered to the CDF and CTF, by Date, December 31, 2019 – April 13, 2020.

three types of cleaning and sanitizing agents were made available to clean housing units and that in mid-March 2020 a fourth, peroxide-based multi-surface cleaner was also made available.[49]

Observations and interviews with inmates and staff indicated that inmate access to sufficient cleaning supplies on housing units varied from unit to unit. For example, on one unit, all of the cleaning supplies had been depleted.[50] Furthermore, on several units that had a supply of cleaning agents, inmates reported that they were unable to access them to clean their own cells. *Amici* did not observe any inmates with facility-issued rags that could be used to clean their cells. Most inmates who were interviewed reported that they made rags by tearing facility-issued towels or t-shirts, a phenomenon *amici* observed. For the most part, these make-shift rags were tattered and soiled. *Amici* observed that paper towels were available for inmates to use for cleaning on a small number of housing units, but this was not common and on one of the units, the inventory of paper towels was extremely low.

Amici could not assess whether the concentrations of disinfecting and sanitizing solutions were mixed in the appropriate concentrations necessary to achieve their intended effects. It was evident that knowledge regarding the appropriate use of the different cleaning and sanitizing agents was generally at a very low level.

Access to cleaning and sanitizing solutions is necessary, but not sufficient. Knowledge of proper mixing and appropriate application of cleaning and sanitizing solutions is also necessary. For example, at least two of the products that the DOC distributes – a concentrated surface cleaner and a concentrated sanitizing solution – have prescribed dilution ranges (*i.e.*, must contain a minimum concentration of the chemical agent, which has implications for how

[49] The manufacturer's product description states that it is "effective against emerging viral pathogens after the CDC has declared an outbreak."

[50] Ex. 9, Photograph of empty cleaning supply containers, Correctional Treatment Facility, Building D, April 12, 2020.

much water can be added to the concentrate before the agent is no longer effective). One of these products also has specific prescriptions regarding how long the product must remain on a surface for it to reduce pathogens to indicated levels.

The DOC assigns correctional officers to "environmental posts" and these officers are responsible for cleaning and sanitizing assigned zones of the facilities. One environmental officer informed *amici* that he had never received formal training, but rather reviewed his responsibilities with his supervisor and acknowledged that it had "been a while" since that discussion occurred. The same officer noted that he had begun to mix his own bleach solution to sanitize the areas of the facility he was responsible for and relied on his own judgement regarding the appropriate concentration of bleach solution.

Recommendation: There is a critical need for the defendants to strengthen the environmental health and safety program at both the CDF and the CTF. *Amici* recommend that the DOC immediately retain a registered sanitarian to oversee the environmental health and safety programs at both facilities and provide training so that cleaning tools and products are used properly. A registered sanitarian should bring the appropriate knowledge, oversight, and quality control necessary to mitigate at least some of the critical public health concerns that are evident in both facilities.

Question Six: Do housing units, and particularly common spaces such as bathrooms and showers, appear to be sufficiently cleaned?

Cleaning the common spaces in housing units is the responsibility of designated inmate "detail workers" at the CDF and CTF, who are supervised by correctional officers. As indicated in the response to Question Five, several different cleaning, disinfecting, and sanitizing solutions are available on the housing unit of both facilities. Nevertheless, the cleanliness of common spaces was inconsistent from one housing unit to the next. With cleaning responsibilities

delegated to the inmate level, there is little quality control. Some housing units appeared relatively clean and tidy, others were not. This was especially the case in some of the housing units at the CDF that appeared to have significant inmate management and supervision challenges.[51] In addition to the limitations in the cleanliness of some housing units, some cell block corridors had trash on the floor. Moreover, Building D at the CTF includes showers with tiles and in some of those showers there was visible mold growth.[52]

Recommendation: In addition to engaging a sanitarian, supervisory correctional staff must ensure that housing unit staff properly manage the work performed by the inmate detail workers. In order to accomplish that goal, correctional staff and detail workers require guidance from a sanitarian trained to oversee the facility's environmental health program.

Question Seven: Do professional cleaning crews clean hallways and common areas (not in housing units)? Do inmate details clean the housing units? common spaces?

A professional cleaning contractor was engaged to clean certain common areas on the non-secure side of both facilities on a daily basis in late March 2020. However, there was an apparent misunderstanding about the scope of the contractor's services and none of the floors in the common areas on the administrative side of both facilities were cleaned, including bathroom floors and floors in the Officer's Dining Room. The DOC Deputy responsible for the administration of the contract informed *amici* earlier this week that this limitation is being corrected.

Inmate detail workers clean the common areas in the housing units. They have not been adequately trained and are not appropriately supervised. The detail workers have inconsistent knowledge about the products they use and do not have adequate equipment. For example, they

[51] In at least two housing units at the CDF, *amici* observed food and other refuse scattered on the cellblock floors, including on the floors under stairwells.

[52] Ex. 10, Photograph of a Shower in the Correctional Treatment Facility, Building D, April 12, 2020.

reuse mops and make-shift rags that do not appear to have been appropriately sanitized between uses. As part of the DOC response to COVID-19, detail workers are required to clean all surfaces in the common areas of the housing units at two-hour intervals. This appears to occur on a consistent basis; however, the efficacy of these efforts is undermined by inadequate training, limitations in supervision, the absence of any quality controls, and the apparent limitations in the equipment and possibly in the cleaning and disinfecting agents that they are using.[53]

Recommendation: In addition to engaging a sanitarian, the defendants should consider contracting for professional cleaning services on the secure side of the facility at least until a sanitarian is hired to bolster the existing environmental health and safety program at both facilities. Additionally, proper cleaning supplies that have been sanitized regularly should be immediately provided to each unit, and a schedule for cleaning common areas and cells should be established and enforced.

Question Eight: Is hand sanitizer provided, or available to, to residents?

There is no evidence that hand sanitizer is provided to the inmates at either the CDF or the CTF.

Question Nine: Is social distancing possible in common areas in units and in the recreation spaces, and what is the approximate size of common areas?

Amici did not have the opportunity to measure the common areas at the CDF and CTF. However, given the configuration of the physical plant in the housing units, social distancing is possible if inmate out-of-cell time is limited to small groups of inmates at one time. However, as noted elsewhere in this report, the defendants are not enforcing social distancing requirements.

[53] On some housing units the detail workers expressed concerns that the cleaning agents they were using had been inappropriately diluted; on others, inmates complained about fumes associated with the apparent strength of the cleaning products the detail inmates were using.

Enforcing social distancing requires consistent, direct observation by staff. Ensuring that correctional officers carry these functions out requires active supervision by mid-level managers, who must provide both oversight to correctional officers and support (*i.e.,* by ensuring officers get appropriate relief for breaks over the course of their 12-hour shifts). *Amici* observed numerous instances in which correctional officers assigned to housing units left their posts without relief, leaving housing units short staffed. It appears that the DOC does not have sufficient line and supervisory staff available to appropriately enforce social distancing policies.

Recommendation: The defendants should reduce the extent to which common spaces encourage inmates to congregate in close quarters (*e.g.,* around a single television in a small enclosed area, or next to one another in order to use telephones that are mounted closer than six feet apart). The effectiveness of this strategy would increase if the defendants were to consistently apply their stated policy of allowing no more than small groups of inmates out of their cells at any given time. Whatever strategies the defendants adopt, increased active and direct supervision will be required by both housing unit correctional officers and the midlevel managers responsible for overseeing and supporting the correctional officers assigned to housing units. Enforcing social distancing standards as a public health measure is a new responsibility for correctional staff and they must be supported as they adjust to this new role. Moreover, the defendants should assess whether any additional security staff are needed to provide appropriate supervision, on a unit-by-unit basis, taking into consideration the layout of the housing units, the number of inmates housed on the units, and the security designation of the unit, in order to enforce social distancing policies.

Question Ten: Approximately how many residents share a cell, and what is the approximate size of the cell?

Amici analyzed individual-level inmate housing data for the period between March 15, 2020 and April 13, 2020. At the CDF, as of April 13, 2020, 586 inmates, 56 percent of the population, shared a cell.[54] At the CTF, as of April 13, 2020, 22 inmates, five percent of the population, shared a cell.[55]

A representative-sized cell was measured at each of the two facilities. The selected cell at the CDF measured 85.6 square feet and the selected cell at the CTF measured 72.4 square feet.

Question Eleven: Do all residents have access to sinks, soap, and toilets in their cells?

As noted above, at the CDF, all cells include sinks and toilets. At the CTF, the housing units in the portion of the facility known as Building D contain cells without sinks and toilets. Inmates assigned to housing units in Building D share common sinks and toilets. On each housing unit there are two, double-tiered corridors of cells. Each tier of each corridor is comprised of eight cells. Inmates housed in the eight cells share two sinks, two toilets, and a shower. The cell doors in Building D, by design, do not lock in order for inmates housed in the cells to access the sink and toilet without the intervention of a correctional officer. *Amici* identified multiple sinks and toilets in housing units in Building D that were not functional or out of service at the time of the site visit.

Representatives of the DOC stated that every inmate receives a facility-issued bar of soap each week. Every inmate that *amici* spoke with indicated that they possessed at least one bar of soap. Some inmates verified that soap was distributed to them weekly; however, others stated that they had purchased their soap from the commissary and that soap was not distributed

[54] *See* Ex. 1, s*upra* note 4.
[55] *See* Ex. 2*, supra* note 9.

weekly. There were multiple reports that inmates sometimes use their bars of soap to clean their clothes in the shower and under those circumstances a single bar of soap does not last an entire week.

V. Conclusion

Communicable disease outbreaks in locked facilities such as jails and prisons where individuals live in close proximity can spread rapidly through a population if not addressed quickly with appropriate prevention, detection, and management systems. The current novel coronavirus pandemic, which is already present within both the CDF and the CTF, poses a serious risk to the health and safety of inmates and staff alike.

This report describes certain efforts undertaken by the DOC to respond to the current public health emergency. DOC staff and Unity's contract providers should be commended for performing essential public health and safety functions while knowingly exposing themselves to significant health risks on a daily basis.

In light of the limitations identified in this report, substantial effort must be undertaken to ensure that the DOC manages its response to COVID-19 in a manner that ensures conformity with CDC Guidelines. This will require active on-site support at both facilities from public health professionals. For example, contact tracing must be strengthened, staff and inmate education on relevant public health considerations must be intensified, and business processes must be refined to ensure inmates and staff presenting with symptoms potentially consistent with COVID-19 are quickly identified, tested and isolated. Moreover, on an expedited basis, the defendants must provide inmates in isolation who have tested positive for COVID-19 with access to showers, clean clothing, clean laundry, personal telephone calls and legal calls.

Amici's investigation reveals that there is an equally urgent need for the DOC to substantially bolster the agency's environmental health program in the immediate and longer term. A professional sanitarian with appropriate health and safety credentials should be charged with organizing and managing the DOC's environmental health program to ensure, among other matters, appropriate cleaning and sanitizing practices are implemented, regular facility inspections are conducted, and corrective actions are undertaken to resolve systemic risks. In the immediate term, the defendants should ensure that they have a sufficient number of both line level and supervisory staff throughout both facilities to promote appropriate supervision and enforce the altered operational policies adopted to address the contagion during this public health crisis.

As *amici* were in the process of finalizing this report, defendants provided counsel for plaintiffs and amici with a copy of an April 27, 2020 memorandum from the DOC Director, Quincy Booth, to all DOC employees and contractors.[56] The memorandum addresses COVID-19 policies and procedures, including updated policies and procedures that appear to be intended to respond to the matters addressed during the April 15, 2020 teleconference. In light of the current filing deadline, *amici* have not had an opportunity to consider the content of the memorandum, but have included it in the appendix to this report so that the Court can be promptly apprised of the most current information that the defendants have provided.

Amici recognize the substantial challenges that confront both parties and are available to answer any questions the Court or the parties have about the matters addressed in this summary report.

[56] Ex. 11, Memorandum from Quincy L. Booth, Director, to All DOC Employees and Contractors, April 17, 2020, Reminders and Updated COVID-19 Policies and Procedures.

Respectfully submitted,

/s/ Grace M. Lopes

Amicus Curiae
Grace M. Lopes
Bar No. 358650
Executive Director
Rising for Justice
901 4th Street, N.W., Suite 6000
Washington, D.C. 20001
202-607-2224
gmlopes@risingforjustice.org

Mark Jordan
mark@markjordan.consulting
1220 19th Street, N.W.
Suite 500
Washington, D.C. 20036
202-525-6732

April 19, 2020
Washington, D.C.

INDEX TO EXHIBITS

Ex. 1

Number of Cells Housing One Inmate and Two Inmates at the Central Detention Facility
March 15 - April 13, 2020
Based on Department of Corrections Data

	3/15/2020	3/16/2020	3/17/2020	3/18/2020	3/19/2020	3/20/2020	3/21/2020	3/22/2020	3/23/2020	3/24/2020	3/25/2020	3/26/2020	3/27/2020	3/28/2020	3/29/2020	3/30/2020	3/31/2020
Cells Housing One Inmate	462	467	449	445	447	502	507	512	520	452	457	458	451	466	467	474	467
Cells Housing Two Inmates	412	408	413	406	396	362	354	350	346	370	358	353	351	339	339	334	333
Total Population	1290	1287	1278	1260	1242	1229	1218	1215	1215	1195	1176	1167	1156	1147	1148	1146	1136
Percentage Inmates Single Celled	36%	36%	35%	35%	36%	41%	42%	42%	43%	38%	39%	39%	39%	41%	41%	41%	41%
Percentage Inmates Double Celled	64%	63%	65%	64%	64%	59%	58%	58%	57%	62%	61%	60%	61%	59%	59%	58%	59%

	4/1/2020	4/2/2020	4/3/2020	4/4/2020	4/5/2020	4/6/2020	4/7/2020	4/8/2020	4/9/2020	4/10/2020	4/11/2020	4/12/2020	4/13/2020
Cells Housing One Inmate	470	472	458	464	478	478	475	478	469	452	455	452	452
Cells Housing Two Inmates	326	317	318	312	306	306	300	297	299	301	292	293	293
Total Population	1125	1109	1097	1091	1093	1093	1078	1075	1071	1058	1042	1041	1041
Percentage Inmates Single Celled	42%	43%	42%	43%	44%	44%	44%	44%	44%	43%	44%	43%	43%
Percentage Inmates Double Celled	58%	57%	58%	57%	56%	56%	56%	55%	56%	57%	56%	56%	56%

Ex. 2

Number of Cells Housing One Inmate and Two Inmates at the Correctional Treatment Facility
March 15 - April 13, 2020
Based on Department of Corrections Data

	3/15/2020	3/16/2020	3/17/2020	3/18/2020	3/19/2020	3/20/2020	3/21/2020	3/22/2020	3/23/2020	3/24/2020	3/25/2020	3/26/2020	3/27/2020	3/28/2020	3/29/2020	3/30/2020	3/31/2020
Cells Housing One Inmate	396	395	391	391	390	384	389	389	383	372	372	352	349	339	344	342	346
Cells Housing Two Inmates	82	83	78	75	74	72	68	69	67	72	72	79	71	72	69	69	65
Total Population	575	561	547	541	538	528	525	527	517	516	516	510	491	483	482	480	476
Percentage Inmates Single Celled	69%	70%	71%	72%	72%	73%	74%	74%	74%	72%	72%	69%	71%	70%	71%	71%	73%
Percentage Inmates Double Celled	29%	30%	29%	28%	28%	27%	26%	26%	26%	28%	28%	31%	29%	30%	29%	29%	27%

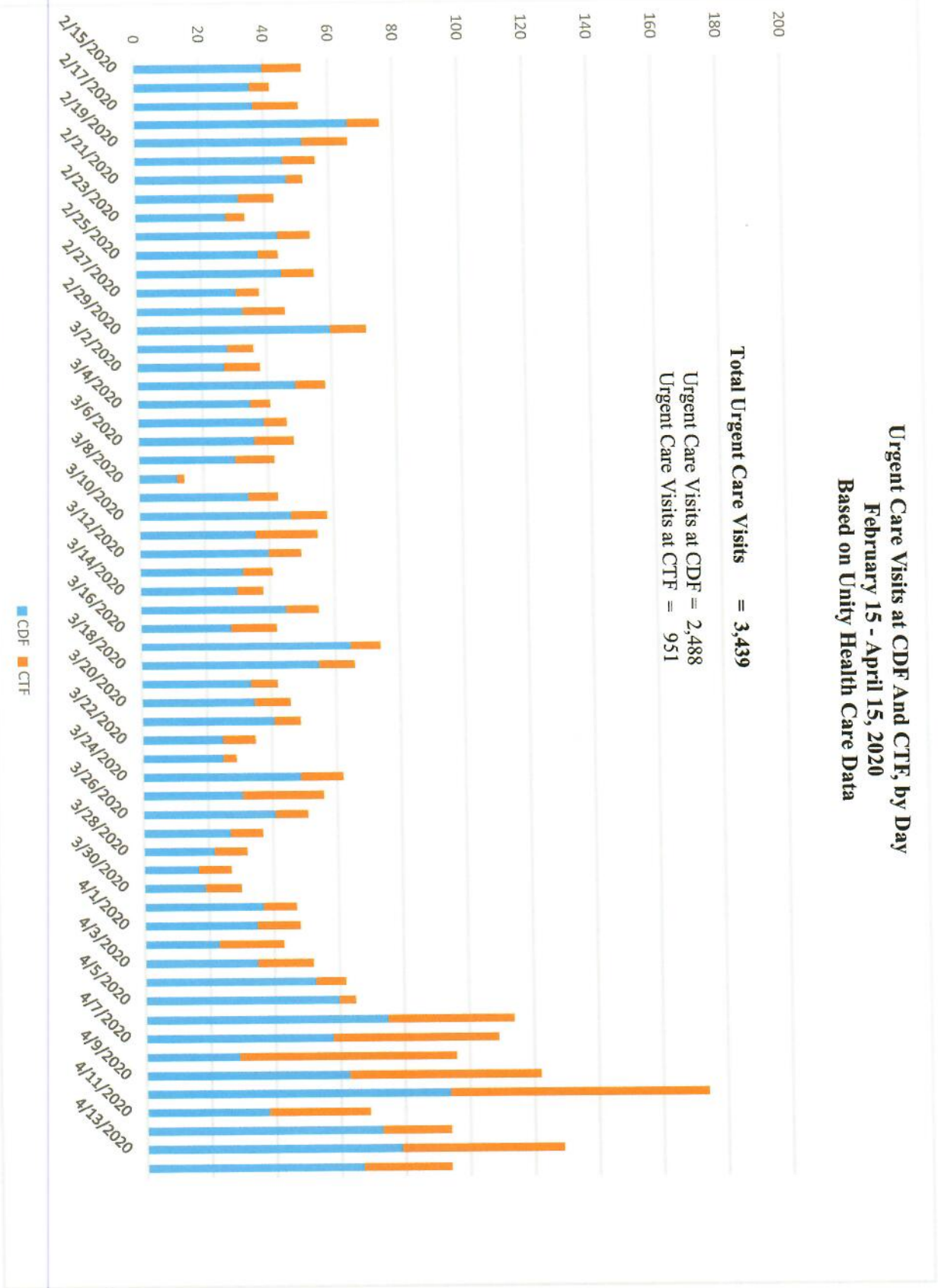
	4/1/2020	4/2/2020	4/3/2020	4/4/2020	4/5/2020	4/6/2020	4/7/2020	4/8/2020	4/9/2020	4/10/2020	4/11/2020	4/12/2020	4/13/2020
Cells Housing One Inmate	349	349	342	330	332	332	324	307	303	315	360	375	379
Cells Housing Two Inmates	62	55	53	47	46	46	47	54	53	47	20	13	11
Total Population	473	459	448	424	424	424	418	415	409	409	400	401	401
Percentage Inmates Single Celled	74%	76%	76%	78%	78%	78%	78%	74%	74%	77%	90%	94%	95%
Percentage Inmates Double Celled	26%	24%	24%	22%	22%	22%	22%	26%	26%	23%	10%	6%	5%

Ex. 3

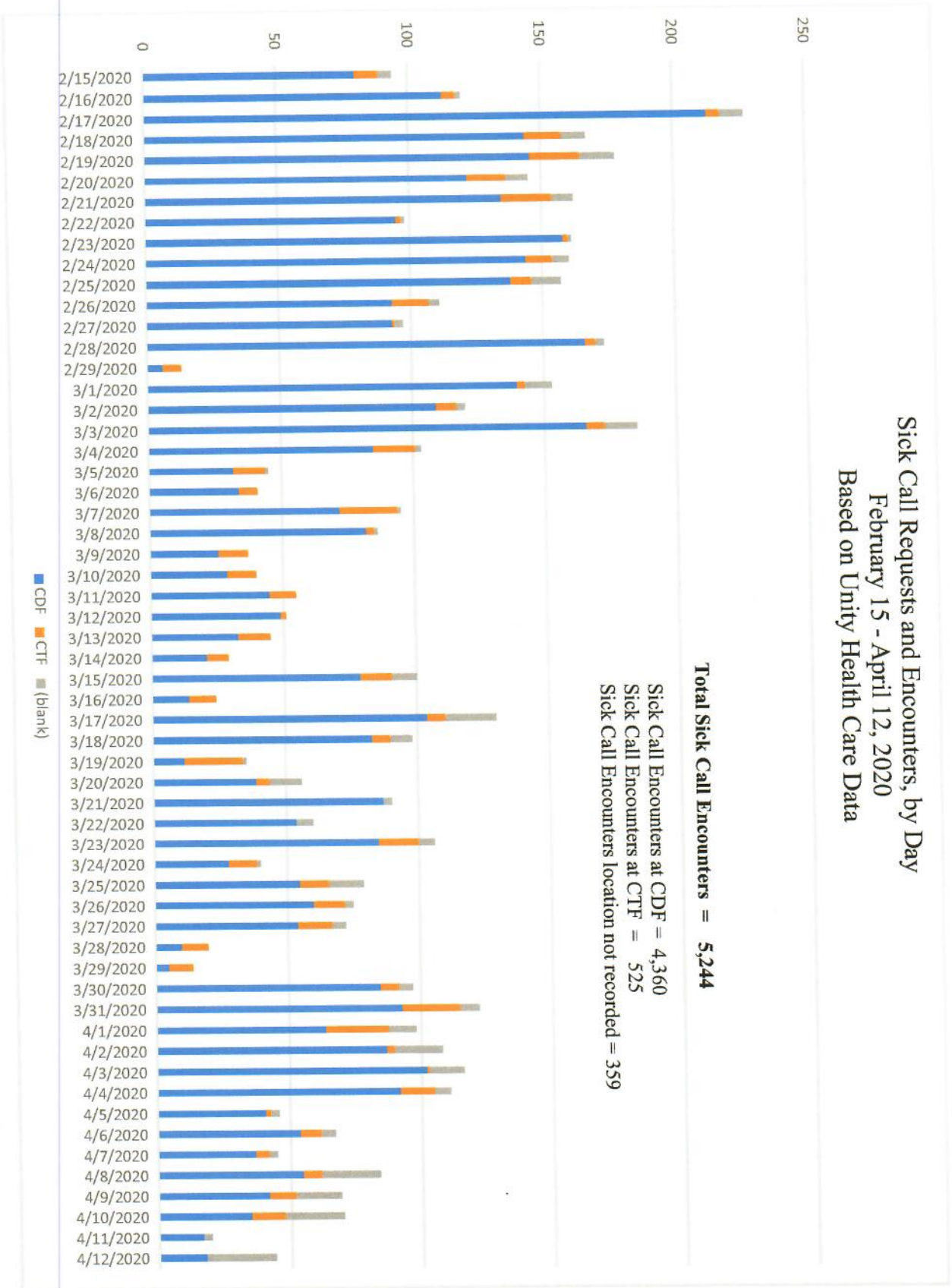
Urgent Care Visits at CDF And CTF, by Day
February 15 - April 15, 2020
Based on Unity Health Care Data

Total Urgent Care Visits = 3,439

Urgent Care Visits at CDF = 2,488
Urgent Care Visits at CTF = 951

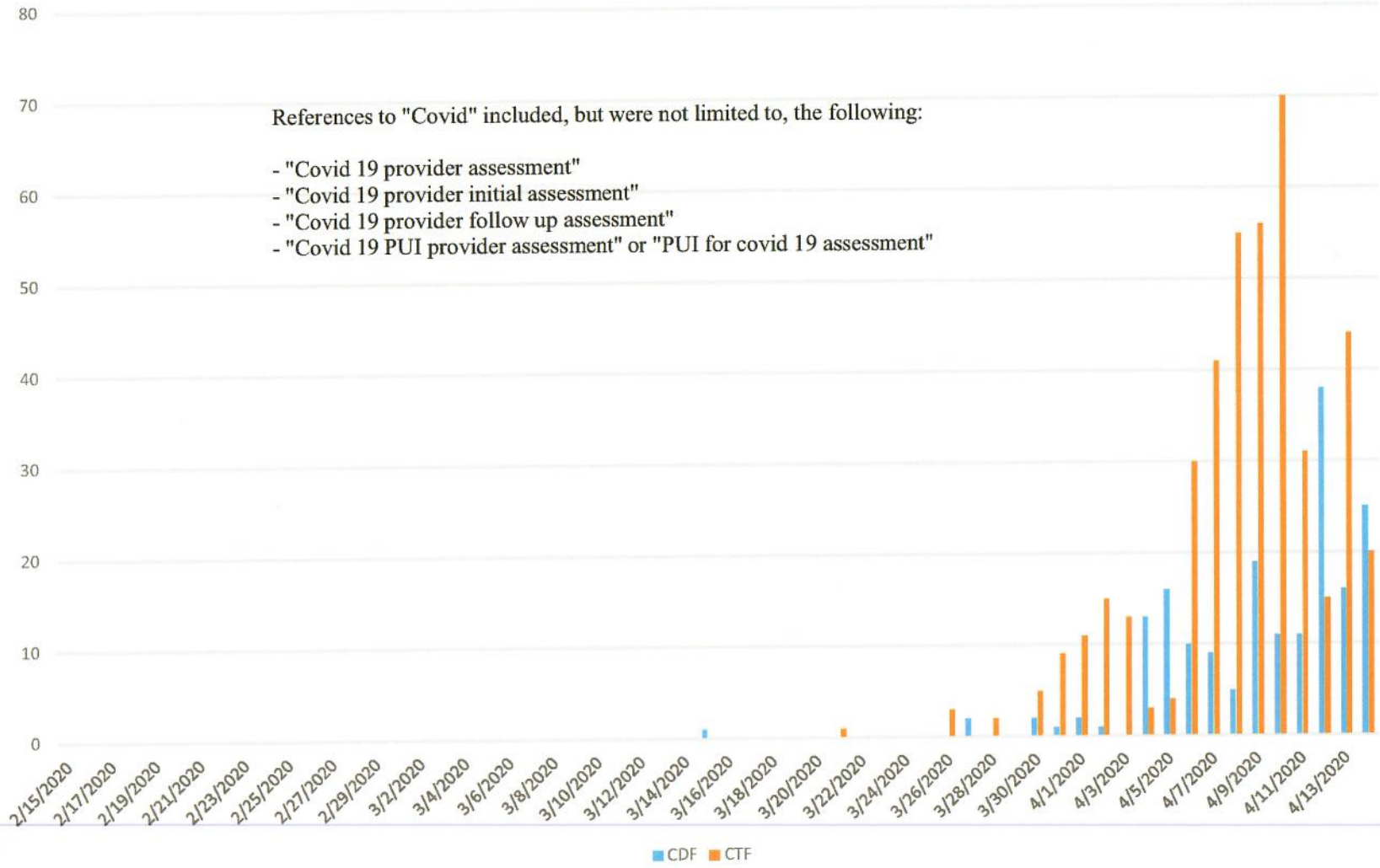


Ex. 4


Sick Call Requests and Encounters, by Day
February 15 - April 12, 2020
Based on Unity Health Care Data
Total Sick Call Encounters = 5,244
Sick Call Encounters at CDF = 4,360
Sick Call Encounters at CTF = 525
Sick Call Encounters location not recorded = 359
CDF
CTF
(blank)
0
50
100
150
200
250
2/15/2020
2/16/2020
2/17/2020
2/18/2020
2/19/2020
2/20/2020
2/21/2020
2/22/2020
2/23/2020
2/24/2020
2/25/2020
2/26/2020
2/27/2020
2/28/2020
2/29/2020
3/1/2020
3/2/2020
3/3/2020
3/4/2020
3/5/2020
3/6/2020
3/7/2020
3/8/2020
3/9/2020
3/10/2020
3/11/2020
3/12/2020
3/13/2020
3/14/2020
3/15/2020
3/16/2020
3/17/2020
3/18/2020
3/19/2020
3/20/2020
3/21/2020
3/22/2020
3/23/2020
3/24/2020
3/25/2020
3/26/2020
3/27/2020
3/28/2020
3/29/2020
3/30/2020
3/31/2020
4/1/2020
4/2/2020
4/3/2020
4/4/2020
4/5/2020
4/6/2020
4/7/2020
4/8/2020
4/9/2020
4/10/2020
4/11/2020
4/12/2020

Ex. 5

Urgent Care Medical Encounters With Clinical Summary Descriptions
Including The Word "Covid," by Day
February 15 - April 15, 2020
Based on Unity Health Care Data



Ex. 6

Johnson, Lennard (DOC)

From: Blackmon, Keena (DOC)
Sent: Friday, April 03, 2020 9:28 PM
To: DOC CDF Mailing List; DOCHQMailingList
Subject: EFFECTIVE SATURDAY, APRIL 4, 2020: Medical Stay-In-Place

DOC
THE DEPARTMENT OF CORRECTIONS

Medical Stay-In-Place

Saturday, April 4, 2020 – Your health and safety is extremely important to us. Together, everyone needs to play their part in helping to flatten the curve. To mitigate the possible spread of coronavirus (COVID-19) through DC Department of Corrections (DC DOC) facilities, the Department will implement a medical stay-in-place, **effective immediately**, which will further limit movement of residents and help "flatten the curve", as we anticipate the pandemic's peak in the next several weeks.

During the medical stay in place, the following activities will occur:

- Residents will largely be restricted to their cells with the exception of a modified recreation schedule, where groups no larger than five are out at any one time, and practice social distancing of six feet to the fullest extent possible;
- All non-urgent medical visits will be re-scheduled to minimize movement. To the extent possible medical care will be provided on the unit;
- Commissary will continue once a week as scheduled;
- Laundry will continue once a week as scheduled;
- Out of cell time of 30 minutes each day for phone calls, showers, and cell wipe down;
- Parole Commission and Video Court Hearings would continue;
- Medical escorts will continue for matters that cannot be handled on the unit;
- Disciplinary hearings will continue as scheduled;
- Culinary and Environmental details will continue as scheduled;
- Mail services will continue as scheduled;

- Stop all group activities and minimize the number of residents participating in recreation on tier (no more than 10 at a time);
- Cease all movement between facilities unless in an emergency situation;
- Cease all video visitation; and
- Cease all visits with attorneys unless actively in trial for the same reason listed above.

These changes are for the health and safety of our workforce, residents, and contractors.

Please continue to utilize health and safety precautions to help keep our DOC facilities, staff, and residents safe and healthy. Follow the guidance below on how to reduce your risk of infection and slow its spread.

- Thoroughly wash your hands for at least 20 seconds.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth
- Sanitize your equipment.
- Follow the safety protocols in place at each of the DOC facilities.
- If you are sick, contact your healthcare provider and request sick leave through your supervisor.

Thank you for your continued commitment to serving our city and our neighbors.

For the latest information on the District Government's response to COVID-19 (Coronavirus), please visit coronavirus.dc.gov.

Ex. 7

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

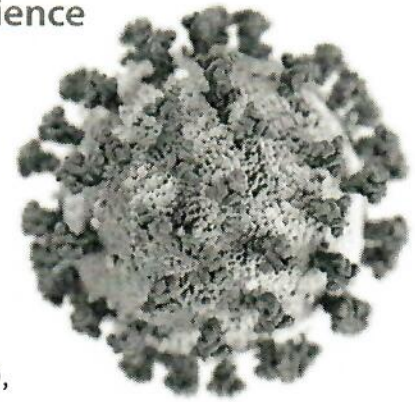
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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

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

In this guidance

Who is the intended audience for this guidance?



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

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

Why is this guidance being issued?

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

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

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

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

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

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

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

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

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

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

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

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

- o **For all:** symptoms of COVID-19 and hand hygiene instructions
- o **For incarcerated/detained persons:** report symptoms to staff
- o **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.
- o Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

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

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

√ **Identify staff whose duties would allow them to work from home. Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.**

- o Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
- o Put systems in place to implement work from home programs (e.g., time tracking, etc.).

√ **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.

- o Allow staff to work from home when possible, within the scope of their duties.
- o Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
- o Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
- o Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.

√ **Consider offering revised duties to staff who are at** higher risk of severe illness with COVID-19**.** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.

- o Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.

√ **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.

√ **Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.**

√ **Review** CDC's guidance for businesses and employers to identify any additional strategies the facility can use within its role as an employer.

Operations & Supplies

√ **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**

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

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

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

- See CDC guidance optimizing PPE supplies.

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

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

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

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

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

Prevention

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

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

Operations

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

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

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

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

Cleaning and Disinfecting Practices

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

Hygiene

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

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

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

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

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

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

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

Prevention Practices for Incarcerated/Detained Persons

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

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

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

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

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

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

Prevention Practices for Staff

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

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

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

Prevention Practices for Visitors

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

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

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

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

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

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

√ **Promote non-contact visits:**

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

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

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

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

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

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

Management

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

Operations

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

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

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

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

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

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

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

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

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

Hygiene

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

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

Cleaning and Disinfecting Practices

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

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

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cleaning Spaces where COVID-19 Cases Spent Time

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

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

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

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

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

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

√ **Electronics cleaning and disinfection**

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

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

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

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

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

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

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

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

Quarantining Close Contacts of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

√ **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**

- If an individual develops symptoms, they should be moved to medical isolation 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 COVID-19 cases.

√ **If an individual who is part of a quarantined cohort becomes symptomatic:**

- **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
- **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.

√ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**

√ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**

√ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

√ **Laundry from quarantined individuals can be washed with other individuals' laundry.**

- Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

√ **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See** Medical Isolation **section above.**

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

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

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

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

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

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

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

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

Management Strategies for Staff

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

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

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

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

Infection Control

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

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

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

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

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

Clinical Care of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **N95 respirator**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ex. 8

Dates and Quantities of Cleaning Supplies and Soap Delivered to the CDF and CTF, by Date
December 31, 2019 - April 13, 2020

Summary	Product							
Date of Delivery	Bar Soap 5oz (100 bars)	Ecolab AB Foam Hand Soap (6, 25 oz)	Ecolab Disinfectant Cleaner (2.5 gallons)	Ecolab E Foam Hand Sanitizer (6,25 oz)	Ecolab Multi-Quat Sanitizer (2.5 gallons)	Ecolab Orange Force (2.5 gallons)	Ecolab Peroxide Multi Surface (2.0 gallons)	Grand Total
12/31/2019	31							31
1/7/2020			2					2
1/8/2020		3	3			3		9
1/10/2020	20							20
1/14/2020	7							7
1/16/2020		8	10	5	5	8		36
1/21/2020	20	1						21
1/22/2020		3	4					7
1/31/2020		4	5	4	3	3		19
2/6/2020	25	10	15					50
2/10/2020			1					1
2/12/2020	7	4	4			4		19
2/19/2020		3	5					8
2/26/2020	20		6	3	3			32
2/27/2020			1		1	1		3
3/4/2020	7	6	5		3	3		24
3/6/2020			31	30	4	3		68
3/9/2020				8				8
3/10/2020		14	16	8	8	8		54
3/12/2020		11	10	3	6	6	7	43
3/13/2020	20							20
3/17/2020	13							13
3/18/2020	6	10	7	12	6	6	9	56
3/19/2020				1				1
3/23/2020	0							0
3/24/2020	2	8	5	11	4	5	6	41
3/25/2020				4				4
3/28/2020				1				1
3/31/2020	12	8	5	10	4	4	6	49
4/3/2020				3				3
4/7/2020	12	2		2				16
4/8/2020	5	8	2	13	2	2	3	35
4/13/2020		5	2	9		2	3	21
Grand Total	**207**	**108**	**139**	**127**	**49**	**58**	**34**	**722**

Ex. 9


ECOLAB
Disinfectant Cleaner 2.0
D1B
ECOLAB
Multi-Quat Sanitizer
D1B
C4A
ECOLAB
Rubbermaid
WAVEBRAKE

Ex. 10

Ex. 11

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS

DOC
THE DEPARTMENT OF CORRECTIONS

Office of the Director

MEMORANDUM

TO: All DOC employees and contractors

FROM: Quincy L. Booth, Director

DATE: April 17, 2020

SUBJECT: Reminders and Updated COVID-19 Policies and Procedures

---

This memorandum serves as a reminder to all District of Columbia Department of Corrections (DOC) staff and contractors of the agency's COVID-19 policies and procedures, informed by some new guidance from Mayor's Order 2020-06, dated April 15, 2020. It is imperative that the following policies and procedures are enforced and maintained:

1. Social Distancing Measures

    a. Correctional officers must enforce social distancing in DOC's correctional facilities at all times.

    b. There shall be multiple daily announcements over the agency's public address (PA) system reminding staff and residents of social distancing. Specifically, the PA announcement shall remind residents to stay at least six feet apart from each other and not to gather in groups.

    c. Strict limits on the number of persons out of their cells at one time will help with social distancing. In general, only six residents from a unit will be out at one time for out of cell time, plus an occasional two to three cleaning detailees.

d. Group activities, such as classes, shall continue to be suspended for the duration of the emergency period.

2. Resident out of cell time

a. All DOC residents, except those on isolation units, shall be allowed one hour of out of cell time each day.

b. PA announcements shall be made daily to remind DOC staff and residents that out of cell time is one hour per day.

3. Personal Protective Equipment (PPE), COVID-19 and Sick Call Education Training

a. DOC shall conduct PPE refresher courses for its staff during roll call of each shift, until otherwise directed. These courses are and shall continue to be documented by DOC.

b. DOC's medical staff and sick call staff shall visit DOC's housing units to refresh staff and residents on PPE use, COVID-19 prevention and how to submit sick call slips for medical visits, until otherwise directed. These visits shall be documented by DOC.

c. All DOC staff shall wear PPE in compliance with Centers for Disease Control guidelines while working in DOC's correctional facilities.

4. Isolation Units

a. All residents housed in isolation units shall be allowed to shower each day.

b. All residents housed in isolation units shall be allowed, each day, free 30-minute legal calls to their attorney of record on an un-secure and non-monitored telephone line. Notably, a "rolling phone" will be transporting to the residents' cells for legal calls.

c. DOC shall provide tablets with entertainment and education content pre-programed and activity packets (pamphlets with education materials) to residents housed on isolation units who feel well enough to use them.

5. Unit Common Area and Cell Cleaning

a. At the beginning of each shift, correctional officers working in DOC housing units shall document the amount of cleaning product and equipment available in the housing unit. Any shortages of cleaning product and equipment shall be documented by the correctional officer on duty and he/she shall notify his/her supervisor of any shortages so that additional cleaning product and the equipment may be ordered for the housing unit.

b. During a resident's out of cell time, correctional officers shall spray towels with cleaning product and provide the resident with the cleaning product sprayed paper towels and dry paper towels to clean his/her cell.

c. During each shift, correctional officers working in housing units shall verify and document that the housing unit's common areas are cleaned in accordance with DOC's cleaning schedules.

d. DOC shall post listings of all cleaning products and equipment available to residents in each housing unit.

e. Cleaning product are diluted appropriately by DOC's environmental team before being provided to the units; there is no need for further dilution.

6. Linen and Laundry Exchanges

a. Each week, DOC shall provide its residents with fresh clothing and undergarments (laundry) and towels and sheets (linens) and collect the residents' used items as part of the agency's laundry and linen exchanges.

b. If a resident refuses to participate in either exchange, he/she will still be provided with fresh laundry and linen, if supplies are available.

7. Contractor and Staff Screening and Hygiene

a. All staff and contractors who enter DOC's facilities (except emergency personnel responding to an emergency) shall continue to undergo a COVID-19 screening, including a temperature check with a contactless infrared thermometer, and answering of brief questions designed to spot early signs of COVID-19 infection.

b. All entrants who fail the COVID-19 screening shall be denied entry to DOC's facilities.

c. All staff responsible for COVID-19 screenings shall be re-trained on the use of contactless infrared thermometers.

d. Non-essential visitors shall continue to be excluded for the duration of the emergency.

e. Following the screening and before starting their tour of duty, entrants shall wash their hands with soap and water for at least twenty seconds to prevent the spread of disease.

f. Staff who have been determined to have recently been in sustained, close contact with another staffer or inmate who tests positive for COVID-19 will be informed, consistent with privacy protections, and directed according to protocol.

8. Access to Legal Calls

a. All residents shall be allowed, each day, free 30-minute legal calls to their attorney of record on a non-secure and un-monitored telephone line.

b. DOC staff shall cooperate to facilitate residents' receipt of incoming calls from their attorney. Specifically, DOC's Case Management team has and will continue to coordinate legal calls between DOC's residents and their attorney.

9. Medical Care

a. DOC staff who observe a resident exhibiting symptoms of COVID-19 shall direct the resident to medical care, and medical staff will determine appropriate next steps for the inmate's health and the health of those nearby.

10. Tablets

a. Inmates may have the tablets in their cells at least for the duration of the Public Health Emergency.

b. To facilitate the sharing of the tablets by residents, all tablets shall be sanitized between use by different residents.

ALSO, PLEASE BE ADVISED:

1. **Single Cells:** DOC is balancing the competing needs to protect residents' mental health and prevent anxiety, self-harm, and suicide with the goal of providing single cells where possible to reduce the spread of COVID-19. Cooperate as directed in facilitating resident moves to make better use of our space as our population decreases.

2. **Medical Reserve Corps Assistance:** You may see new staffers on the units, as DOC is requesting staff augmentation through the Medical Reserve Corps (Corps). Corps members (thirty are being requested) may perform such tasks as assisting with temperature checks for incoming staff and contractors; checking residents' temperatures daily; helping in the medical unit and isolation units; and performing such other duties as may be required. Their valued service will be of great assistance as needs are higher during this challenging time.

3. **Provision of Tablets** Presently, DOC does not have a tablet for every resident. Thus, we are requesting additional tablets to eliminate the need to share, and to enable residents to communicate with their attorneys through the tablets, as well as to enjoy the entertainment, inspirational, and educational offerings that are pre-loaded. Activity packets shall also be provided to residents upon request.

4. **Quarantine of new arrivals.** Be advised that new intakes to the facility are placed in an "enhanced monitoring" for 14 days and should be presumed not to have COVID-19. However, if the new intake develops COVID-19 symptoms during the "enhanced monitoring" period, they will be tested for COVID-19 and moved to a quarantine housing in until the agency receives their test results. If they test positive, they will be housed in an isolation unit for treatment. If they test negative, they will remain in a quarantine unit until they are no longer symptomatic.

5. **Mobile testing:** As mobile testing becomes available, DOC will request its deployment to its facilities to screen staff and residents, per CDC and DOH guidelines.

THIS MEMO SHALL BE READ DURING ROLL CALL DURING THE NEXT SEVEN CONSECUTIVE DAYS AND POSTED ON ALL APPROPRIATE BULLETIN BOARDS.