Exhibit 6

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

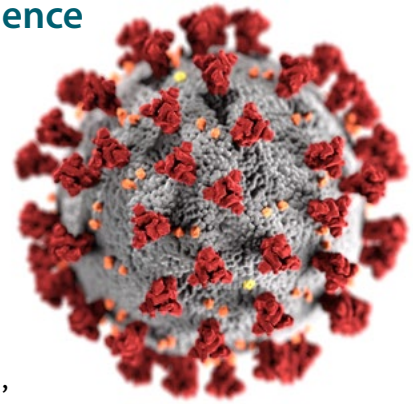
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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.

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

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

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

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

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

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

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

Personnel Practices

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

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

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

Operations & Supplies

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

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

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

- See CDC guidance optimizing PPE supplies.

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

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

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

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

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

Prevention

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

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

Operations

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

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

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

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

Cleaning and Disinfecting Practices

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

Hygiene

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

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

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

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

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

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

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

Prevention Practices for Incarcerated/Detained Persons

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

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

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

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

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

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

Prevention Practices for Staff

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

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

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

Prevention Practices for Visitors

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

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

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

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

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

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

√ **Promote non-contact visits:**

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

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

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

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

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

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

Management

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

Operations

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

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

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

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

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

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

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

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

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

Hygiene

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

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

Cleaning and Disinfecting Practices

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

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

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cleaning Spaces where COVID-19 Cases Spent Time

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

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

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

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

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

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

√ **Electronics cleaning and disinfection**

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

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

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

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

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

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

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

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

Quarantining Close Contacts of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

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

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

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

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

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

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

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

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

Management Strategies for Staff

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

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

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

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

Infection Control

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

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

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

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

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

Clinical Care of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **N95 respirator**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 7

Doctors in NYC Hospitals, Jails, and Shelters Call on the City to Take More Aggressive Action to Combat the Spread of Coronavirus

Brad Lander Follow
Mar 12 · 3 min read

From NYC Council Members Brad Lander and Ritchie Torres:

As public representatives, we have been talking with constituents, public health experts, schools, and city officials about how to balance the urgent need to slow the spread of coronavirus with the need to continue providing services, maintain public order, and lessen the hardships on families and vulnerable populations. In that spirit, we are sharing the following letter, provided to us by a group of doctors working in the City's hospitals, jails, clinics and shelters, which calls for the City to rapidly take far more aggressive steps (as they term it: "enforced solidarity") to halt community spread.

***

March 12, 2020

An Open Letter to Mayor de Blasio and City Officials

As doctors and public health officials working in the City's hospitals, jails, clinics, and shelters, we are extremely anxious about the impact of the COVID-19 virus on vulnerable populations and by the City's hesitance to take more dramatic action. Given the information we have about the exponential growth of the virus and the limited capacity of our health system to care for the number of people who will become sick and need care at the same time, we believe that aggressive measures must be taken now. Actions taken now to encourage and facilitate what we are calling enforced solidarity (a more accurate description than social distancing) will mitigate the impact of the virus on vulnerable populations and our health system.

We call on the City to:

Act immediately and boldly to slow the spread of the virus:

- Suspend classes at public schools, while keeping schools open for emergency childcare for essential workers and vulnerable families. Keep childcare groups small, under 10 kids per group. Close schools immediately and reopen some as centers of family support and mitigation.
- Order the NYPD to stop making low level arrests for violations and misdemeanors, in order to prevent the spread of the virus through our jails, courts, and precincts.

- Order the courts to consider release for anyone in pretrial detention over 60. Administratively reschedule all criminal court proceedings for people who are not currently incarcerated. Reschedule all other court proceedings.
- Urge businesses to have all non-essential workers work from home. Employers may have discretion over who is “essential,” but give guidance that only those providing services that must be maintained during a state of emergency should be considered essential.
- Strongly advise people over 60 to avoid public transit.
- Cancel all City events and revoke permits for events.
- Ensure that medical personnel have adequate personal protective equipment.
- Open a virus hotline for residents to be able to call a nurse and get a home visit if needed for quarantined people with moderate symptoms rather than bring people into the ER.
- Order the Administration of Children’s Services (ACS) to stop requiring parents to attend groups and programs; halt non-emergency family court proceedings, guarantee tele-visitation for parents and children.

Take steps to strengthen the social safety net to protect vulnerable New Yorkers.

- Turn schools into centers for community aid: food pantry, crisis navigation, and eventually satellite testing sites once we have capacity to test widely.
- Urge the State to adopt paid sick leave for up to 2 weeks for all workers immediately.
- Work with the State to institute an immediate moratorium on evictions and provide benefits for families and businesses.
- Divert workers from other non-essential services to Naturally Occurring Retirement Communities and public housing to check on quarantined elderly. Can do by phone/remote to minimize unnecessary contact.
- Increase Meals-on-Wheels service.

- Increase staffing for the City's mental health hotline to deal with increased anxiety and suicidality exacerbated by isolation and uncertainty.
- Take steps to address the digital divide, including providing burner cell phones at crisis centers and shelters for people who do not have cell phones.

We are grateful for the City's caution and attention to the impact of the coronavirus and associated response on vulnerable populations. We urge the City to begin taking more aggressive steps to shut down business as usual to slow community spread, while also increasing support for vulnerable populations.

Sincerely,

Doctors and public health officials working in NYC's hospitals, jails, clinics, and shelters

Healthcare Jail Shelter Doctors

Exhibit 8

March 25, 2020

Hon. Larry Hogan
Governor of Maryland
Annapolis, MD

Dear Governor Hogan:

We are writing as faculty members of the Johns Hopkins Bloomberg School of Public Health, School of Nursing and School of Medicine to express our urgent concern about the spread of COVID-19 in Maryland's prisons, jails, and juvenile detention centers. As you know, COVID-19 is highly contagious, difficult to prevent except through social distancing, and especially dangerous to individuals over age 60 or with a chronic disease. Moreover, recent data suggest that the virus can remain on surfaces for up to 72 hours, thus rendering social distancing less effective in circumstances where the virus is present.

Jails, prisons, detention facilities and other closed settings have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, influenza, MRSA (methicillin resistant staph aureus), and viral hepatitis. Several deaths were reported in the US in immigration detention facilities associated with ARDS (acute respiratory distress syndrome) following influenza A, including a 16 year old immigrant child who died of untreated ARDS in custody in May 2019. ARDS is the life-threatening complication of COVID-19 disease and has a 30% mortality given ideal care. A correctional officer in New York has also died of the disease.

The close quarters of jails and prisons, the inability to employ effective social distancing measures, and the many high-contact surfaces within facilities, make transmission of COVID-19 more likely. Soap and hand sanitizers are not freely available in some facilities. Hand sanitizers like Purell, are banned in many facilities, because they contain alcohol. Further, for incarcerated individuals who are infected or very sick, the ability properly to treat them and save their lives is very limited. Testing kits are in short supply, and prisons and jails have limited options for proper respiratory isolation.

A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of COVID-19 and other infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilets, showers, and eating environments and limited availability of hygiene and personal protective equipment such as masks and gloves in some facilities. The high rate of turnover and population mixing of staff and detainees also increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff.

These populations are also at additional risk, due to high rates of chronic health conditions; substance use; mental health issues; and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after COVID-19 infection, and to death. Given that Maryland prisons, jails, and juvenile detention centers incarcerate high

numbers of marginalized populations and African Americans will be disproportionately affected by these risks.

Prison, jail, and detention center staff may bring the virus into the facility and are also at risk of acquisition from infected incarcerated individuals. Once infected, staff may also transmit the virus back into the communities and to their families. As jail, prison, and detention center health care staff themselves get sick with COVID-19, workforce shortages will make it even more difficult to adequately address all the health care needs in facilities.

Every effort should be made to reduce exposure in jails and other detention facilities, and we appreciate the efforts thus far of administrators toward this goal. To ensure that there are no impediments for inmates to come forward when sick, health care must be available to inmates without co-pays. But there should also be efforts to reduce the state prison population as well. It may be extremely difficult, however, to achieve and sustain prevention of transmission in these closed settings and given the design feature of the facilities. Moreover, lockdowns and use of solitary confinement should not be used as a public health measure, both because they have limited effectiveness and because they are a severe infringement of the rights of incarcerated people. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.

Treatment needs of infected incarcerated individuals also need to be met, including expanded arrangements with local hospitals. It is essential that these facilities, which are public institutions, be transparent about their plans for addressing COVID-19. Such transparency will help public health officials and families of incarcerated people know what facilities are doing, and it also can help jurisdictions across the state share information and best practices. Other counties across the country have shared their action plans with the public and Maryland should follow these examples.

We therefore urge you to take the following steps:

1. Require correctional facility administrators to make their plans for prevention and management of COVID-19 in their institutions publicly available, as the San Francisco Sheriff's Department has done. Protocols should be in line with national CDC guidance. Frequently updated recommendations and model protocols are available from the National Commission on Correctional Health Care (https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections)
2. Ensure that intake screening protocols are updated to include COVID-specific questions.
3. Ensure the availability of sufficient soap and hand sanitizer for incarcerated individuals without charge; restrictions on alcohol (in hand sanitizers) should be suspended.
4. Implement other precautions to limit transmission within prisons and jails without relying on widespread use of lockdowns and solitary confinement. Additional precautions jointly issued by the Vera Institute of Justice and Community Oriented

Correctional Health Services are available at https://cochs.org/files/covid-19/covid-19-jails-prison-immigration.pdf

5. Consider pre-trial detention only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, or parole or probation violations, should be prioritized for release. No one in these categories should be sent to jail
6. Expedite consideration of all older incarcerated individuals and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) for parole or other form of release from prison, with alternative forms of supervision and with supports in the community once released. Clemency power and expanded authority in Maryland law for administrative parole should be employed.
7. Invest in increased resources for discharge planning and re-entry transitions to facilitate prison release of people under these revised policies.
8. Arrange for COVID-19 testing of incarcerated individuals and correctional facility workers who become ill.
9. Cease any collection of fees or co-pays or medical care.
10. Seek a Medicaid 1135 waiver to enable hospitals to provide an appropriate level of care to incarcerated individuals who are sick. See https://cochs.org/files/medicaid/COVID-19-Justicie-Involved-1135-Waiver.pdf

This pandemic is shedding a bright light on the extent of the connection between all members of society: jails, prisons and other detention facilities are not separate, but are fully integrated with our community. As public health experts, we believe these steps are essential to support the health of incarcerated individuals, who are some of the most vulnerable people in our society; the vital personnel who work in prisons and jail; and all people in the state of Maryland. Our compassion for and treatment of these populations impact us all.

Thank you very much.

This letter represents the views of the following signatories, and do not necessarily reflect the views of The Johns Hopkins University

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Exhibit 9

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

COREAS, et al., *Petitioners-Plaintiffs*, v. BOUNDS, et al, *Respondents-Defendants*.	Civil Action No.:

DECLARATION OF Ranit Mishori, MD, MHS, FAAFP

I, Ranit Mishori, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct.

I. Background

1. I am Dr. Ranit Mishori. I am a senior medical advisor at Physicians for Human Rights (PHR), and Professor of Family Medicine at the Georgetown University School of Medicine, where I am the director of the department's Global Health Initiatives, Health Policy fellowship and our practice-based research network. A fellow of the American Academy of Family Physicians and Diplomate of the American Board of Family Medicine, I did my residency training at the Georgetown University/Providence Hospital Family Medicine Residency program. I received my medical degree from Georgetown University School of Medicine and a master's degree in International Health from the Johns Hopkins Bloomberg School of Public Health, in the Disease Control and Prevention Track (focusing on the science of how to halt the spread of infectious disease).

2. I am the faculty leader for Georgetown University School of Medicine's Correctional Health Interest group, where I supervise medical students placed at various area jails, prisons and detention centers. In addition, I am the director of Georgetown University's Asylum program which focuses on the care and medico-legal issues of asylum seekers, including immigration detention. I have written extensively and given talks and lectures about such issues nationally and internationally. In my role as senior medical advisor at PHR (and prior to that, as a consultant for PHR), I have reviewed and analyzed dozens of cases related to health outcomes of individuals in correctional facilities, and advised the organization and other partners (civil society, legal aid organizations and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and care of pregnant women in such settings.[1]

3. As an attending physician at the Georgetown University/Washington Hospital Center Family Medicine Residency Program, I work with urban underserved populations, including the homeless, formerly incarcerated individuals, immigrants and refugees. I routinely come in contact with victims of abuse, trauma and poverty where I regularly assess their medical as well as psycho-social needs in the context of their social-determinants of health (such as housing and incarceration).

[1] *See, e.g.*, Ranit Mishori, *Risk Behind Bars: Coronavirus and Immigration Detention*, The Hill (Mar. 17, 2020), https://thehill.com/opinion/immigration/487986-risk-behind-bars-coronavirus-and-immigration-detention; Amanda Holpuch, *Coronavirus Inevitable in Prison-Like US Immigration Centers, Doctors Say*, The Guardian (Mar. 11, 2020), https://www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-immigration-centers; Abigail Hauslohner, et al., *Coronavirus Could Pose Serious Concern in ICE Jails, Immigration Courts*, The Washington Post (Mar. 12, 2020), https://www.washingtonpost.com/immigration/coronavirus-immigration jails/2020/03/12/44b5e56a-646a-11ea-845d-e35b0234b136_story.html; Silvia Foster-Frau, *Coronavirus Cases in Migrant Detention Facilities Called 'Inevitable'*, Express News (Mar. 15, 2020) https://www.expressnews.com/news/us-world/border-mexico/article/Whether-in-detention-or-in-Mexico-U-S-15129447.php.

4. For four years I was an elected member of the American Academy of Family Physicians' Commission on the Health of the Public and Science, where I chaired the Public Health Issues sub-committee. During that time, I was a one of the lead authors of the Academy's comprehensive position paper on Incarceration and Health.

5. My CV is attached as Exhibit A.

II. COVID-19

6. The novel coronavirus, officially known as SARS-CoV-2 (Coronavirus), causes a disease known as COVID-19. COVID-19 has now reached pandemic status. As of March 24, 2020, according to the World Health Organization (WHO), more than 334,000 people have been diagnosed with COVID-19 around the world and 14,652 have died.[2] In the United States, about 31,537 people have been diagnosed and more than 400 people have died as of the same date.[3] The numbers of infection and death in the United States are likely underestimated due to the lack of test kits available.

7. The transmission of Coronavirus is expected to grow exponentially. Nationally, projections by the Centers for Disease Control and Prevention (CDC) indicate that over 200 million people in the United States could be infected with Coronavirus over the course of the pandemic without effective public health intervention, with as many as 1.5 million deaths in certain projections.

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[2] *See* Novel Coronavirus (COVID-19) Situation, World Health Organization, https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd, accessed Mar. 18, 2020 (at noon EDT).

[3] *See* Mitch Smith, et al., *U.S. Coronavirus Map: Cases Now Reported in All 50 States*, The New York Times, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?searchResultPosition=1, accessed Mar. 18, 2020 (at noon EDT).

8. The novel coronavirus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but it also survives on surfaces for some period of time. The virus can cause severe damage to lung tissue, requiring an extensive period of rehabilitation, and in some cases, a permanent loss of respiratory capacity. The virus also targets the heart muscle, leading to myocarditis, or inflammation of the heart muscle. It is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where Coronavirus originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. The "contagiousness" of this novel coronavirus—its R0 (the number of people who can get infected from a single infected person)—is twice that of the flu. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. For this reason, only with aggressive testing for the virus can we track the disease, isolate those affected, and stop its spread.

9. COVID-19 is a serious disease, which can lead to respiratory failure, kidney failure, and death. Older patients and patients with chronic underlying conditions are at a particularly high risk for severe cases and complications.[4] The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 than from influenza. According to recent estimates, the fatality rate of people infected with COVID-19 is about ten times higher than a severe seasonal influenza, even in advanced countries with highly effective health care systems.

[4] Fei Zhou, et al., *Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China*, The Lancet (published online Mar. 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

According to preliminary data from China, serious illness, sometimes resulting in death, occurs in up to 16% of cases, with a higher rate among those older and high-risk individuals. [5]

10. The CDC previously identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age, including: blood disorders, chronic kidney or liver disease, immunosuppression, endocrine disorders (including diabetes), metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

11. Those in high-risk categories who do not die may have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that are likely to soon be in very short supply, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from neurological damage and loss of respiratory capacity.

12. Complications from COVID-19, including severe damage to lung, heart, liver, or other organs, can manifest at an alarming pace. Patients can show the first symptoms of infection in as little as two days after exposure, and their condition can seriously deteriorate in as little as five days or sooner.

13. There is no vaccine to prevent COVID-19. There is no known cure or antiviral treatment for COVID-19 at this time.

[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention, accessed Mar. 14, 2020, https://www.cdc.gov/coronavirus/2019-ncov/summary.html.

14. COVID-19 prevention strategies include containment and mitigation. Containment requires identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Unfortunately, due to the lack of testing availability, most public health experts agree that it is too late to effectively implement a containment strategy in the United States at-large.

15. As the infectious disease spreads in a community, public health demands mitigation strategies, which include scrupulous hand hygiene and social distancing. For that reason, public health officials have recommended extraordinary measures to combat the rapid spread of coronavirus. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of this risk mitigation strategy.

III. Detention Centers, Jails, & Prisons

16. The risk posed by infectious diseases in immigration detention facilities, including jails and prisons, is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

17. Globally, outbreaks of contagious diseases are all too common in confined detention settings and are more common than in the community at large. Though they contain a captive population, these settings are not isolated from exposure. ICE has temporarily suspended social visitation in all detention facilities.[6] However, staff arrive and leave on a shift basis; there is no ability to adequately screen staff for new, asymptomatic infection. Contractors and vendors

[6] *ICE Guidance on Covid-19*, U.S. Immigration and Customs Enforcement, accessed Mar. 18, 2020 (at 1:00 p.m. EDT), https://www.ice.gov/covid19.

also pass between communities and facilities and can bring infectious diseases into facilities. People are often transported to, from, and between facilities.

18. Jails, prisons and detention centers often do not have access to vital community health resources that can be crucial in identifying infectious diseases, including sufficient testing equipment and laboratories. This is especially true when, as now, there is a shortage in available test kits.

19. During an infectious disease outbreak, a containment strategy requires people who are ill to be isolated and that caregivers have adequate personal protective equipment (PPE). Jails and prisons are often under-resourced and ill-equipped to provide sufficient PPE for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak. Moreover, efforts to mitigate disease spread in jails, prisons and detention centers will help limit its transmission in the community, since staff members are able to come and go, and return to their family members at the end of their shifts. This is especially true when, as now, facemasks are already in short supply.

20. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. Toilets, sinks, and showers are shared, without disinfection between use. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Detainees often have a small number of telephones that they share, and which form their only contact with the outside world—including

their family and lawyers. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

21. Additionally, jails and prisons are often unable to adequately provide the mitigation recommendations described above. During an infectious disease outbreak, people can protect themselves by washing hands. Detention centers, jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons.

22. People incarcerated in detention centers, jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[7] This is because people in detention centers, jails and prisons, for a variety of reasons, have higher rates of chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and suppressed immune systems from HIV or other conditions, than people in the community.

23. Detention centers, jails and prisons are often poorly equipped to manage infectious disease outbreaks. Some detention centers, jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at detention centers, jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of

[7] *Active Case Finding For Communicable Diseases in Prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

droplet-borne infectious diseases, people who are infected and symptomatic need to be isolated in specialized negative pressure rooms. Most detention centers, jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). ICE has admitted that not all of the detention centers it oversees have even one.[8] In the course of an infectious disease outbreak, resources will become exhausted rapidly and any beds available will soon be at capacity.

24. Even assuming adequate space, solitary confinement is not an effective disease containment strategy. Isolation of people who are ill using solitary confinement is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms, air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and the staff. This makes both containing the illness and caring for those who have become infected much more difficult.

25. Infectious disease outbreaks, such as COVID-19, may exacerbate existing mental health conditions and contribute to the development of new mental health conditions.[9] Mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation. Moreover, failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by an infectious

[8] Brittny Mejia, *ICE Says No Confirmed Coronavirus Among Detainees After 4 Test Negative*, Los Angeles Times, accessed Mar. 18, 2020, https://www.latimes.com/california/story/2020-03-10/ice-says-no-detainees-have-coronavirus-four-being-tested

[9] Brian Honermann, *An "Epidemic Within an Outbreak:" The Mental Health Consequences of Infectious Disease Epidemics*, O'Neill Institute for National and Global Health Law (Feb. 26, 2015), accessed Mar. 19, 2020, https://oneill.law.georgetown.edu/epidemic-within-outbreak-mental-health-consequences-infectious-disease-epidemics/; Müller N, *Infectious Diseases and Mental Health*, Comorbidity of Mental and Physical Disorders; Shultz JM, *Mental Health Consequences of Infectious Disease Outbreaks*, accessed Mar. 19, 2020, https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/flrtc/documents/Slides-MH-CONSEQUENCES-OF-ID-OUTBREAKSV2.pdf.

disease outbreak such as COVID-19, may result in poor health outcomes and even death. The scientific evidence points to a bi-directional relationship between mental health conditions and infectious diseases. Not only are individuals with mental health conditions more at risk for communicable diseases, they are also harder to treat, once infected, due to the nature of their underlying mental health disorder. For individuals in these facilities, especially those with chronic mental health conditions, the experience of an epidemic and the lack of care while confined to small, crowded quarters can itself be traumatizing, compounding the trauma of incarceration.

26. A coronavirus brought into a detention facility can quickly spread among the dense detainee cohort. Soon many are sick—including high-risk groups such as those with chronic conditions—quickly overwhelming the already strained health infrastructure within the facility. This can also lead to a strain on the surrounding hospitals to which these individuals may be transferred.

27. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[10] Subsequent CDC investigation of 995 inmates and 235 staff members across the two facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[11] H1N1 is far less contagious than coronavirus. These scenarios occurred in the "best case" of influenza, a viral infection for which

[10] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention, Apr. 6, 2020, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

[11] David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/.

there was an effective and available vaccine and antiviral medications, unlike the coronavirus COVID-19, for which there is currently neither.

28. In recent years in immigration detention facilities, overcrowding, poor hygiene measures, medical negligence, and poor access to resources and medical care have led to outbreaks of other infectious diseases as well, including mumps and chickenpox.

29. Additionally, as health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions.

30. We have ample basis to conclude that detention settings are equally unprepared for the rapid spread of Coronavirus. Not surprisingly, Chinese prison officials report that over 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons. In Israel, an entire prison was quarantined. Recognizing that the release of those incarcerated is the only solution, US jails in at least a dozen states have begun releasing inmates. In Iran, over 80,000 prisoners were released as a means of preventing death in government prisons. Major human rights organizations such as Human Rights Watch, Physicians for Human Rights and Amnesty International have issued calls to release those detained in immigration facilities to prevent the spread of coronavirus.

31. In my professional opinion, it is inevitable that SARS-CoV-2, the virus that causes COVID-19, will infect prisons, jails, and/or other immigration detention centers in the United States. This is consistent with the prediction of other experts that all detention centers, prisons and jails should anticipate. Given the shortage of COVID-19 tests in the United States, it is likely that detention facilities are unable to conduct aggressive, widespread testing to identify all positive

coronavirus cases. The ability to identify cases is crucial in order to be able to determine whether there is a risk for coronavirus transmission in an institution.

IV. The Maryland Detention Facilities

32. Based on the description of the Maryland facilities contained in the Lopez Declaration, it is my professional opinion that the Maryland facilities are particularly susceptible to rapid spread of the virus and are not equipped to handle a coronavirus outbreak.

33. The living conditions described in the Lopez Declaration are not amenable to the necessary social distancing and hygiene measures that would be necessary to contain or minimize spread of the virus.

34. In particular, the fact that persons detained in those facilities share dorms, cells, living spaces, and bathroom space that is not disinfected between each use, and regularly interact with each other in narrow hallways and other areas where maintaining distance is not possible makes it all but inevitable that the virus would spread rapidly within the facility.

35. Because routine testing is not being undertaken at the facility, it is impossible to tell how many asymptomatic carriers of the disease may already be at the facility or to screen for new instances of the virus before an individual with COVID-19 becomes symptomatic. Since testing is not widely available, it is highly unlikely that the facility would even be able to keep up with the need to test individuals exhibiting symptoms for the virus. Rapid spread of the virus within the facility is therefore extremely likely.

36. The fact that medical units are shared spaces exacerbates this problem, as there appears to be no way to isolate individuals infected with the virus when this becomes necessary. The fact that there is only a small amount of space available in the medical unit makes it highly

unlikely that the facility could accommodate expanded need for services as a result of a coronavirus outbreak.

37. Moreover, the absence of 24-hour onsite medical facilities, the minimal and part-time nature of medical staffing, and that detainees appear to have had difficulties accessing routine medical care in the past renders it highly unlikely that the facility would be able to provide appropriate screening or treatment should that become necessary.

38. Based on the description of the facilities I have reviewed, it is my professional opinion that an outbreak is highly likely and that the consequences of rampant COVID-19 infection in the facility would be disastrous, especially for high-risk individuals like the plaintiffs in this case.

V. Specific Cases.

39. The two plaintiffs in this lawsuit present with personal health characteristics that put them at high risk for complications from COVID-19 should they be exposed to the virus in detention.

40. Mr. Coreas, who suffers from Diabetes is also at a higher risk for complications due to this chronic medical condition. According to the CDC and the American Diabetes Association, those with diabetes are at a higher risk for COVID-19 complications, but also to deadly conditions resulting from the viral infection itself overwhelming the body, such as DKA – or diabetic ketoacidosis.

41. Mr. Cedillo suffers from hypertension. Early research has shown that those with a diagnosis of hypertension have worse symptoms and are more likely to die from COVID-19.

VI. Conclusion and Recommendations

42. For the reasons above, it is my professional judgment that the plaintiffs, currently in ICE's immigration detention centers, are at a significantly higher risk of infection with Coronavirus as compared to the population in the community, and that they are at a significantly higher risk of complications and poor outcomes if they do become infected. These outcomes include severe illness (including respiratory, cardiac and kidney failure) and even death.

43. Given that the only viable public health strategy available in the United States currently is risk mitigation, reducing the size of the population in detention centers, jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large. Not doing so is not only inadvisable but also reckless given the public health realities we now face in the United States.

44. Even with the best-laid plans to address the spread of Coronavirus in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my professional opinion, the only viable public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of an effective vaccine for prevention or effective treatment for the disease at this stage. My professional opinion is consistent with the view of the medical profession as a whole that there are no conditions of confinement in carceral settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic.

45. Immediate release is crucial for the above-mentioned individuals.

46. Releasing people from incarceration is the best and safest way to prevent the spread of disease and reduce the threat to the most vulnerable incarcerated people. It is my professional opinion that this step is both necessary and urgent. The window of opportunity is rapidly narrowing

for mitigation of COVID-19 in these facilities. It is a matter of days, not weeks. Once a case of Coronavirus is identified in a facility, it will likely be too late to prevent a widespread outbreak.

47. Release of the most vulnerable people also reduces the burden on these facilities' limited health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.

48. Release of the most vulnerable people – such as the plaintiffs in this case -- also reduces the burden on regional hospitals and health centers, which will otherwise bear the brunt of having to treat these individuals when infected, thus reducing the number of hospital beds and equipment available for the general population.

VII. Expert Disclosures

49. None.

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

Executed this 24th day of March, 2020 in Washington, D.C.

Ranit Mishori, M.D, MHS, FAAFP

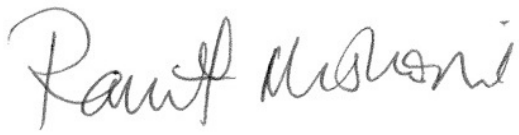

Exhibit 10

Declaration of Robert B. Greifinger, MD

I, Robert B. Greifinger, declare as follows:

1. I am a physician who has worked in health care for prisoners for more than 30 years. I have managed the medical care for inmates in the custody of New York City (Rikers Island) and the New York State prison system. I have authored more than 80 scholarly publications, many of which are about public health and communicable disease. I am the editor of *Public Health Behind Bars: from Prisons to Communities,* a book published by Springer (a second edition is due to be published in early 2021); and co-author of a scholarly paper on outbreak control in correctional facilities.[1]

2. I have been an independent consultant on prison and jail health care since 1995. My clients have included the U.S. Department of Justice, Division of Civil Rights (for 23 years) and the U.S. Department of Homeland Security, Section for Civil Rights and Civil Liberties (for six years). I am familiar with immigration detention centers, having toured and evaluated the medical care in approximately 20 immigration detention centers, out of the several hundred correctional facilities I have visited during my career. I currently monitor the medical care in three large county jails for Federal Courts. My resume is attached as Exhibit A.

3. COVID-19 is a coronavirus disease that has reached pandemic status. As of today, according to the World Health Organization, more than 132,000 people have been diagnosed with COVID-19 around the world and 4,947 have died.[2] In the United States, about 1,700 people have been diagnosed and 41 people have died thus far.[3] These numbers are likely an underestimate, due to the lack of availability of testing.

4. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death in older patients and patients with chronic underlying conditions. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The only way to mitigate COVID-19 is to use scrupulous hand hygiene and social distancing.

5. People in the high-risk category for COVID-19, i.e., the elderly or those with underlying disease, are likely to suffer serious illness and death. According to preliminary data from China, 20% of people in high risk categories who contract COVID-19 have died.

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[1] Parvez FM, Lobato MN, Greifinger RB. Tuberculosis Control: Lessons for Outbreak Preparedness in Correctional Facilities. Journal of Correctional Health Care OnlineFirst, published on May 12, 2010 as doi:10.1177/1078345810367593.

[2] See https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd, accessed March 13, 2020.

[3] See https://www nytimes.com/interactive/2020/us/coronavirus-us-cases html?searchResultPosition=1, accessed March 13, 2020.

6. Those who do not die have prolonged serious illness, for the most part requiring expensive hospital care, including ventilators that will likely be in very short supply.

7. The Centers for Disease Control and Prevention (CDC) has identified underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

8. Social distancing and hand hygiene are the only known ways to prevent the rapid spread of COVID-19. For that reason, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. At least one nursing home in the Seattle area has had cases of COVID-19 and has been quarantined.

9. The Seattle metropolitan area, hit hard by COVID, is the epicenter of the largest national outbreak at this time. Therefore, it is highly likely, and perhaps inevitable, that COVID-19 will reach the immigration detention facility in Tacoma, Washington. Immigration courts and the ICE field office in Seattle have already closed this month due to staff exposure to COVID-19.

10. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

11. Immigration detention facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. People live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

12. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals.

13. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of high-risk individuals is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks

to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

14. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released.

15. This release cohort can be separated into two groups. Group 1 could be released to home quarantine for 14 days, assuming they can be picked up from NWDC by their families or sponsors. Group 2 comprises those who cannot be easily transported to their homes by their families or sponsors. Group 2 could be released to a housing venue for 14 days, determined in concert with the Pierce County or Washington State Department of Health.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this *14th* day in March, 2020 in New York City, New York.

Robert B. Greifinger, M.D.

Exhibit 11

Executive Order 2020-29 (COVID-19)

EXECUTIVE ORDER

No. 2020-29

Temporary COVID-19 protocols for entry into Michigan Department of Corrections facilities and transfers to and from Department custody;

temporary recommended COVID-19 protocols and enhanced early-release authorization for county jails, local lockups, and juvenile detention centers

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.

The Emergency Management Act vests the governor with broad powers and duties to "cop[e] with dangers to this state or the people of this state presented by a disaster or emergency," which the governor may implement through "executive orders, proclamations, and directives having the force and effect of law." MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, "the governor may promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control." MCL 10.31(1).

To mitigate the spread of COVID-19, protect the public health, and provide essential protections to vulnerable Michiganders who work at or are incarcerated in prisons, county jails, local lockups, and juvenile detention centers across the state, it is reasonable and necessary to implement limited and temporary COVID-19-related protocols and procedures regarding entry into facilities operated by the Michigan Department of Corrections and transfers to and from the Department's custody; to recommend limited and temporary COVID-19-related protocols and measures for county jails, local lockups, and juvenile detention centers; and to temporarily suspend certain rules and procedures to facilitate the implementation of those recommendations.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. The Michigan Department of Corrections (the "Department") must continue to implement risk reduction protocols to address COVID-19 ("risk reduction protocols"), which the Department has already developed and implemented at the facilities it operates and which include the following:

a. Screening all persons arriving at or departing from a facility, including staff, incarcerated persons, vendors, and any other person entering the facility, in a manner consistent with guidelines issued by the Centers for Disease Control and Prevention ("CDC"). Such screening includes a temperature reading and obtaining information about travel and any contact with persons under investigation for COVID-19 infection.

b. Restricting all visits, except for attorney-related visits, and conducting those visits without physical contact to the extent feasible.

c. Limiting off-site appointments for incarcerated persons to only appointments for urgent or emergency medical treatment.

d. Developing and implementing protocols for incarcerated persons who display symptoms of COVID-19, including methods for evaluation and processes for testing, notification of the Department of Health and Human Services ("DHHS"), and isolation during testing,

while awaiting test results, and in the event of positive test results. These protocols should be developed in consultation with local public health departments.

e. Notifying DHHS of any suspected case that meets the criteria for COVID-19 through communication with the applicable local public health department.

f. Providing, to the fullest extent possible, appropriate personal protective equipment to all staff as recommended by the CDC.

g. Conducting stringent cleaning of all areas and surfaces, including frequently touched surfaces (such as doorknobs, handles, light switches, keyboards, etc.), on a regular and ongoing basis.

h. Ensuring access to personal hygiene products for incarcerated persons and correctional staff, including soap and water sufficient for regular handwashing.

i. Ensuring that protective laundering protocols are in place.

j. Posting signage and continually educating on the importance of social distancing, handwashing, and personal hygiene.

k. Practicing social distancing in all programs and classrooms—meaning a distance of at least six feet between people in any meeting, classroom, or other group.

- Minimizing crowding, including interactions of groups of 10 or more people, which may include scheduling more times for meal and recreation to reduce person-to-person contact.

2. To mitigate the risk of COVID-19 spreading in county jails, strict compliance with the capacity and procedural requirements regarding county jail overcrowding states of emergency in the County Jail Overcrowding Act ("CJOA"), 1982 PA 325, MCL 801.51 et seq.,

is temporarily suspended. While this order is in effect, all actions that would be authorized under the CJOA in the event of a declaration of a county jail overcrowding state of emergency are authorized and shall remain authorized without regard to any reduction in jail population or any other such limitations on the duration of authorization imposed by the CJOA.

3. Anyone authorized to act under section 2 of this order is strongly encouraged to consider early release for all of the following, so long as they do not pose a public safety risk:

a. Older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, and people nearing their release date.

b. Anyone who is incarcerated for a traffic violation.

c. Anyone who is incarcerated for failure to appear or failure to pay.

d. Anyone with behavioral health problems who can safely be diverted for treatment.

4. Effective immediately, all transfers into the Department's custody are temporarily suspended. Beginning seven (7) days from the effective date of this order, and no more than once every seven (7) days, a county jail or local lockup may request that the director of the Department determine that the jail or lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order. Upon inspection, if the director of the Department determines that a county jail or local lockup has satisfactorily implemented risk reduction protocols, transfers from that jail or lockup will resume in accordance with the Department's risk reduction protocols. The director of the Department may reject transfers that do not pass the screening protocol for entry into a facility operated by the Department.

5. Parole violators in the Department's custody must not be transported to or lodged in a county jail or local lockup unless the director of the Department has determined that such county jail or local lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order.

6. The State Budget Office must immediately seek a legislative transfer so that counties may be reimbursed for lodging incarcerated persons that would have been transferred into the Department's custody if not for the suspension of transfers described in section 4 of this order.

7. Juvenile detention centers are strongly encouraged to reduce the risk that those at their facilities will be exposed to COVID-19 by implementing as feasible the following measures:

a. Removing from the general population any juveniles who have COVID-19 symptoms.

b. Eliminating any form of juvenile detention or residential facility placement for juveniles unless a determination is made that a juvenile is a substantial and immediate safety risk to others.

c. Providing written and verbal communications to all juveniles at such facilities regarding COVID-19, access to medical care, and community-based support.

d. To the extent feasible, facilitating access to family, education, and legal counsel through electronic means (such as telephone calls or video conferencing) at no cost, rather than through in-person meetings.

8. Unless otherwise directed by court order, for juveniles on court-ordered probation, the use of out-of-home confinement for technical violations of probation and any requirements for in-person meetings with probation officers are temporarily suspended.

9. This order is effective immediately and continues through April 26, 2020 at 11:59 pm.

Given under my hand and the Great Seal of the State of Michigan.

Exhibit 12

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Fax 313.965.0372
www.sado.org

March 31, 2020 Sent via email

Re: Reducing Your Jail Population Pursuant to Executive Order 2020-29

Dear Chief Judge:

The ACLU of Michigan ("ACLU") and the State Appellate Defender Office ("SADO") appreciate the efforts that many courts and law enforcement officials around the state have already taken to try to reduce jail populations in order to mitigate the probability of a disastrous COVID-19 outbreak in our jails and to reduce the impact when one inevitably occurs despite everyone's best efforts. On March 29, 2020, Governor Whitmer signed Executive Order 2020-29, attached here for your convenience. The Order underscores the life-or-death threat that the COVID-19 pandemic poses to people incarcerated in county jails throughout Michigan, as well as to jail staff and the community at large. The Order suspends the capacity and procedural requirements of Michigan's County Jail Overcrowding Act ("JOA"), thus empowering sheriffs and courts to swiftly but safely take bold and urgent steps to dramatically reduce jail populations to alleviate these risks.

We write to highlight the specific measures that sheriffs and courts can now take to further reduce jail populations under the JOA, as modified by EO 2020-29, while maintaining public safety. We note that Chief Justice Bridget McCormack and Sheriff Matt Saxton of the Michigan Sheriffs' Association recently issued a press release urging courts and sheriffs to take similar measures, emphasizing that "[f]ollowing this advice WILL SAVE LIVES." The ACLU and SADO agree.

It is important to note that all of the powers conferred by the JOA allow courts and sheriffs to act promptly and efficiently without conducting separate hearings in each individual case. And, as expressly authorized by EO 2020-29, you may immediately implement any or all of the JOA's population reduction measures without regard to the capacity, procedural, and waiting-period requirements that strict compliance with the statute would otherwise entail. Accordingly, the following critical measures can now be taken immediately by judges and sheriffs working together—and as a matter of public health, *must* be taken without any delay—in order to reduce the risks of fatal COVID-19 outbreaks in our jails:

- Release of pre-trial detainees. The JOA permits the chief district judge, chief circuit judge, the sheriff (and in some jurisdictions a few additional judges) to vote to establish a "maximum value" for convertible cash bonds. The sheriff is then authorized to convert the bond of any person in jail because of inability to pay a bond up to the "maximum value" into a personal bond and to release that individual upon approval from the chief circuit judge. MCL 801.51a(1)(a), (2). Courts and sheriffs should immediately use this

power by establishing high "maximum values." Then sheriffs should promptly provide lists of individuals who qualify for release because of their bond amount, and chief circuit judges should promptly and summarily approve such lists.

The JOA also provides ways to promptly and safely release most individuals whose cash bail exceeds the "maximum value." The JOA allows chief judges to modify bond to facilitate the release of any pre-trial detainee, except for individuals accused of crimes against their romantic partner or children, who does not pose "a high risk to public safety." MCL 801.56(2)(b), (3), (4)(b). Sheriffs should promptly provide lists of all individuals who are still in jail in a format that complies with MCL 801.56(2)(b). Chief judges should then make determinations about whether to modify bond as rapidly as possible and in recognition that an individual accused of a crime should not be presumed guilty and should not be presumed to be likely to re-offend in the absence of extraordinary facts suggesting a recurring pattern of violent activity.

- Release of prisoners who have served 85% of their sentence. The JOA permits sheriffs to release people who were convicted of most crimes immediately if they have already served 85% or more of their sentence, unless the chief circuit judge concludes that immediate release will present a threat to public safety. MCL 801.51a(1)(b). This option exists for all criminal convictions except "assaultive offense, sex offense, prison or jail escape offense, weapons offense, drunk driving offense, or a controlled substance offense except possession of less than 25 grams of a controlled substance." Accordingly, sheriffs should immediately provide lists of eligible individuals who have served 85% of their sentence to chief circuit judges. Chief circuit judges should promptly order the release of all such people absent persuasive evidence that the individuals will be a danger to the public, evidence of which should be very rare given the offenses that are eligible for release.

- Reduction of sentences for other prisoners. The JOA provides three ways to reduce the sentences of people housed in county jails. First, section 56 states that sheriffs should provide a list of all individuals currently serving sentences in the jails to the chief circuit judges. MCL 800.56(2)(a). Chief circuit judges must then classify the list into two categories: individuals who present a "high risk to public safety" if released and those who do not. The chief judge can then set a minimum and maximum percentage amount by which sentences of the non-high risk individuals may be reduced, and the sheriff may immediately reduce the sentences of all such people by any amount within the range set by the chief judge. MCL 801.56(4)(a).

  Second, sheriffs can *unilaterally* reduce the sentences of all people in a county jail by up to 30% without approval from a circuit judge. MCL 801.57.

  Third, any sentencing judge "may suspend or reduce any validly imposed jail sentence imposed by that judge." MCL 800.59b(1). Judges can delegate these powers to their chief judge. All judges should be encouraged to exercise this power (or delegate it to their chief judges) to reduce or suspend sentences of all people who do not pose an immediate high risk to public safety. In particular, judges should suspend sentences in

situations where the defendant has not yet begun to serve their sentence, so as to avoid introducing new individuals and risks into the carceral environment.

- Refuse to detain new people in the jails. The JOA authorizes sheriffs to defer admitting new detainees to the jail except for individuals convicted of certain, more serious, crimes, until the crisis has abated. Specifically, sheriffs may decline to admit new individuals to their jails unless such individuals have been convicted of "violent or assaultive crimes, sex offenses, escape from prison or jail, drunk driving offenses, controlled substance offenses except possession of less than 25 grams of a controlled substance, or weapons offenses." MCL 801.58(1). Sheriffs are now able to exercise these powers to refuse to admit all new pre-trial detainees, people convicted of most offenses, as well as anyone charged with technical probation violations or failure to appear, unless the chief circuit judge affirmatively determines that detention is necessary because of a "threat to public safety." Significantly, sheriffs can decline to admit new detainees under this section without first obtaining approval from the circuit court.

- Review and termination of agreements to house other detainees, especially ICE detainees. Section 55(f) of the JOA allows sheriffs to review agreements to house detainees from other governmental actors and authorizes termination of such arrangements. MCL 801.55(f). This allows sheriffs to revisit contracts to hold federal detainees, including ICE detainees. In our experience, most such contracts allow for immediate termination in the event of an "emergency." Accordingly, sheriffs should consider immediately terminating such contracts and releasing ICE detainees as an efficient way to significantly reduce jail populations without imperiling public safety.[1]

  In addition, local jails should not hold people on detainers for Immigrations and Customs Enforcement (ICE), which are not judicially issued warrants, but are merely requests to hold individuals for ICE. See *Lopez-Lopez v. County of Allegan*, 321 F Supp 3d 794, 799 (WD Mich., 2018) ("[C]ooperation with ICE detainers is discretionary rather than mandatory").

In addition to the specific powers enumerated above, the JOA includes several other measures that courts and jails have at their disposal to reduce jail populations. For example, MCL 801.55(a)–(q) sets forth a panoply of alternatives to incarceration that can be utilized. A full copy of the relevant provisions of the JOA are attached to this letter for your convenience.

EO 2020-29 also offers additional categories of people for special consideration of release. These include older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, people nearing their release date, people incarcerated for traffic violations or for failure to appear or failure to pay, and people with behavioral health problems who can safely be diverted for treatment.

[1] The standard Intergovernmental Service Agreement (IGSA) between county jails and ICE specifically provides that you can bring medically vulnerable individuals to ICE's attention for release within 48 hours, and that limitations on releasing ICE detainees do not apply in "medical or emergency situations."

Finally, EO 2020-29 complements the tools already in place to reduce jail populations. MCL 771.2(5) provides for modification of probation, where jail is a condition of the probation, and MCL 801.257 permits reductions of jail sentences by one quarter.

SADO and the ACLU of Michigan appreciate that sheriffs and courts have already been working around the clock in many jurisdictions to improve public safety. EO 2020-29 provides a powerful new tool to accelerate those efforts, and rapidly deploying these new powers is urgent to protect both people in jails, and jail staff and their loved ones, as well as the health of the public at large. Our organizations would be eager to speak with you about ways to facilitate the swift and safe release of people in jails pursuant to the Governor's order. Thank you for your consideration of these matters in a challenging time.

Sincerely,

Dan Korobkin, Legal Director
Phil Mayor, Senior Staff Attorney
ACLU of Michigan
dkorobkin@aclumich.org
pmayor@aclumich.org

Jonathan Sacks, Director
State Appellate Defender Office
JSacks@sado.org

Cc: Chief Justice Bridget Mary McCormack (via email)
Matt Saxton, Executive Director, Michigan Sheriffs' Association

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

GRETCHEN WHITMER
GOVERNOR

GARLIN GILCHRIST II
LT. GOVERNOR

EXECUTIVE ORDER

No. 2020-29

Temporary COVID-19 protocols for entry into Michigan Department of Corrections facilities and transfers to and from Department custody; temporary recommended COVID-19 protocols and enhanced early-release authorization for county jails, local lockups, and juvenile detention centers

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.

The Emergency Management Act vests the governor with broad powers and duties to "cop[e] with dangers to this state or the people of this state presented by a disaster or emergency," which the governor may implement through "executive orders, proclamations, and directives having the force and effect of law." MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, "the governor may promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control." MCL 10.31(1).

To mitigate the spread of COVID-19, protect the public health, and provide essential protections to vulnerable Michiganders who work at or are incarcerated in prisons, county jails, local lockups, and juvenile detention centers across the state, it is reasonable and necessary to implement limited and temporary COVID-19-related protocols and procedures regarding entry into facilities operated by the Michigan Department of Corrections and transfers to and from the Department's custody; to recommend limited and temporary COVID-19-related protocols and measures for county jails, local lockups, and juvenile detention centers; and to temporarily suspend certain rules and procedures to facilitate the implementation of those recommendations.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. The Michigan Department of Corrections (the "Department") must continue to implement risk reduction protocols to address COVID-19 ("risk reduction protocols"), which the Department has already developed and implemented at the facilities it operates and which include the following:

   (a) Screening all persons arriving at or departing from a facility, including staff, incarcerated persons, vendors, and any other person entering the facility, in a manner consistent with guidelines issued by the Centers for Disease Control and Prevention ("CDC"). Such screening includes a temperature reading and obtaining information about travel and any contact with persons under investigation for COVID-19 infection.

   (b) Restricting all visits, except for attorney-related visits, and conducting those visits without physical contact to the extent feasible.

   (c) Limiting off-site appointments for incarcerated persons to only appointments for urgent or emergency medical treatment.

   (d) Developing and implementing protocols for incarcerated persons who display symptoms of COVID-19, including methods for evaluation and processes for testing, notification of the Department of Health and Human Services ("DHHS"), and isolation during testing, while awaiting test results, and in the event of positive test results. These protocols should be developed in consultation with local public health departments.

   (e) Notifying DHHS of any suspected case that meets the criteria for COVID-19 through communication with the applicable local public health department.

   (f) Providing, to the fullest extent possible, appropriate personal protective equipment to all staff as recommended by the CDC.

   (g) Conducting stringent cleaning of all areas and surfaces, including frequently touched surfaces (such as doorknobs, handles, light switches, keyboards, etc.), on a regular and ongoing basis.

   (h) Ensuring access to personal hygiene products for incarcerated persons and correctional staff, including soap and water sufficient for regular handwashing.

   (i) Ensuring that protective laundering protocols are in place.

   (j) Posting signage and continually educating on the importance of social distancing, handwashing, and personal hygiene.

   (k) Practicing social distancing in all programs and classrooms—meaning a distance of at least six feet between people in any meeting, classroom, or other group.

(l) Minimizing crowding, including interactions of groups of 10 or more people, which may include scheduling more times for meal and recreation to reduce person-to-person contact.

2. To mitigate the risk of COVID-19 spreading in county jails, strict compliance with the capacity and procedural requirements regarding county jail overcrowding states of emergency in the County Jail Overcrowding Act ("CJOA"), 1982 PA 325, MCL 801.51 et seq., is temporarily suspended. While this order is in effect, all actions that would be authorized under the CJOA in the event of a declaration of a county jail overcrowding state of emergency are authorized and shall remain authorized without regard to any reduction in jail population or any other such limitations on the duration of authorization imposed by the CJOA.

3. Anyone authorized to act under section 2 of this order is strongly encouraged to consider early release for all of the following, so long as they do not pose a public safety risk:

   (a) Older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, and people nearing their release date.

   (b) Anyone who is incarcerated for a traffic violation.

   (c) Anyone who is incarcerated for failure to appear or failure to pay.

   (d) Anyone with behavioral health problems who can safely be diverted for treatment.

4. Effective immediately, all transfers into the Department's custody are temporarily suspended. Beginning seven (7) days from the effective date of this order, and no more than once every seven (7) days, a county jail or local lockup may request that the director of the Department determine that the jail or lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order. Upon inspection, if the director of the Department determines that a county jail or local lockup has satisfactorily implemented risk reduction protocols, transfers from that jail or lockup will resume in accordance with the Department's risk reduction protocols. The director of the Department may reject transfers that do not pass the screening protocol for entry into a facility operated by the Department.

5. Parole violators in the Department's custody must not be transported to or lodged in a county jail or local lockup unless the director of the Department has determined that such county jail or local lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order.

6. The State Budget Office must immediately seek a legislative transfer so that counties may be reimbursed for lodging incarcerated persons that would have been transferred into the Department's custody if not for the suspension of transfers described in section 4 of this order.

7. Juvenile detention centers are strongly encouraged to reduce the risk that those at their facilities will be exposed to COVID-19 by implementing as feasible the following measures:

   (a) Removing from the general population any juveniles who have COVID-19 symptoms.

   (b) Eliminating any form of juvenile detention or residential facility placement for juveniles unless a determination is made that a juvenile is a substantial and immediate safety risk to others.

   (c) Providing written and verbal communications to all juveniles at such facilities regarding COVID-19, access to medical care, and community-based support.

   (d) To the extent feasible, facilitating access to family, education, and legal counsel through electronic means (such as telephone calls or video conferencing) at no cost, rather than through in-person meetings.

8. Unless otherwise directed by court order, for juveniles on court-ordered probation, the use of out-of-home confinement for technical violations of probation and any requirements for in-person meetings with probation officers are temporarily suspended.

9. This order is effective immediately and continues through April 26, 2020 at 11:59 pm.

Given under my hand and the Great Seal of the State of Michigan.

Date: March 29, 2020

Time: 7:23 pm

GRETCHEN WHITMER
GOVERNOR

By the Governor:

SECRETARY OF STATE

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.51a County jail population exceeding 95% of jail's rated design capacity; actions by county sheriff; maximum value of outstanding bonds; duration; applicability of subsections (1) to (3).

Sec. 1a. (1) In a county other than a county described in subsection (4), the sheriff of that county shall take the following actions on the fifth consecutive day on which the general population of the county jail exceeds 95% of the jail's rated design capacity:

(a) The sheriff shall review the outstanding bonds for each prisoner. If the total of a prisoner's outstanding bonds does not exceed a maximum value determined as provided in subsection (2), the sheriff, subject to the approval of the chief circuit judge in that county, shall modify each outstanding bond for that prisoner to a personal recognizance bond in that same amount, issue to the prisoner a receipt similar to an interim bond receipt, and send a copy of the receipt to the court that set the bond.

(b) The following prisoners, except for any prisoner that the chief circuit judge in that county believes would present a threat to the public safety if released, shall be released immediately:

(*i*) Any sentenced prisoner who has served 85% or more of his or her sentence, unless he or she is serving a sentence for a violent or assaultive offense, sex offense, prison or jail escape offense, weapons offense, drunk driving offense, or a controlled substance offense except possession of less than 25 grams of a controlled substance.

(*ii*) Any prisoner detained in the county jail for a civil contempt adjudication for failure to pay child support who has no other charges pending against him or her.

(2) The maximum value of outstanding bonds, for purposes of subsection (1)(a), shall be determined by a majority vote of the following individuals, as applicable:

(a) In a single-county or multicounty judicial district, the chief circuit judge for the judicial circuit that includes that county, the chief district judge for that district, and the sheriff of the county.

(b) In a county containing 2 or more judicial districts, the chief circuit judge for the judicial circuit that includes that county, the chief probate judge for that county, the sheriff of the county, and 2 district judges chosen by the chief district judges sitting in that county.

(3) A determination made under subsection (2) remains in effect for 1 year after the date on which that determination was made.

(4) Subsections (1) to (3) do not apply to either of the following:

(a) A county for which a county jail management plan has been approved under section 9a.

(b) A county having a population greater than 650,000 as of the most recent federal decennial census that, on the effective date of this section, has implemented a written jail management plan in which the basis of the plan is jail bed allocation. The exception provided by this subsection applies only as long as that plan remains in effect.

History: Add. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.55 Reduction of prisoner population by sheriff, notified persons, and other judges; means.

Sec. 5. The sheriff, the persons notified pursuant to section 4, and other circuit, district, and municipal judges may attempt to reduce the prisoner population of the county jail through any available means which are already within the scope of their individual and collective legal authority, including, but not limited to, the following:

(a) Accelerated review and rescheduling of court dates.

(b) Judicial review of bail for possible bail reduction, release on recognizance, or conditional release of prisoners in the county jail.

(c) Prosecutorial pre-trial diversion.

(d) Judicial use of probation, fines, community service orders, restitution, and delayed sentencing as alternatives to commitment to jail.

(e) Use of work-release, community programs, and other alternative housing arrangements by the sheriff, if the programs and alternative housing arrangements are authorized by law.

(f) Review of agreements which allow other units of government to house their prisoners in the overcrowded county jail to determine whether the agreements may be terminated.

(g) Entering into agreements which allow the sheriff for the county in which the overcrowded county jail is located to house prisoners in facilities operated by other units of government.

(h) Refusal by the sheriff to house persons who are not required by law to be housed in the county jail.

(i) Acceleration of the transfer of prisoners sentenced to the state prison system, and prisoners otherwise under the jurisdiction of the department of corrections, to the department of corrections.

(j) Judicial acceleration of pending court proceedings for prisoners under the jurisdiction of the department of corrections who will be returned to the department of corrections regardless of the outcome of the pending proceedings.

(k) Reduction of waiting time for prisoners awaiting examination by the center for forensic psychiatry.

(*l*) Alternative booking, processing, and housing arrangements, including the use of appearance tickets instead of booking at the county jail and the use of weekend arraignment, for categories of cases considered appropriate by the persons notified pursuant to section 4.

(m) Acceptance by the courts of credit cards for payments of bonds, fines, and court costs.

(n) Use of community mental health and private mental health resources in the county as alternatives to housing prisoners in the county jail for those prisoners who qualify for placement in the programs and for whom placement in the programs is appropriate.

(o) Use of community and private substance abuse programs and other therapeutic programs as alternatives to housing prisoners in the county jail for those prisoners who qualify for placement in the programs and for whom placement in the programs is appropriate.

(p) Preparation of a long-range plan for addressing the county jail overcrowding problem, including recommendations to the county board of commissioners on construction of new jail facilities and funding for construction or other options designed to alleviate the overcrowding problem.

(q) Review of sentencing procedures, including the elimination of delays in preparing presentence reports for prisoners awaiting sentence, and staggering the dates on which prisoners will start serving a jail sentence to minimize fluctuating demands on jail capacity.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.56 Requirement of further actions; failure of certain actions to reduce population to level prescribed in subsection (1); presenting prisoner information to chief circuit judge; applicability of subsection (2)(b) to certain prisoners; review; classification of prisoners; reduction of sentences; duration; report.

Sec. 6. (1) The further actions prescribed in subsections (2) to (5) and in sections 7 and 8 shall be required unless the actions taken pursuant to section 5 reduce the county's jail population to the higher of the following:

(a) 90% of rated design capacity or a percentage of rated design capacity less than 90% as set by a court prior to February 8, 1983.

(b) A prisoner population such that the jail has the following number of empty beds:

(*i*) For a jail with a rated design capacity of less than 500 beds, at least 10 empty beds.

(*ii*) For a jail with a rated design capacity of 500 beds or more, at least 25 empty beds.

(2) If the actions taken pursuant to section 5 do not reduce the county jail's population to the level prescribed in subsection (1) within 14 days after the declaration of the county jail overcrowding state of emergency, the sheriff shall present to the chief circuit judge for the county in which the jail is located the following information for each prisoner housed in the county jail on that date:

(a) For prisoners who are serving a sentence of imprisonment for conviction of 1 or more crimes:

(*i*) The name of each prisoner.

(*ii*) The offense for which the prisoner was convicted.

(*iii*) The length of sentence imposed for the prisoner.

(*iv*) The date on which the prisoner began serving his or her sentence.

(*v*) The date on which the prisoner will be released from the jail according to the terms of his or her sentence, including computations for good time.

(*vi*) The name of the judge who imposed the sentence.

(b) For prisoners housed in the county jail, other than a prisoner described in subsection (3), who are not serving a sentence of imprisonment for conviction of a crime:

(*i*) The name of the prisoner.

(*ii*) The offense for which the prisoner is being detained in the county jail.

(*iii*) The amount of the prisoner's bond.

(*iv*) The date on which the prisoner began his or her period of detention.

(*v*) The name of the judge who ordered the prisoner to be detained.

(3) Subsection (2)(b) does not apply to a prisoner who is detained in the county jail in connection with a crime or an allegation of a crime in which the victim was a spouse, a former spouse, an individual with whom he or she has had a child in common, an individual residing or having resided in the same household, or an individual with whom he or she has or has had a dating relationship as that term is defined in section 2950 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2950.

(4) After the chief circuit judge for the county in which the jail is located reviews the information presented by the sheriff pursuant to subsection (2), the chief circuit judge shall, for purposes of county jail population reduction, do both of the following:

(a) Classify prisoners who are serving sentences of imprisonment for conviction of crimes into 2 groups: those prisoners who, if released, would present a high risk to the public safety, and those who, if released, would not present a high risk to the public safety. The chief circuit judge shall also determine a minimum and a maximum percentage by which the sentences can be reduced. The sheriff shall reduce the sentences of all prisoners who, if released, would not present a high risk to the public safety by an equal percentage which is within the minimum and maximum percentages determined by the chief circuit judge.

(b) Review the list of prisoners housed in the county jail who are not serving a sentence for conviction of crimes and determine for each prisoner whether the release of that prisoner would or would not present a high risk to public safety. The chief circuit judge may do either or both of the following with regard to a prisoner whose release would not present a high risk to the public safety:

(*i*) Modify the bond of the prisoner, subject to any conditions reasonably necessary to ensure the appearance of the individual in court.

(*ii*) Release the prisoner subject to the condition that he or she be placed on electronic monitoring.

(5) The sentences of prisoners sentenced to and housed in the county jail after the fourteenth day of the county jail overcrowding state of emergency may continue to be reduced in the same manner as prescribed in subsections (2)(a) and (4)(a), but shall not be reduced after the county jail overcrowding state of emergency is

ended or after the sheriff orders a sentence reduction pursuant to section 7, whichever occurs first.

(6) The department of corrections, in cooperation with the Michigan sheriffs' association, shall annually report to the chairpersons of the senate and house standing committees responsible for legislation concerning corrections. The report shall evaluate the effect on the overcrowding state of emergency procedures under this section.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988;—Am. 2008, Act 542, Imd. Eff. Jan. 13, 2009.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.57 Failure of certain actions to reduce population to level prescribed in MCL 801.56(1); equal reduction of original sentences.

Sec. 7. If the actions taken pursuant to sections 5 and 6 do not reduce the county jail's population to the level prescribed in section 6(1) within 28 days of the declaration of the county jail overcrowding state of emergency, the original sentences, not including good time, of all prisoners sentenced to and housed in the county jail on that date shall be equally reduced by the sheriff by the least possible percentage reduction necessary, not to exceed 30%, to reduce the county jail's prisoner population to the level prescribed in section 6(1).

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.58 Failure of certain actions to reduce population to level prescribed in MCL 801.56(1); deferring acceptance for incarceration of certain persons.

Sec. 8. (1) Except as otherwise provided in this subsection and subsection (2), if the actions taken pursuant to sections 5, 6, and 7 do not reduce the county jail's population to the level prescribed in section 6(1) within 42 days of the declaration of the county jail overcrowding state of emergency, the sheriff shall defer acceptance for incarceration in the general population of the county jail persons sentenced to or otherwise committed to the county jail for incarceration until the county jail overcrowding state of emergency is ended pursuant to section 9, except that the sheriff shall not defer acceptance for incarceration all persons under sentence for or charged with violent or assaultive crimes, sex offenses, escape from prison or jail, drunk driving offenses, controlled substance offenses except possession of less than 25 grams of a controlled substance, or weapons offenses.

(2) The sheriff shall not defer acceptance of a prisoner for incarceration into the general population of the county jail if both of the following occur:

(a) The sheriff or the sentencing judge presents to the chief circuit judge for the county in which the county jail is located information alleging that deferring acceptance of the prisoner for incarceration would constitute a threat to public safety.

(b) The chief circuit judge, based upon the presence of a threat to public safety, approves of accepting the prisoner for incarceration.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988;—Am. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.59b Suspension or reduction of jail sentence by sentencing judge; delegation of authority to chief judge; modification of bond.

Sec. 9b. (1) For purposes of this act, a sentencing judge may suspend or reduce any validly imposed jail sentence imposed by that judge. A sentencing judge may delegate the authority conferred under this subsection to the chief judge of the judicial district or circuit in which the sentencing judge serves or his or her designee.

(2) For purposes of this act, a judge may modify bond set by the court for unsentenced prisoners. A judge may delegate the authority conferred under this subsection to the chief judge of the judicial district or circuit in which the judge serves, or his or her designee.

History: Add. 2007, Act 139, Imd. Eff. Nov. 13, 2007.

Popular name: Jail Overcrowding Emergency Powers Act

Exhibit 13

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March 31, 2020 Sent via email

Re: Reducing Your Jail Population Pursuant to Executive Order 2020-29

Dear Sheriff:

The ACLU of Michigan ("ACLU") and the State Appellate Defender Office ("SADO") appreciate the efforts that many courts and law enforcement officials around the state have already taken to try to reduce jail populations in order to mitigate the probability of a disastrous COVID-19 outbreak in our jails and to reduce the impact when one inevitably occurs despite everyone's best efforts. On March 29, 2020, Governor Whitmer signed Executive Order 2020-29, attached here for your convenience. The Order underscores the life-or-death threat that the COVID-19 pandemic poses to people incarcerated in county jails throughout Michigan, as well as to jail staff and the community at large. The Order suspends the capacity and procedural requirements of Michigan's County Jail Overcrowding Act ("JOA"), thus empowering sheriffs and courts to swiftly but safely take bold and urgent steps to dramatically reduce jail populations to alleviate these risks.

We write to highlight the specific measures that sheriffs and courts can now take to further reduce jail populations under the JOA, as modified by EO 2020-29, while maintaining public safety. We note that Chief Justice Bridget McCormack and Sheriff Matt Saxton of the Michigan Sheriffs' Association recently issued a press release urging courts and sheriffs to take similar measures, emphasizing that "[f]ollowing this advice WILL SAVE LIVES." The ACLU and SADO agree.

It is important to note that all of the powers conferred by the JOA allow courts and sheriffs to act promptly and efficiently without conducting separate hearings in each individual case. And, as expressly authorized by EO 2020-29, you may immediately implement any or all of the JOA's population reduction measures without regard to the capacity, procedural, and waiting-period requirements that strict compliance with the statute would otherwise entail. Accordingly, the following critical measures can now be taken immediately by judges and sheriffs working together—and as a matter of public health, *must* be taken without any delay—in order to reduce the risks of fatal COVID-19 outbreaks in our jails:

- Release of pre-trial detainees. The JOA permits the chief district judge, chief circuit judge, the sheriff (and in some jurisdictions a few additional judges) to vote to establish a "maximum value" for convertible cash bonds. The sheriff is then authorized to convert the bond of any person in jail because of inability to pay a bond up to the "maximum value" into a personal bond and to release that individual upon approval from the chief circuit judge. MCL 801.51a(1)(a), (2). Courts and sheriffs should immediately use this

power by establishing high "maximum values." Then sheriffs should promptly provide lists of individuals who qualify for release because of their bond amount, and chief circuit judges should promptly and summarily approve such lists.

The JOA also provides ways to promptly and safely release most individuals whose cash bail exceeds the "maximum value." The JOA allows chief judges to modify bond to facilitate the release of any pre-trial detainee, except for individuals accused of crimes against their romantic partner or children, who does not pose "a high risk to public safety." MCL 801.56(2)(b), (3), (4)(b). Sheriffs should promptly provide lists of all individuals who are still in jail in a format that complies with MCL 801.56(2)(b). Chief judges should then make determinations about whether to modify bond as rapidly as possible and in recognition that an individual accused of a crime should not be presumed guilty and should not be presumed to be likely to re-offend in the absence of extraordinary facts suggesting a recurring pattern of violent activity.

- Release of prisoners who have served 85% of their sentence. The JOA permits sheriffs to release people who were convicted of most crimes immediately if they have already served 85% or more of their sentence, unless the chief circuit judge concludes that immediate release will present a threat to public safety. MCL 801.51a(1)(b). This option exists for all criminal convictions except "assaultive offense, sex offense, prison or jail escape offense, weapons offense, drunk driving offense, or a controlled substance offense except possession of less than 25 grams of a controlled substance." Accordingly, sheriffs should immediately provide lists of eligible individuals who have served 85% of their sentence to chief circuit judges. Chief circuit judges should promptly order the release of all such people absent persuasive evidence that the individuals will be a danger to the public, evidence of which should be very rare given the offenses that are eligible for release.

- Reduction of sentences for other prisoners. The JOA provides three ways to reduce the sentences of people housed in county jails. First, section 56 states that sheriffs should provide a list of all individuals currently serving sentences in the jails to the chief circuit judges. MCL 800.56(2)(a). Chief circuit judges must then classify the list into two categories: individuals who present a "high risk to public safety" if released and those who do not. The chief judge can then set a minimum and maximum percentage amount by which sentences of the non-high risk individuals may be reduced, and the sheriff may immediately reduce the sentences of all such people by any amount within the range set by the chief judge. MCL 801.56(4)(a).

  Second, sheriffs can *unilaterally* reduce the sentences of all people in a county jail by up to 30% without approval from a circuit judge. MCL 801.57.

  Third, any sentencing judge "may suspend or reduce any validly imposed jail sentence imposed by that judge." MCL 800.59b(1). Judges can delegate these powers to their chief judge. All judges should be encouraged to exercise this power (or delegate it to their chief judges) to reduce or suspend sentences of all people who do not pose an immediate high risk to public safety. In particular, judges should suspend sentences in

situations where the defendant has not yet begun to serve their sentence, so as to avoid introducing new individuals and risks into the carceral environment.

- Refuse to detain new people in the jails. The JOA authorizes sheriffs to defer admitting new detainees to the jail except for individuals convicted of certain, more serious, crimes, until the crisis has abated. Specifically, sheriffs may decline to admit new individuals to their jails unless such individuals have been convicted of "violent or assaultive crimes, sex offenses, escape from prison or jail, drunk driving offenses, controlled substance offenses except possession of less than 25 grams of a controlled substance, or weapons offenses." MCL 801.58(1). Sheriffs are now able to exercise these powers to refuse to admit all new pre-trial detainees, people convicted of most offenses, as well as anyone charged with technical probation violations or failure to appear, unless the chief circuit judge affirmatively determines that detention is necessary because of a "threat to public safety." Significantly, sheriffs can decline to admit new detainees under this section without first obtaining approval from the circuit court.

- Review and termination of agreements to house other detainees, especially ICE detainees. Section 55(f) of the JOA allows sheriffs to review agreements to house detainees from other governmental actors and authorizes termination of such arrangements. MCL 801.55(f). This allows sheriffs to revisit contracts to hold federal detainees, including ICE detainees. In our experience, most such contracts allow for immediate termination in the event of an "emergency." Accordingly, sheriffs should consider immediately terminating such contracts and releasing ICE detainees as an efficient way to significantly reduce jail populations without imperiling public safety.[1]

  In addition, local jails should not hold people on detainers for Immigrations and Customs Enforcement (ICE), which are not judicially issued warrants, but are merely requests to hold individuals for ICE. See *Lopez-Lopez v. County of Allegan*, 321 F Supp 3d 794, 799 (WD Mich., 2018) ("[C]ooperation with ICE detainers is discretionary rather than mandatory").

In addition to the specific powers enumerated above, the JOA includes several other measures that courts and jails have at their disposal to reduce jail populations. For example, MCL 801.55(a)–(q) sets forth a panoply of alternatives to incarceration that can be utilized. A full copy of the relevant provisions of the JOA are attached to this letter for your convenience.

EO 2020-29 also offers additional categories of people for special consideration of release. These include older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, people nearing their release date, people incarcerated for traffic violations or for failure to appear or failure to pay, and people with behavioral health problems who can safely be diverted for treatment.

[1] The standard Intergovernmental Service Agreement (IGSA) between county jails and ICE specifically provides that you can bring medically vulnerable individuals to ICE's attention for release within 48 hours, and that limitations on releasing ICE detainees do not apply in "medical or emergency situations."

Finally, EO 2020-29 complements the tools already in place to reduce jail populations. MCL 771.2(5) provides for modification of probation, where jail is a condition of the probation, and MCL 801.257 permits reductions of jail sentences by one quarter.

SADO and the ACLU of Michigan appreciate that sheriffs and courts have already been working around the clock in many jurisdictions to improve public safety. EO 2020-29 provides a powerful new tool to accelerate those efforts, and rapidly deploying these new powers is urgent to protect both people in jails, and jail staff and their loved ones, as well as the health of the public at large. Our organizations would be eager to speak with you about ways to facilitate the swift and safe release of people in jails pursuant to the Governor's order. Thank you for your consideration of these matters in a challenging time.

Sincerely,

Dan Korobkin, Legal Director
Phil Mayor, Senior Staff Attorney
ACLU of Michigan
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Jonathan Sacks, Director
State Appellate Defender Office
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Cc: Chief Justice Bridget Mary McCormack (via email)
Matt Saxton, Executive Director, Michigan Sheriffs' Association

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

GRETCHEN WHITMER
GOVERNOR

GARLIN GILCHRIST II
LT. GOVERNOR

EXECUTIVE ORDER

No. 2020-29

Temporary COVID-19 protocols for entry into Michigan Department of Corrections facilities and transfers to and from Department custody; temporary recommended COVID-19 protocols and enhanced early-release authorization for county jails, local lockups, and juvenile detention centers

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.

The Emergency Management Act vests the governor with broad powers and duties to "cop[e] with dangers to this state or the people of this state presented by a disaster or emergency," which the governor may implement through "executive orders, proclamations, and directives having the force and effect of law." MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, "the governor may promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control." MCL 10.31(1).

To mitigate the spread of COVID-19, protect the public health, and provide essential protections to vulnerable Michiganders who work at or are incarcerated in prisons, county jails, local lockups, and juvenile detention centers across the state, it is reasonable and necessary to implement limited and temporary COVID-19-related protocols and procedures regarding entry into facilities operated by the Michigan Department of Corrections and transfers to and from the Department's custody; to recommend limited and temporary COVID-19-related protocols and measures for county jails, local lockups, and juvenile detention centers; and to temporarily suspend certain rules and procedures to facilitate the implementation of those recommendations.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. The Michigan Department of Corrections (the "Department") must continue to implement risk reduction protocols to address COVID-19 ("risk reduction protocols"), which the Department has already developed and implemented at the facilities it operates and which include the following:

   (a) Screening all persons arriving at or departing from a facility, including staff, incarcerated persons, vendors, and any other person entering the facility, in a manner consistent with guidelines issued by the Centers for Disease Control and Prevention ("CDC"). Such screening includes a temperature reading and obtaining information about travel and any contact with persons under investigation for COVID-19 infection.

   (b) Restricting all visits, except for attorney-related visits, and conducting those visits without physical contact to the extent feasible.

   (c) Limiting off-site appointments for incarcerated persons to only appointments for urgent or emergency medical treatment.

   (d) Developing and implementing protocols for incarcerated persons who display symptoms of COVID-19, including methods for evaluation and processes for testing, notification of the Department of Health and Human Services ("DHHS"), and isolation during testing, while awaiting test results, and in the event of positive test results. These protocols should be developed in consultation with local public health departments.

   (e) Notifying DHHS of any suspected case that meets the criteria for COVID-19 through communication with the applicable local public health department.

   (f) Providing, to the fullest extent possible, appropriate personal protective equipment to all staff as recommended by the CDC.

   (g) Conducting stringent cleaning of all areas and surfaces, including frequently touched surfaces (such as doorknobs, handles, light switches, keyboards, etc.), on a regular and ongoing basis.

   (h) Ensuring access to personal hygiene products for incarcerated persons and correctional staff, including soap and water sufficient for regular handwashing.

   (i) Ensuring that protective laundering protocols are in place.

   (j) Posting signage and continually educating on the importance of social distancing, handwashing, and personal hygiene.

   (k) Practicing social distancing in all programs and classrooms—meaning a distance of at least six feet between people in any meeting, classroom, or other group.

(l) Minimizing crowding, including interactions of groups of 10 or more people, which may include scheduling more times for meal and recreation to reduce person-to-person contact.

2. To mitigate the risk of COVID-19 spreading in county jails, strict compliance with the capacity and procedural requirements regarding county jail overcrowding states of emergency in the County Jail Overcrowding Act ("CJOA"), 1982 PA 325, MCL 801.51 et seq., is temporarily suspended. While this order is in effect, all actions that would be authorized under the CJOA in the event of a declaration of a county jail overcrowding state of emergency are authorized and shall remain authorized without regard to any reduction in jail population or any other such limitations on the duration of authorization imposed by the CJOA.

3. Anyone authorized to act under section 2 of this order is strongly encouraged to consider early release for all of the following, so long as they do not pose a public safety risk:

   (a) Older people, people who have chronic conditions or are otherwise medically frail, people who are pregnant, and people nearing their release date.

   (b) Anyone who is incarcerated for a traffic violation.

   (c) Anyone who is incarcerated for failure to appear or failure to pay.

   (d) Anyone with behavioral health problems who can safely be diverted for treatment.

4. Effective immediately, all transfers into the Department's custody are temporarily suspended. Beginning seven (7) days from the effective date of this order, and no more than once every seven (7) days, a county jail or local lockup may request that the director of the Department determine that the jail or lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order. Upon inspection, if the director of the Department determines that a county jail or local lockup has satisfactorily implemented risk reduction protocols, transfers from that jail or lockup will resume in accordance with the Department's risk reduction protocols. The director of the Department may reject transfers that do not pass the screening protocol for entry into a facility operated by the Department.

5. Parole violators in the Department's custody must not be transported to or lodged in a county jail or local lockup unless the director of the Department has determined that such county jail or local lockup has satisfactorily implemented risk reduction protocols as described in section 1 of this order.

6. The State Budget Office must immediately seek a legislative transfer so that counties may be reimbursed for lodging incarcerated persons that would have been transferred into the Department's custody if not for the suspension of transfers described in section 4 of this order.

7. Juvenile detention centers are strongly encouraged to reduce the risk that those at their facilities will be exposed to COVID-19 by implementing as feasible the following measures:

   (a) Removing from the general population any juveniles who have COVID-19 symptoms.

   (b) Eliminating any form of juvenile detention or residential facility placement for juveniles unless a determination is made that a juvenile is a substantial and immediate safety risk to others.

   (c) Providing written and verbal communications to all juveniles at such facilities regarding COVID-19, access to medical care, and community-based support.

   (d) To the extent feasible, facilitating access to family, education, and legal counsel through electronic means (such as telephone calls or video conferencing) at no cost, rather than through in-person meetings.

8. Unless otherwise directed by court order, for juveniles on court-ordered probation, the use of out-of-home confinement for technical violations of probation and any requirements for in-person meetings with probation officers are temporarily suspended.

9. This order is effective immediately and continues through April 26, 2020 at 11:59 pm.

Given under my hand and the Great Seal of the State of Michigan.

Date: March 29, 2020

Time: 7:23 pm

GRETCHEN WHITMER
GOVERNOR

By the Governor:

SECRETARY OF STATE

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.51a County jail population exceeding 95% of jail's rated design capacity; actions by county sheriff; maximum value of outstanding bonds; duration; applicability of subsections (1) to (3).

Sec. 1a. (1) In a county other than a county described in subsection (4), the sheriff of that county shall take the following actions on the fifth consecutive day on which the general population of the county jail exceeds 95% of the jail's rated design capacity:

(a) The sheriff shall review the outstanding bonds for each prisoner. If the total of a prisoner's outstanding bonds does not exceed a maximum value determined as provided in subsection (2), the sheriff, subject to the approval of the chief circuit judge in that county, shall modify each outstanding bond for that prisoner to a personal recognizance bond in that same amount, issue to the prisoner a receipt similar to an interim bond receipt, and send a copy of the receipt to the court that set the bond.

(b) The following prisoners, except for any prisoner that the chief circuit judge in that county believes would present a threat to the public safety if released, shall be released immediately:

(*i*) Any sentenced prisoner who has served 85% or more of his or her sentence, unless he or she is serving a sentence for a violent or assaultive offense, sex offense, prison or jail escape offense, weapons offense, drunk driving offense, or a controlled substance offense except possession of less than 25 grams of a controlled substance.

(*ii*) Any prisoner detained in the county jail for a civil contempt adjudication for failure to pay child support who has no other charges pending against him or her.

(2) The maximum value of outstanding bonds, for purposes of subsection (1)(a), shall be determined by a majority vote of the following individuals, as applicable:

(a) In a single-county or multicounty judicial district, the chief circuit judge for the judicial circuit that includes that county, the chief district judge for that district, and the sheriff of the county.

(b) In a county containing 2 or more judicial districts, the chief circuit judge for the judicial circuit that includes that county, the chief probate judge for that county, the sheriff of the county, and 2 district judges chosen by the chief district judges sitting in that county.

(3) A determination made under subsection (2) remains in effect for 1 year after the date on which that determination was made.

(4) Subsections (1) to (3) do not apply to either of the following:

(a) A county for which a county jail management plan has been approved under section 9a.

(b) A county having a population greater than 650,000 as of the most recent federal decennial census that, on the effective date of this section, has implemented a written jail management plan in which the basis of the plan is jail bed allocation. The exception provided by this subsection applies only as long as that plan remains in effect.

History: Add. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.55 Reduction of prisoner population by sheriff, notified persons, and other judges; means.

Sec. 5. The sheriff, the persons notified pursuant to section 4, and other circuit, district, and municipal judges may attempt to reduce the prisoner population of the county jail through any available means which are already within the scope of their individual and collective legal authority, including, but not limited to, the following:

(a) Accelerated review and rescheduling of court dates.

(b) Judicial review of bail for possible bail reduction, release on recognizance, or conditional release of prisoners in the county jail.

(c) Prosecutorial pre-trial diversion.

(d) Judicial use of probation, fines, community service orders, restitution, and delayed sentencing as alternatives to commitment to jail.

(e) Use of work-release, community programs, and other alternative housing arrangements by the sheriff, if the programs and alternative housing arrangements are authorized by law.

(f) Review of agreements which allow other units of government to house their prisoners in the overcrowded county jail to determine whether the agreements may be terminated.

(g) Entering into agreements which allow the sheriff for the county in which the overcrowded county jail is located to house prisoners in facilities operated by other units of government.

(h) Refusal by the sheriff to house persons who are not required by law to be housed in the county jail.

(i) Acceleration of the transfer of prisoners sentenced to the state prison system, and prisoners otherwise under the jurisdiction of the department of corrections, to the department of corrections.

(j) Judicial acceleration of pending court proceedings for prisoners under the jurisdiction of the department of corrections who will be returned to the department of corrections regardless of the outcome of the pending proceedings.

(k) Reduction of waiting time for prisoners awaiting examination by the center for forensic psychiatry.

(*l*) Alternative booking, processing, and housing arrangements, including the use of appearance tickets instead of booking at the county jail and the use of weekend arraignment, for categories of cases considered appropriate by the persons notified pursuant to section 4.

(m) Acceptance by the courts of credit cards for payments of bonds, fines, and court costs.

(n) Use of community mental health and private mental health resources in the county as alternatives to housing prisoners in the county jail for those prisoners who qualify for placement in the programs and for whom placement in the programs is appropriate.

(o) Use of community and private substance abuse programs and other therapeutic programs as alternatives to housing prisoners in the county jail for those prisoners who qualify for placement in the programs and for whom placement in the programs is appropriate.

(p) Preparation of a long-range plan for addressing the county jail overcrowding problem, including recommendations to the county board of commissioners on construction of new jail facilities and funding for construction or other options designed to alleviate the overcrowding problem.

(q) Review of sentencing procedures, including the elimination of delays in preparing presentence reports for prisoners awaiting sentence, and staggering the dates on which prisoners will start serving a jail sentence to minimize fluctuating demands on jail capacity.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.56 Requirement of further actions; failure of certain actions to reduce population to level prescribed in subsection (1); presenting prisoner information to chief circuit judge; applicability of subsection (2)(b) to certain prisoners; review; classification of prisoners; reduction of sentences; duration; report.

Sec. 6. (1) The further actions prescribed in subsections (2) to (5) and in sections 7 and 8 shall be required unless the actions taken pursuant to section 5 reduce the county's jail population to the higher of the following:

(a) 90% of rated design capacity or a percentage of rated design capacity less than 90% as set by a court prior to February 8, 1983.

(b) A prisoner population such that the jail has the following number of empty beds:

(*i*) For a jail with a rated design capacity of less than 500 beds, at least 10 empty beds.

(*ii*) For a jail with a rated design capacity of 500 beds or more, at least 25 empty beds.

(2) If the actions taken pursuant to section 5 do not reduce the county jail's population to the level prescribed in subsection (1) within 14 days after the declaration of the county jail overcrowding state of emergency, the sheriff shall present to the chief circuit judge for the county in which the jail is located the following information for each prisoner housed in the county jail on that date:

(a) For prisoners who are serving a sentence of imprisonment for conviction of 1 or more crimes:

(*i*) The name of each prisoner.

(*ii*) The offense for which the prisoner was convicted.

(*iii*) The length of sentence imposed for the prisoner.

(*iv*) The date on which the prisoner began serving his or her sentence.

(*v*) The date on which the prisoner will be released from the jail according to the terms of his or her sentence, including computations for good time.

(*vi*) The name of the judge who imposed the sentence.

(b) For prisoners housed in the county jail, other than a prisoner described in subsection (3), who are not serving a sentence of imprisonment for conviction of a crime:

(*i*) The name of the prisoner.

(*ii*) The offense for which the prisoner is being detained in the county jail.

(*iii*) The amount of the prisoner's bond.

(*iv*) The date on which the prisoner began his or her period of detention.

(*v*) The name of the judge who ordered the prisoner to be detained.

(3) Subsection (2)(b) does not apply to a prisoner who is detained in the county jail in connection with a crime or an allegation of a crime in which the victim was a spouse, a former spouse, an individual with whom he or she has had a child in common, an individual residing or having resided in the same household, or an individual with whom he or she has or has had a dating relationship as that term is defined in section 2950 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2950.

(4) After the chief circuit judge for the county in which the jail is located reviews the information presented by the sheriff pursuant to subsection (2), the chief circuit judge shall, for purposes of county jail population reduction, do both of the following:

(a) Classify prisoners who are serving sentences of imprisonment for conviction of crimes into 2 groups: those prisoners who, if released, would present a high risk to the public safety, and those who, if released, would not present a high risk to the public safety. The chief circuit judge shall also determine a minimum and a maximum percentage by which the sentences can be reduced. The sheriff shall reduce the sentences of all prisoners who, if released, would not present a high risk to the public safety by an equal percentage which is within the minimum and maximum percentages determined by the chief circuit judge.

(b) Review the list of prisoners housed in the county jail who are not serving a sentence for conviction of crimes and determine for each prisoner whether the release of that prisoner would or would not present a high risk to public safety. The chief circuit judge may do either or both of the following with regard to a prisoner whose release would not present a high risk to the public safety:

(*i*) Modify the bond of the prisoner, subject to any conditions reasonably necessary to ensure the appearance of the individual in court.

(*ii*) Release the prisoner subject to the condition that he or she be placed on electronic monitoring.

(5) The sentences of prisoners sentenced to and housed in the county jail after the fourteenth day of the county jail overcrowding state of emergency may continue to be reduced in the same manner as prescribed in subsections (2)(a) and (4)(a), but shall not be reduced after the county jail overcrowding state of emergency is

ended or after the sheriff orders a sentence reduction pursuant to section 7, whichever occurs first.

(6) The department of corrections, in cooperation with the Michigan sheriffs' association, shall annually report to the chairpersons of the senate and house standing committees responsible for legislation concerning corrections. The report shall evaluate the effect on the overcrowding state of emergency procedures under this section.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988;—Am. 2008, Act 542, Imd. Eff. Jan. 13, 2009.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.57 Failure of certain actions to reduce population to level prescribed in MCL 801.56(1); equal reduction of original sentences.

Sec. 7. If the actions taken pursuant to sections 5 and 6 do not reduce the county jail's population to the level prescribed in section 6(1) within 28 days of the declaration of the county jail overcrowding state of emergency, the original sentences, not including good time, of all prisoners sentenced to and housed in the county jail on that date shall be equally reduced by the sheriff by the least possible percentage reduction necessary, not to exceed 30%, to reduce the county jail's prisoner population to the level prescribed in section 6(1).

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.58 Failure of certain actions to reduce population to level prescribed in MCL 801.56(1); deferring acceptance for incarceration of certain persons.

Sec. 8. (1) Except as otherwise provided in this subsection and subsection (2), if the actions taken pursuant to sections 5, 6, and 7 do not reduce the county jail's population to the level prescribed in section 6(1) within 42 days of the declaration of the county jail overcrowding state of emergency, the sheriff shall defer acceptance for incarceration in the general population of the county jail persons sentenced to or otherwise committed to the county jail for incarceration until the county jail overcrowding state of emergency is ended pursuant to section 9, except that the sheriff shall not defer acceptance for incarceration all persons under sentence for or charged with violent or assaultive crimes, sex offenses, escape from prison or jail, drunk driving offenses, controlled substance offenses except possession of less than 25 grams of a controlled substance, or weapons offenses.

(2) The sheriff shall not defer acceptance of a prisoner for incarceration into the general population of the county jail if both of the following occur:

(a) The sheriff or the sentencing judge presents to the chief circuit judge for the county in which the county jail is located information alleging that deferring acceptance of the prisoner for incarceration would constitute a threat to public safety.

(b) The chief circuit judge, based upon the presence of a threat to public safety, approves of accepting the prisoner for incarceration.

History: 1982, Act 325, Eff. Feb. 8, 1983;—Am. 1988, Act 399, Imd. Eff. Dec. 27, 1988;—Am. 2007, Act 140, Eff. Feb. 11, 2008.

Popular name: Jail Overcrowding Emergency Powers Act

COUNTY JAIL OVERCROWDING STATE OF EMERGENCY (EXCERPT)
Act 325 of 1982

801.59b Suspension or reduction of jail sentence by sentencing judge; delegation of authority to chief judge; modification of bond.

Sec. 9b. (1) For purposes of this act, a sentencing judge may suspend or reduce any validly imposed jail sentence imposed by that judge. A sentencing judge may delegate the authority conferred under this subsection to the chief judge of the judicial district or circuit in which the sentencing judge serves or his or her designee.

(2) For purposes of this act, a judge may modify bond set by the court for unsentenced prisoners. A judge may delegate the authority conferred under this subsection to the chief judge of the judicial district or circuit in which the judge serves, or his or her designee.

History: Add. 2007, Act 139, Imd. Eff. Nov. 13, 2007.

Popular name: Jail Overcrowding Emergency Powers Act

Exhibit 14

DECLARATION OF DR. ADAM LAURING

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

I. Background and Qualification

1. My name is Adam Lauring, M.D., Ph.D.

2. I am a board-certified medical doctor in Infectious Diseases

3. I have been a physician for more than 18 years, and I have worked in Infectious Diseases for 14 years.

4. My bio, attached as Exhibit A, includes a brief description of my education and relevant experience

5. My Curriculum Vitae, attached as Exhibit B, includes a full list of my honors, experience, and publications.

6. I am donating my time reviewing materials and preparing this Declaration. Any live testimony I provide will also be *pro bono*.

II. Heightened Risk of Epidemics in Jails and Prisons

7. As I will discuss below, the risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of multiple risks of transmission and exposure to individuals who become infected.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails, however, are closely connected to communities. Staff, visitors, contractors, and vendors pass between communities and these facilities and, if infected, these individuals can carry with them and transmit infectious diseases. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities, posing the same risk. People often need to be transported to

and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people share dining halls, bathrooms, showers, telephones, and other common areas, the opportunities for transmission are greater. Where infectious diseases are transmitted from person to person by droplets, and no vaccine exists, the best initial strategy is to practice social distancing – maintaining a physical distance of at least six feet from any other person. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community.

10. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting, therefore, dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases, and significantly increases the likelihood of the spread of infection. For example, in mid-March, the jail at Rikers Island in New York City had not had a single confirmed COVID-19 case. By March 30, 167 inmates, 114 correction staff and 20 health workers at Rikers tested positive for COVID-19; two correction staff members have died and multiple inmates have been hospitalized.[1] As of April 8, Rikers had a rate of infection that is far higher than the infection rates of the most infected regions of the world. More than 700 people have tested positive for COVID-19, including more than 400 staff.[2] The Chief Medical Officer of Rikers has described a "public health disaster unfolding before our eyes." In his view, following CDC guidelines has not been enough to stem the crisis: "infections in our jails are growing quickly despite these efforts."[3]

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[1] Jan Ransom, *We're Left for Dead: Fears of Virus Catastrophe at Rikers Jail*, NY Times, Mar. 30, 2020.

[2] Asher Stockler, *More Than 700 People Have Tested Positive for Coronavirus on Rikers Island, Including Over 440 Staff*, Newsweek (April 8, 2020), https://www.newsweek.com/rikers-island-covid-19-new-york-city-1496872.

[3] Ross MacDonald (@RossMacDonaldMD), Twitter (Mar. 30, 2020, 8:03 PM), https://twitter.com/rossmacdonaldmd/status/1244822686280437765?s=12 ("I can assure you we were following the CDC guidelines before they were issued. We could

Like the explosive growth at Rikers, the Cook County Jail went from two confirmed COVID-19 cases on March 23 to more than 350 confirmed cases, 238 inmates and 115 staff members, two weeks later.[4] As of April 13, the number of confirmed cases totaled 500, of which two-thirds are inmates.[5]

11. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other jail or prison inmates, staff, and visitors.

12. Reduced prevention opportunities: During an infectious disease outbreak, people can curb their risk of infection by washing hands. Jails and prisons often do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers. When handwashing is unavailable, then the risk of infection and rate of infection spread is much greater. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, telephones, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

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have written them ourselves. . . [I]nfections in our jails are growing despite these efforts.").

[4] Timothy Williams and Danielle Ivory, Chicago's Jail Is Top U.S. Hot Spot as Virus Spreads Behind Bars, NY Times (April 8, 2020), https://www.nytimes.com/2020/04/08/us/coronavirus-cook-county-jail-chicago.html.

[5] Cheryl Corley, *The Covid-19 struggle in the Cook County Jail*, *NPR* (April 13, 2020), https://www.npr.org/2020/04/13/833440047/the-covid-19-struggle-in-chicagos-cook-county-jail

13. Additional reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk to everyone in the facility of a widespread outbreak.

14. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[6] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

15. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms, if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes containing the illness and caring for those who have become infected nearly impossible.

16. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes

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[6] Active case finding for communicable diseases in prison, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

access to testing equipment, laboratories, medications, and specialized equipment, such as ventilators.

17. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During a pandemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves. To help ease the collective burden on Southeastern Michigan hospitals, the state is constructing make-shift field hospitals.[7] The patient volume at Detroit's Sinai-Grace Hospital is so overwhelming that patients are lining the hallways, and patient care is suffering from staff, supplies, and equipment shortages.[8] In some cases, patients have died waiting for medical attention.[9]

18. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines may be limited. Locally, for example, two Wayne County Jail physicians, including the Jail's medical director, have died from COVID-19.[10]

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[7] *TCF Center makeshift hospital in Detroit ready to accept first patients*, WXYZ Detroit, Channel 7 (April 9, 2020) https://www.wxyz.com/news/coronavirus/4-local-health-systems-will-help-staff-tcf-center-temporary-hospitals-first-patients-arriving-friday

[8] Paul P. Murphy, *Detroit hospital workers say people are dying in the ER hallways before help can arrive* (April 9, 2020), https://www.cnn.com/2020/04/09/us/detroit-hospital-workers-sinai-grace-coronavirus/index.html

[9] *Id*.

[10] Charlie LeDuff, *LeDuff: Covid Has Killed 2 Wayne County Jail Doctors, A Commander, And Still: Silence*, Deadline Detroit (April 13, 2020), https://www.deadlinedetroit.com/articles/24965/leduff_covid_has_killed_2_wayne_county_jail_doctors_a_commander_and_still_silence

19. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public. Furthermore, rapid spread of infectious diseases among the inmates can often worsen the epidemic outside of the incarcerated population because staff are more likely to be infected and spread the disease to their families and the wider population.

20. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[11] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[12] Even facilities on "quarantine" continued to accept new cases" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[13]

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[11] *Influenza Outbreaks at Two Correctional Facilities—Maine, March 2011,* Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

[12] David. M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deathsare-few/.

[13] This whole section draws from Broks J. Global Epidemiology and Prevention of COVID19, COVID-10 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virual (March 10, 2020); Coronavirus (COVID-19), Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, COVID-19 (Coronavirus): What You Need to Know in Corrections, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-toknow-in-corrections.

21. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but recent data from China has demonstrated that almost 13% of transmission occurs from asymptomatic individuals before they start to show symptoms, and it is possible that transmission can occur for weeks after their symptoms resolve.[14] In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. A recent study out of Singapore found 10% of new infections could be caused by asymptomatic patients.[15] Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for over a year to the general public. Antiviral medications are currently in testing but not yet FDA-approved. People in prison and jail will likely have even less access to these novel health strategies as they become available.

22. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[16] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease,

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[14] Du Z, Xu X, Wu Y, Wang L, Cowling BJ, Ancel Meyers L. Serial interval of COVID-19 mong publicly reported confirmed cases. Emerg Infect Dis. 2020 Jun [*date cited*]. https://doi.org/10.3201/eid2606.200357

[15] Linda Givetash, *New Chinese data on asymptomatic coronavirus cases could help world response*, NBC News (April 9, 2020), https://www.nbcnews.com/news/world/new-chinese-data-asymptomatic-coronavirus-cases-could-help-world-response-n1173896.

[16] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/casesupdates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.html.

and diabetes, and older age.[17] 74% of cases requiring hospitalization are people over the age of 50.[18] Among those individuals, the risk of poor outcomes, included the need for mechanical intervention is over 20%. Death in COVID-19 infection is usually due to pneumonia, and sepsis, and would occur between approximately 1-4% of the population. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine

23. The care of people who are infected with COVID-19 depends on how seriously they are ill.[19] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. As discussed earlier, Southeastern Michigan hospitals are already overwhelmed and beyond capacity to provide this type of intensive care. This will worsen as COVID-19 becomes more widespread in communities.

24. In order to reduce the burden on the local health systems, aggressive containment and COVID-19 prevention is of utmost importance. To this end, State of Michigan and the City of Detroit have mandated COVID-19 prevention strategies, such as "shelter in place" or "stay at home" orders, which have gone beyond containment and mitigation. Jails and prisons already have difficulty with containment because it requires

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[17] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study*, The Lancel (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

[18] Center for Disease Control, Morbidity and Mortality Weekly Report – Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Cases (April 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm

[19] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2002), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. However, even with these efforts, it is nearly impossible for jails and prisons to provide the atmosphere of "shelter in place" or "stay at home" social distancing, given the number of individuals that work in and are housed in these facilities in the current system.

25. The time to act is now. Data from other settings demonstrates what happens when jails and prisons are unprepared for COVID-19. To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place.[20] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in the Oakland County Jail

26. In preparing this report I have reviewed the declarations of Oakland County Jail Inmates Arsineau, Bates, Briggs, J. Cameron, M. Cameron, Kucharski, Lee, and Saunders.

27. Based on my expertise in virology, review of the relevant literature, and my review of the declarations referred to paragraph 25, it is my professional judgment that immediate action is necessary to stem the spread of COVID-19 in the Oakland County Jail and prevent an even worse outbreak, which will result in severe harm to detained individuals, jail staff, and the broader community. The Oakland County Jail is not only obviously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak assuming what is described in the declarations is true, but in some cases, according to declarants, it is intentionally exposing inmates to COVID-19 as retribution for raising concerns about safety. The reasons for this conclusion are detailed as follows.

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[20] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-preparecoronavirus-federal-prisons-providing- significant/story?id=69433690.

28. According to the declarants, people confined in the jail sleep on bunks spaced one to three feet apart and in some cases are sleeping on the floor right next to cellmates. They further stated that inmates share showers, toilets, and sinks in small common areas, and some toilets are close to their beds. Declarants also state that much of the time, whether they are sitting, standing, walking, eating, or sleeping, they are within six feet of at least one other person. Notwithstanding their close proximity to one another, the declarants stated that there have been shortages in personal protective equipment, such as masks and gloves, for all people incarcerated and some working in the jail. Declarants further attested to the fact that staff inconsistently wears personal protective equipment when they interact with inmates. If these statements are true, the jail is not following basic CDC protection and prevention. And, given this layout and crowded environment in which individuals are held, largely without protection, it is impossible to provide an environment where social distancing can occur, and, in turn, impossible to prevent the risk or spread of infection.

29. According to the declarants, some inmates are not provided with regular access to soap, and, in some cases, have been without soap for more than one week. Declarants also state that they do not have access to any hand sanitizer or other personal sanitation supplies, even for purchase. The jail's failure to provide adequate hygiene supplies deprives individuals of the most important CDC-recommended measures to protect themselves from infection.

30. Declarants attested to the fact that individuals confined at the jail have limited access to disinfectant, if at all, or basic cleaning supplies with which to clean their shared cells, shared living quarters, common areas, or high-touch surfaces. High-touch surfaces, such as light switches, door and sink knobs, telephones, tables, etc., should be sanitized after <u>each use</u>. Failure to properly sanitize shared spaces, common areas, and high-touch surfaces that detained individuals heavily use, seriously increases the risk of the spread of COVID-19 and demonstrates the Jail's failure to take the most fundamental precautions for preventing the spread of the disease.

31. The declarations attest to significant neglect of inmates' medical needs and the ability to provide the care necessary to prevent serious illness or

death. The declarants stated that, although they were initially able to make requests for medical attention, those requests were ignored for days or dismissed. Presently, according to declarants, inmates are essentially unable to request medical attention because nurses and doctors are unavailable and jail guards tell the inmates that they cannot assist with to those requests. This is true, according to declarants, even for inmates who are particularly vulnerable to risk of severe illness or death, as a result of underlying health conditions.

32. The Jail's failure to provide inmates with adequate medical care for their underlying chronic health conditions, as described by the declarants, results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected. According to their declarations, some Plaintiffs, and others held in the jail have serious medical vulnerabilities. A worsening outbreak in the jail would prove disastrous, and potentially fatal, for these medically vulnerable individuals. Based upon the declarations, it is apparent that the Jail is not providing adequate medical treatment to infected inmates. This is also worrisome because it will surely cause unnecessary risk of severe illness or death, and because patients from the Jail will further strain already-burdened Southeastern Michigan medical facilities who will have to absorb patients from the jail.

33. The declarants further attested to the fact that inmates who exhibit COVID-like symptoms, such as cough, shortness of breath, or a fever are not immediately tested or quarantined, if at all. Failure to adequately test for infection results in dramatic undercounting of persons infected, and, in turn, makes it impossible to protect against an outbreak.

34. The quarantine procedures described by declarants will not in any way mitigate or prevent the spread of infection. The declarants stated that the jail is "quarantining" presumably infected inmates in cells immediately adjacent to and within arms-reach of cells with inmates who are not presumed to be infected.

V. Conclusion and Recommendations

35. For the reasons above, it is my professional judgment that individuals placed in the Oakland County Jail are at a significantly higher risk of infection with COVID-19 as compared to the population in the

community, given the procedural and housing conditions in the facility, and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

36. Indeed, based on the circumstances described in the declarations, my expertise in virology, and based upon my knowledge and understanding of the ways in which the novel coronavirus is transmitted, drastically reducing the jail's population is the *only* way to protect the health and safety of people detained in the facility and the public at large..

37. For the medically vulnerable – individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune systems, cancer, and diabetes) or who are over the age of 50[21] – immediate release is the only option because the Jail's widespread neglect of medical needs and failure to both identify and quarantine infection, coupled with the inmates' limited access to lifesaving protections, if any, and inability to practice physical distancing creates a meaningfully higher risk of death.

38. From a public health perspective, it is my strong opinion that individuals who can **safely and appropriately** remain in the community must not be placed in the Oakland County Jail facilities at this time. I am also strongly of the opinion that individuals who are already in these facilities should be evaluated for release, and that a careful evaluation of procedural and housing guidance is created for those who remain in the facility during the "stay at home" mandate, and possibly until the epidemic is contained.

39. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in this facility is a matter of days, not weeks.

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[21] Center for Disease Control, Morbidity and Mortality Weekly Report – Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Cases (April 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm

40. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

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

Executed on this 15th day of April 2020.

ADAM LAURING, M.D., Ph.D

Exhibit 15

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Janet Malam,

Petitioner,

v.

Rebecca Adducci, *et al.*,

Respondents.

_____/

Case No. 20-10829

Judith E. Levy
United States District Judge

Mag. Judge Anthony P. Patti

AMENDED OPINION AND ORDER GRANTING IN PART PETITIONER'S EMERGENCY APPLICATION FOR A TEMPORARY RESTRAINING ORDER [2][1]

This is an emergency petition challenging Janet Malam's mandatory detention pursuant to 8 U.S.C. § 1226(c) because of danger posed to her by the COVID-19 pandemic. Petitioner claims that her continued detention violates her Fifth Amendment rights by exposing her to substantial risk of illness and death. She requests a temporary restraining order (TRO) requiring that Respondents release her on her

[1] On April 6, 2020 the Court amended its April 5, 2020 Order to include additional terms of supervision.

own recognizance and refrain from re-detaining her for the pendency of her immigration proceedings.

For the foregoing reasons, the Court GRANTS IN PART this emergency application for relief.

BACKGROUND

Petitioner Janet Malam, born in the United Kingdom, is a lawful permanent resident. (ECF No. 1, PageID.3.) She was legally admitted to the United States in 1967 at the age of four and is now fifty-six years old. (*Id.*) Petitioner has been detained since March 4, 2020, in the Calhoun County Correctional Facility[2] in conjunction with removal proceedings at the Detroit Immigration Court. (*Id.*) She brings suit against the following Respondents: Rebecca Adducci, the Detroit District Director of United

[2] The parties each refer to the Calhoun County Correctional Facility with different terminology. *See Jail/Corrections Division*, Calhoun County, https://www.calhouncountymi.gov/departments/sheriffs_office/jail.php (last visited Apr. 5, 2020) ("Calhoun County Correctional Facility"); *Detention Facilities*, U.S. Immigrations and Customs Enforcement, https://www.ice.gov/detention-facility/calhoun-county-correctional-center (last visited Apr. 5, 2020) ("Calhoun County Correctional Center"); *Calhoun County Jail*, Google Maps, at https://www.google.com/maps/place/Calhoun+County+Jail/@42.3166565,-85.1757947,15z/data=!4m2!3m1!1s0x0:0x4f8faa7bcca370c4?sa=X&ved=2ahUKEwiRwvHM3NHoAhUQmHIEHWeUCl4Q_BIwCnoECA4QCA (last visited Apr. 5, 2020) ("Calhoun County Jail"). The Court will refer to Petitioner's current place of detention as the Calhoun County Correctional Facility or CCCF.

States Immigration and Customs Enforcement (ICE); Matthew Albence, Deputy Director of ICE; Chad Wolf, Acting Secretary of the U.S. Department of Homeland Security; William Barr, Attorney General of the United States; ICE; and Heidi Washington, Director of the Michigan Department of Corrections (MDOC). (*Id.*)

Petitioner alleges that she suffers from a number of health conditions, including: multiple sclerosis; bipolar disorder; pain; anemia; essential primary hypertension; hypothyroidism; chronic obstructive pulmonary disease; fibromyalgia; mild cognitive impairment; carpal tunnel syndrome; severe major depressive disorder; opioid addiction; nicotine dependence; and polyneuropathy. (ECF No. 1, PageID.7.) According to Petitioner's extensive medical records, these diagnoses are current and accurate as of March 3, 2020. (ECF No. 1-4, PageID.31.)

Because Petitioner has committed two or more crimes involving moral turpitude, her detention is mandatory pursuant to 28 U.S.C. § 1226(c).[3] On March 30, 2020, Petitioner filed a petition requesting

[3] Petitioner does not specify the nature of these crimes in either her petition or this application. In their response to Petitioner's application for a temporary restraining order, Respondents note that Petitioner's charge of removal is based on a 2003 Michigan state conviction of Larceny from the Person, Mich. Comp. Laws § 750.737, a 2008 conviction of Larceny $100 or Less in violation of a Taylor City,

emergency relief in either one of two forms: a writ of habeas corpus or an injunction "ordering Defendants to immediately release [Petitioner], with appropriate precautionary public health measures, on the grounds that her continued detention violates the Due Process Clause [of the Fifth and Fourteenth Amendments]." (*Id.* at PageID.17.) Petitioner simultaneously filed an Application for Temporary Restraining Order requesting that the Court order Petitioner's release during the pendency of her immigration proceedings due to the substantial risk to her health posed by COVID-19 as a result of Petitioner's continued detention in the enclosed group environment endemic to the Calhoun County Correctional Facility. (ECF No. 2.)

For the reasons stated below, the Court GRANTS Petitioner's application for a temporary restraining order requiring her immediate release from detention for the duration of the COVID-19 State of Emergency in Michigan or until further Court order.

LAW AND ANALYSIS

Michigan ordinance, a 2009 conviction of Retail Fraud in violation of a City of Flat Rock, Michigan ordinance, a 2011 conviction of Attempted Simple Larceny in violation of a City of Tyler, Michigan ordinance, and a 2012 conviction of Retail Fraud 3rd Degree $200 or less in violation of a City of Southgate, Michigan ordinance. (ECF No. 11-1, PageID.192.)

I. Jurisdiction

"Federal courts are not courts of general jurisdiction; they have only the power that is authorized by Article III of the Constitution and the statutes enacted by Congress." *Hamama v. Adducci,* 912 F.3d 869, 874 (6th Cir. 2018) (citing *Bender v. Williamsport Area Sch. Dist.*, 475 U.S. 534, 541 (1986)). All courts have an "independent obligation to determine whether subject-matter jurisdiction exists, even in the absence of a challenge from any party." *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 514 (2006) (citing *Ruhgras AG v. Marathon Oil Co.*, 526 U.S. 574, 583 (1999)). A court must determine whether it has jurisdiction before deciding a cause of action. *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 95 (1998).

Petitioner pleads that "[t]he Court has subject matter jurisdiction over this case pursuant to Article I, § 9, cl. 2 of the U.S. Constitution (Suspension Clause); the Due Process Clauses of the Fifth and Fourteenth Amendments to the U.S. Constitution; 28 U.S.C. § 1331 (federal question); 28 U.S.C. §1651 (All Writs Act); and 28 U.S.C. § 2241 (habeas corpus)." (ECF No. 1, PageID.5.) The Court has jurisdiction to adjudicate Petitioner's claims under 28 U.S.C. § 2241. Moreover, even if

Petitioner's claims could not be heard under 28 U.S.C. § 2241, 28 U.S.C. § 1331 provides an independent source of jurisdiction.

A. 28 U.S.C. § 2241 Jurisdiction

28 U.S.C. § 2241 provides a district court with jurisdiction over petitions for habeas corpus where a petitioner is "in custody in violation of the Constitution or laws or treaties of the United States." 28 U.S.C. § 2241(c)(3). *See INS v. St. Cyr*, 533 U.S. 289, 298 (2001) (recognizing 28 U.S.C. § 2241 as a jurisdictional statute). For over 100 years, habeas corpus has been recognized as the vehicle through which noncitizens may challenge the fact of their detention. *See Chin Yow v. U.S.*¸ 208 U.S. 8, 13 (1908) ("Habeas corpus is the usual remedy for unlawful imprisonment.") In 2001, the Supreme Court recognized the continued viability of the writ in cases involving the detention of noncitizens: "§ 2241 habeas corpus proceedings remain available as a forum for statutory and constitutional challenges to post-removal-period detention." *Zadvydas v. Davis*, 533 U.S. 678, 688 (2001). In 2018, the Court ruled on the merits of a habeas petition challenging the validity of pre-removal detention. *Jennings v. Rodriguez,* 138 S. Ct. 830 (2018).

Respondents claim, citing *Luedtke v. Berkebile*, that the Court lacks jurisdiction to grant habeas relief because 28 U.S.C. § 2241 "is not the proper vehicle for a prisoner to challenge conditions of confinement." *Luedtke v. Berkebile*, 704 F.3d 465, 466 (6th Cir. 2013). Though the Supreme Court has left as an open question "the reach of the writ with respect to claims of unlawful conditions of treatment or confinement," *Boumedienne v. Bush*, 553 U.S. 732, 792 (2006), the Sixth Circuit, conversely, has held that "a § 2241 habeas petition is not the appropriate vehicle for challenging the conditions of . . . confinement." *Velasco v. Lamanna*, 16 F. App'x 311, 314 (6th Cir. 2001). In 2018, the Sixth Circuit reiterated this holding, affirming a district court that dismissed a § 2241 petition raising an Eighth Amendment challenge to subpar prison conditions because such a claim must be brought in a civil-rights action such as one under *Bivens v. Six Unknown Named Agents of the Fed. Bureau of Narcotics*, 403 U.S. 388 (1971). *Solano-Moreta v. Fed. Bureau of Prisons*, No. 17-1019, 2018 WL 6982510 (6th Cir. Sep. 24, 2018); *but see Aamer v. Obama*, 742 F.3d 1023 (D.C. Cir. 2014) ("Habeas corpus tests not only the fact but also the form of detention.") (internal citation

omitted); *Roba v. U.S.*, 604 F.2d 215 (2d Cir. 1979) (holding that § 2241 petition may be used to challenge conditions of confinement).

The Respondents argue that "there is no dispute that Petitioner brings a challenge to the conditions of her confinement." (ECF No. 11, PageID.175.) On its face, the application appears to concern Petitioner's conditions of confinement. Petitioner titles her claim for relief: "Freedom from Cruel Treatment and Conditions of Confinement." (ECF No. 1, PageID.16.) But Petitioner may nonetheless bring her claim under 28 U.S.C. § 2241 because she seeks immediate release from confinement as a result of there being no conditions of confinement sufficient to prevent irreparable constitutional injury under the facts of her case.

Supreme Court and Sixth Circuit precedent support the conclusion that where a petitioner claims no set of conditions would be sufficient to protect her constitutional rights, her claim should be construed as challenging the fact, not conditions, of her confinement and is therefore cognizable in habeas. In *Nelson v. Campbell*, the Supreme Court held that a death-row inmate's challenge to the method of his upcoming execution constituted a challenge to the conditions—not the fact or duration—of his execution, and therefore his claim fell outside the "core"

of habeas corpus. 541 U.S. 637, 644-45 (2004). However, the Court speculated that if the challenged method "were a statutorily mandated part of the lethal injection protocol, or if as a factual matter petitioner were unable or unwilling to concede acceptable alternatives," there would be a "stronger argument that success on the merits, coupled with injunctive relief, would call into question the death sentence itself," bringing the claim into the core of habeas corpus. *Id.* at 645. In *Adams v. Bradshaw*, the Sixth Circuit relied on *Nelson* to uphold habeas jurisdiction over a claim where a petitioner challenged the method of his execution but did not concede that any acceptable alternative existed. 644 F.3d 481, 483 (6th Cir. 2011) ("Adams has not conceded the existence of an acceptable alternative procedure. . . . Thus, Adams's lethal-injection claim, if successful, could render his death sentence effectively invalid.") Here, Petitioner has not conceded the existence of acceptable alternative conditions of her confinement; her Fifth Amendment claim, if successful, would render her continued detention invalid.

In contrast to this case, claims which the Sixth Circuit has held noncognizable in habeas are those in which the petitioner seeks relief other than release from custody: *See Solano-Moreta*, 2018 WL 6982510,

at *1 (seeking transfer); *Luedtke v. Berkebile*, 704 F.3d 465, 465–66 (6th Cir. 2013) (challenge to lack of compensation and conditions of work performed in prison); *Hodges v. Bell*, 170 F. App'x 389, 390 (6th Cir. 2006) (seeking amelioration of conditions or transfer to mental health facility); *Sullivan v. United States*, 90 Fed. App'x 862, 862 (6th Cir. 2004) (seeking medical treatment in prison); *Lutz v. Hemingway*, 476 F.Supp. 2d 715, 718 (E.D. Mich. 2007) (seeking restoration of mail privileges in prison); *see also Martin v. Overton*, 391 F.3d 710, 712 (6th Cir. 2004) (seeking transfer). Indeed, in *Preiser v. Rodriguez*, the Supreme Court distinguished conditions of confinement claims from claims seeking immediate or speedier release. 411 U.S. 475, 500 (1973) (distinguishing habeas case seeking good-time credits from § 1983 conditions of confinement cases on the grounds that "none of the state prisoners in those cases was challenging the fact or duration of his physical confinement itself, and none was seeking immediate release or a speedier release from that confinement—the heart of habeas corpus.")

Although Petitioner here titles her claim for relief "Freedom from Cruel Treatment and Conditions of Confinement," her Petition is a challenge to the continued validity of her confinement, regardless of its

conditions. Petitioner argues that the only adequate relief is her release from confinement. As Petitioner explains,

> [S]ocial distancing and hygiene measures [are] Janet's only defense against COVID-19. Those protective measures are exceedingly difficult, if not impossible, in the environment of an immigration detention center, where Janet shares toilets, sinks, phones, and showers, eats in communal spaces, and is in close contact with the many other detainees and officers.

(ECF No. 1, PageID.16.) At the Court's March 31, 2020 status conference for this case, counsel for Respondents conceded that social distancing between prisoners of at least six feet would be impossible at the Calhoun County Correctional Facility. This concession supports the conclusion of multiple doctors and public health experts: that "[t]he only viable public health strategy available is risk mitigation. . . . [T]he public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety" (ECF No. 6-1, PageID.87 (Declaration of Infectious Disease Epidemiologist Joseph Amon)); the only way to "prevent serious illness including death" in ICE facilities is to "release all people with risk factors." (ECF No. 20-3, PageID.374 (Declaration of Dr. Robert B. Greifingert).)

In this case, Petitioner does not take issue with the steps taken at the Calhoun County Correctional Facility to mitigate the risk of detainees contracting COVID-19. Rather, she says that no matter what steps are taken, due to her underlying serious health conditions, there is no communal holding facility where she could be incarcerated during the Covid-19 pandemic that would be constitutional. Petitioner's claim must therefore be considered as a challenge to the continued validity of confinement itself. Accordingly, Petitioner's claim is properly brought under 28 U.S.C. § 2241, and the Court has jurisdiction.

B. 28 U.S.C. § 1331 Jurisdiction

Even if the Court were to lack jurisdiction under 28 U.S.C. § 2241, the Fifth Amendment provides Petitioner with an implied cause of action, and thus 28 U.S.C. § 1331 would offer an independent source of jurisdiction.

28 U.S.C. § 1331 provides that "[t]he district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." Petitioner properly framed her pleading as a civil rights action "[i]n the alternative." In addition to her request for a writ of habeas corpus, Petitioner requests "injunctive relief

ordering Defendants to immediately release Janet, with appropriate precautionary public health measures, on the grounds that her continued detention violates the Due Process Clause." (ECF No. 1, PageID.17.) She titles her single claim for relief "Violation of Fifth Amendment Right to Substantive and Procedural Due Process (Unlawful Punishment; Freedom from Cruel Treatment and Conditions of Confinement." (*Id.* at PageID.16.)

Should Petitioner's habeas petition fail on jurisdictional grounds, the Fifth Amendment provides Petitioner with an implied cause of action, and accordingly 28 U.S.C. 1331 would vest the Court with jurisdiction. In *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics*, the Supreme Court first upheld the proposition that the Constitution itself provided an implied cause of action for claims against federal officials. 403 U.S. at 388. In 2017, the Supreme Court held that federal courts should not extend a *Bivens* remedy into new contexts if there exist any "special factors counseling hesitation." *Ziglar v. Abassi*, 137 S.Ct. 1843, 1857 (2017). However, there is no corresponding limitation on the Constitution as a cause of action to seek injunctive or other equitable relief. *See Ziglar*, 137 S. Ct. at 1862 (declining to extend

Bivens to conditions of confinement claim, but noting that "Respondents . . . challenge large-scale policy decisions concerning the conditions of confinement imposed on hundreds of prisoners. To address those kinds of decisions, detainees may seek injunctive relief."). Instead, there is a "presumed availability of federal equitable relief against threatened invasions of constitutional interests." *Hubbard v. E.P.A.*, 809 F.2d 1, 11 (D.C. Cir. 1986) (citing *Bivens*, 403 U.S. at 404 (Harlan, J., concurring)). Indeed, "the power of the federal courts to grant equitable relief for constitutional violations has long been established." *Mitchum v. Hurt*, 73 F.3d 30, 35 (3d Cir. 1995). Here, Petitioner seeks only injunctive and declaratory relief. Accordingly, she may bring her claim directly under the Fifth Amendment, and the Court has jurisdiction to hear the claim under 28 U.S.C. § 1331.

At oral argument, counsel for Respondent raised the question of whether the United States may be entitled to sovereign immunity if Petitioner brought this case under the Fifth Amendment. Sovereign immunity does not apply in this instance, and even if it did, it has been statutorily waived. Federal courts may exercise the traditional powers of equity in cases within their jurisdiction to enjoin violations of

constitutional rights by government officials. In *Ex Parte Young*, the Supreme Court first articulated the principle that state government officials may be sued for acting unconstitutionally, even if an ensuing injunction would bind the state. 209 U.S. at 123. In *Philadelphia Co. v. Stimson*, the Supreme Court recognized the applicability of that principle to suits against federal officials. 223 U.S. 605, 620 (1912) ("in case of an injury threatened by his illegal action, the officer cannot claim immunity from injunction process"). More recently, the Supreme Court affirmed this principle in *Dalton v. Specter*: "sovereign immunity would not shield an executive officer from suit if the officer acted either 'unconstitutionally or beyond his statutory powers.'" 511 U.S. 462, 472 (1994) (citing *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 691 n.11 (1949)). In *Malone v. Bowdoin*, the Court called this principle the "constitutional exception to the doctrine of sovereign immunity." 369 U.S. 643, 647 (1962). Petitioner here raises a constitutional challenge to her detention as the result of actions taken by Respondent Adducci, a federal officer. Sovereign immunity does not apply.

Even absent this constitutional exception, the Administrative Procedure Act (APA) provides a statutory waiver to any defense of sovereign immunity. 5 U.S.C. § 702 provides that:

> An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party.

In 2013, the Sixth Circuit recognized that this waiver extends beyond suits brought under the APA:

> [W]e now join all of our sister circuits who have done so in holding that § 702's waiver of sovereign immunity extends to all non-monetary claims against federal agencies and their officers sued in their official capacity, regardless of whether plaintiff seeks review of "agency action" or "final agency action" as set forth in § 704.

Muniz-Muniz v. U.S. Border Patrol, 741 F.3d 668, 673 (6th Cir. 2013); *see also Chamber of Commerce v. Reich*, 74 F.3d 1322, 1328 (D.C. Cir. 1996) ("The APA's waiver of sovereign immunity applies to any suit whether under the APA or not."). ICE is a federal agency, of which Respondent Adducci is an officer or employee thereof. Petitioner challenges

Respondent's actions made in her official capacity. Accordingly, the APA provides a statutory waiver of sovereign immunity.

C. Petitioner's Status as a Noncitizen

Petitioner's status as a noncitizen who is undergoing removal proceedings does not affect the Court's jurisdiction to hear this case. Although several statutes limit a district court's authority to hear cases in the immigration context, none apply here, as set forth below.

28 U.S.C. § 1252(b)(9) provides that judicial review of:

> all questions of law and fact, including interpretation and application of constitutional and statutory provisions, arising from any action taken or proceeding brought to remove an alien from the United States under this subchapter [including §§ 1225 and 1226] shall be available only in judicial review of a final order under this section.

28 U.S.C. § 1252(b)(9). Petitioner does not have a final order of removal. In *Jennings v. Rodriguez*, the Supreme Court held that 1252(b)(9) did not strip jurisdiction from courts to hear challenges to detention pending removal because detention was not an action taken to remove a noncitizen from the United States. 138 S. Ct. 830, 841 (2018). Petitioner challenges her continued detention; accordingly, 28 U.S.C. § 1252(b)(9) does not strip this Court of jurisdiction.

8 U.S.C. § 1226(e) bars federal court review of any discretionary decision made by the Attorney General regarding detention, release, bond, or parole in an immigration case. However, in *Demore v. Kim*, 123 S. Ct. 1708, 1713–14 (2003), the Supreme Court held that § 1226(e) did not prevent noncitizens from raising constitutional challenges to mandatory detention under § 1226(c). Petitioner here raises a Fifth Amendment challenge to her continued mandatory detention under § 1226(c); thus, § 1226(e) does not prevent this Court from exercising jurisdiction.

Finally, 8 U.S.C. § 1252(f), titled "Limit on Injunctive Relief," provides that:

> [N]o court (other than the Supreme Court) shall have jurisdiction or authority to enjoin or restrain the operation of the provisions of part IV of this subchapter, as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, other than with respect to the application of such provisions to an individual alien against whom proceedings under such part have been initiated.

8 U.S.C. § 1252(f)(1). But as the Supreme Court recognized in *Reno v. Amer.-Arab Anti-Discrim. Comm.*, "this ban does not extend to individual cases." 525 U.S. 471, 481–82 (1999). Petitioner seeks individual relief.

Therefore, 8 U.S.C. § 1252(f) does not affect this Court's jurisdiction to enter injunctive or declaratory relief.

II. Proper Habeas Respondent

Petitioner names as Respondents: Rebecca Adducci, the Detroit District Director of ICE; Matthew Albence, Deputy Director; Chad Wolf, Acting Secretary of the U.S. Department of Homeland Security; William Parr, Attorney General of the United States; U.S. Immigration and Customs Enforcement; and Heidi Washington, Director of the Michigan Department of Corrections. Only Respondent Rebecca Adducci is properly named with respect to the petition for a writ of habeas corpus.

"Historically, the question of who is 'the custodian,' and therefore the appropriate respondent in a habeas suit, depends primarily on who has power over the petitioner and . . . on the convenience of the parties and the court." *Roman v. Ashcroft*, 340 F.3d 314, 319 (6th Cir. 2003) (citing *Henderson v. INS*, 157 F.3d 106, 122 (2d Cir. 1998)). In *Roman*, the Sixth Circuit held that for habeas petitions in immigration contexts, "the INS District Director for the district where a detention facility is located 'has power over' alien habeas corpus petitioners." *Id.* at 320. The court, in finding that the Attorney General was not a proper respondent

for a noncitizen's habeas claim and that a habeas claim could properly have only one respondent, reiterated 28 U.S.C. § 2243's requirement that a writ of habeas corpus "shall be directed to *the* person having custody of the person detained." *Id.* at 321. Michigan only has one ICE District, located in Detroit. *See Enforcement and Removal Operations Field Offices*, https://www.ice.gov/contact/ero. Accordingly, Rebecca Adducci, the Detroit District Director, is the proper Respondent for Petitioner's request for a writ of habeas corpus.

III. Petitioner's Application for a Temporary Restraining Order

Petitioner, along with her complaint, filed an emergency application for a temporary restraining order. (ECF No. 3.) In determining whether to grant such an order, courts evaluate four factors: 1) whether the movant has a strong likelihood of success on the merits; 2) whether the movant would suffer irreparable injury absent an injunction; 3) whether granting the injunction would cause substantial harm to others; and 4) whether the public interest would be served by granting the injunction. *Northeast Ohio Coal. for Homeless and Serv. Emps. Intern. Union, Local 1199 v. Blackwell*, 467 F.3d 999, 1009 (6th Cir. 2006). These four factors "are not prerequisites that must be met,

but are interrelated considerations that must be balanced together. For example, the probability of success that must be demonstrated is inversely proportional to the amount of irreparable injury the movants will suffer absent the stay." *Id.* (internal quotations omitted). "[P]reliminary injunctions are extraordinary and drastic remedies [] never awarded as of right." *Am. Civil Liberties Union Fund of Michigan v. Livingston Cty.*, 796 F.3d 636, 642 (6th Cir. 2015). Nonetheless, each of the four factors weighs in Petitioner's favor, and the Court grants Petitioner's motion for a temporary restraining order.

A. Irreparable Harm

Petitioner is likely to experience irreparable injury absent an injunction, both in the form of loss of health or life, and in the form of an invasion of her constitutional rights.

1. Loss of Health or Life from COVID-19

The ongoing COVID-19 pandemic creates a high risk that absent an injunction by this Court, Petitioner will suffer irreparable harm in the form of loss of health or life as a result of contracting the COVID-19 virus.

On March 22, 2020, the Governor of Michigan issued the following statement: "The novel coronavirus (COVID-19) is a respiratory disease

that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease." Executive Order, No. 2020-20 (Mar. 22, 2020).

Since March 4, 2020, the date of Petitioner's detention at the Calhoun County Correctional Facility, the exceptionally dangerous nature of the COVID-19 pandemic has become apparent. On March 10, 2020, the Governor of Michigan announced the state's first two cases of COVID-19 and simultaneously declared a State of Emergency. Executive Order, No. 2020-4 (Mar. 10, 2020). The number of new cases then began to grow exponentially. As of April 5, 2020, there are now 15,718 confirmed cases of COVID-19 and 617 known related deaths, with 238 confirmed cases within the Michigan Department of Corrections system specifically. *See* *Coronavirus*, Michigan.gov, https://www.michigan.gov/coronavirus/0,9753,7-406-98163-520743--,00.html. COVID-19 has a high risk of transmission, and the number and

rate of confirmed cases indicate broad community spread.[4] Executive Order, No. 2020-20 (Mar. 22, 2020). Nationally, ICE detention facilities across our country are experiencing the same thing. As of April 4, 2020, ICE has confirmed at least 13 cases of COVID-19 among immigration detainees and 7 cases among detention facility employees and personnel. *ICE Guidance on COVID-19*, U.S. Immigration and Customs Enforcement, https://www.ice.gov/coronavirus (updated Apr. 4, 2020 at 8:00pm).

On March 23, 2020, the Centers for Disease Control and Prevention (CDC) acknowledged that correctional and detention facilities "present[] unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors." *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control (Mar. 23, 2020),

[4] Indeed, since the time of Respondent's brief, the numbers have continued to grow. Respondent reported that, as of April 3, 2020, Calhoun County alone had 25 cases. (ECF No. 11, PageID.169) By the time the Court held oral argument later that day, that number had grown to 31, with 1 reported death. On April 5, the date of this Order, the number of confirmed cases is now 42, with 1 reported death. *Coronavirus*, https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html.

https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html. [Hereinafter "CDC Guidance 3/23/2020"]. Specifically, the CDC noted that many detention conditions create a heightened risk of danger to detainees. These include: low capacity for patient volume, insufficient quarantine space, insufficient on-site medical staff, highly congregational environments, inability of most patients to leave the facility, and limited ability of incarcerated/detained persons to exercise effective disease prevention measures (e.g., social distancing and frequent handwashing). *Id.*

Though the CDC has recommended public health guidance for detention facilities, and though the Calhoun County Correctional Facility has indeed implemented measures designed to prevent spread of the disease, these measures are inadequate to sufficiently decrease the substantial likelihood that Petitioner will contract COVID-19. As prison officials are beginning to recognize around the country, even the most stringent precautionary measures—short of limiting the detained population itself—simply cannot protect detainees from the extremely high risk of contracting this unique and deadly disease. For example, on April 1, 2020, the Rikers Island jail complex's chief physician

acknowledged that "infections are soaring" despite the facility's "following Centers for Disease Control and Prevention guidelines and having moved mountains to protect our patients." Miranda Bryant, *Coronavirus Spread at Rikers is a 'Public Health Disaster', Says Jail's Top Doctor*, The Guardian (Apr. 1, 2020), https://www.theguardian.com/us-news/2020/apr/01/rikers-island-jail-coronavirus-public-health-disaster. In the immigration context specifically, despite Respondents' argument that the federal government has effectively incorporated appropriate and effective precautions, medical experts at the Department of Homeland Security have warned that detention confinement creates a "tinderbox scenario" where rapid outbreak is extremely likely, and extremely likely to lead to deadly results as resources dwindle on an exponential level. Catherine E. Shoichet, *Doctors Warn of 'Tinderbox Scenario' if Coronavirus Spreads in ICE Detention*, CNN (Mar. 20, 2020), https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html.

Petitioner is 56 years old and suffers from the following conditions, almost all of which place her at an increased risk of a dire outcome from

contracting the COVID-19 virus: multiple sclerosis, bipolar disorder, anemia, essential primary hypertension, hypothyroidism, chronic obstructive pulmonary disease, fibromyalgia, severe major depressive disorder, opioid addition, and polyneuropathy. (ECF No. 1-4, PageID.31.) *See* Centers for Disease Control, *Groups at Higher Risk for Severe Illness*, (Apr. 2, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html (noting that "people of all ages with underlying medical conditions are at higher risk for severe illness, particularly if the underlying medical conditions are not well controlled"). Additionally, Respondents have confined Petitioner in an environment where she "shares toilets, sinks, phones, and showers, eats in communal spaces, and is in close contact with the many other detainees and officers." (ECF No. 1, PageID.16.) Petitioner's involuntary interaction with purportedly asymptomatic guards who rotate shifts is also a significant exposure factor. *How COVID-19 Spreads*, CDC (April 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-

covidspreads.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Ftransmission.html.[5]

These are many of the conditions that the CDC has identified as being particularly likely to increase COVID-19 transmissions in detention facilities. CDC Guidance 3/23/2020. For these reasons, Petitioner's confinement at the Calhoun County Correctional Facility renders her substantially likely to contract COVID-19, and Petitioner's severe health conditions render her substantially likely to suffer irreparable harm or death as a result.

Respondents focus on one particular issue: whether Petitioner is more likely to contract COVID-19 if released than if she remains confined in their jail. Respondents acknowledge that "there is a health risk posed by COVID-19 and that Petitioner is in the category of people identified to be at higher risk for serious health consequences if she contracts COVID-

[5] On April 3, 2020, after Petitioner filed her emergency application for a temporary restraining order, the CDC updated its guidance in light of new evidence of asymptomatic transmission of COVID-19 to recommend that all individuals wear cloth face coverings "in public settings where other social distancing measures are difficult to maintain." *Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission*, CDC (Apr. 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html.

19." (ECF No. 11, PageID.178.) Respondents also acknowledge that Petitioner "does not have to wait until she has COVID-19 to claim that the precautions taken to reduce exposure were insufficient." (*Id.* at PageID.179.) Indeed, the crux of Respondents' argument is not that COVID-19 does not pose a deadly threat to Petitioner if contracted. Rather, Respondents' argument relies on the proposition that Petitioner does not have a substantial risk for *exposure* at the Calhoun County Correctional Facility, and her risk of exposure in the community may be greater. (*Id.* at PageID.178.)

To this end, Respondents posit the following: Petitioner has not established that she has either been exposed to COVID-19, or that her exposure is "imminent," because there are currently no cases in the facility in which she is detained "and only 25 cases in the surrounding county."[6] (ECF No. 11, PageID.179.) Additionally, Respondents argue that their facility has implemented "numerous precautions to reduce the risk of exposure and spread of COVID-19,"[7] and that even if Petitioner is

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[6] Hours later, due to the exponential nature of COVID-19's spread, this statistic was already out of date. *See supra* fn.2.

[7] Specifically, Respondents note that the ICE and CCCF precautions are as follows: tracking the disease, screening incoming detainees, isolating and testing

at a "generalized risk" of contracting COVID-19, that does not mean that she is at a "substantial risk" for purposes of her constitutional claim. (*Id.* at PageID.179-180, citing *Wooler v. Hickman Cty.*, 377 Fed. Appx. 502, 505 (6th Cir. 2010)).

Respondents' arguments fail to address the stark reality of this particular global public health crisis. In the face of a deadly pandemic with no vaccine, no cure, limited testing capacity, and the ability to spread quickly through asymptomatic human vectors, a "generalized risk" *is* a "substantial risk" of catching the COVID-19 virus for any group of human beings in highly confined conditions, such as Petitioner within the CCCF facility. In acknowledgment of this simple truth, both the United States Attorney General and the Governor of Michigan have issued independent directives to consider early release for detainees who do not pose a public safety risk, as minimizing crowded populations is the only known way to mitigate spread of this pandemic. *Prioritization of*

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symptomatic detainees, quarantining detainees who test positive, screening incoming staff, suspending in-person social visitation and limiting professional visitation to non-contact, increasing sanitation, educating all staff and detainees, providing detainees with toilet paper, personal soap, and disinfectants, and increasing hand-washing stations. (ECF No. 11, PageID.172.)

Home Confinement as Appropriate in Response to COVID-19 Pandemic, Att'y Gen. (Mar. 26, 2020); Executive Order, No. 2020-29 (COVID-19) (Mar. 26, 2020). Moreover, Petitioner's risk of contracting COVID-19 outside of Respondents' custody has no bearing on whether they have exposed her to the likelihood of irreparable harm. Though the Court commends Respondents for the steps they have taken to prevent spread of the disease, as prisons and courts around the country are beginning to recognize, such measures are insufficient to stem deadly prison outbreaks. *See, e.g.*, *New York City Board of Correction Calls for City to Begin Releasing People From Jail as Part of Public Health Response to COVID-19*, N.Y.C. Bd. of Corr. (Mar. 17, 2020), https://www1.nyc.gov/assets/boc/downloads/pdf/News/2020.03.17%20-%20Board%20of%20Correction%20Statement%20re%20Release.pdf (arguing that, despite the "heroic work" of Department of Correction and Correctional Health Services staff "to prevent the transmission of COVID-19 in the jails and maintain safe and humane operations, the City must drastically reduce the number of people in jail right now and limit new admissions to exceptional circumstances."). Even the Calhoun County Correctional Facility's additional measure of screening incoming

shift workers for high temperatures is insufficient to stem the spread of disease, as COVID-19 spreads asymptomatically. *How COVID-19 Spreads*, CDC (Apr. 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covidspreads.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Ftransmission.html.

Accordingly, the Court concludes that Petitioner's continued confinement at the Calhoun County Correctional Facility exposes her to a substantial risk of contracting COVID-19, which due to her specific underlying health conditions exposes her to a substantial risk of irreparable harm to her health or life.

2. Violation of Constitutional Rights

Petitioner's Fifth Amendment claim triggers a finding that Petitioner will suffer irreparable harm absent an injunction. Petitioner alleges that in "subjecting Janet to detention conditions that amount to punishment and that fail to ensure her safety and health," Respondent is "subjecting [her] to a substantial risk of serious harm, in violation of [her] rights under the Due Process Clause." (ECF No. 1, PageID.17.) The alleged violation of a constitutional right is sufficient for a court to find

irreparable harm. *See Overstreet v. Lexington-Fayette Urban Cty. Gov.*, 305 F.3d 566, 578 (6th Cir. 2002) (citing *Connection Distrib. Co. v. Reno*, 154 F.3d 281, 288 (6th Cir. 1998); *Covino v. Patrissi*, 967 F.2d 73, 77; *McDonell v. Hunter*, 746 F.2d 785, 787 (8th Cir. 1984) ; *see also Rhinehart v. Scutt*, 408 F. App'x 510, 514 (6th Cir. 2018) (suggesting that allegation of "continuing violation of . . . Eighth Amendment rights" would trigger a finding of irreparable harm). Below, the Court finds Petitioner is likely to succeed on the merits of this Fifth Amendment claim. Accordingly, "no further showing of irreparable injury is necessary." *Mitchell v. Cuomo*, 748 F.2d 804, 806 (2d Cir. 1984) ("When an alleged deprivation of a constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary.").

B. Likelihood of Success on the Merits

Petitioner is likely to succeed on the merits of her claim that her continued confinement during the COVID-19 pandemic violates her Fifth Amendment rights.

The Due Process Clause of the Fifth Amendment to the United States Constitution forbids the government from depriving a person of life, liberty, or property without due process of law. U.S. Const. amend.

V. The protection applies to "all 'persons' within the United States, including [noncitizens], whether their presence here is lawful, unlawful, temporary, or permanent." *Zadvydas v. Davis*, 533 U.S. 678, 693 (2001). As it pertains to Petitioner, the Due Process Clause prohibits the government from imposing torture or cruel and unusual confinement conditions on non-convicted detainees. *See Bell v. Wolfish*, 441 U.S. 520, 535 (1979) ("[U]nder the Due Process Clause, a detainee may not be punished prior to an adjudication of guilt."). This type of Fifth Amendment claim is analyzed "under the same rubric as Eighth Amendment claims brought by prisoners." *Villegas v. Metropolitan Government of Nashville*, 709 F.3d 563, 568 (6th Cir. 2013).

Eighth Amendment claims require a showing of deliberate indifference, *see Farmer v. Brennan*, 511 U.S. 825, 835 (1994), which has both an objective and a subjective component. *Villegas v. Metro. Gov't of Nashville*, 709 F.3d 563, 568 (6th Cir. 2013) (citing *Harrison v. Ash*, 539 F.3d 510, 518 (6th Cir. 2008)).

1. Objective Component

The objective component is satisfied by showing that, "absent reasonable precautions, an inmate is exposed to a substantial risk of

serious harm." *Richko v. Wayne Cty.*, 819 F.3d 907, 915 (6th Cir. 2016) (citing *Amick v. Ohio Dep't of Rehab. & Corr.*, 521 Fed.Appx. 354, 361 (6th Cir.2013)). Respondents argue that the precautions they have taken at the Calhoun County Correctional Facility combined with the lack of a confirmed outbreak of COVID-19 at the facility show that Petitioner is unable to demonstrate she is at substantial risk of serious harm. (ECF No. 11, PageID.180.) Instead, Respondents argue that Petitioner merely has a "generalized risk" of contracting COVID-19, which is insufficient to prevail on a Fifth Amendment constitutional claim. (*Id.*) But as noted above, in Petitioner's case, a generalized risk is a substantial risk.

As the Supreme Court explained in *Helling v. McKinney*, "[w]e have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." 509 U.S. 25, 33 (1993). "That the Eighth Amendment protects against future harm to inmates is not a novel proposition." *Id.* "It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening

condition in their prison on the ground that nothing yet had happened to them." *Id.*

Respondents attempt to distinguish this case from *Helling* on the grounds that the Petitioner in *Helling* alleged a sufficiently imminent danger from "actual exposure to high levels of cigarette smoke because his former cellmate was a five-pack a day smoker." (ECF No. 11, PageID.179 (citing *Helling*, 509 U.S. at 29).) Respondents argue that "Petitioner has not established that she either has been exposed to COVID-19, or that her exposure is "imminent."" (*Id.*) But as the above analysis regarding the risk of irreparable injury to Petitioner demonstrates, the Respondents grievously underestimate the seriousness of the risk to Petitioner, in spite of precautionary measures and despite the lack of confirmed CCCF outbreak to date. The ever-growing number of COVID-19 outbreaks in prisons and detention facilities,[8] despite a range of precautionary measures, demonstrates that

[8] *See, e.g.*, Ted Rod Roelofs, *Coronavirus Cases Surge in Michigan's Crowded Prisons*, Bridge (Mar. 27, 2020), https://www.bridgemi.com/michigan-government/coronavirus-cases-surge-michigans-crowded-prisons; *Oregon Inmate in Salem Tests Positive for COVID-19, the First in the State Prison System*, SalemReporter (Apr. 3, 2020), https://www.salemreporter.com/posts/2168/oregon-inmate-in-salem-tests-positive-for-covid-19-the-first-in-the-state-prison-system (noting outbreak despite precautionary measures); Ames Alexander and Jessica

the risk of a COVID-19 outbreak in Respondent's facility is significant. Nor, given the percentage of asymptomatic COVID-19 cases and the virus' incubation period of up to fourteen days, can Respondents reasonably assert, as they do, that there are no COVID-19 cases in CCCF; they can only allege that there are no confirmed cases. By the time a case is confirmed, it will almost certainly be too late to protect Petitioner's constitutional rights. Petitioner, so long as she remains detained, is therefore exposed to a substantial risk of serious harm.

2. Subjective Component

The subjective component is demonstrated by showing that "(1) the official being sued subjectively perceived facts from which to infer a substantial risk to the prisoner, (2) the official did in fact draw the inference, and (3) the official then disregarded that risk." 819 F.3d at 915–16 (citing *Rouster v. Cty. of Saginaw*, 749 F.3d 437, 446 (6th Cir. 2014)). "Because government officials do not readily admit the subjective

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Banov, *In NC Prisons, Five Employees and Four Inmates Have Now Tested Positive for COVID-19*, Charlotte Observer (Apr. 1, 2020), https://www.charlotteobserver.com/news/coronavirus/article241675886.html; Alexandra Kelley, *Louisiana Prison Records Third Inmate Death as a Result of the Coronavirus*, The Hill (Apr. 1, 2020), https://thehill.com/changing-america/well-being/prevention-cures/490839-louisiana-prison-records-third-inmate-death-as-a.

component of this test, it may be demonstrated in the usual ways, including inference from circumstantial evidence. . . . " *Richko,* 819 F.3d at 916 (citing *Dominguez v. Corr. Med. Servs*., 555 F.3d 543, 550 (6th Cir. 2009)). Additionally, "a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Farmer*, 511 U.S. at 842.

Respondents concede the COVID-19 risk to Petitioner: "The government does not dispute that there is a health risk posed by COVID-19 and that Petitioner is in the category of people identified to be at higher risk for serious health consequences if she contracts COVID-19." (ECF No. 11, PageID.178.) Rightfully so: the above analysis pertaining to the risk of irreparable harm reveals that the substantial risk to Petitioner is obvious. *Farmer*, 511 U.S. at 842.

Respondents instead argue that Calhoun County Correctional Facility's precautionary measures preclude a finding of deliberate indifference because government officials cannot be said to have disregarded the risk to Petitioner. As noted above, officials at the Calhoun County Correctional Facility have taken a range of precautionary measures to protect against a potential outbreak. (*See*

ECF No. 11-3.) But as Plaintiff's pleadings and the above analysis regarding irreparable injury demonstrate, even with these precautionary measures, in light of Petitioner's underlying health conditions, she is not ensured anything close to "reasonable safety." *Farmer*, 511 U.S. at 844. (*See* ECF No. 6-3, PageID.112 (Declaration of Doctor Golob stating, "[V]ulnerable people, people over the age of 50 and people of any age with lung disease . . . living in an institutional setting . . . are at grave risk of severe illness and death from COVID-19."); ECF No. 6-1, PageID.87 (Declaration of Infectious Disease Epidemiologist Joseph Amon, stating "The only viable public health strategy available is risk mitigation. . . . [T]he public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety.").) Based on the record before the Court, the only reasonable response by Respondents is the release of Petitioner; any other response demonstrates a disregard of the specific, severe, and life-threatening risk to Petitioner from COVID-19.

For the same reasons, Petitioner's continued detention cannot "reasonably relate[] to any legitimate government purpose." *Bell v. Wolfish*, 441 U.S. 520, 536-39 (1979) (holding that pretrial detention not

reasonably related to a legitimate government purpose must be considered punishment and therefore contrary to the Fifth Amendment). In their response, Respondents do not directly address the justification for Petitioner's continued detention. The Court notes that Petitioner is in civil detention pending removal proceedings pursuant to 28 U.S.C. § 1226(c). Petitioner faces significant risk of death due to COVID-19; accordingly, her continued confinement at the Calhoun County Correctional Facility is both unrelated and contrary to the government purpose of carrying out her removal proceedings.

Both the objective and subjective components are met; Petitioner has shown a likelihood of success on the merits. The Court reiterates that at this early stage in the litigation, Petitioner need not show a certainty of success on the merits. Indeed, "the probability of success that must be demonstrated is inversely proportional to the amount of irreparable injury the movants will suffer absent the stay." *Northeast Ohio Coalition for Homeless and Service Employees Intern. Union, Local 1199*, 467 F.3d at 1009 (6th Cir. 2006). Given the risk and severity of irreparable harm to Petitioner and the weight of public health evidence indicating release

as the only reasonable option under these facts, Petitioner has met her current burden with respect to the merits of her claim.

Respondents nonetheless cite to some authority that release is an inappropriate remedy for Petitioner's claim. *See Glaus v. Anderson,* 408 F.3d 382, 387 (7th Cir. 2005) (noting release is not among the proper remedies for Eighth Amendment deliberate indifference claims, which are limited to injunctive relief for proper treatment and damages); *Heximer v. Woods*, No. 08-14170, 2018 WL 1193368, at *2 (E.D. Mich. Mar. 8, 2018) (noting that "release from custody is not an available remedy for a deliberate indifference claim."). As explained above, Petitioner has shown a likelihood of success on the merits of her claim that given the extraordinary nature of the COVID-19 pandemic, no set of possible confinement conditions would be sufficient to protect her Fifth Amendment rights. Release from custody represents the only adequate remedy in this case, and it is within this Court's broad equitable power to grant it. *See Swann v. Charlotte–Mecklenburg Bd. of Educ.*, 402 U.S. 1, 15–16 (1971) ("Once a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies.")

3. Qualified Immunity

In its supplemental brief, Respondents note that to the extent Petitioner brings a civil rights case, Respondents are entitled to assert a defense of qualified immunity. (ECF No. 19, PageID.317.) Qualified immunity is unavailable as a defense in cases seeking injunctive relief. *See Pearson v. Callahan*, 555 U.S. 223, 242 (2009) (noting that qualified immunity defense is not available in "suits against individuals where injunctive relief is sought in addition to or instead of damages"); *Harlow v. Fitzgerald*, 457 U.S. 800, 806 (1982) (describing qualified immunity as "immunity from suits for damages"). Because Petitioner here seeks only declaratory and injunctive relief, qualified immunity does not apply.

C. Balance of Equities and Public Interest

When the government opposes the issuance of a temporary restraining order, as Respondents do here, the final two factors—the balance of equities and the public interest—merge, because "the government's interest is the public interest." *Pursuing America's Greatness v. Fed. Election Comm'n*, 831 F.3d 500, 512 (D.C. Cir. 2016) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)).

The public interest favors Petitioner's release because of the risk that Petitioner's constitutional rights will be deprived absent an injunction. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *G & V Lounge Inc. v. Mich. Liquor Control Comm.*, 23 F.3d 1071, 1079 (6th Cir.1994).

Additionally, Petitioner's release will protect public health. Given the highly unusual and unique circumstances posed by the COVID-19 pandemic and ensuing crisis, "the continued detention of aging or ill civil detainees does not serve the public's interest." *Basank,* 2020 WL 1481503, at *6; *see also Fraihat v. U.S. Imm. and Customs Enforcement*, 5:19 Civ. 1546, ECF No. 81-11 (C.D. Cal. Mar. 24, 2020) ("the design and operation of detention settings promotes the spread of communicable diseases such as COVID-19"); *Castillo v. Barr*, CV-20-00605-TJH (C.D. Cal. 2020). Protecting public health and safety is in the public interest. *See Neinast v. Bd. Of Trustees*, 346 F.3d 585, 592 (6th Cir. 2003) (recognizing public health and safety as legitimate government interests).

Respondents argue that public interest favors Petitioner's continued detention because "the public interest in enforcement of the

United States' immigration laws is significant." (ECF No. 11, PageID.187 (citing *United States v. Martinez-Fuerte*, 428 U.S. 543, 556–58 (1976); *Blackie's House of Beef, Inc. v. Castillo*, 659 F.2d 1211, 1221 (D.C. Cir. 1981) ("The Supreme Court has recognized that the public interest in enforcement of the immigration laws is significant.")).

Respondents point to only one immigration law that will see continued enforcement by denying relief to Petitioner. That law is 8 U.S.C. § 1226(c), and it authorizes Petitioner's continued detention. But as set forth above, Petitioner's continued detention is in violation of the United States Constitution, to which 8 U.S.C. § 1226(c) must give way.

The enforcement of the remainder of U.S. immigration laws against Petitioner will continue unabated should the Court grant Petitioner relief. A hearing on Petitioner's request for cancellation of removal is scheduled for April 14, 2020. (ECF No. 11, PageID.170). Respondents do not argue that Petitioner's release will jeopardize her appearance at that hearing, nor do they argue that Petitioner's release will undermine her removal from this country, should Petitioner's defense fail and should conditions allow such removal.

The public interest and balance of equities demand that the Court protect Petitioner's constitutional rights and the public health over the continued enforcement of a detention provision that, as applied to Petitioner, is unconstitutional. The remaining factors counsel granting Petitioner relief.

Because all four factors weigh in favor of issuing emergency injunctive relief, Petitioners motion for a temporary restraining order is granted.

IV. Conclusion

For the reasons stated above, Petitioner's Application for a Temporary Restraining Order is GRANTED IN PART. Respondent Adducci is ORDERED to release Petitioner on April 6, 2020 on her own recognizance. Petitioner will be subject to the following restrictions: Petitioner is subject to fourteen days of home quarantine; Petitioner must comply with all Michigan Executive Orders; and Petitioner must appear at all hearings pertaining to her removal proceedings. Respondents may impose other reasonable nonconfinement terms of supervision.

Respondents are further RESTRAINED from arresting Petitioner for civil immigration detention purposes until the State of Emergency in

Michigan (related to COVID-19) is lifted or until further Court Order stating otherwise.

The Temporary Restraining Order will expire on April 17, 2020, at 6:30 p.m. No later than April 10, 2020, at 12:00 p.m., Respondents must show cause why this Order should not be converted to a preliminary injunction. Petitioner may file a response no later than April 16, 2020, at 12:00 p.m.

IT IS SO ORDERED.

Dated: April 6, 2020
Ann Arbor, Michigan

s/Judith E. Levy
JUDITH E. LEVY
United States District Judge

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing document was served upon counsel of record and any unrepresented parties via the Court's ECF System to their respective email or First Class U.S. mail addresses disclosed on the Notice of Electronic Filing on April 6, 2020.

s/William Barkholz
WILLIAM BARKHOLZ
Case Manager