IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

JOHN BAXLEY, JR., *et al.*,

Plaintiffs,

v. **Civil Action No. 3:18-cv-01526**
(Chambers, J.)

BETSY JIVIDEN, *et al.*,

Defendants.

DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS'
EMERGENCY MOTION FOR PRELIMINARY INJUNCTION

In opposition to Plaintiffs' Emergency Motion for Preliminary Injunction Regarding Defendants' Prevention, Management, and Treatment of COVID-19, Defendants state as follows:

I. OVERVIEW AND SUMMARY OF ARGUMENT

Plaintiffs' seek three forms of relief: 1) an order requiring Defendants "to develop, disclose, and implement a plan that undertakes all appropriate actions to protect Plaintiffs;" 2) "an order directing WVDCR to release a sufficient number of inmates [to] reduce overcrowding;" and, 3) an order requiring "appropriate social distancing within the jails and prisons to protect medically vulnerable inmates as well as those who remain incarcerated and correctional staff." The motion is nothing but a recycled version of a similar motion seeking a TRO/habeas corpus relief recently denied by a Federal Court in Washington based upon some of the exact same evidentiary support. Plaintiffs fail to identify the source of their evidentiary support and also fail to inform this Court that an attempt to seek similar relief has already failed using the same evidence.

Moreover, Plaintiffs' motion is completely unfounded because it raises new claims that are not within the scope of the Amended Complaint and which did not exist until after the filing of the Amended Complaint. Plaintiffs are not permitted to simply bootstrap their COVID-19 claims into

an existing case. Instead, these new claims could only be considered by this Honorable Court after a successful motion to amend under Rule 15 of the Federal Rules of Civil Procedure.

In addition, Plaintiffs' motion is based upon the false premise that WVDCR currently does not have an adequate plan in effect to deal with the COVID-19 pandemic. Plaintiffs are well-aware of the fact that WVDCR already has a plan in effect to deal with the COVID-19 pandemic. Counsel for Plaintiffs has even acknowledged that this plan may be "adequate" and that the motion for emergency relief is based upon nothing other than her assumption that it may be "inadequate" simply because she has not seen it. This does not come even close to meeting the standard required to justify application of the extraordinary remedy of a preliminary injunction.

For security and public safety reasons, the Policy Directive related to the COVID-19 pandemic is confidential, and the WVDCR has declined all requests by the ACLU and others to publicly disclose it. Defendants affirmatively represent to the Court that each and every one of the 12 "bullet point" concerns of Plaintiffs identified in their emergency motion are either affirmatively addressed by the Policy Directive and related memoranda, or are non-issues due to current policy and practice of WVDCR.

In the alternative, Defendants suggest that a narrow order, requiring the Defendants to file the Policy Directive under seal and to permit this Court to review it *in camera* is all that is necessary. Should this Court undertake this *in camera* review, it will be able to see for itself that all of Plaintiffs' concerns stated in their emergency motion are already affirmatively addressed.

There are two additional major impediments to the relief requested. First, Plaintiffs are not seeking a traditional prohibitory injunction that would maintain the *status quo*. They are seeking a mandatory injunction that would require Defendants to take affirmative action such as developing a COVID-19 plan that meets their specifications. They also seek the release of inmates

and enforcement of social distancing policies. As a general rule, mandatory injunctions are disfavored. Second, this Court's ability to issue an injunction in this case is severely restricted by the provisions of the Prison Litigation Reform Act of 1995. Specifically, under 18 U.S.C. § 3626(a)(1)(A), this Court is required to narrowly draw any injunction so that it "extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right" and any such injunction is for a limited period of time. Further, under § 3626(a)(3), this Court has no authority to release an inmate, as that remedy is restricted to a three-judge court, and only after a previous less restrictive order has been entered. Based upon the provisions of the PLRA, as more fully discussed herein, this Court should deny the Plaintiffs' motion.

Finally, Defendants respectfully submit that this motion is nothing but an improper attempt to use this Court as a de facto appeal of the FOIA process. For these reasons, as more fully discussed herein, this Court should deny the Plaintiffs' motion.

II. LAW AND ARGUMENT

A. Standard of Review for a Preliminary Injunction.

As this Court has previously noted: "preliminary injunctions are extraordinary remedies involving the exercise of very far reaching power to be granted only sparingly and in limited circumstances." *Wei-Ping Zeng v. Marshall University*, 2018 U.S. Dist. LEXIS 46151, 2018 WL 1410418 (S.D. W.Va. 2018). The party seeking injunctive relief "bears the burden of demonstrating, by a clear showing, his entitlement to relief." *Id.* (citing *Winter v. NRDC, Inc.*, 555 U.S. 22 (1974)). As this Court has further noted: "[w]hen assessing the appropriateness of a preliminary injunction, the threshold determination is the plaintiff's showing that irreparable harm

is likely to occur if the injunction is not granted." *Wei-Ping Zeng* at pp. 40-41 (citing *Hughes Network Sys., Inc. v. InterDigital Communications Cor.*, 17 F. 3d 691 (4th Cir. 1994)).

Furthermore, as discussed at length herein, the Plaintiffs' request for emergency injunctive relief is not based upon any actual evidence. Rather, it is based upon Plaintiffs' speculative concerns about the mere possibility of harm. However, a plaintiff must establish "more than just the 'possibility' of irreparable harm," and injunctive relief is only appropriate based upon a "clear showing that the plaintiff is entitled to relief." *Di Biase v. SPX Corp.*, 872 F. 3d 224 (4th Cir. 2017). Plaintiffs fail to meet this standard and their motion should be denied.

Finally, this Court should be mindful of the fact that mandatory injunctions, particularly in the prison context that seek to alter the status quo, are disfavored. As Judge Goodwin recognized in *Murray v. Terry*, 2018 U.S. Dist. LEXIS 122262 (S.D. W. Va. 2018) at pp. 5-6:

> "[I]n the prison context, a request for injunctive relief must always be viewed with great caution because judicial restraint is especially called for in dealing with the complex and intractable problems of prison administration." *Barnett v. Young*, No. 5:18-cv-279, 2018 U.S. Dist. LEXIS 117088, 2018 WL 3405415, at *2 (S.D. W. Va. June 21,2018). …"
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> Ordinarily, preliminary injunctions are issued to 'protect the status quo and to prevent irreparable harm during the pendency of a lawsuit ultimately to preserve the court's ability to render a meaningful judgment on the merits.'" *Perry v. Judd*, 471 F. App'x 219, 223 (4th Cir. 2012) (quoting *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir.2003)). These are known as "prohibitory injunctions." Here, the plaintiff seeks not to preserve, but instead to alter the status quo by requesting transfer from MOCC to a different WVDOC facility. Pl.'s Mot. 1. This type of injunction is known as a "mandatory injunction." Courts disfavor mandatory preliminary injunctions, and they are "warranted only in the most extraordinary circumstances." *Perry v. Judd*, 471 F. App'x 219, 223 (4th Cir. 2012).

As discussed more fully herein, a mandatory injunction, such as requested by Plaintiffs, should not be granted in this case.

Also relevant is the four-part test for granting a preliminary injunction set forth in *In re Microsoft Corp. Antitrust Litig.*, 333 F.3 517 (4th Circ. 2003) under which the Court must consider:

"1) the likelihood of irreparable harm to the plaintiff if a preliminary injunction is denied; 2) the likelihood of harm to the defendant if the injunction is granted, 3) the likelihood that the plaintiff will succeed on the merits, and 4) the public interest." *Id.*

B. Added Considerations of the Prison Litigation Reform Act ("PLRA")

Plaintiffs' motion must also be considered under the restrictions imposed by the PLRA. The Fourth Circuit in *Alexander S. v. Boyd*, 113 F.3d 1373, 1380 (4th Cir. 1997) *cert. denied*, 522 U.S. 1090 (1998), first discussed these restrictions when the law was enacted and it noted the following limitations:

> Section 802 limits the remedies available in actions challenging conditions of confinement brought under any Federal law, as in this action, which was brought under 42 U.S.C.A. § 1983. Commonly known as the "Stop Turning Out Prisoners" (STOP) provisions, § 802 limits a federal court's ability to grant prospective relief. Specifically, § 802's provisions restrict preliminary injunctive relief, see 18 U.S.C.A. § 3626(a)(2); prohibit the imposition of population caps except as a last resort, see 18 U.S.C.A. § 3626(a)(3); allow for the immediate termination of prospective relief after a limited time, see 18 U.S.C.A. § 3626(b); restrict approval of consent decrees, see 18 U.S.C.A. § 3626(c); require prompt judicial decisions on motions to modify or terminate relief, see 18 U.S.C.A. § 3626(e); and limit the authority and payment of special masters, *see* 18 U.S.C.A. § 3626(f)….
>
> In an attempt to stem the tide of frivolous lawsuits initiated by federal and state prisoners, Congress passed § 803 of the PLRA (codified at 42 U.S.C.A. § 1997e), which places new procedural restrictions on lawsuits "with respect to prison conditions" whether brought under § 1983 or any other Federal law by "a prisoner confined in any jail, prison, or other correctional facility." In addition to mandating administrative exhaustion, § 803 of the PLRA, entitled "Suits by prisoners," provides for the immediate dismissal of frivolous lawsuits, see 42 U.S.C.A. § 1997e(c); limits recovery for mental and emotional injuries, see 42 U.S.C.A. § 1997e(e); limits the removal of a prisoner from confinement during pretrial proceedings, see 42 U.S.C.A. § 1997e(f); allows the waiver of the right to reply to prisoner lawsuits, see 42 U.S.C.A. § 1997e(g); and, as is pertinent to this action, restricts the availability and amount of attorney's fees recoverable by prisoners under 42 U.S.C.A. § 1988, see 42 U.S.C.A. § 1997e(d).

Here Defendants note the following impediments under the PLRA to the Plaintiffs' motion in this case:

- There is no showing that Plaintiffs have exhausted their administrative grievance remedies prior to filing this motion, as required under 42 U.S.C. § 1997e(a);

- To the extent Plaintiffs are requesting that this Court issue an order directing Defendants to release any inmates or pretrial detainees, the Defendants have no such authority, as stated in its other Response filed this date (Doc 167), and said order would be in violation of the provisions of 18 U.S.C. § 3626 (a)(1)(B) that precludes any order "requires or permits a government official to exceed his or her authority under State or local law. . .;"

- Under 18 U.S.C. § 3626 (a)(2) no preliminary injunction shall issue unless the court "shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief;"

- Under 18 U.S.C. § 3626 (a)(2) no preliminary injunction may exceed ninety-days, unless specific findings may be made, and such findings should not be made in this case; and,

- To the extent that Plaintiffs are seeking an order of release of inmates and pretrial detainees, under 18 U.S.C. § 3626 (a)(3) a court must first enter an order providing for "less intrusive relief," and only after that fails to work, may a three-judge court consider an order for release.

Finally, an additional consideration for this Court arises under *O'Dell v. Netherland*, 112 F.3d 773, 776-77 (4th Cir. 1997), wherein the Court of Appeals admonished district courts that it was not their job to micromanage state prisons:

> [e]ssentially, the district court subjected the State's informed security judgment to the very kind of "inflexible strict-scrutiny analysis," which the Supreme Court has repeatedly held impermissibly hamstrings prison administrators in their efforts "to anticipate security problems and to adopt innovative solutions to the intractable problems of prison administration." *Casey*, 116 S. Ct. at 2185 (quoting *Jones v. North Carolina Labor Union, Inc*., 433 U.S. 119, 128, 53 L. Ed. 2d 629, 97 S. Ct. 2532 (1977)). As we have repeatedly held, on instruction from the Supreme Court, it is not for the federal courts to so micromanage the Nation's prisons. *Taylor v. Freeman*, 34 F.3d 266 (4th Cir. 1994).

With the Plaintiffs requesting relief in terms of a COVID-19 policy that meets their specified parameters and their request that social distancing policies should be imposed by this Court, they are really requesting that this Court micromanage the West Virginia prisons and Regional Jails. This Court should respectfully reject the Plaintiffs' motion on this basis.

C. Factual Background.

As of this date, there are no known or confirmed employee or inmate cases of COVID-19 in either the Regional Jails or Prisons of West Virginia. Despite the lack of cases, WVDCR has been proactive in its response to the COVID-19 Pandemic. This due in large part to WVDCR's efforts to address and proactively take appropriate steps, formal and informal, that began before the recent extraordinary measures involving the general public. On March 11, 2020, WVDCR Commissioner Betsy Jividen sent the first formalized memorandum to all WVDCR employees regarding COVID-19. *See* Jividen affidavit attached as **Exhibit 1**. In that memorandum, Commissioner Jividen noted that "we are mindful of the need to reduce the risk and protect the health and safety of our employees, populations, volunteers, contractors, and others who enter our facilities and do business with us." *Id.* The memorandum outlined certain "proactive guidelines and controls" based upon input and guidance from the Center for Disease Control ("CDC") and certain West Virginia health agencies. *Id.* The memorandum provided historical background regarding COVID-19 and also set forth policies regarding: 1) good health habits and sanitation; 2) frequent hand washing and/or sanitizing; 3) respiratory (coughing and sneezing) etiquette; 4) avoiding touching the face, eyes, nose and mouth; 5) increased emphasis on disinfection of "high touch" areas; 6) screening of inmates, employees, contractors, volunteers, and others; 7) cancellation of "non-attorney" in-person visits; and 8) approval of the use of electronic visitation and telephone calls. *Id.* In addition, the memorandum directed that all job-related out-of-state and international travel for employees was cancelled until further notice. *Id.* Employees that were sick or showing flu-like symptoms were also instructed to stay home, contact their medical providers, and be tested. *Id.*

The memorandum also mandated health care administrators to provide supervisors with the training needed to conduct daily screenings of employees reporting to work. *Id.* Employees under movement restriction were not to be permitted to return to work until the completion of an appropriate monitoring period. *Id.* The memorandum also contained:

- information and strategies designed to eliminate or minimize out-of-pocket expenses to employees related to testing for COVID-19 and insurance deductibles;
- information to employees regarding mental health support and a "hotline" for those suffering from fear or stress over the COVID-19 pandemic;
- instruction and policies related to the screening of contractors, vendors and volunteers; and
- instructions and policies regarding the use of respirator masks for medical personnel and WVDCR employees. *Id.*

Thereafter, on March 20, 2020, Commissioner Jividen issued a second comprehensive Policy Directive entitled "COVID-19 RESPONSE PLAN" incorporating additional information, policies, instructions, and procedures based upon evolving guidance from multiple governmental and medical sources. *Id.* The COVID-19 Response Plan is confidential for security and public safety reasons. *Id.* The Policy Directive sets forth specific, comprehensive policies regarding administration and coordination, communication and education, preventative measures, policies regarding visitors, volunteers, contractors, and lawyers, employee/inmate screening, management and testing of respiratory illness victims, personal protective equipment, transportation of inmates, isolation and cohorting of symptomatic persons, care for the sick, and quarantine. *Id.*

Even more recently, on March 26, 2020, Commissioner Jividen addressed a memorandum to all facility superintendents and directors discussing "Interim Guidance from the Centers for Disease Control and Prevention." *Id.* The purpose of the memorandum was to disseminate a document from CDC entitled "*Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.*" The CDC memorandum is attached hereto

as **Exhibit 2**. As the Court can see, this CDC memorandum addresses, among other things, specific "guidance" to correctional and detention facilities related to COVID-19 and outlines certain "best practices" related to: 1) operational and communications preparations for COVID-19; 2) enhanced cleaning and disinfecting and hygiene practices; 3) social distancing strategies; 4) visitor policies; 5) infection control; 6) screening for inmates, staff and visitors; 7) medical isolation/cohorting; 8) healthcare for suspected cases; 9) clinical care; and 10) considerations for high risk persons. *Id.*

While Plaintiffs now move this Court to order Defendants to adopt a COVID-19 plan, Plaintiffs have at the same time acknowledged that WVDCR has already adopted a plan to deal with COVID-19. *See* March 23, 2020 email from Plaintiffs' counsel attached as **Exhibit 3**.[1] Incredibly, Plaintiffs' counsel even acknowledged in that email that the plan may be "adequate." *Id.* Thus, this emergency motion is based solely upon speculation that the plan may somehow be inadequate and/or Plaintiffs' dissatisfaction with not being provided with a copy of the COVID-19 Policy Directive.

C. Plaintiffs' motion is just a recycled "kit motion" that already failed in another jurisdiction.

While Plaintiffs do not disclose the source of their arguments or evidentiary support in this case, Defendants have learned that the motion and all of the declarations related to it are available on the internet and are being indiscriminately used in numerous cases across the country. Most significantly, the affidavits submitted to the Court by Plaintiffs were used in conjunction with another similar case in the State of Washington in which the ACLU was unsuccessful in its attempt to obtain a temporary restraining order ("TRO"). Attached as **Exhibit 4** is a motion for TRO filed by the American Civil Liberties Union ("ACLU") in the case styled *Karlena Dawson et al. v.*

[1] It is noted that this email was redacted in part because it related to negotiations over the ninety-day extension requested by Defendants and other matters not pertinent to the Plaintiffs' motion.

Nathalie Asher et al.¸ Case No. 2:20-cv-409 in the United States District Court for the Western District of Washington. As the Court can see, the text of the substantive legal arguments made in that case on pages 12-13 are identical to the text of the arguments made by Plaintiffs in the instant motion at pages 10-11. In addition, the declarations of Dr. Robert B. Greifinger (Exhibit 2 to Plaintiffs' motion, Doc 161-2); Dr. Marc Stern (Exhibit 3 to Plaintiffs' motion, Doc 161-3); and Dr. Jonathan Golob (Exhibit 5 to Plaintiffs' motion, Doc 161-5) are identical to the declarations offered from these same physicians in support of the unsuccessful motion for TRO in *Asher*. *See Asher* declarations of Greifinger, Stern, and Golob attached hereto as **Exhibits 5, 6, and 7**, respectively.[2] Even more importantly, Plaintiffs failed to disclose that a substantively identical motion for a TRO was denied by the District Court in *Asher* upon consideration of much of this same "evidence" after the Court found that there was insufficient evidence to support a finding of "irreparable harm." *See* Order in *Asher* denying a TRO attached as **Exhibit 8**.

Attorneys generally owe a duty of candor to both the Court and the litigants. At the "heart of the general duty of candor" is an attorney's "continuing duty to inform the Court of any development which may conceivably affect the outcome of the litigation." *Tiverton Board of License Com's v. Pastore*, 469 U.S. 238 (1985). The law is also clear that the duty of candor is violated by "the concealment of material information" and not just an "overt false statement." *Gum v. Dudley*, 202 W. Va. 477, 505 S.E.2d 391 (1977) (additional citations omitted).

[2] Upon information and belief, some of the same declarations relied upon by Plaintiffs herein (Golob, Meyer and Stern) are also available online as part of a COVID-19 kit established by the National Juvenile Defender Center (NJDC). *See* https://njdc.info/our-work/juvenile-defense-resources/. The undersigned was not able to obtain actual copies of the referenced declarations because to get access, one must represent that they are a "certified JTIP trainer" or "practicing juvenile defense attorney." *Id.* The Court may also note that identical declarations for Stern, Golob, Greifinger, and Meyer were filed in the Eastern District of California in support of a Motion requesting revocation of a Pretrial Detention Order in *United States v. Toro*, Civil Action No. 1:19 CR 256 NONE/SKO (Doc. 145). Undersigned counsel has found other cases through the internet where some of the identical declarations in this case were filed as well.

In the instant case, one would have expected a candid Plaintiffs' counsel to disclose at a minimum: 1) that some or all of their evidentiary support came from other cases; 2) that none of the expert affidavits submitted are based upon an analysis of the WVDCR system, resources, practices, and policies; and 3) that a similar motion filed before another Federal Court and based upon the same evidentiary support was previously denied. Based upon the above, this Court should take notice of the fact that the instant motion is nothing but a recycled attempt to seek relief that has already been rejected by another Federal Court considering much of the same evidence. This Court should likewise reject the motion in this case.

D. Plaintiffs' Motion Must be Denied as it is Not Relevant to this Case.

Plaintiffs' emergency motion must also be denied because it has nothing to do with the present case. In their "First Amended Class Action Complaint for Injunctive and Declaratory Relief," Plaintiffs set forth in the first paragraph the following summary of their claims:

> [s]pecifically, ***plaintiffs seek to ensure that jails in West Virginia promptly provide appropriate and necessary medical and mental health treatment to inmates upon admission***, as required under the Eighth and Fourteenth Amendments….In addition, the named plaintiffs, who are all housed at Western Regional Jail and Correctional Facility ("Western Regional") in Barboursville, West Virginia, bring this action on behalf of inmates housed at Western Regional stemming from the Defendants' violation of the Eighth and Fourteenth Amendments to the United States Constitution for deliberate indifference to plaintiff's health and safety ***as a result of the conditions of confinement in that facility.***

Document 14-1 at ¶ 1. Thus, this case as pled is about only two things: 1) statewide claims related to how inmates generally receive medical and mental health treatment upon admission; and 2) general conditions of confinement at Western Regional Jail.

Plaintiffs are now improperly attempting to bootstrap claims related to the COVID-19 pandemic that have nothing to do with the claims previously pled and which claims did not even exist at the time the Amended Complaint was filed. However, the law is clear that "a plaintiff may

not raise new claims after discovery has begun without amending his complaint." *Wahi v. Charleston Area Medical Center*, 562 F.3d 599 (4th Cir. 2009) (citing *Barclay White Skanska, Inc. v. Battelle Mem'l Inst.*, 262 Fed. APPX. 556 (4th Circ. 2008) (additional citations omitted). Discovery has more than "begun" in this case. Plaintiffs have not even attempted to amend their Complaint to assert claims related to COVID-19. The emergency motion for injunctive relief must be denied as it attempts to seek adjudication of claims not properly before this Court.[3]

E. Plaintiffs' motion must be denied as WVDCR already has in place an adequate "plan" related to the COVID-19 pandemic.

Plaintiffs' emergency motion is based upon the false premise that WVDCR has no plan for the prevention and management of COVID-19. However, two days before filing the emergency motion, counsel for Plaintiffs stated in an email to Defendants' counsel: "in regard to the ID/COVID-19 plan, we appreciate you sending us the 2016 policy. We understand, however, that a specific policy was put in place for the pandemic on March 20, which you have not provided." *See* March 23, 2020 email attached as **Exhibit 3**.

Thus, Plaintiffs are in effect asking this Court to order the creation of a policy that they know already exists. Once again, counsel for Plaintiffs are demonstrating a lack of candor towards this Court. At a minimum, the duty of candor required Plaintiffs to acknowledge that they know a WVDCR plan for dealing with COVID-19 exists, but they have concerns that it is not adequate and/or not being publically disclosed. Instead they have ignored the undisputed fact that plan exists and improperly asked this Court to order Defendants to promulgate one under its supervision.

[3] It should be noted that counsel for Plaintiffs have by the filing of this motion ironically diverted attention, efforts, and resources of WVDCR away from dealing with the COVID-19 pandemic so that they can properly respond to a baseless emergency motion that seeks only to accomplish things that they know or should know have already been accomplished.

F. Plaintiffs' speculation that the plan adopted by WVDCR "may" be inadequate is not a proper basis for injunctive relief.

Plaintiffs fall far short of the standard required to obtain a preliminary injunction because they cannot prove "irreparable harm." Counsel for Plaintiffs acknowledges in **Exhibit 3** that WVDCR has, in fact, adopted a specific plan for dealing with the COVID-19 pandemic. Plaintiffs do not know that the plan is inadequate but rather admit that they simply must "assume" it is inadequate since they do not have a copy of it. *See* **Exhibit 3**. Plaintiffs' counsel has even acknowledged that the plan adopted by WVDCR might very well be "adequate." *Id.* An assumption of harm falls far short of meeting the standard for the extraordinary remedy of a preliminary injunction. In fact, the law is clear that a plaintiff must establish "more than just the 'possibility' of irreparable harm," and injunctive relief is only appropriate based upon a "clear showing that the plaintiff is entitled to relief." *Di Biase v. SPX Corp.*, 872 F. 3d 224 (4th Cir. 2017).

As stated, Plaintiffs have selectively failed to identify for the Court a motion for TRO that failed based upon the same evidentiary support, but they did not hesitate to bring to the Court's attention "supplemental authority" (Doc 166), an order recently issued in *Basank v. Decker*, 20-civ-2518 (S.D.N.Y. Mar. 26, 2020). However, that Order had nothing to do with the issues before this Court, i.e., whether it should order Defendants to adopt some type of COVID-19 action plan. Rather, the Order in *Basank* dealt with the actual release of several ICE detainees[4] who were suffering from various "chronic medical conditions." Order at p. 2. Moreover, the Order in *Basank* specifically notes that the affected persons were "housed in New Jersey county jails where either detainees or staff have tested positive for COVID-19." No inmates or staff in any West Virginia

[4] It is obviously an important distinction that the "detainees" in *Basank* were not "inmates" and that unlike the majority of Plaintiffs herein, they had not been charged, arraigned, and/or convicted of a specific criminal act.

jail or prison have yet tested positive for COVID-19. As the Court is also aware, West Virginia has the distinction of being the last state to have a person diagnosed with COVID-19. *See, e.g.*, https://time.com/5805097/west-virginia-covid-19-testing/. The situation in West Virginia is simply not as pronounced as it is in New York and New Jersey.

It is also worthy of noting that while Plaintiffs (much like the rest of us) are exposed to some risk of contracting COVID-19, this does not automatically support a constitutional claim for "deliberate indifference" to medical needs under the Eighth Amendment or mean that there is an unreasonable risk of harm. *See, e.g.*, *Jackson v. Rikers Island Facility*, 2011 U.S. Dist. LEXIS 84842, 2011 WL 3370205 (S.D.N.Y Aug. 2, 2011) (finding no deliberate indifference when reasonable steps were taken to prevent exposure and provide timely treatment to prisoners experiencing the swine flu and that "exposure to swine flu, in and of itself, does not involve an unreasonable risk of serious damage to future health and does not constitute a deprivation of basic human needs that was objectively sufficiently serious"); *Glaspie v. New York City Dep't of Corr.*, 2010 U.S. Dist. LEXIS 131629, 2010 WL 4967844 (S.D.N.Y Nov. 30 2010) (finding that "mere exposure to swine flu does not involve an unreasonable risk of serious damage…to future health" and did not constitute an Eight Amendment violation); *Ayala v. NYC Dep't of Corr.*, 2011 WL 2015499, *2 (S.D.N.Y. May 9, 2011) (prisoner who contracted swine flu could not prevail on deliberate indifference claim because prison officials took reasonable measures to sanitize contaminated facility and prevent inmate infections); and, *Washington v. Harrington*, 2012 WL 3763964, *2–6 (E.D. Cal. Aug. 29, 2012), aff'd, 549 F. App'x 679 (9th Cir. 2013) (inmate suffering from asthma could not state deliberate indifference claim where symptoms of swine flu were recognized and monitored and inmate was transferred outside of prison for treatment).

As noted by the Fourth Circuit in *Johnson v. Quinones*, 145 F.3d 164 (4th Cir. 1998), to establish a claim of "deliberate indifference," the prisoner must prove two elements: "1) that objectively the deprivation of a basic human need was sufficiently serious, and 2) that subjectively the prison officials acted with a sufficiently culpable state of mind." *Id.* (citations omitted). The "objective" component is "satisfied by a serious medical condition." *Id.* at p. 167. The "subjective" component is satisfied by proof of "something more than negligence but is satisfied by something less than the acts or omissions for the very purpose of causing harm or with knowledge that harm will result." *Id.* On the other hand, governmental officials "may be found free from liability if they responded reasonably to a perceived risk." *Parrish v. Cleveland*, 372 F. 3d 294 (4th Circ. 2004).

In the instants case, no Plaintiff or inmate has yet to be diagnosed with COVID-19 and the existence of only the fear that they someday may be exposed to or contract COVID-19 is not sufficient to satisfy the objective component. *See, also, Quarles v. De La Cuesta*, 1993 U.S. Dist. LEXIS 3575, 1993 WL 86460 (E.D. Pa. 1993) (finding that mere "fear of exposure" to tuberculosis was insufficient to establish a constitutional claim) and *Wash v. Gilless*, 2000 U.S. App. LEXIS 11578 (6th Circ. 2000) (finding that an inmates "subjective fear" of being exposed to HIV was not sufficient to establish a "serious medical need"). Plaintiffs likewise cannot establish the "subjective" component of a deliberate indifference claim insofar as there has been no diagnosis of COVID-19 within the jail and prison system in West Virginia; but, more importantly, because Defendants already have a plan in place that is reasonable to deal with COVID-19 in the unfortunate event that it does so arise.

G. The WVDCR COVID-19 plan already in place adequately addresses each and every one of Plaintiffs' specified concerns.

Plaintiffs ask for this Court to order Defendants to implement a plan that addresses the following 12 specific issues or concerns: 1) Inmate education; 2) Staff education; 3) Requiring staff experiencing any COVID-19 symptoms to stay home until tested or for 14 days; 4) Staffing for running the facilities safely as staff stays home sick or quarantined; 5) Staffing plans for services provided by the inmates themselves as inmates get sick; 6) Screening, testing, treatment and housing of imates; 7) Plans for "additional precautions" to prevent the exposure of vulnerable populations within the facilities to the virus; 8) Housing of inmates exposed to the virus; 9) Provision of hygiene and cleaning supplies to all inmates; 10) Enhanced plans for cleaning shared spaces and items (such as phones) in between each inmate's use; 11) Coordination with community hospitals and among the correctional facilities in the state; and 12) Plans for removal of charges for telephone calls or other methods of communication and psychological support for inmates while visitation is eliminated. See Motion, Doc 161 at pp. 12-13.

However, all of these specific issues and concerns are already adequately addressed in the existing Policy Directive that was put into place by Commissioner Jividen on March 20, 2020, and/or in the internal memoranda described above dated March 11, 2020, and March 26, 2020. Attached as **Exhibit 1** is the affidavit of Commissioner Jividen in which she states that her COVID-19 Policy Directive and the related memoranda specifically address, among other things, inmate and staff education, work stoppage by employees with COVID-19 symptoms, increased staffing of inmates in critical areas such as sanitation and food service, the screening, testing, and treatment of inmates, plans to prevent or minimize exposure and spread of the virus, the quarantining of exposed inmates, plans for extra sanitation with respect to frequently touched surfaces and items, and coordination with community hospitals. *Id.*

WVDCR has lawful security and public safety reasons for choosing not to disclose to the public its policy directive regarding COVID-19.[5] However, Defendants are willing to disclose the Policy Directive for *in camera* review by the Court if so ordered.

If this Court undertakes this *in camera* review, it will see that all of Plaintiffs' concerns are all already reasonably, adequately, and specifically addressed by the plan. More specifically, each "bullet point" concern from Plaintiffs' motion is addressed separately as follows:

- Regarding inmate/staff "education" (concerns 1 and 2), the Policy Directive is itself educational and provides information regarding the history and nature of COVID-19. *Id.* at pp. 1-4. It also contains provisions related to the educating of staff and inmates. *Id.* at pp. 4-5. Also, both the March 11, 2020 memoranda and the CDC memoranda attached as **Exhibit 2** contain educational information conveyed to employees of WVDCR. *Id.*

- Regarding Plaintiffs' concern number 3 (requiring staff who are experiencing symptoms to stay home), the Policy Directive requires staff screening and reporting of symptoms (p. 20), and requires employees to stay home if they are either exposed or sick. *Id.* at pp. 5-6.

- With respect to Plaintiffs' concern number 4 (staffing plans for keeping facilities running safely as staff stay home), staffing of medical personnel is not undertaken by WVDCR but rather by the contractors hired by WVDCR to provide inmate medical care, Wexford Health Sources, Inc. and PrimeCare Medical, Inc. Defendants attempted to assert third party claims against those entities as necessary parties but after Plaintiffs objected, this Court denied a motion by Defendants to bring them into this case as third-party Defendants. Defendants have obtained, through counsel Wexford and PrimeCare's COVID-19 policies or plans for review. These two companies are in competition in this State and other States, and they have their own business proprietary reasons to not disclose their policies. To the extent that those third-party policies are deemed relevant and responsive, and to the extent that this Court requires it, Defendants will supplement with this information.

- Regarding Plaintiffs' concern number 5 (staffing plans for services provided by inmates themselves as inmates get sick), the Policy Directive in place has specific provisions for the screening of inmates assigned to work in various parts of each facility with particular emphasis on those working in food service. *Id.* at p. 8. The plan also calls for additional staffing of inmates assigned to the duties of cleaning and sanitation. *Id.* at p. 6.

[5] Assistant Commissioner Marvin Plumley will be made available at the hearing to address the security concerns of WVDCR regarding release of its policy directive to the public. It is difficult to address those concerns without compounding them in a Response available for public review. It is also noted that the ACLU was advised that the COVID-19 was exempt from FOIA disclosure pursuant to WV Code 29B-1-4 (19).

- With respect to Plaintiffs' concern number 6 (screening, testing, treatment, and housing of plaintiffs and potential class members), the Policy Directive specifically addresses inmate screening (pp. 7-8), testing (p. 8), and treatment (p. 11). Housing of infected inmates is not addressed in the plan insofar as any inmate diagnosed with COVID-19 will be sent to the hospital for treatment. *See* Jividen affidavit attached hereto as **Exhibit 1.**

- Regarding Plaintiffs' concern number 7 (plans for "additional precautions" to prevent exposure of vulnerable populations), the Policy Directive has numerous provisions related to measures designed to prevent or minimize the risk or spread of COVID 19. *See, e.g., id. at* p. 10, section J. Information addressing these concerns is also discussed in the memoranda from March 11, 2020 and the CDC memorandum attached as **Exhibit 2.**

- With respect to Plaintiffs' concern number 8 (housing of inmates exposed to the virus), the Policy Directive has specific provisions regarding the housing and quarantine of exposed but asymptomatic inmates. *Id.* at pp. 11-12, Section L.

- Regarding Plaintiffs' concern number 9 (provision of hygiene and cleaning supplies to all inmates), inmates are already automatically provided with regular access to hygiene and cleaning supplies even when there is no pandemic. The Policy Directive specifically discusses education of inmates and staff as to hygiene (p. 5) and provides for increased frequency of environmental cleaning (p. 6).

- With respect to Plaintiffs' concern number 10 (enhanced plans for cleaning shared spaces and items such as telephones), the Policy Directive specifically addresses these concerns and calls for an increased frequency of cleaning of "frequently touched surfaces" such as telephones and doorknobs. *Id.* at p. 6.

- With respect to Plaintiffs' concern number 11 (coordination with community hospitals and among the correctional facilities in the state), the Policy Directive specifically addresses the issue of administration and coordination of correctional and health care leadership within the jail and prison system (p. 4), and it also specifically addresses contact and coordination with "local community hospitals" (p. 5).

- Finally, with respect to Plaintiffs' concern number 12 (free phone calls and other methods of contact with loved ones), all inmates are already now permitted to make multiple free telephone calls each week and also now have access to free weekly video visitation with loved ones. *See* email from Stacy Nowicki, Deputy General Counsel for the Department of Military Affairs and Public Safety to Loree Stark, Legal Director at the ACLU of West Virginia attached as **Exhibit 9**. These are above and beyond normal policy.

Based upon all of the above, it is clear that application of the four-part test from *Microsoft*, *supra* results in a finding that no preliminary injunction should be issued. Under the first factor (likelihood of irreparable harm to the plaintiff), this risk is low and certainly not any greater than

the risk of the public-at-large. To date there are no confirmed cases of COVID-19 in the Regional Jail or prison system in West Virginia and, even if a case is confirmed, the plan which Plaintiffs are demanding is already in place. Regarding the second factor (likelihood of harm to the defendant), this also favors denial of the motion because, in addition to seeking formulation of a plan that already exists, Plaintiffs are also asking this Court to order Defendants to release certain inmates and enforce social distancing policies, that would be tantamount to micromanaging the prison system and contrary to the restrictions in the PLRA. This dovetails with the fourth factor (public interest) and Defendants respectfully submit that there are obvious public safety issues related to the premature mass release of inmates who are incarcerated by virtue of being accused and/or convicted of a crime against the citizens of the State of West Virginia. Finally, with respect to the third *Microsoft* factor (likelihood of success on the merits), this is not even applicable here because due to Plaintiffs' failure to seek leave to amend, claims related to COVID-19 have not been pled in this case and therefore the likelihood of success on the merits of those claims is not something that can be analyzed.

H. This motion is an improper attempt by Plaintiffs to appeal the denial of a FOIA request by another party before the wrong forum.

Finally, it should be noted that with respect to the instant motion, Plaintiffs are in effect improperly attempting to use this case as a vehicle to appeal the denial of a FOIA request made by the ACLU. Plaintiffs specifically rely upon a FOIA request from the ACLU in their motion. *See* Exhibits 6 and 7 (Doc 161-6 and 7). The ACLU is not a party to this matter, and any ACLU requests for information are not relevant. Moreover, even if the FOIA request had come from Plaintiffs, the appropriate remedy was not to seek relief in an existing Federal case but rather to "institute proceedings for injunctive or declaratory relief in the circuit court in the county where the public record is kept." W.Va. Code § 29B-1-5(1).

Even if Plaintiffs were attempting to appeal their own FOIA request before the appropriate court, the information sought in the request is exempt from disclosure under W.Va. Code § 29B-1-4(a)(19) which exempts:

> [r]ecords of the Division of Corrections….relating to the …policy directives and operational procedures of personnel relating to the safe and secure management of inmates or residents that if released, could be used by an inmate or resident to escape a facility, or to cause injury to another inmate, resident, or to facility personnel.

Id. As identified in the attached affidavit of Betsy Jividen, Defendants have legitimate security concerns regarding the public release of its Policy Directive. These security concerns, and appropriate citation to the FOIA exemption, was provided to the ACLU in addition to a special memorandum from Department of Military Affairs and Public Safety Jeff Sandy addressing non-security sensitive COVID-19 precautions being taken by WVDCR. *See* Exhibits 6 and 7 to Plaintiffs' motion (Doc 161-6 and 7). Plaintiffs' reliance upon the ACLU FOIA request is nothing but a red herring.

CONCLUSION

WHEREFORE, based upon the foregoing, Defendants respectfully request that this Court deny Plaintiffs' Emergency Motion For Preliminary Injunction Regarding Defendants' Prevention, Management, and Treatment of COVID-19 and that it order any other further relief that the Court deems just and proper.

Respectfully submitted on behalf of all Defendants by:

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

JOHN BAXLEY, JR., *et al.*

Plaintiffs,

v.

Civil Action No. 3:18-cv-01526
(Chambers, J.)

BETSY JIVIDEN, *et al.*,

Defendants.

CERTIFICATE OF SERVICE

I, Webster J. Arceneaux, III, co-counsel for all Defendants, do hereby certify that on this 30th day of March 2020, I electronically served a copy of the foregoing "**DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' EMERGENCY MOTION FOR PRELIMINARY INJUNCTION REGARDING DEFENDANTS' PREVENTION, MANAGEMENT, AND TREATMENT OF COVID-19**" via the CM/ECF system that will send notification to the following counsel of record:

Lydia C. Milnes, Esq.
Jennifer S. Wagner, Esq.
Mountain State Justice
Counsel for Plaintiffs

/s/ Webster J. Arceneaux, III_____
Webster J. Arceneaux, III, State Bar #155

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

JOHN BAXLEY, JR., ERIC L. JONES, SAMUEL STOUT, AMBER ARNETT, EARL EDMONDSON, JOSHUA HALL, DONNA WELLS-WRIGHT, ROBERT WATSON, HEATHER REED, and DANNY SPIKER, JR., on their own behalf and on behalf of all others similarly situated,

Plaintiffs,

v.

Civil Action No. 3:18-cv-01526 (Chambers, J.)

BETSY JIVIDEN, in her official capacity as Commissioner of the WEST VIRGINIA DIVISION OF CORRECTIONS AND REHABILITATION, the WEST VIRGINIA DIVISION OF CORRECTIONS AND REHABILITATION, and SHELBEY SEARLS, in his official capacity as the Superintendent of WESTERN REGIONAL JAIL AND CORRECTIONAL FACILITY,

Defendants.

AFFIDAVIT OF BETSY JIVIDEN

STATE OF WEST VIRGINIA, COUNTY OF KANAWHA, to wit:

I, Betsy Jividen, do hereby affirm and state the following:

1. I am Commissioner of the West Virginia Division of Corrections and Rehabilitation ("WVDCR") and a named defendant in the above-styled lawsuit.

2. On March 11, 2020, I issued a memorandum directed to all WVDCR employees regarding COVID-19.

3. In the March 11, 2020, I noted that "we are mindful of the need to reduce the risk and protect the health and safety of our employees, populations, volunteers, contractors, and others who enter our facilities and do business with us."

4. The March 11, 2020 memorandum outlined certain "proactive guidelines and controls" based upon input and guidance from the Center for Disease Control ("CDC") and certain West Virginia health agencies.

5. The March 11, 2020 memorandum provides historical background regarding COVID-19 and also set forth policies regarding: 1) good health habits and sanitation; 2) frequent hand washing and/or sanitizing; 3) respiratory (coughing and sneezing) etiquette; 4) avoiding touching the face, eyes, nose and mouth; 5) increased emphasis on disinfection of "high touch" areas; 6) screening of inmates, employees, contractors, volunteers, and others; 7) cancellation of "non-attorney" in-person visits; and 8) approval of the use of electronic visitation and telephone calls.

6. In the March 11, 2020 memorandum, I directed that all job-related out-of-state and international travel for employees was cancelled until further notice.

7. In the March 11, 2020 memorandum, I instructed all employees that were sick or showing flu-like symptoms to stay home, contact their medical providers, and be tested.

8. In the March 11, 2020 memorandum, I instructed health care administrators to provide supervisors with the training needed to conduct daily screenings of employees reporting to work and employees under movement restriction were told that they would not be permitted to return to work until the completion of an appropriate monitoring period.

9. The March 11, 2020 memorandum contains information and strategies designed to eliminate or minimize out-of-pocket expenses to employees related to testing for COVID-19 and insurance deductibles.

10. The March 11, 2020 memorandum provided information to employees regarding mental health support and a "hotline" for those suffering from fear or stress over the COVID-19 pandemic.

11. The March 11, 2020 memorandum contains instruction and policies related to the screening of contractors, vendors and volunteers.

12. The March 11, 202 memorandum contains instruction and policies regarding the use of respirator masks for medical personnel and WVDCR employees. *Id.*

13. On March 20, 2020, at my direction, WVDCR adopted a Policy Directive entitled "COVID-19 RESPONSE PLAN".

14. The purpose of the plan was and is to adopt formal policies and procedures within WVDCR related to the prevention and management of COVID-19 within the prisons and jails in West Virginia.

15. For security and public safety reasons, WVDCR considers the Policy Directive to be confidential and it purposefully resists attempts to have the Policy Directive released to the public.

16. The COVID-19 RESPONSE PLAN Policy Directive specifically addresses and calls for inmate and staff education regarding COVID-19.

17. The COVID-19 RESPONSE PLAN Policy Directive requires work stoppage by any employees exhibiting COVID-19 symptoms.

18. The COVID-19 RESPONSE PLAN Policy Directive provides for increased staffing of inmates in critical areas such as sanitation and food service.

19. The COVID-19 RESPONSE PLAN Policy Directive provides for the screening, testing, and treatment of inmates either exposed to or exhibiting symptoms of COVID-19.

20. The COVID-19 RESPONSE PLAN Policy Directive contains specific strategies designed to prevent or minimize exposure and spread of the COVID-19 virus.

21. The COVID-19 RESPONSE PLAN Policy Directive provides for the quarantining of any exposed inmates to help prevent the spread of COVID-19 to other inmates or employees.

22. The COVID-19 RESPONSE PLAN Policy Directive provides instruction related to additional sanitary measures for frequently touched surfaces and items such as telephones and doorknobs.

23. The COVID-19 RESPONSE PLAN Policy Directive provides for communication and coordination with community hospitals related to COVID-19.

24. Medical staffing decisions are generally made by the contractors that actually provide the medical care to inmates in prisons and jails in West Virginia, Wexford Health Sources, Inc. and PrimeCare Medical, Inc. So far, we have identified no issues related to the medical staffing of any jail as it relates to COVID-19.

25. During the COVID-19 pandemic, inmates are being given free telephone calls and free access to video visitation with loved ones that is beyond the normal policy of WVDCR. Additionally, inmate medical copays for medical services have been eliminated.

26. On March 26, 2020, I issued a memorandum to all facility superintendents and directors discussing "Interim Guidance from the Centers for Disease Control and Prevention."

The purpose of the memorandum was to disseminate a document from CDC entitled "*Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.*" This CDC memorandum addresses, among other things, specific "guidance" to correctional and detention facilities related to COVID-19 and outlines certain "best practices" related to: 1) operational and communications preparations for COVID-19; 2) enhanced cleaning and disinfecting and hygiene practices; 3) social distancing strategies; 4) visitor policies; 5) infection control; 6) screening for inmates, staff and visitors; 7) medical isolation and cohorting; 8) healthcare for suspected cases; 9) clinical care; and 10) considerations for persons as higher risk of severe disease from COVID-19.

FURTHER THE AFFIANT SAYETH NOT

Betsy Jividen

STATE OF WEST VIRGINIA,

COUNTY OF KANAWHA, to wit:

The foregoing instrument was acknowledged and sworn to before me this 30th day of March, 2020, by Betsy Jividen.

My Commission expires: August 20, 2022.

Beth A. Hager

Notary Public

OFFICIAL SEAL
Beth A. Hager
Notary Public
State of West Virginia
My Commission Expires
August 20, 2022
14 ST. CHARLES PLACE
CHARLESTON, WV 25314

EXHIBIT 2

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

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 the date of posting, 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 CDC website periodically for updated interim guidance.

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

Who is the intended audience for this guidance?

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., 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.
  - Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
  - 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.
  - Allow staff to work from home when possible, within the scope of their duties.
  - Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
  - 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.
  - 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.
  - 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.**
  - Standard medical supplies for daily clinic needs
  - Tissues
  - Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
  - Hand drying supplies
  - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
  - Cleaning supplies, including EPA-registered disinfectants effective against 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. Visit CDC's website for a calculator to help determine rate of PPE usage.
  - Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated
- **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**
  - See CDC guidance optimizing PPE supplies.
- **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.
- **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)
  - Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
- **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**
- **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

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

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

Operations

- **Stay in communication with partners about your facility's current situation.**
  - State, local, territorial, and/or tribal health departments
  - Other correctional facilities
- **Communicate with the public about any changes to facility operations, including visitation programs.**
- **Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.**
  - Strongly consider postponing non-urgent outside medical visits.
  - 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.
  - 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).
  - Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
  - 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.
  - 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:**
  - Symptoms of COVID-19 and its health risks
  - 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.
  - In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
  - Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

- **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
  - Symptoms of COVID-19 and its health risks
  - Employers' sick leave policy
  - **If staff develop a fever, 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.
  - **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.
  - **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.**
  - 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
- **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 without onsite healthcare capacity, 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:
  - **Cover** their mouth and nose with a tissue when they cough or sneeze
  - **Dispose** of used tissues immediately in the lined trash receptacle
  - **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water 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:**
    - At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
    - 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.**
  - 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.**
  - 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.
    - 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**
    - If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
    - 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**
    - For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
        - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
        - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.
- **Electronics cleaning and disinfection**
    - For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
        - Follow the manufacturer's instructions for all cleaning and disinfection products.
        - Consider use of wipeable covers for electronics.
        - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

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

- **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.**
    - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
    - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
    - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
    - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.
- **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
  - 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.
  - 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:**
  - 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, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
  - As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door
  - As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
  - As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.

  - As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
  - Safely transfer to another facility with capacity to quarantine in one of the above arrangements (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):
  - If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
  - If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
  - All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
  - 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).
  - Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.
- **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical isolation section above.)
  - See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- **If an individual who is part of a quarantined cohort becomes symptomatic:**
  - **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
  - **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- **Laundry from quarantined individuals can be washed with other individuals' laundry.**
  - Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

- **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.**
- **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See Medical Isolation section above.**
- **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.
- **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
  - If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
  - If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

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

- **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**
  - Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
  - Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
- **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.**See Screening section for a procedure to safely perform a temperature check.
- **Consider additional options to intensify social distancing within the facility.**

Management Strategies for Staff

- **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
  - Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
  - See above for definition of a close contact.
  - Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

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

- **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates.**
  - Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to

facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
  - Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).
- **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).
- **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

- **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**
  - If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
  - The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
- **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**
- **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask.**
  - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.
- **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**
- **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**
- **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

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

- **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases.**
  - Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program.
  - For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.
- **Ensure that all staff are trained to perform hand hygiene after removing PPE.**
- **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (see Table 1). Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**
- **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**
- **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**
  See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.
- **Face mask**
- **Eye protection** – goggles or disposable face shield that fully covers the front and sides of the face
- **A single pair of disposable patient examination gloves**
  Gloves should be changed if they become torn or heavily contaminated.
- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
  - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.

- **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**
  - Guidance in the event of a shortage of N95 respirators
    - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
  - Guidance in the event of a shortage of face masks
  - Guidance in the event of a shortage of eye protection
  - Guidance in the event of a shortage of gowns/coveralls

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		X			
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact				X	X
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.			X	X
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.			

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons		X	X	X	X
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	X**		X	X	X
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	X		X	X	X
Staff handling laundry or used food service items from a COVID-19 case or case contact				X	X
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.			X	X

Classification of Individual Wearing PPE

* 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

Page last reviewed: March 23, 2020

EXHIBIT 4

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

KARLENA DAWSON; ALFREDO ESPINOZA ESPARZA; NORMA LOPEZ-NUNEZ; MARJORIS RAMIREZ OCHOA; MARIA GONZALEZ MENDOZA; JOE HLUPHEKA BAYANA; LEONIDAS PLUTIN HERNANDEZ; KELVIN MELGAR ALAS; JESUS GONZALEZ HERRERA, Petitioners-Plaintiffs, v. NATHALIE ASHER, Director of the Seattle Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; STEVEN LANGFORD, Warden, Tacoma Northwest Detention Center, Respondents-Defendants.	Case No. 2:20-cv-409 **MOTION FOR TEMPORARY RESTRAINING ORDER** NOTE ON MOTION CALENDAR: MARCH 16, 2020

INTRODUCTION

The novel coronavirus that causes COVID-19 has led to a global pandemic. In only a few months, 153,517 people worldwide have received confirmed diagnoses of COVID-19, and over

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5,735 of those people have died.[1] There is no vaccine against COVID-19 and there is no known cure. No one is immune. COVID-19 is most likely to cause serious illness and elevated risk of death for older adults and those with certain medical conditions or underlying disease. The COVID-19 virus can cause severe damage to lung tissue, sometimes leading to a permanent loss of respiratory capacity, and can damage tissues in other vital organs including the heart and liver. Patients with serious cases of COVID-19 require advanced medical support, including positive pressure ventilation and extracorporeal mechanical oxygenation in intensive care. Patients who do not die from serious cases of COVID-19 may face prolonged recovery periods, including extensive rehabilitation from neurologic damage and loss of respiratory capacity. The only known effective measures to reduce the risk for vulnerable people from serious illness or death caused by COVID-19 are social distancing and improved hygiene, which have led to unprecedented public health measures around the world. According to preliminary data from China, 20 percent of people in high risk categories who contracted COVID-19 there died. Decl. of Dr. Robert Greifinger ¶ 5.

People in congregate environments, which are places where people live, eat, and sleep in close proximity, face increased danger of contracting COVID-19, as already evidenced by the rapid spread of the virus in cruise ships and nursing homes. People who are confined in prisons, jails, and detention centers will find it virtually impossible to engage in the necessary social distancing and hygiene required to mitigate the risk of transmission, even with the best-laid plans. For this reason, correctional public health experts have recommended the release from custody of people most vulnerable to COVID-19. Release protects the people with the greatest

[1] World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report-55, March 15, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200315-sitrep-55-covid-19.pdf?sfvrsn=33daa5cb_6.

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vulnerability to COVID-19 from transmission of the virus, and also allows for greater risk mitigation for all people held or working in a prison, jail, or detention center. Release of the most vulnerable people from custody also reduces the burden on the region's 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.

Petitioners-Plaintiffs (hereinafter Plaintiffs) are people who are particularly vulnerable to serious illness or death if infected by COVID-19. They are being held in civil detention by Immigration and Customs Enforcement (ICE) at the Tacoma Northwest Detention Center (NWDC) in Tacoma, Washington as they await the adjudication of their immigration cases. Plaintiffs are older adults or have medical conditions that lead to high risk of serious COVID-19 infection, including lung disease, heart disease, diabetes, epilepsy, kidney disease, autoimmune disorders, spinal cord injury, asthma, and hypertension. The NWDC is located in the Seattle, Washington metropolitan area, the epicenter of the largest COVID-19 outbreak in the United States, and one of the largest known outbreaks in the world. The danger posed by Plaintiffs' detention during the current outbreak of COVID-19 is "so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk," and violates their constitutional right to safety in government custody. *Helling v. McKinney*, 509 U.S. 25, 36 (1993). For these reasons, Plaintiffs request a temporary restraining order for their immediate release from detention.

Notice to Defendants

Counsel for Plaintiffs called the U.S. Attorney's Office for the Western District of Washington to advise it of the emergency reasons requiring them to seek a temporary restraining order. In addition, Plaintiffs' Counsel e-mailed a copy of the Petition for a Writ of Habeas

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Corpus and Complaint and Motion for Temporary Restraining Order to Assistant U.S. Attorney Micki Brunner, 206-553-5172, Micki.Brunner@usdoj.gov. Decl. of Matt Adams ¶¶ 2-4.

FACTUAL BACKGROUND

I. COVID-19 Poses Grave Risk of Harm, Including Serious Illness or Death, to Older Adults People and Those with Certain Medical Conditions.

COVID-19 is a disease caused by a coronavirus that has reached pandemic status. As of March 15, 2020, 153,517 people worldwide have confirmed diagnoses, including 1,678 people in the United States. 5,735 people have died after contracting COVID-19 worldwide, including 41 in the United States. *See supra* n.1. The transmission of COVID-19 is expected to grow exponentially. Decl. of Dr. Jonathan Golob ¶ 2.

People over the age of fifty and those with certain medical conditions face greater chances of serious illness or death from COVID-19. Certain underlying medical conditions increase the risk of serious COVID-19 disease for people of any age, including lung disease, heart disease, chronic liver or kidney disease (including hepatitis and dialysis patients), diabetes, epilepsy, hypertension, compromised immune systems (such as from cancer, HIV, or autoimmune disease), blood disorders (including sickle cell disease), inherited metabolic disorders, stroke, developmental delay, and pregnancy. Golob Decl. ¶ 3; Greifinger Decl. ¶ 7; Decl. of Dr. Marc Stern ¶ 5.

In many people, COVID-19 causes fever, cough, and shortness of breath. But for people over the age of fifty or with medical conditions that increase the risk of serious COVID-19 infection, shortness of breath can be severe. Golob Decl. ¶ 5. COVID-19 can severely damage lung tissue, which requires an extensive period of rehabilitation, and in some cases, can cause a permanent loss of respiratory capacity. COVID-19 may also target the heart muscle, causing a

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medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work. Emerging evidence also suggests that COVID-19 can trigger an over-response of the immune system, further damaging tissues in a cytokine release syndrome that can result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury. Golob Decl. ¶ 7; Stern Decl. ¶ 6. These complications 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. Stern Decl. ¶ 4.

Even some younger and healthier people who contract COVID-19 may require supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Most people in higher risk categories who develop serious disease, however, will need advanced support. This level of supportive care requires highly specialized equipment that is in limited supply, and an entire team of care providers, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians. This level of support can quickly exceed local health care resources. Golob Decl. ¶¶ 5-6; Greifinger Decl. ¶ 6; Stern Decl. ¶ 6.

The need for care, including intensive care, and the likelihood of death, is much higher from COVID-19 infection 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. For people in the highest risk populations, the fatality rate of COVID-19 infection is about 15 percent. Golob Decl. ¶ 4.

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Preliminary data from China showed that 20 percent of people in high-risk categories who have contracted COVID-19 there have died. Greifinger Decl. ¶ 5. Patients in high-risk categories who do not die from COVID-19 should expect a prolonged recovery, including the need for extensive rehabilitation for profound reconditioning, loss of digits, neurologic damage, and the loss of respiratory capacity. Golob Decl. ¶ 4.

There is no vaccine against COVID-19 and there is no known medication to prevent or treat infection from COVID-19. The only known effective measures to reduce the risk for vulnerable people from injury or death from COVID-19 are to prevent them from being infected in the first place. Social distancing, or remaining physically separated from known or potentially infected individuals, and vigilant hygiene, including washing hands with soap and water, are the only known effective measures for protecting vulnerable people from COVID-19. Golob Decl. ¶ 8; Greifinger Decl. ¶¶ 4, 8; Stern Decl. ¶ 3. Projections by the Centers for Disease Control and Prevention (CDC) indicate that over 200 million people in the United States could be infected with COVID-19 over the course of the epidemic without effective public health intervention, with as many as 1.5 million deaths in the most severe projections. Golob Decl. ¶ 10.

II. People Detained at the Northwest Detention Center Face an Elevated Risk of COVID-19 Transmission.

The NWDC is located in the Seattle, Washington metropolitan area, the epicenter of the largest COVID-19 outbreak in the United States at this time, and one of the largest known outbreaks in the world. Golob Decl. ¶ 9; Greifinger Decl. ¶ 9. As of March 15, 2020, there were 769 confirmed cases of COVID-19 and 42 deaths from COVID-19 in Washington State.[2] The COVID-19 outbreak in Washington has resulted in unprecedented health measures to facilitate

[2] Washington State Department of Health, 2019 Novel Coronavirus Outbreak (COVID-19) (last updated Mar. 15, 2020), https://www.doh.wa.gov/Emergencies/Coronavirus.

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and enforce social distancing. Golob Decl. ¶ 12. Immigration courts and the ICE field office in Seattle have already closed in the past month due to staff exposure to COVID-19. It is highly likely, and "perhaps inevitable that COVID-19 will reach NWDC." Greifinger Decl. ¶ 9.

People who live in institutional settings, such as immigration detention centers, who are over the age of 50 or are any age with certain specified medical conditions, "are at grave risk of severe illness and death" if infected by COVID-19. Golob Decl. ¶ 14. Immigration detention facilities are "congregate environments," or places where people live and sleep in close proximity. Infectious diseases that are communicated by air or touch are more likely to spread in these environments. This presents an increased danger for the spread of COVID-19 if and when it is introduced into a facility. Stern Decl. ¶ 7. Enclosed group environments, like cruise ships or nursing homes, have become the sites for the most severe outbreaks of COVID-19. The highest known person-to-person transmission rate for COVID-19 took place in a skilled nursing home facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. Golob Decl. ¶ 11.

The conditions of immigration detention facilities pose a heightened public health risk for the spread of COVID-19 that is even greater than in non-carceral institutions. Immigration detention facilities have even greater risk of infectious spread because 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. They may be unable to maintain the recommended distance of 6.5 feet from others, and may share or touch objects used by others. Toilets, sinks, and showers are shared, without disinfection between each use. Food preparation and service is communal with little opportunity for surface disinfection. Staff arrive and leave on a shift basis, and there is limited

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ability to adequately screen staff for new, asymptomatic infection. Greifinger Decl. ¶¶ 10-11; Stern Decl. ¶ 7. Many immigration detention facilities lack adequate medical infrastructure to address the spread of infectious disease and treatment of people most vulnerable to illness in detention. Greifinger Decl. ¶ 12. During the H1N1 influenza epidemic in 2009, jails and prisons were sites of severe outbreaks. It is reasonable to expect COVID-19 will also readily spread in detention centers, especially when people cannot engage in proper hygiene and isolate themselves from infected residents or staff. Golob Decl. ¶ 13.

III. People Most Vulnerable to COVID-19 Should Be Released from ICE Detention.

Because risk mitigation is the only known strategy that can protect vulnerable groups from COVID-19, public health experts with experience in immigration detention and correctional settings have recommended the release of vulnerable detainees from custody. Greifinger Decl. ¶ 13; Stern Decl. ¶ 9. Dr. Marc Stern, a correctional health expert, has concluded that "[f]or detainees who are at high risk of serious illness or death should they contract the COVID-19 virus, release from detention is a critically important way to meaningfully mitigate that risk." Stern Decl. ¶ 9. For that reason, Dr. Stern recommends the "release of eligible individuals from detention, with priority given to older adults and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19." Stern Decl. ¶ 11. Dr. Robert Greifinger, a correctional health expert, has concluded that "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." Greifinger Decl. ¶ 13. In the event that vulnerable detainees

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have been exposed to COVID-19, these experts recommend testing where possible and the release of detainees to a quarantine setting outside of detention in coordination with local health authorities. Greifinger Decl. ¶¶ 14-15; Stern Decl. ¶ 12.

IV. Plaintiffs Are Vulnerable to Serious Illness or Death If Infected by COVID-19 and Should Be Released from Custody.

All Plaintiffs have underlying medical conditions that increase their risk of serious illness or death if exposed to COVID-19. Stern Decl. ¶ 13. They are detained at the NWDC as they await adjudication of their civil immigration cases.

Karlena Dawson is a 48-year-old citizen of Jamaica. Dawson Decl. ¶ 1. Ms. Dawson has been detained by ICE at the NWDC since February of 2019. *Id.* ¶ 2. Ms. Dawson has been diagnosed with cholangitis, a progressive autoimmune liver disease. *Id.* ¶ 4; *see also* Maltese Decl. Ex. A. She has been informed that she has a life expectancy of 10-12 years. Dawson Decl. Ex. 4. She must take ursodiol twice a day to suppress enzymes because of her auto-immune disease. *Id.* She also has diabetes, which requires her to take insulin and metformin. *Id.* ¶ 5. Ms. Dawson is critically vulnerable to COVID-19 because of her autoimmune disease and diabetes. *Id.* ¶ 7.

Alfredo Espinoza Esparza is a 41-year-old citizen of Mexico. On or about January 16, 2020, while detained at the NWDC, he suffered acute chest pain that required hospitalization to receive treatment for a heart attack. *See* Maltese Decl. Ex. B. He was subsequently returned to the NWDC. He also suffers from a rectal hemorrhage which requires medication. *Id.* Mr. Espinoza is critically vulnerable to COVID-19 because of his significant health issues.

Norma Lopez Nunez is a 65-year-old citizen of Mexico. She is detained by ICE at the NWDC. Ms. Lopez has hypertension and heart disease, in addition to major depression and other

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mental health problems. Maltese Decl. Ex. C. Ms. Lopez is critically vulnerable to COVID-19 because of her age and her significant health problems.

Marjoris Ramirez-Ochoa is a 43-year-old citizen of Cuba. Ramirez-Ochoa Decl. ¶ 1. She is detained by ICE at the NWDC. Ms. Ramirez has kidney disease, epilepsy, and chronic high blood pressure. *Id.* ¶¶ 3-6; *see also* Maltese Decl. Ex. D. While detained, she has suffered five seizures, but has not been referred to medical care outside of the detention center. Ramirez-Ochoa Decl. ¶ 6. She also suffers from respiratory problems, and has contracted pneumonia in the past. *Id.* ¶ 9. Finally, she has depression, gastritis, and an ovarian cyst, among other conditions. *Id.* ¶¶ 7-8. Ms. Ramirez is critically vulnerable to COVID-19 because of her significant health problems. *Id.* ¶¶ 12-13.

Maria Gonzalez Mendoza is a 49-year-old citizen of Mexico. Ms. Gonzalez has diabetes, asthma, and high blood pressure. Gonzalez Decl. ¶¶ 3-5; *see also* Maltese Decl. Ex. E. Ms. Gonzalez is critically vulnerable to COVID-19 because of her significant health problems. Gonzalez Decl. ¶¶ 4, 8-11.

Joe Hlupheka Bayana is a 57-year-old citizen of Zimbabwe. Bayana Decl. ¶ 1. Mr. Bayana has type II diabetes. *Id.* ¶ 3; *see also* Maltese Decl. Ex. F. He takes insulin three times a day to treat his condition. Bayana Decl. ¶ 3. He receives medication to treat seizures, as well as depression. *Id.* ¶ 4. Mr. Bayana is critically vulnerable to COVID-19 because of his age and significant health conditions. *Id.* ¶¶ 5, 8-10.

Leonidas Plutin Hernandez is a 59-year-old citizen of Cuba. Plutin Hernandez Decl. ¶ 1. Mr. Plutin has chronic high blood pressure, for which he receives daily medication. *Id.* ¶¶ 3-4. Mr. Plutin is critically vulnerable to COVID-19 because of his age and chronic high blood pressure. *Id.* ¶ 10.

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Kelvin Melgar Alas is a 40-year-old citizen of El Salvador. Melgar Decl. ¶ 1. He has been detained by ICE since July of 2018. *Id.* ¶ 7. Mr. Melgar has been confined to a wheelchair since 1995, when he was shot in the spinal cord. *Id.* ¶ 4; *see also* Maltese Decl. Ex. G. In addition, he requires a colonoscopy bag and a catheter. Melgar Decl. ¶ 6. While detained at the NWDC he has been transferred for hospitalization on five separate occasions, including multiple times for suspected pneumonia. *Id.* ¶ 7. Mr. Melgar is critically vulnerable to COVID-19 because of his significant health problems. *Id.* ¶ 8.

Jesus Gonzalez Herrera is a 46-year-old citizen of Mexico. Gonzalez Herrera Decl. ¶ 1. Mr. Gonzalez has diabetes and high blood pressure, which require him to take three different types of medication daily. *Id.* ¶ 5; *see also* Maltese Decl. Ex. H. Mr. Gonzalez is critically vulnerable to COVID-19 because of his significant health problems. Gonzalez Herrera Decl. ¶ 7.

LEGAL STANDARD

On a motion for a temporary restraining order, the plaintiff "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); *Stuhlbarg Int'l Sales Co. v. John D. Brush & Co.*, 240 F.3d 832, 839 n.7 (9th Cir. 2001) (noting that preliminary injunction and temporary restraining order standards are "substantially identical"). A temporary restraining order may issue where "serious questions going to the merits [are] raised and the balance of hardships tips sharply in [plaintiff's] favor." *All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011) (citation omitted). To succeed under the "serious question" test, plaintiffs must show that they are likely to suffer irreparable injury and that an injunction is in the public's interest. *Id.* at 1132.

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ARGUMENT

I. Plaintiffs Are Likely to Succeed on the Merits.

a. Plaintiffs' Continued Detention Violates Their Constitutional Right to Reasonable Safety in Custody.

i. The Constitution Is Violated by an Unreasonable Risk of Future Harm from Contagious Disease.

The government has an affirmative duty to provide conditions of reasonable health and safety to the people it holds in its custody. As the Supreme Court has made clear,

> [W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being . . . . The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e.g.,* food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment . . . .

DeShaney v. Winnebago County Dept. of Soc. Servs., 489 U.S. 189, 199-200 (1989).[3] Conditions that pose an unreasonable risk of future harm violate the Eighth Amendment's prohibition against cruel and unusual punishment, even if that harm has not yet come to pass.

> That the Eighth Amendment protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is "reasonable safety." . . . . 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.

Helling, 509 U.S. at 33 (quoting *DeShaney*, 489 U.S. at 200). The Court in *Helling* specifically recognized that the risk of contracting a communicable disease could constitute such an "unsafe, life-threatening condition":

> In *Hutto v. Finney,* 437 U.S. 678, 682 (1978), we noted that inmates in punitive isolation were crowded into cells and that some of them had infectious maladies such as hepatitis

[3] Many of the cases discussed in this Motion involve the protections of the Eighth Amendment, which applies to convicted prisoners. As explained below, *see infra* Sec. II.a.ii, the Plaintiffs here are civil detainees and are entitled to greater protections than are convicted persons or pretrial criminal detainees.

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> and venereal disease. This was one of the prison conditions for which the Eighth Amendment required a remedy, even though it was not alleged that the likely harm would occur immediately and even though the possible infection might not affect all of those exposed . . . . Nor can we hold that prison officials may be deliberately indifferent to the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms.

Id. at 33; *see also id.* at 34 (citing with approval *Gates v. Collier,* 501 F.2d 1291 (5th Cir. 1974), which held that prisoners were entitled to relief under the Eighth Amendment when they showed, *inter alia*, "the mingling of inmates with serious contagious diseases with other prison inmates").

In this case, Plaintiffs are at serious risk of severe illness or death from COVID-19. *See* Golob Decl. ¶ 14 (detained persons over age 50 or with pre-existing medical conditions like Plaintiffs' "are at grave risk of severe illness and death from COVID-19"). Thus, as the Court recognized in *Helling* and *Hutto*, the Constitution "require[s] a remedy" that ensures that protection of Plaintiffs' safety. *Helling*, 509 U.S. at 33.

ii. Plaintiffs, As Civil Detainees, Are Entitled to Conditions Superior to Those of Criminal Detainees, and Need Not Show Deliberate Indifference to Establish a Constitutional Violation.

Immigrant detainees, even those with prior criminal convictions, are *civil detainees* held pursuant to civil immigration laws. *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001). Their constitutional protections while in custody are thus derived from the Fifth Amendment, which provides protection even greater than the Eighth Amendment. The Eighth Amendment, which applies to persons convicted of criminal offenses, allows punishment as long as it is not cruel and unusual, but the Fifth Amendment's due process protections do not allow punishment at all. *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979) ("Due process requires that a pretrial detainee not be punished.").

Following the Supreme Court's holding that civil detainees are entitled to "more considerate treatment" than their criminal counterparts, *Youngberg v. Romeo*, 457 U.S. 307, 321-

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22 (1982), the Ninth Circuit held that civil detainees, like Plaintiffs here, are entitled to conditions of confinement that are superior to those of convicted prisoners and to those of criminal pretrial detainees. *Jones v. Blanas*, 393 F.3d 918, 933-34 (9th Cir. 2004), *cert. denied*, 546 U.S. 820 (2005); *see also King v. Cty. of Los Angeles*, 885 F.3d 548, 557 (9th Cir. 2018) (finding presumption of punitive, and thus unconstitutional, treatment where conditions of confinement for civil detainees are similar to those faced by pre-trial criminal detainees). And while convicted persons must show "deliberate indifference" on the part of prison officials to establish a violation of the Eighth Amendment, *Farmer v. Brennan,* 511 U.S. 825, 828 (1994), there is no such requirement for civil detainees challenging their conditions of confinement. *Jones*, 393 F.3d at 934. A condition of confinement for a civil immigration detainee violates the Constitution "if it imposes some harm to the detainee that significantly exceeds or is independent of the inherent discomforts of confinement and is not reasonably related to a legitimate governmental objective or is excessive in relation to the legitimate governmental objective." *Unknown Parties v. Johnson*, No. CV-15-00250-TUC-DCB, 2016 WL 8188563, at *5 (D. Ariz. Nov. 18, 2016), *aff'd sub nom. Doe v. Kelly*, 878 F.3d 710 (9th Cir. 2017) (citing *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2473-74 (2015)).

iii. The Threat of COVID-19 Imposes a Harm that Significantly Exceeds the Inherent Discomforts of Confinement and Is Excessive in Relation to the Government's Interest.

The risk of serious illness or death from COVID-19 significantly exceeds "the inherent discomforts of confinement." *Unknown Parties*, 2016 WL 8188563, at *5. In normal times, crowding and close quarters, the sharing of toilets, sinks, and showers, and communal food preparation and service may be considered uncomfortable. But in light of COVID-19, these conditions present a deadly threat to Plaintiffs' lives. Plaintiffs are older adults and people with

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medical conditions who are at "grave risk of severe illness or death" if they contract COVID-19. Golob Decl. ¶ 14. Social distancing and hygiene measures are Plaintiffs' only defense against COVID-19. Golob Decl. ¶ 12; Greifinger Decl. ¶¶ 10-11; Stern Decl. ¶ 8. Like cruise ships and nursing homes, which have been the sites for the most severe outbreaks of COVID-19, immigration detention centers are "congregate environments" where people live, sleep, and eat in close quarters. These conditions pose even greater risk of infectious spread, and as a result, Plaintiffs face unreasonable harm from continued detention.

By the same token, the threat of serious illness and death from COVID-19 "is not reasonably related to" and vastly outweighs any government interest in Plaintiffs' confinement. *Unknown Parties*, 2016 WL 8188563, at *5. As the Supreme Court has emphasized, "[t]he proceedings at issue here are civil, not criminal, and we assume that they are nonpunitive in purposes and effect." *Zadvydas*, 533 U.S. at 690. Thus, "[t]here is no sufficiently strong special justification . . . for indefinite civil detention." *Id.* If the government's interest in effectuating removal and protecting the community cannot justify indefinite detention, it also cannot justify the similarly "potentially permanent" medical harm and death that Plaintiffs could face. *See id.* at 690-91; *cf. D'Alessandro v. Mukasey*, 628 F. Supp. 2d 368, 399 (W.D.N.Y. 2009) (considering immigrant's age and "constellation of serious, debilitating, and progressive health problems" to weigh against government's concern with flight risk and interest in continued detention).

b. ICE Has the Authority to Release Detained People in Its Custody.

ICE both has the authority to exercise discretion to release individuals from custody and routinely exercises this discretion to release particularly vulnerable detainees like Plaintiffs. Decl. of Andrew Lorenzen-Strait ¶¶ 3-8; 8 U.S.C. §§ 1182(d)(5); 1226(a), 1231(a)(3); 8 C.F.R. §§ 212.5(b)(1), 236.1(c)(8). As former Deputy Assistant Director for Custody Programs in ICE

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Enforcement and Removal Operations Lorenzen-Strait explains, "ICE has exercised and still exercises discretion for purposes of releasing individuals with serious medical conditions from detention," Lorenzen-Strait Decl. ¶ 3, and "ICE exercises humanitarian parole authority *all the time* for serious medical reasons." *Id.* ¶ 4 (emphasis added). Indeed, regulations governing ICE's release authority explicitly state that serious medical conditions are a reason to parole an individual, as "continued detention would not be appropriate." 8 C.F.R. § 212.5(b)(1). This exercise of discretion comes from a long line of authority and agency directives explicitly instructing officers to exercise favorable discretion in cases involving severe medical concerns and other humanitarian equities militating against detention. Lorenzen-Strait Decl. ¶¶ 4 n.1, 12 (citing memoranda from former DHS Secretary DHS Jeh Johnson, former ICE Director John Torres, and former ICE Director John Morton).

Importantly, ICE's discretion applies regardless of the statutory basis for the noncitizen's detention. *Id.* ¶ 10 ("[I]ndividuals held under mandatory detention, pursuant to [8 U.S.C. § 1226(c)], were also eligible for release"). Thus, the agency's policy and practice has been to limit the detention of any individuals regardless of their status if they had particular vulnerabilities, such as those who are suffering from serious physical or mental illness, have disabilities, are pregnant, or whose detention was otherwise not in the public interest. *Id.* ¶ 4 (citing, *inter alia*, ICE's risk classification assessment tools). In particular, ICE has taken into consideration factors such as whether the detainees faced a heightened risk of medical harm in detention, *id.* ¶¶ 5-7, and would release individuals where appropriate medical care was not available in custody, *id.* ¶ 9.

Plaintiffs, who are all at a high risk from suffering complications and/or death from COVID-19, are detainees with special vulnerabilities for whom detention is plainly dangerous

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and unjustified. *Id.* ¶ 8; *see supra* Factual Background Sec. II-IV. Considering ICE's well-established authority and practice of exercising discretion in these circumstances, along with the substantial medical and health care costs that ICE would otherwise bear from an outbreak, Plaintiffs' immediate release would serve the interests of all detainees and the agency.

c. The Court Has Authority to Order Plaintiffs' Release as the Sole Effective Remedy for the Constitutional Violation.

"Federal courts possess whatever powers are necessary to remedy constitutional violations because they are charged with protecting these rights." *Stone v. City & Cnty. of San Francisco*, 968 F.2d 850, 861 (9th Cir. 1992). As a result, "[w]hen necessary to ensure compliance with a constitutional mandate, courts may enter orders placing limits on a prison's population." *Brown v. Plata*, 563 U.S. 493, 511 (2011).

This principle is well-established. For example, in cases involving prisons and jails, federal courts have repeatedly ordered the release of detained persons when necessary to remedy constitutional violations caused by overcrowding. *See, e.g.*, *Duran v. Elrod*, 713 F.2d 292, 297-98 (7th Cir. 1983), *cert. denied*, 465 U.S. 1108 (1984) (concluding that court did not exceed its authority in directing release of low-bond pretrial detainees as necessary to reach a population cap); *Mobile Cty. Jail Inmates v. Purvis*, 581 F. Supp. 222, 224-25 (S.D. Ala. 1984) (concluding that district court properly exercised remedial powers to order a prison's population reduced to alleviate unconstitutional conditions, and noting other cases); *Inmates of the Allegheny Cty. Jail v. Wecht*, 565 F. Supp. 1278, 1297 (W.D. Pa. 1983) (order to reduce overcrowding "is within our power to correct the constitutional violations"); *Brenneman v. Madigan*, 343 F. Supp. 128, 139 (N.D. Cal. 1972) ("If the state cannot obtain the resources to detain persons . . . in accordance with minimum constitutional standards, then the state simply will not be permitted to detain such

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persons."); *Herrera v. Pierce Cty.*, No. C-95-5025 (W.D. Wash. Oct. 31, 1995) (stipulated order).[4]

In this case, the release of Plaintiffs from detention is the only effective remedy for the constitutional violation they face. Preventive measures that may be effective in the community, such as maintaining a distance of six feet from other persons and frequent disinfection, are simply not possible in the detention setting. *See supra* Factual Background Sec. II-III; Greifinger Decl. ¶ 11; Stern Decl. ¶ 7. "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." Greifinger Decl. ¶ 13.

For the foregoing reasons, Plaintiffs are likely to succeed on the merits of their claim that their continued detention violates their Fifth Amendment due process right to safety in government custody.

II. The Remaining Factors Weigh Heavily in Favor of Granting a Temporary Restraining Order.

a. Plaintiffs Are Likely to Suffer Irreparable Harm Absent the Temporary Restraining Order.

The Ninth Circuit has made clear that "the deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (internal quotation marks omitted). Moreover, as at least one judge in this district has recognized, the dangerous and unsafe conditions of detention that Plaintiffs face also constitute

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[4] In 1996, Congress enacted the Prison Litigation Reform Act (PLRA) which, *inter alia*, imposed a heightened standard for "prisoner release orders." 18 U.S.C. § 3626(a)(3). Applying those heightened standards, the Supreme Court affirmed an order directing California to reduce crowding in its prisons where overcrowding was the "primary cause" of "severe and unlawful mistreatment of prisoners through grossly inadequate provision of medical and mental health care." *Brown v. Plata*, 563 U.S. 493, 502 (2011). The PLRA does not apply to cases brought by detained immigrants challenging the conditions of their confinement. *Agyeman v. I.N.S.*, 296 F.3d 871, 886 (9th Cir. 2002).

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irreparable harm supporting injunctive relief. *Padilla v. U.S. Immigration & Customs Enforcement*, 387 F. Supp. 3d 1219, 1231 (W.D. Wash. 2019) (recognizing that "substandard physical conditions, [and] low standards of medical care" in immigration detention constitute irreparable harm justifying injunctive relief). The Ninth Circuit also has recognized that irreparable harm exists where government actions threaten to worsen an individual's health. *See M.R. v. Dreyfus*, 663 F.3d 1100, 1111 (9th Cir. 2011), *as amended by* 697 F.3d 706 (9th Cir 2012); *see also, e.g.*, *Indep. Living Cent. of S. California, Inc. v. Shewry*, 543 F.3d 1047, 1050 (9th Cir. 2008) (recognizing that Medi-Cal beneficiaries would suffer irreparable harm where new policy would limit beneficiaries' access to "much-needed pharmaceuticals").

Each of these reasons support immediate relief here. Plaintiffs are older adults or people with underlying medical conditions that increase their likelihood of severe illness or death if they contract COVID-19. Stern Decl. ¶ 13. As discussed above, the fatality rate for 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. Golob Decl. ¶ 4. The fatality rate is estimated to be about 15 percent for people in the highest risk populations. *Id.* Patients in high-risk categories who do not die from COVID-19 should expect a prolonged recovery, including the need for extensive rehabilitation for profound reconditioning, loss of digits, neurologic damage, and the loss of respiratory capacity. *Id.* For these reasons, public health experts have concluded that people with these characteristics in institutional settings such as immigration detention centers "are at grave risk of severe illness and death." *Id.* ¶ 14.

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b. The Public Interest and Balance of Equities Weigh Heavily in Plaintiffs' Favor.

Both the balance of equities and the public interest heavily favor the Plaintiffs. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *Melendres*, 695 F.3d at 1002 (quotation omitted).

Furthermore, Plaintiffs will suffer irreparable harm without immediate relief, including unreasonable risk of long-lasting medical harm or death if infected by COVID-19. *See supra* Sec. II.a. Plaintiffs are civil detainees who are at grave risk of serious illness or death if exposed to COVID-19. Golob Decl. ¶ 14; Greifinger Decl. ¶¶ 7-10; Stern Decl. ¶¶ 3-6, 13. Whatever interest that the government asserts in their continued detention cannot be outweighed by such irreparable harm. "Faced with . . . preventable human suffering, [the Ninth Circuit] ha[s] little difficulty concluding that the balance of hardships tips decidedly in plaintiffs' favor." *Hernandez v. Sessions*, 872 F.3d 976, 996 (9th Cir. 2017) (quoting *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir. 1983)).

Moreover, it is in both the *Defendants'* and the broader public interest to release detainees with particular medical vulnerabilities. The release of people most vulnerable to COVID-19 reduces the overall health risk for detainees and facility staff alike at the NWDC. Stern Decl. ¶ 9. ICE has an interest in preventing any potential spread of COVID-19 in its detention facility, particularly because detainees face great difficulty engaging in proper hygiene and social distancing in a detention environment. *Id.* ¶¶ 7-9. Immigration detention facilities face greater risk of infectious spread because of crowding, the high percentage of detained people vulnerable to serious illness in the event of COVID-19 transmission, and limited availability of medical care. Golob Decl. ¶ 13; Greifinger Decl. ¶¶ 10-12. Public health officials have testified that even with the best-laid plans, the release of vulnerable individuals is key to the risk

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mitigation strategy of any detention facility because it reduces the total number of detainees, allows for greater social distancing, and prevents overloading the work of detention staff. Stern Decl. ¶¶ 9-11; Greifinger Decl. ¶ 13. Plaintiffs' release not only imposes minimal harm to the government, but also *furthers* ICE's interests in maintaining a healthy and orderly environment at the NWDC. Stern Decl. ¶ 9; Greifinger Decl. ¶ 13.

Lastly, releasing Plaintiffs is clearly in the broader public's interest. Here, "the impact of [a temporary restraining order] reaches beyond the parties, carrying with it a potential for public consequences." *Hernandez*, 872 F.3d at 996 (quoting *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1139 (9th Cir. 2009)). An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure. Stern Decl. ¶ 6. The COVID-19 outbreak in Seattle has already resulted in the need for unprecedented public health measures and caused a strain on the local health care system. Golob Decl. ¶ 12; Greifinger Decl. ¶ 9. The release of people most vulnerable to serious illness from COVID-19 reduces the health and economic burden on the local community and health infrastructure at large. Greifinger Decl. ¶¶ 8, 13; Stern Decl. ¶¶ 9-11; Golob Decl. ¶ 14; *see also Hernandez*, 872 F.3d at 996-97 ("[T]he general public's interest in efficient allocation of the government's fiscal resources favors granting [relief]").

III. The Court Should Not Require Plaintiffs to Provide Security Prior to Issuing a Temporary Restraining Order.

Federal Rule of Civil Procedure 65(c) provides that "The court may issue a preliminary injunction or a temporary restraining order only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." However, "Rule 65(c) invests the district court with discretion as to the amount of security required, *if any*." *Jorgensen v. Cassiday,* 320 F.3d 906, 919 (9th Cir. 2003) (internal quotation marks and citation omitted). District courts routinely

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exercise this discretion to require no security in cases brought by indigent and/or incarcerated people. *See, e.g.*, *Toussaint v. Rushen,* 553 F. Supp. 1365, 1383 (N.D. Cal. 1983) (state prisoners); *Orantes–Hernandez v. Smith,* 541 F. Supp. 351, 385 n. 42 (C.D. Cal. 1982) (detained immigrants). This Court should do the same here.

CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a temporary restraining order should be granted.

Respectfully submitted on this 16th of March, 2020.

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CERTIFICATE OF SERVICE

I hereby certify that on March 16, 2020, I electronically filed the foregoing document and accompanying proposed order with the Clerk of the Court using the CM/ECF system. I further certify that I have mailed Respondents-Defendants a copy of this document and the accompanying proposed order via certified, first class mail. In addition, I have emailed copies of these documents to the following email addresses at the U.S. Attorney's Office for the Western District of Washington:

Micki.Brunner@usdoj.gov
Kristin.B.Johnson@usdoj.gov

Dated: March 16, 2020

s/ Matt Adams

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EXHIBIT 5

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 6

Declaration of Dr. Marc Stern

I, Marc Stern, declare as follows:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I also have considerable familiarity with the immigration detention system. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I have also served as a consultant to Human Rights Watch in their preparation of two reports on health-related conditions of confinement in ICE detention facilities. In those capacities, I have visited and examined more than 20 ICE detention facilities and reviewed hundreds of records, including medical records and detention death reviews of individuals in ICE detention. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease and has reached pandemic status. At least 132,758 people around the world have received confirmed diagnoses of COVID 19 as of March 13, 2020, including 1,629 people in the United States. At least 4,955 people have died globally as a result of COVID-19 as of March 13, 2020, including 41 in the United States. These numbers will increase, perhaps exponentially.

3. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. The only way to control the virus is to use preventive strategies, including social distancing.

4. The time course of the disease can be very rapid. Individuals 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 (perhaps sooner) after that.

5. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

6. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure.

7. Detention facilities are congregate environments, i.e. places where people live and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread. This therefore presents an increased danger for the spread of COVID-

19 if and when it is introduced into the facility. To the extent that detainees are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, the risks of spread are greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in another congregate environment: nursing homes and cruise ships.

8. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in detention facilities, placing people at risk, especially when the number of detainees is high.

9. For detainees who are at high risk of serious illness or death should they contract the COVID-19 virus, release from detention is a critically important way to meaningfully mitigate that risk. Additionally, the release of detainees who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of detainees in a facility. Combined, this has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff such that they can continue to ensure the safety of detainees.

10. The release of detainees, especially those with increased health-related vulnerability, also supports the broader community because carceral and detention settings, regardless of the level of government authorities that oversee them, are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a Federal immigration detention center slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large.

11. As a correctional public health expert, I recommend release of eligible individuals from detention, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19.

12. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court. One of the most worrisome changes would be confirmation of a case of COVID-19 within the detention center, either among staff or detainees. In the event of this occurring, and eligible detainees being quarantined or isolated due to possible exposure to the virus, I recommend that the detainee(s) be tested for the virus if testing is available. Armed with the results of that test if it is available, or in the absence of other instructions from the health authority of the municipality to which they will be returning or the Washington State public health authority, those who can easily return to a home without exposure to the public, should be released to that home for continued quarantine or isolation for the appropriate time period. All others can be released to appropriate housing as directed or arranged in coordination with the relevant health authority.

13. I have reviewed Plaintiffs' complaint and on the basis of the claims presented, conclude that Plaintiffs have underlying medical conditions that increase the risk of serious illness or death if exposed to COVID-19. Due to the risks caused by the congregate environment in immigration

detention, compounded by the marked increase in risk conferred by their underlying medical conditions, I recommend their release.

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

Executed this __15th___ day in March, 2020 in Tumwater, Washington.

Dr. Marc Stern

EXHIBIT 7

DECLARATION OF DR. JONATHAN LOUIS GOLOB

I, Jonathan Louis Golob, declare as follows:

1. I am an Assistant Professor at the University of Michigan School of Medicine in Ann Arbor, Michigan, where I am a specialist in infectious diseases and internal medicine. At the University of Michigan School of Medicine, I am a practicing physician and a laboratory-based scientist. My primary subspecialization is for infections in immunocompromised patients, and my recent scientific publications focus on how microbes affect immunocompromised people. I obtained my medical degree and completed my residency at the University of Washington School of Medicine in Seattle, Washington, and also completed a Fellowship in Internal Medicine Infectious Disease at the University of Washington. I am actively involved in the planning and care for patients with COVID-19. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a novel zoonotic coronavirus that has been identified as the cause of a viral outbreak that originated in Wuhan, China in December 2019. The World Health Organization has declared that COVID-19 is causing a pandemic. As of March 12, 2020, there are over 140,000 confirmed cases of COVID-19. COVID-19 has caused over 5,000 deaths, with exponentially growing outbreaks occurring at multiple sites worldwide, including within the United States.

3. COVID-19 makes certain populations of people severely ill. People over the age of fifty are at higher risk, with those over 70 at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions include: those with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy.

4. For all people, even in advanced countries with very effective health care systems such as the Republic of Korea, the case fatality rate of this infection is about ten fold higher than that observed from a severe seasonal influenza. In the more vulnerable groups, both the need for care, including intensive care, and death is much higher than we observe from influenza infection: In the highest risk populations, the case fatality rate is about 15%. For high risk patients who do not die from COVID-19, a prolonged recovery is expected to be required, including the need for extensive rehabilitation for profound deconditioning, loss of digits, neurologic damage, and loss of respiratory capacity that can be expected from such a severe illness.

5. In most people, the virus causes fever, cough, and shortness of breath. In high-risk individuals as noted above, this shortness of breath can often be severe. Even in younger and healthier people, infection of this virus requires supportive care, which includes supplemental oxygen, positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation.

6. Most people in the higher risk categories will require more advanced support: positive pressure ventilation, and in extreme cases, extracorporeal mechanical oxygenation. Such care requires highly specialized equipment in limited supply as well as an entire team of care providers, including but not limited to 1:1 or 1:2 nurse to patient ratios, respiratory therapists and intensive care physicians. This level of support can quickly exceed local health care resources.

7. The COVID-19 virus can severely damage the lung tissue, requiring an extensive period of rehabilitation and in some cases a permanent loss of respiratory capacity. The virus also seems to target the heart muscle itself, causing a medical condition called mycocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, which reduces the heart's ability to pump, leading to rapid or abnormal heart rhythms in the short term, and heart failure that limits exercise tolerance and the ability to work lifelong. There is emerging evidence that the virus can trigger an over-response by the immune system in infected people, further damaging tissues. This cytokine release syndrome can result in widespread damage to other organs, including permanent injury to the kidneys (leading to dialysis dependence) and neurologic injury.

8. There is no vaccine for this infection. Unlike influenza, there is no known effective antiviral medication to prevent or treat infection from COVID-19. Experimental therapies are being attempted. The only known effective measures to reduce the risk for a vulnerable person from injury or death from COVID-19 are to prevent individuals from being infected with the COVID-19 virus. Social distancing, or remaining physically separated from known or potentially infected individuals, and hygiene, including washing with soap and water, are the only known effective measures for protecting vulnerable communities from COVID-19.

9. COVID-19 is known to be spreading in the Seattle, Washington-area community. As of March 11, 2020 there are 270 confirmed cases of COVID-19 (an increase of 36 from March 10, 2020) and twenty-seven deaths from COVID-19 in the Seattle area. This

represents the largest known outbreak in the United States, and one the largest known outbreaks in the world as of March 12, 2020.

10. Nationally, without effective public health interventions, CDC projections indicate about 200 million people in the United States could be infected over the course of the epidemic, with as many as 1.5 million deaths in the most severe projections. Effective public health measures, including social distancing and hygiene for vulnerable populations, could reduce these numbers.

11. Based on the recovered genomes of the virus from the community analyzed by the Nextstrain project run by Dr. Trevor Bedford of the Fred Hutchinson Cancer Research Center in Seattle, it is known that the infection is being shared from person to person in and around Seattle. COVID-19 strains have specifically traced infection between residents and staff members of a skilled nursing facility in the Seattle area. This evidence suggests that COVID-19 is capable of spreading rapidly in institutionalized settings. The highest known person-to-person transmission rates for COVID-19 are in a skilled nursing facility in Kirkland, Washington and on afflicted cruise ships in Japan and off the coast of California. The strain of virus spreading in the Seattle area is genetically related to the strain of virus that spread readily on the cruise ships.

12. The COVID-19 outbreak in Seattle has resulted in the need for unprecedented public health measures, including multiple efforts to facilitate and enforce social distancing. These include encouraging employees to work from home, bans of gathering of more than 250 people, closure of schools, closure of the University of Washington campus in Seattle, limitations of visitation to skilled nursing facilities, and cancellation of major public events. Individuals have been asked to delay or cancel health care procedures in order to free up capacity within the system.

13. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection. Given the avid spread of COVID-19 in skilled nursing facilities and cruise ships, it is reasonable to expect COVID-19 will also readily spread in detention centers, particularly when residents cannot engage in proper hygiene and isolate themselves from infected residents or staff.

14. This information provides many reasons to conclude that vulnerable people, people over the age of 50 and people of any age with lung disease, heart disease, diabetes, or immunocompromised (such as from cancer, HIV, autoimmune diseases), blood disorders (including sickle cell disease), chronic liver or kidney disease, inherited metabolic disorders, stroke, developmental delay, or pregnancy living in an institutional setting,

such as an immigration detention center, with limited access to adequate hygiene facilities and exposure to potentially infected individuals from the community are at grave risk of severe illness and death from COVID-19.

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

Executed this 13th day in March, 2020 in Ann Arbor, Michigan.

Dr. Jonathan Louis Golob

EXHIBIT 8

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

KARLENA DAWSON, et al., Petitioner-Plaintiffs, v. NATHALIE ASHER, et al., Respondent-Defendants.	CASE NO. C20-0409JLR-MAT ORDER DENYING TEMPORARY RESTRAINING ORDER

I. INTRODUCTION

Before the court is Petitioner-Plaintiffs Karlena Dawson, Alfredo Espinoza Esparza, Normal Lopez-Nunez, Marjoris Ramirez Ochoa, Maria Gonzalez Mendoza, Joe Hlupheka Bayana, Leonidas Plutin Hernandez, Kelvin Melgar Alas, and Jesus Gonzalez Herrera's (collectively, "Plaintiffs") motion for a temporary restraining order ("TRO"). (Mot. (Dkt. # 2).) Respondent-Defendants Nathalie Asher, Matthew T. Albence, Steven Langford, and United States Immigration and Customs Enforcement ("ICE") (collectively, "Defendants") filed a response. (*See* Resp. (Dkt. # 28).)

The court has reviewed the motion, the response, the petition and complaint[1] (Compl. (Dkt. # 1)), the parties' submissions in support of and in opposition to the motion, the relevant portions of the record, and the applicable law. Being fully advised, [2] the court DENIES the motion.

II. BACKGROUND

Plaintiffs are nine individuals currently held in civil detention by ICE at the Tacoma Northwest Detention Center ("NWDC") in Tacoma, Washington. (*See* Compl. ¶¶ 39-66.) On March 16, 2020, Plaintiffs filed their complaint, seeking a writ of habeas corpus, or in the alternative, injunctive relief, against Defendants. (*See id.* at 20.) Plaintiffs represent that they are "particularly vulnerable to serious illness or death if infected by COVID-19" as a result of their age and/or medical condition. (*See id.* ¶¶ 39-66.) Plaintiffs then filed the present motion, in which they seek "immediate release" from detention as they await adjudication of their immigration cases. (*See* Mot. at 7.) They argue that "[t]he conditions of immigration detention facilities pose a heightened public health risk for the spread of COVID-19" due to "crowding, the proportion of vulnerable people detained, and often scant medical care resources," in addition to the inability to achieve the social

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[1] Petitioner-Plaintiffs' initial filing is a "petition for writ of habeas corpus . . . and complaint for injunctive relief." (*See* Compl. at 1.) For simplicity's sake, the court refers to the parties as "Plaintiffs" and "Defendants" and the petition-complaint as the "complaint."

[2] Neither party requests oral argument (*see* Mot. at 1; Resp. at 1), and the court finds oral argument unnecessary to its disposition of the motion, *see* Local Rules W.D. Wash. LCR 7(b)(4); LCR 65(b)(3).

distancing needed to effectively prevent the spread of COVID-19. (*See id.*) The court now considers the motion.

III. ANALYSIS

Plaintiffs contend that their continued detention in the face of the COVID-19 pandemic violates their Fifth Amendment right to reasonable safety while in custody. (*See* Mot. at 12.) For the reasons set forth below, the court DENIES Plaintiffs' motion for a TRO.

A. Legal Standard

The standard for issuing a TRO is the same as the standard for issuing a preliminary injunction. *See New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 434 U.S. 1345, 1347 n.2 (1977). A TRO is "an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). "The proper legal standard for preliminary injunctive relief requires a party to demonstrate (1) 'that he is likely to succeed on the merits, (2) that he is likely to suffer irreparable harm in the absence of preliminary relief, (3) that the balance of equities tips in his favor, and (4) that an injunction is in the public interest.'" *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1127 (9th Cir. 2009) (citing *Winter*, 555 U.S. at 20).

As an alternative to this test, a preliminary injunction is appropriate if "serious questions going to the merits were raised and the balance of the hardships tips sharply in the plaintiff's favor," thereby allowing preservation of the status quo when complex legal questions require further inspection or deliberation. *All. for the Wild Rockies v. Cottrell*,

632 F.3d 1127, 1134-35 (9th Cir. 2011). However, the "serious questions" approach supports the court's entry of a TRO only so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest. *Id.* at 1135. The moving party bears the burden of persuasion and must make a clear showing that it is entitled to such relief. *Winter*, 555 U.S. at 22.

B. Plaintiffs' Motion

The court concludes that Plaintiffs do not meet their burden to make a clear showing that they are likely to succeed on the merits or that they are likely to face irreparable harm. Therefore, the court DENIES Plaintiffs' motion for a TRO.[3]

1. Likelihood of Success on the Merits

To evaluate the constitutionality of a pretrial detention condition under the Fifth Amendment, a district court must determine whether those conditions "amount to punishment of the detainee." *Bell v. Wolfish*, 441 U.S. 520, 535, 99 S. Ct. 1861, 1872, 60 L. Ed. 2d 447 (1979); *see also see also Kingsley v. Hendrickson*, --- U.S. ---, 135 S. Ct. 2466, 2473-74 (2015). Punishment may be shown through express intent or a restriction or condition that is not "reasonably related to a legitimate governmental objective." *Bell*, 441 U.S. at 539.

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[3] Having concluded that Plaintiffs fail to meet the first two prongs of the TRO standard, the court finds it unnecessary to address the third and fourth prongs. Defendants also raise arguments based on Article III standing and the limits of the habeas statutes. Plaintiffs have not had an opportunity to respond to those arguments, and because they are not necessary to resolve Plaintiffs' present motion, the court leaves them for another day.

First, Plaintiffs do not present allegations or evidence to show Defendants have an "express intent" to punish Plaintiffs. (*See generally* Mot.) Second, preventing detained aliens from absconding and ensuring that they appear for removal proceedings is a legitimate governmental objective. *See Jennings v. Rodriguez*, --- U.S ---, 138 S. Ct. 830, 836 (2018); *Demore v. Kim*, 538 U.S. 510, 523 (2003); *Zadvydas v. Davis*, 533 U.S. 678, 690-91 (2001). Third, Plaintiffs' current confinement does not appear excessive in relation to that objective. Plaintiffs do not cite to authority, and the court is aware of none, under which the fact of detention itself becomes an "excessive" condition solely due to the risk of a communicable disease outbreak—even one as serious as COVID-19.

Plaintiffs' cited authority addresses the exposure of inmates or detainees to existing conditions within the facility at issue. *See, e.g.*, *Hutto v. Finney*, 437 U.S. 678, 682-83 (1978) (mingling of inmates with infectious diseases with others); *Gates v. Collier*, 501 F.2d 1291, 1300 (5th Cir. 1974) (same); *Helling v. McKinney*, 509 U.S. 25 at 33, 35 (1993) (placement of inmate with emphasema in a cell with a cellmate who smoked often). Here, there is no evidence that anyone at NWDC has COVID-19, and Plaintiffs do not address the measures Defendants are taking to prevent such a spread from occurring. (*See* Resp. at 3-6 (detailing measures to prevent the spread of COVID-19, including suspending social visitation, assessing detainees for fever and respiratory illness, isolating detainees with COVID-19-compatible symptoms, and instructing detainees on hand washing and hygiene).) Finally, even if Plaintiffs could show a Fifth Amendment violation, Plaintiffs provide no authority under which such a violation would justify immediate release, as opposed to injunctive relief that would

leave Plaintiffs detained while ameriolating any alleged violative conditions within the facility. Thus, the court concludes that Plaintiffs fail to meet their burden of clearly showing that they are likely to succeed on the merits of their claims.

2. Irreparable Harm

Plaintiffs do not show that "irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22. The "possibility" of harm is insufficient to warrant the extraordinary relief of a TRO. *See id.* There is no evidence of an outbreak at the detention center or that Defendants' precautionary measures are inadequate to contain such an outbreak or properly provide medical care should it occur.[4] Accordingly, the court concludes that Plaintiffs fail to meet their burden of clearly showing that irreparable harm is likely in the absence of an injunction.

IV. CONCLUSION

For the foregoing reasons, the court DENIES Plaintiffs' motion for a temporary restraining order (Dkt. # 2).

Dated this 19th day of March, 2020.

JAMES L. ROBART
United States District Judge

[4] The court is mindful of the gravity and rapidly changing nature of the COVID-19 pandemic. The court emphasizes that this order is based on and extends no further than the narrow set of facts, arguments, and requested relief presently before the court.

EXHIBIT 9

From: Nowicki, Stacy L
To: Briana J. Marino
Subject: Fwd: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)
Date: Thursday, March 26, 2020 9:51:50 AM

Sent from my iPhone

Begin forwarded message:

From: "Nowicki, Stacy L" <Stacy.L.Nowicki@wv.gov>
Date: March 19, 2020 at 11:59:00 AM EDT
To: Loree Stark <LStark@acluwv.org>, "Jividen, Betsy" <Betsy.Jividen@wv.gov>
Cc: "Valentino, William R" <William.R.Valentino@wv.gov>, "Messina, Lawrence C" <Lawrence.C.Messina@wv.gov>
Subject: RE: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)

CenturyLink is giving the prison facility inmates 2 15-minute calls per week.
GTL is giving the jail facility inmates 2 5-minute calls per week
GTL is giving prison facility 1 15-minute video visitation per inmate, per week
Tech Friends is giving jail facility 1 15-minute video visitation per inmate, per week (working on this to implement, a lot of cameras have been broken at the jails)
Keep in mind, this is given based on type of facility, not type of inmate. This is also a very quickly evolving situation, and these numbers are subject to change.

Stacy L. Nowicki, Esq.
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CONFIDENTIAL: ATTORNEY - CLIENT PRIVILEGED COMMUNICATION

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please notify the sender at 304. 558.2036.

From: Loree Stark <LStark@acluwv.org>
Sent: Thursday, March 19, 2020 11:46 AM
To: Nowicki, Stacy L <Stacy.L.Nowicki@wv.gov>; Jividen, Betsy <Betsy.Jividen@wv.gov>
Cc: Valentino, William R <William.R.Valentino@wv.gov>
Subject: RE: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)

Terrific, thank you so much!
-Loree

Loree Stark
Legal Director
ACLU of West Virginia
P.O. Box 3952
Charleston, WV 25339-3952
(304) 345-9246
Pronouns: she/her/hers

From: Nowicki, Stacy L <Stacy.L.Nowicki@wv.gov>
Sent: Thursday, March 19, 2020 11:45 AM
To: Loree Stark <LStark@acluwv.org>; Jividen, Betsy <Betsy.Jividen@wv.gov>
Cc: Valentino, William R <William.R.Valentino@wv.gov>
Subject: RE: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)

Ms. Stark- I will get back with you when I have a moment to let you know what the polices are on electronic communications.

Stacy L. Nowicki, Esq.
Deputy General Counsel
Department of Military Affairs and Public Safety
1900 Kanawha Blvd., East
Building 1, Suite 400-W
Charleston, WV 25305
Phone- (304)558-2930
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please notify the sender at 304. 558.2036.

From: Loree Stark <LStark@acluwv.org>
Sent: Thursday, March 19, 2020 11:39 AM
To: Jividen, Betsy <Betsy.Jividen@wv.gov>
Cc: Nowicki, Stacy L <Stacy.L.Nowicki@wv.gov>; Valentino, William R <William.R.Valentino@wv.gov>
Subject: RE: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)

Thanks—I thought I left my cell phone number on the voicemail, and I'm not sure what happened if it didn't come through on there. I'm working from home and having difficulty accessing our voicemail at work. Thanks for letting me know and I appreciate your response.

While we are waiting on the policy, can you confirm if the current policy regarding communications is that those that are incarcerated get two free calls a week and one free video visitation? I've heard conflicting things and I just want to make sure we have it right.

-Loree

Loree Stark
Legal Director
ACLU of West Virginia
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From: Jividen, Betsy <Betsy.Jividen@wv.gov>
Sent: Thursday, March 19, 2020 11:33 AM
To: Loree Stark <LStark@acluwv.org>
Cc: Nowicki, Stacy L <Stacy.L.Nowicki@wv.gov>; Valentino, William R <William.R.Valentino@wv.gov>
Subject: RE: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)

I tried to call you back yesterday. There was no answer, and no machine picked up. We are updating a policy and I am forwarding your request to Legal.

From: Loree Stark <LStark@acluwv.org>
Sent: Thursday, March 19, 2020 11:23 AM
To: Jividen, Betsy <Betsy.Jividen@wv.gov>
Subject: [External] FW: Followup on Request for Meeting and Documents (ACLU-WV)

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Commissioner Jividen,

I am following up on the below request for documents and a meeting. Please let me know if I have missed a responsive email or phone call. I am now following up on the request for documents today with the attached, outlining our organization's right to access information under WV FOIA laws.

Thanks,

-Loree

Loree Stark
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From: Loree Stark
Sent: Tuesday, March 10, 2020 2:08 PM
To: 'betsy.jividen@wv.gov' <betsy.jividen@wv.gov>
Subject: ACLU-WV Request for Meeting Regarding COVID-19 Plans

Commissioner Jividen,

I don't believe we've yet met. I'm the legal director here at ACLU-WV. Along with other ACLU affiliates around the country, our organization is concerned for the health of our incarcerated populations in the wake of the COVID-19 pandemic. I'd like to meet, either in person or via phone, with the appropriate person in the Division as soon as practicable. Please see the attached letter.

It's easiest to reach me via email or on my cell. My number is 914-393-4614.

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