UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
CIVIL DIVISION

EDWARD BANKS, et al.,	:	
	:	
Plaintiff,	:	Civil Action No.: 20-00849 (CKK)
	:	
v.	:	
	:	
QUINCY BOOTH, et al.,	:	
	:	
Defendants.	:	

MOTION OF THE FRATERNAL ORDER OF POLICE FOR THE DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS LABOR COMMITTEE FOR LEAVE TO SUBMIT AN *AMICUS CURIAE* BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER

The Fraternal Order of Police for the District of Columbia Department of Corrections Labor Committee (FOP/DOC), through its attorneys with HANNON LAW GROUP, LLP, respectfully presents this motion for leave to file a brief as *amicus curiae* in support of the position of Plaintiffs. Counsel for Plaintiffs consent to the relief sought in this motion. Counsel for Defendants oppose this motion.

INTRODUCTION

Local Civil Rule 7 (o)(1) provides that a party seeking to file a brief as *amicus curiae* may do so upon leave of court. LCvR 7 (o)(2) provides:

> A motion for leave to file an amicus brief shall concisely state the nature of the movant's interest; identify the party or parties supported, if any; and set forth the reasons why an amicus brief is desirable, why the movant's position is not adequately represented by a party, and why the matters asserted are relevant to the disposition of the case. The motion shall state the position of each party as to the filing of such a brief and be accompanied by a proposed order. The motion shall be filed in a timely manner such that it does not unduly delay the Court's ability to rule on any pending matter. Any party may file an opposition to a motion for leave to file an amicus brief, concisely stating the reasons for such opposition, within 14 days after service of the motion or as ordered by the Court. There shall be no further briefing unless otherwise ordered by the Court.

ARGUMENT

District courts have discretion whether to grant leave to file an *amicus* brief. *Jin v. Ministry of State Sec.*, 557 F. Supp. 2d 131, 136 (D.D.C. 2008); *see also Stuart v. Huff*, 706 F.3d 345, 355 (4th Cir. 2013). There is no Federal Rule of Civil Procedure that applies to motions for leave to appear as *amicus curiae* in district court. Therefore, district courts often look for guidance to Federal Rule of Appellate Procedure 29, which applies to *amicus* briefs in federal appellate cases. *See, e.g.*, *Am. Humanist Ass'n v. Md.-Nat'l Capital Park & Planning Comm'n*, 147 F. Supp. 3d 373, 389 (D. Md. 2015). Rule 29 provides that prospective *amici* must file along with the proposed brief, a motion that states "the movant's interest" and "the reason why an *amicus* brief is desirable and why the matters asserted are relevant to the disposition of the case." Fed. R. App. Proc. 29(a)(3). Our Local Civil Rule 7 (o)(2) requires this information plus more.

A. The Nature of the Interest of the FOP/DOC

The FOP/DOC consists of over 900 members who work at the D.C. Jail. The majority work in positions in Housing Units requiring them to interact with inmates throughout the shift. Others work in locations which require them to have contact with inmates as well as other staff at the Jail. The members' interest is the same as that of the inmates whom they guard and protect: to be free of infection from the COVID-19 virus already rampant at the D.C. Jail. Two of our members have tested positive for COVID-19, as well as the wife of one of them. The members still working at the Jail are not tested. As the expert for the Plaintiffs opines, the likelihood is very high that a very large percentage of our members are now infected with COVID-19.

The interest of the FOP/DOC includes a right to be heard. As is detailed in the *amicus* brief lodged herewith, the leadership of the DOC has failed to communicate with the FOP/DOC regarding the crisis at the D.C. Jail. In addition, the leadership fails to employ recognized standards for providing for the protection of the health and safety of our members and their families.

In short, the members of the FOP/DOC believe that their lives are at risk if Plaintiffs do not succeed in portraying to the Court the truth of the inferno in which they work.

B. An *Amicus* Brief from the FOP/DOC is Desirable.

The Court's ruling on Plaintiffs' request for a temporary restraining order turns on the facts of what is occurring on a daily basis at the D.C. Jail. The FOP/DOC Labor Committee has reviewed the factual allegations and declarations filed by the DOC in this case. The members of the Committee know from personal knowledge, and from the personal knowledge of their members in the Jail, that the information being provided to the Court is false in many respects, misleading and incomplete. In addition, during this crisis the leadership of the DOC is not coming into the D.C. Jail. Their representations of what is happening in the Housing Units, in inmates' cells, in the quarantine units, in the transportation units, in the halls of the Jail are not based on personal knowledge. What FOP/DOC is able to present to the Court is even superior to that found so far by Plaintiffs' counsel, who are themselves severely hampered in finding the truth.

C. The Interests of the FOP/DOC are not Adequately Represented.

The DOC defendants will not represent our interests. The inmate Plaintiffs, even with compulsory process, cannot adequately learn the facts, know where to look for them, or in some cases know what they mean. On the other hand, Plaintiffs' counsel complement the knowledge

of the FOP/DOC Labor Committee, as counsel are in the unique position as legal representatives for incarcerated citizens. Their understanding of their clients' lives in the D.C. Jail will be complemented by the knowledge of their clients' custodians.

D. Why the Matters to be Asserted by FOP/DOC are Relevant.

The matters that FOP/DOC intends to assert consist, in part, of the following: (1) the facts regarding the failure of DOC to provide COVID-19 protections to inmates and staff; (2) the facts which contradict almost every averment in the Declarations of Beth Jordan, M.D., and Warden Lennard Johnson; (3) the departures of DOC from both CDC Guidance and their own protocol for protection of inmates and staff from COVID-19; and (4) how the DOC leadership and the Mayor of the District of Columbia have attempted to cover-up the disaster of the D.C. Jail COVID-19 crisis.

CONCLUSION

For the foregoing reasons, the FOP/DOC respectfully requests that the Court grant leave for the filing of a brief *amicus curiae,* attached hereto as Exhibit A, in support of Plaintiffs' Motion for a Temporary Restraining Order.

Dated: April 2, 2020

Respectfully submitted,

HANNON LAW GROUP, LLP

/s/ J. Michael Hannon

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ORDER

Upon consideration of the Motion of the FOP/DOC Labor Committee for leave to file an *amicus* brief in support of Plaintiffs' Motion for a Temporary Restraining Order, it is on this _____day of April, 2020, hereby

ORDERED that Plaintiff's Motion is **GRANTED;** and it is

FURTHER ORDERED that the Clerk of the Court shall accept for filing the brief attached as Exhibit A to the Motion of the FOP/DOC Labor Committee.

_____
COLLEEN KOLLAR-KOTELLY
United States District Judge

EXHIBIT A

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FRATERNAL ORDER OF POLICE FOR THE DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS LABOR COMMITTEE'S MEMORANDUM OF POINTS AND AUTHORITIES AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS

The Fraternal Order of Police for the District of Columbia Department of Corrections Labor Committee (FOP/DOC), through its attorneys with HANNON LAW GROUP, LLC, respectfully present this memorandum as *amicus curiae* in support of the position of Plaintiffs.

FACTUAL BACKGROUND[1]

The Fraternal Order of Police for the District of Columbia Department of Corrections Labor Committee (FOP/DOC) is the recognized bargaining unit for corrections officers, case managers, transportation personnel, and some ancillary employees who work at the D.C. Jail. The D.C. Jail consists of two detention centers: the Central Detention Facility (CDF) for men and restricted inmates; and, the Central Treatment Facility (CTF) for women and men. The relationship between the DOC and the FOP/DOC is governed by a Collective Bargaining Agreement and D.C. Personnel law and regulations.

[1] If necessary and if called upon to testify, the undersigned represents to the Court that the members of the FOP/DOC Labor Committee and its Stewards will testify on personal knowledge to the facts set forth in this section. The facts presented are also known to the undersigned from his personal participation as counsel.

HANNON LAW GROUP has represented FOP/DOC as its general counsel since 2006, the first year of the administration of DOC Director Devon Brown. During Brown's administration of the Jail, HANNON LAW GROUP represented dozens of FOP/DOC members who were proposed for discipline or dismissal by Director Brown. In winning the majority of those cases, HANNON LAW GROUP obtained well over $3 million dollars in back pay for members and attorneys' fees.

During the administration of the DOC's current Director Quincy Booth, the rate of discipline proposed by Director Booth mimics that of Director Brown.[2] Once again, HANNON LAW GROUP has succeeded in overturning almost all of the disciplinary actions, again resulting in a loss to the taxpayers of well over $1 million dollars in back pay and attorneys' fees.

The FOP/DOC is led by five elected members of the Labor Committee: Cpl. Benjamin Olubasusi, Chairman; Cpl. Arnold Hudson Sr., Vice Chairman; Sgt. Jannease Johnson, Executive Secretary; Cpl. Laurrine Ellis, Recording Secretary; and Cpl. Naomi Namata, Treasurer. Twelve Shops Stewards also represent the FOP/DOC in the Jail. The Labor Committee meets regularly among themselves, and during the COVID-19 crisis meets daily with HANNON LAW GROUP.

Failure of DOC Leadership to Communicate with the FOP/DOC Over the COVOD-19 Crisis

As part of good operational practice, the FOP/DOC and the DOC should conduct a labor/management meeting on a monthly basis. The FOP/DOC first meets with the warden at the Jail, and next the team meets with the Director at the Reeves Center. Director Booth has

[2] During the interim administration of Director Thomas Faust, proposals for discipline were at a minimum. The FOP/DOC lobbied the City Council and the Mayor for appointment of Director Faust to succeed Devon Brown. Labor/Management relations during that period were excellent.

canceled these meetings for January, February and March 2020 during this COVID-19 crisis. As we discuss further below, the DOC leadership has consistently refused to communicate with the Labor Committee or their counsel during this crisis.

On March 25, 2020, the Mayor announced the number of positive COVID-19 infected persons in the District of Columbia increased that day by 46 new cases to a total of 183. Notably, of the new cases 13 were in their 20s, 12 were in their 30s, and only 7 were over the age of 60. The Mayor's update attributed this increase, in part, to correctional and detention centers:

> With ongoing community transmission, contact tracing is focused on positive cases associated with childcare facilities, schools and universities, healthcare facilities, senior care facilities, *correctional and detention centers*, and facilities serving individuals who are experiencing homelessness. Guidance will be published for healthcare providers, employers and the public to provide information on what to do if you have been diagnosed with or are a contact of someone who has COVID-19.

On March 19, HANNON LAW GROUP sent an email to DOC on behalf of the FOP/DOC regarding the quarantine of 50 inmates who came in contact with an infected U.S. Marshal at the Courthouse, requesting immediate provision of Personal Protective Equipment (PPE) for its members. (Exhibit A) We received no response.

On the same date March 19, we sent a "Request for Information on Potentially Dangerous Conditions at the DOC Facilities" to DOC's General Counsel Eric Glover and to its HR Director. (Exhibit D) Among the request for information were the following:

> · Have all in-person visits, programming and volunteer activities at all Agency facilities in fact been suspended?
>
> · Have DOC officials established Incident Command Team? Who is on that team? Are any members of the Union on that team?
>
> · Is the Medical Staff meeting with each housing unit and officer roll call? Please provide details as to time, place and frequency of the meetings that the Medical Staff is holding.
>
> · What is the Agency's strategic communications plan with regard to COVID-

19, and how has it been communicated to the staff? Is it updated and communicated regularly as this situation evolves? The last update on the DOC web page is dated March 14, 2020.

· What does "enhanced cleaning efforts" mean? Have those “enhanced cleaning efforts” been implemented, especially within common areas? How often is this level of cleaning being done?

· The Agency promised to order additional cleaning and sanitation supplies, including protective gloves, masks and clothing for staff. No information was provided about dispensing these items. Have these items been received and distributed? Are there any supplies you need that you do not have? Have sanitizing wipes been provided by the Agency? Is the staff permitted to bring personal sanitation material, other than wipes? Are inmates being provided safety materials that the staff is not?

· Was there a two-hour cleaning of the entire facility? How many times has this happened? Is this occurring daily/regularly?

· Please describe the Agency's efforts in partnering and/or sharing information with criminal justice partners?

· Are daily updates continuing to be sent via emails to the staff regarding COVID-19? Can you please make those available?

· Have the DOC employees (officers and medical staff) been provided appropriate protective devices/material/training? Are staff members knowledgeable on and adequately equipped to prevent transmission, minimize spread and protect themselves and the inmate population from contacting COVID-19?

· Is the DOC working in close connection with the DC Department of Health? What medical support does the Agency have specifically for the virus?

· Are all incoming inmates, staff and other individuals with access to the DOC facilities questioned as to their level of risk?

· What is the procedure for processing all new inmates to the facilities?

· What is the procedure for assessing the risk to existing inmates?

· What testing is being offered to confirm a diagnosis of COVID-19?

· What procedures are in place if an inmate is symptomatic?

· What procedures are in place if an inmate tests positive?

· What procedures are in place for quarantines?

· Are there any of the following:

· Asymptomatic inmates currently housed at any of the facilities who are at high-risk for contracting COVID-19?

· Symptomatic inmates currently housed at any of the facilities? If so, what actions are being taken with regard to those individuals?

· Inmates currently housed at any of the facilities who have tested positive for COVID-19?

· What is being done to track any inmates, visitors, staff, or other individuals with access to any of the facilities who have been at any DOC facility within the past two weeks, including any individuals who were held and released or transferred?

· What is the impact of the Agency's response to the Mayor's Order 2020-048: Prohibition on Mass Gatherings During Public Health Emergency - Coronavirus (COVID-19)?

The next morning, DOC's General Counsel responded: "DOC is preparing a response to your inquires and will contact you as soon as possible." We have received no response.

Also on March 23, 2020, the FOP/DOC Labor Committee delivered to the DOC leadership and posted throughout the D.C. Jail an Announcement regarding critical actions to be addressed by the Labor Committee regarding COVID-19, as well as the failure to prosecute an inmate for the brutal beating of a corrections officer. (Exhibit C)

Instead of communicating with the Union as requested on March 19, 2020, Director Booth issued a notice on the same date of March 23, announced at every roll call, falsely stating: "It has come to the agency's attention that employees of the DOC intend to engage in either a walkout and/or protest on the grounds of the DOC." Rather than communicating honestly with the Union on these critical conditions of work, Director Booth threatened the corrections officers

with discipline. This action was clearly in retaliation for the Union presenting legitimate concerns about DOC's failure to implement protections for inmates and corrections officers.

In the afternoon of March 24, 2020, Director Booth summoned the FOP/DOC Labor Committee Chairman Cpl. Benjamin Olubasusi to his office at the Reeves Center. Without notice to HANNON LAW GROUP, the Director then put Deputy Mayor Kevin Donahue and Mayor Bowser on speaker phone. The Mayor then falsely warned Cpl. Olubasusi that it is a "crime" for D.C. corrections officers "to walk out of the Jail." Director Booth asked Cpl. Olubasusi, "What do you want?"

Also on March 24, HANNON LAW GROUP participated in a National Conference Call sponsored by the National Fraternal Order of Police on COVID-19. Speakers on the call included high-ranking experts from the Department of Homeland Security, FEMA, and the White House, as well as FOP State Representatives from all 50 states. The purpose of the call was to implement protocols for law enforcement officers and corrections officers nationwide. Highlights from the call are the following:

> Increasing infections will reduce the number of officers on duty.
>
> Loss of officers on duty will increase the work load on the uninfected officers.
>
> The resultant lack of officers will lead to additional crime and risk in the corrections system.
>
> PPE equipment is not being provided to officers nationwide.
>
> Because "social distancing" is impossible in law enforcement, the infection rate among officers will be higher than the general population.
>
> Coordination and Communication between and among political leaders and officers is the most important criteria to meet this challenge.
>
> State health departments, which are in control of the distribution of PPE, must make law enforcement and corrections officers a priority group for receipt of PPE and education.

On March 25, 2020, HANNON LAW GROUP also participated in a national conference call sponsored by the Department of Homeland Security at which medical experts with DHS reviewed with participants the March 23, 2020, "CDC Interim Guidance for Management of the Coronavirus 2019 (COVID-19) for Correctional and Detention Facilities." (Exhibit B) HANNON LAW GROUP alerted DOC leadership to the conference and provided them with registration information.

Also on March 25, 2020, in response to Director Booth's question of Cpl. Olubasusi "What do you want?", HANNON LAW GROUP sent a letter to Director Booth outlining conditions at the Jail and listing those actions urgently requested by FOP/DOC. (Exhibit E) The letter reported the current conditions at the Jail, as reported by members working in the Jail, as follows:

1. There is no Communication and Coordination between DOC leaders and the FOP/DOC Labor Committee. Labor/Management meetings are repeatedly cancelled, including one meeting scheduled during this critical time period.

2. Inmates coming into the Jail are not screened for symptoms of COVID-19.

3. Corrections Officers receiving and discharging inmates have no PPE; however, they must have direct contact with these inmates.

4. Inmates continue to move within the Jail. Those inmates in the four restricted housing units must be escorted by hand by corrections officers without any PPE. Inmates in non-restricted housing units travel alone through the Jail as required for appointments. At latest count, there were 1,149 inmates in the Central Detention Facility and 509 in the Correctional Treatment Facility.

5. The corrections officers assigned to housing units have no masks, insufficient gloves, no gowns, no disinfectants, and no comprehensive cleaning occurs on a regular basis in these units. In each unit, one corrections officer is required to be out among the inmates at all times, without any protection.

6. Inmates are not required to engage in any of the behaviors which the Mayor recommends for the general population, such as "social distancing", repeated hand-washing, and health monitoring.

7. Case workers must meet with inmates in small offices with no PPE or other distancing measures.

8. Inmates continue to engage in recreation in a common yard, also without social distancing or other protections from the spread of COVID-19.

9. Corrections officers enter the Jail three shifts a day. There is no distancing at entrances, no distancing at roll calls, no attempt to obtain or record health concerns of each officer.

10. When the D.C. Jail was forced to quarantine 65 inmates who were at risk to exposure to COVID-19 when they were at court, an ERT was designated to remove them from the general population to a "quarantine" housing unit. The ERT members refused the assignment without provision of gowns and other appropriate PPE protection. They were ordered to remove the inmates with only masks and gloves. During the extraction, one of the members was spit upon by an inmate. Sgt. Alexander and Sgt. Graham were then removed from the ERT team and assigned to another post outside the Jail.

11. These inmates were not "quarantined" in any meaningful manner. They were housed two to a cell, and the corrections officers on the unit were not provided with any PPE or other means for protection against infections.

The letter, yet again, detailed FOP/DOC's repeated request for help:

WHAT DO WE WANT?

1. A Daily Meeting among the Labor Committee, its Shop Stewards, its counsel and the DOC Director, Deputy Director, and its counsel to discuss conditions and responses to COVID-19;

2. A COVID-19 Protocol for officers and inmates including the following:

    Restricted movement of inmates
    Distancing among inmates/inmates, officers/officers, and officers/inmates
    Incident Reporting of officers and inmates' symptoms of illness

3. Regular Disinfection of the CDF and CTF

4. Priority for PPE for officers

5. Discontinuation of inmate transport for court appearances

6. 14-day Quarantine for new inmates

7. Establish a quarantine unit

8. Establish an on-site testing unit for those meeting CDC test criteria, including persons living in the household of a corrections officer

9. Treat COVID-19 among officers as duty-connected

Again receiving no response, the Labor Committee then established Protocols for its membership based on CDC Guidance. (Exhibit F) On March 28, 2020, these detailed Protocols were delivered to DOC leadership for implementation and distributed throughout the Jail, along with copies of the March 23, 2020, CDC Guidance for Correctional Facilities. (Exhibit B) Once again, no response was received from the leadership. Although the Labor Committee urged members to refuse to comply with an order to violate those Protocols, members consistently relented when ordered, for example, to escort quarantined inmates to showers without any PPE.

FOP/DOC Decides to Support the PDS/ACLU Lawsuit

On March 29, 2020, the Labor Committee learned that the 50-year-old wife of one of the elected members of the Labor Committee, a 29-year veteran, is infected with COVID-19. She is hospitalized in serious condition. Her husband, our officer and friend, has been tested for COVID-19, and learned on April 1, 2020, that he too is positive for COVID-19. The Labor Committee also learned that two inmates most recently testing positive at the Jail for COVID-19 were among the 65 inmates who were quarantined after exposure to a COVID positive U.S. Marshal at Superior Court. That quarantine lasted for only two days, when DOC's Public Information Officer Keena Blackman announced that the quarantine was being lifted without any of those inmates being tested. The reason given by Dr. Blackman follows:

> After sending out yesterday's Open Letter we learned through the Department of Justice (DOJ) and the DC Department of Health (DC Health) full investigation into the U.S. Marshal's contact tracing that none of the DOC residents were in contact with the individual. The quarantine has been lifted.

Our conclusion from this is that whoever is conducting the "tracing" and "investigations" are not doing so in a professional, effective and reliable manner.

The Labor Committee also learned that the Public Defender Service for the District of Columbia and the American Civil Liberties Union intended to file suit in federal court against the DOC, alleging that failure to protect inmates from COVID-19 is a violation of the Fifth and Eighth Amendments of the Constitution of the United States.

Therefore, the Labor Committee decided to issue a Press Release to correct and supplement information issued by various organizations regarding conditions at the D.C. Jail, namely: the Executive Office of the Mayor, the Department of Corrections, Deputy Mayor Kevin Donahue, Councilmember and Chair of the Public Safety Committee Charles Allen, the United States Attorney for the District of Columbia, the Public Defender Service for the District of Columbia, and various media. (FOP/DOC Press Release, March 29, 2020, Exhibit G) The Labor Committee announced its own conclusion that: (1) the City does not have the resources to combat COVID-19, and the Jail is the lowest priority among the health and safety community; and, (2) the City wants to keep the truth from the public. The Mayor said as much at her press conference when she announced that corrections officers will not be provided with protective equipment because the officers do not provide medical care.

The FOP/DOC Press Release also announced that the Labor Committee decided that the Public Defender Service is correct that DOC is not following the "Guidance on Management of COVID-19 at Correctional and Detention Facilities", issued and updated regularly by the Center for Disease Control. Personal Protective Equipment recommended by CDC is not present at the Jail for corrections officers or is in short supply and hoarded by supervisors under lock and key.

Cleaning and disinfection of the Housing Units is inadequately performed by inmates, and the Department of Health has not conducted inspections of the Housing Units.

In the meantime, the administrative wing of the Jail, occupied by the warden and his staff, is disinfected daily by a team of workers in protective clothing. The Director of the Jail, Quincy Booth, and his leadership staff actually do not even work at the Jail. They are located at the Reeves Center in splendid isolation from the inmates, issuing directives to officers through texts and email. Our Labor Committee members have not seen Director Booth at the Jail in weeks.

Based on the reports of our members who are on-site eye-witnesses and victims of DOC's perfidy, the Labor Committee concludes that DOC misleads the public in its reporting of positive cases of COVID-19 among inmates. Testing is inadequate at the D.C. Jail. Inmates are only tested when it is too late to protect other inmates, and the results take hours to days. No testing is available for corrections officers. Any corrections officer exposed to COVID-19 or with symptoms is sent home for 14-day self-quarantine.

These officers and their family members are unable to obtain testing while on quarantine without going to a hospital with testing. More importantly, the DOC is not addressing the obvious: the rate of quarantine of corrections officers working in the Central Treatment Facility was 25% of the force on March 27, to increase significantly after the announcement of two infected inmates in CTF. Officers assigned to the Central Detention Facility are being re-assigned to CTF due to the number of CTF officers on quarantine. Soon the Jail will have no corrections officers.

Late in the evening of March 31, 2020, the FOP/DOC announced a Press Conference to be held the next morning, April 1, 2020, in front of the D.C. Jail. (Exhibit H) One of the

purposes of the Press Conference was to announce that the FOP/DOC, on behalf of its members working in the D.C. Jail, had authorized HANNON LAW GROUP to seek status in the PDS/ACLU lawsuit as a "friend of the court" in support of the inmates.

Pursuant to the Collective Bargaining Agreement, HANNON LAW GROUP made the following notification to the DOC Public Information Officer:

> Due to the high number of media inquiries re: COVID-19 at the Jail, the FOP/DOC Labor Committee and it Stewards will be giving an open press conference to the media. This notice is sent pursuant to the Collective Bargaining Agreement, and none will violate the guidance and requirements of the agency stated therein.

At 10:45 p.m. that evening, Eric Glover, Esq., General Counsel for the DOC, sent an email to HANNON LAW GROUP, stating:

> Per my previous email to you, per DOC's media policy, "[e]mployees approached by the media for an interview that has any bearing on DOC shall notify the PIO for appropriate review and authorization." As no review has taken place by the agency's PIO, DOC does not authorize the below referenced media event. Thank you.

HANNON LAW GROUP responded:

> There is nothing to review, and the CBA does not require authorization from the DOC. Thank you.

Shortly before the Press Conference ended, the Deputy Warden called the Protective Service Division Police in an attempt to break up the press conference. The officers took no action.

The Structure of the D.C. Jail

The physical structure of the Jail is important to understand in the context of this crisis. The following depicts the usual posts for corrections officers at the D.C. Jail:

> Housing Units in CDF – 18 Housing Units with 80 double cells (with one exception)
>
> Housing Units in CTF – 20 Housing Units with inmate occupancy that varies from 2-50 per unit

Number of Entrances for CDF (Approximately 5) CTF (Approximately 4)

Total Number of Posts in CDF: #1 Shift 90; #2 Shift 160 ; #3 Shift 132

Total Number of Posts in CTF: #1 Shift 66; #2 Shift 101; #3 Shift 81

Total Number of Transportation Officers 30

Total Number of Vehicles Used for Transportation: (9) Medical Holding Unit (2) CCB (10) Court Transport

Each Housing Unit is supervised by 1-3 officers working in a control module known as the "bubble". The bubble is self-contained and allows a view of most of the cells which project out from the bubble in two directions like spokes. Each of the two wings has four tiers, or levels. The cell doors are controlled from the bubble. Showers can be accessed from the tiers, but out of view of the bubble. At least one officer is required to be on the "floor" at all times.

Each Housing Unit in CDF has an office for the unit's Case Manager. The Case Manager ordinarily meets with her clients face to face in the office. Case Managers, before this COVID-19 crisis, afforded their clients use of the phone for legal calls.

Supervisors from the rank of Lieutenant up to Major work in their own module known as the Command Center.

Inmates ordinarily may leave the Housing Unit to go to court, the infirmary, to the visiting hall, and to appointments without escort. However, there are 4 Housing Units at the CDT with restricted movement. The inmates in these units must be escorted at all time by an officer when outside the unit. At the current time, inmates are permitted only 2 ½ hours of free time outside of their cells. This time is spent in the open areas of the unit. An officer must be on the floor at all times.

An inmate sent out to a hospital must be accompanied by a corrections officer.

REBUTTAL TO THE AVERMENTS OF THE DOC

Attached to this brief as Exhibit H is a joint declaration of undersigned counsel and four members of the FOP/DOC Labor Committee and its Stewards. The information contained in the Declaration was obtained during the conference calls held by the FOP/DOC and HANNON LAW GROUP on a daily basis. Any information not actually witnessed by the declarant officers was provided to them directly by other corrections officers. Some of those conversations were witnessed by attorneys at HANNON LAW GROUP. Corrections officers at the D.C. Jail are law enforcement officers as a matter of law; although, the DOC limits their authority to act as LEOs and to exercise some of the privileges of LEOs. Nevertheless, information received from other corrections officers is deemed reliable for assessment of probable cause in the criminal context.

We shall not repeat or summarize here what is said in the declaration. However, the declaration contains a section specifically rebutting the sworn statements of Beth Jordan, M.D., and Warden Lennard Johnson. There are several conclusion to be drawn from comparison of the declarations provided by the DOC and statements by their counsel with the declaration provided by the FOP/DOC Labor Committee members.

1. No one is in charge at the DOC, and the attorneys representing them in this litigation are woefully uninformed by their clients. There are no declarations from Director Quincy Booth, who is appointed by the Mayor and confirmed by the City Council.

2. There is no evidence of how the task of identifying symptomatic inmates and corrections officers is conducted at the Jail. At some point, the Court is told that an inmate is tested. How is that information obtained, to whom is it communicated, and what are the consequences?

3. No one is engaging in the most critical task: to trace contacts from symptomatic inmates and COVID-19 positive inmates to the rest of the Jail community of inmates and corrections officers in order to stem the inevitable spread of this disease. The FOP/DOC is not even told by DOC which of its members have tested positive and which of its members are sent home to quarantine. How can we protect our colleagues and the inmates we protect who have had contacts with these persons. This failure is most evident in the decision to "de-quarantine" 65 inmates only two days after being placed in quarantine. Thereafter, four of this group tested positive for COVID-19 while in the general population.

4. The Mayor of the District of Columbia does not want to tell the citizens the truth about the COVID-19 crisis in the D.C. Jail. We have implored Deputy Mayor Kevin Donahue, the deputy for public safety, to interact with us, and we are greeted by silence. We monitor the Mayor's daily press conference on the COVID-19 crisis, which is becoming less informative and more evasive every day. The Deputy Mayor's announcement of the number of COVID-19 cases at the Jail is always lower than what we know is the truth. There is never any information provided by the Mayor regarding the number of masks, gloves, and other protection on hand, not only for the corrections officers, but also for MPD, the Fire Department and others. For that reason, we contacted FEMA which reported to us the number of such PPE equipment and apparel that has been shipped to the District of Columbia from the federal stockpile. That information is contained in the declaration.

As far as we can determine in our investigation, the District of Columbia has not requested that FEMA arrange for the installation of portable hospitals in the District of Columbia, such as are being completed in New York City, Chicago, and New Orleans to name only a few locations. A field hospital could easily be assembled in the parking lot of the Jail or

in the D.C. Armory adjacent to the Jail. In that event, all quarantined and COVID-19 positive inmates could be isolated from the rest of the Jail population.

THE CENTER FOR DISEASE CONTROL'S GUIDANCE SHOULD INFORM THE COURT'S RULINGS

The FOP/DOC has consistently insisted that the DOC conform its conduct to CDC Guidance. Declarations filed in this case by the DOC claim the same. The CDC Guidance from March 23, 2020, is attached as Exhibit B. Our summary of the salient portions is as follows:

1. The Need for Vigilance in Corrections Facilities:

The CDC Guidance summaries the heightened concerns related to Corrections Facilities during this pandemic as follows:

- 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 Guidance at 2, Ex. B)

2. Close Contact Requiring Precautions:

Precautions are required if a CO or inmate is "within approximately 6 feet of a COVID-19 case for a prolonged period" or in "direct contact with infectious secretions." (CDC Guidance at 3, Ex. B)

3. 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. (CDC Guidance at 4, Ex. B)

4. 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. (*Id.*)

5. Social Distancing:

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. (*Id*.)

6. Communication and Coordination:

The first principle of the CDC Guidance is for the facility to communicate and coordinate with all constituents, including staff, inmates, the courts, law enforcement and facilities in adjacent jurisdictions. (CDC Guidance at 5, Ex. B)

7. Operations and Supplies:

Facilities must 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. (CDC Guidance at 7, Ex. B)

8. Training:

Facilities must 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. (CDC Guidance at 8, Ex. B)

9. 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 CDC recommendations, in an attempt to prevent spread of COVID-19 if introduced. (CDC Guidance at 9, Ex. B)

10. Implementation of Practices:

If an individual has symptoms of COVID-19 (fever, cough, shortness of breath), the facility must require the individual to wear a face mask. Similarly, the facility must ensure that staff who have direct contact with the symptomatic inmate wear recommended PPE. (CDC Guidance at 10, Ex. B) In addition, the facility must implement social distancing strategies to increase the physical space between inmates "regardless of the presence of symptoms." (CDC Guidance at 11, Ex. B) The facility must communicate clearly and frequently with inmates about changes to their daily routine and how inmates can contribute to risk reduction. (CDC Guidance at 12, Ex. B)

11. Personal Protective Equipment:

The Facility should comply with this table for use of PPE:

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

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

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

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

12. Control Movement of Quarantined Inmates:

The facility must keep quarantined inmates' movement to an absolute minimum. Medical evaluation and care should be provided inside or near the quarantined space. Meals should be served inside the space, and individuals must be excluded from all group activities. (CDC Guidance at 19, Ex. B)

13. Communication with Staff:

The facility must 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. (CDC Guidance at 22, Ex. B)

CONCLUSION

The FOP/DOC Labor Committee and its represented members respectfully request that the Court grant a temporary restraining order as requested by Plaintiffs. In particular, we request that the Court appoint a master, in consultation with the parties and the FOP/DOC, to investigate the Plaintiffs allegations.

Dated: April 2, 2020

Respectfully submitted,

HANNON LAW GROUP, LLP

/s/ J. Michael Hannon

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EXHIBIT A

Gmail by Google

J. Michael Hannon <jhannon@hannonlawgroup.com>

Critical Incident at the DC Jail - March 19, 2020

1 message

Ann-Kathryn So <akso@hannonlawgroup.com> Thu, Mar 19, 2020 at 5:52 PM
To: Quincy.Booth@dc.gov, lennard.johnson@dc.gov, Eric.Glover@dc.gov, paulette.johnson@dc.gov
Cc: kevin.donahue@dc.gov, lindsey.maxwell@dc.gov, "J. Michael Hannon" <jhannon@hannonlawgroup.com>, "Olubasusi, Benjamin R. (DOC)" <benjamin.olubasusi@dc.gov>

Good afternoon,

Today, March 19, 2020, at 0545, the Squad Leader (Sgt. Joseph Alexander) and the Team Leader (Sgt. Donald Graham) of the DOC's Emergency Response Team (ERT) were called in, and informed that a US Marshal at D.C. Superior Court tested positive for COVID-19. The two Sergeants were handed a list of 50 inmates who possibly came in contact with the US Marshal. They were ordered to extract the 50 inmates, and quarantine them in an empty cell block. They were ordered to do so using only face masks and gloves. Both Sergeants requested full body coverage (face shield, clothing coverage, etc.) as personal protective equipment (PPE), and were refused. Sgt. Alexander has personal knowledge that the items requested are in the Agency's inventory. Both Sergeants indicated they were uncomfortable performing the inmate extraction without proper PPE. The DOC Management representative, Deputy Warden for Operations, Kathleen Jo Landerkin, again refused to provide the equipment, and asked who on the ERT was also uncomfortable conducting the extraction with only face masks and gloves. Every member of the ERT responded positively. The ERT was ordered to conduct the extraction anyway. All did as they were told. At the time of the extraction, all 50 inmates were housed in general population, with other inmates. Sgt. Alexander asked if inmates with whom the 50 were housed should be quarantined, management told him only the 50 inmates were to be moved into the empty cell block. Those cellmates are still in general population. During the extraction, approximately half of the 50 inmates resisted being moved. All but one moved eventually without incident; however, one inmate spit in the face of one of the ERT officers, who was only protected by the face mask. The 50 at-risk inmates are being housed two to a cell in “quarantine” in an isolated cell block. The officer who was spit on, Hakeem Smith, has gone home. Immediately after the extraction, the two Sergeants were reassigned to a different unit (central cell block) and different shift (night) and their department phones have been taken away. In addition, they were removed from the ERT. They were told by Major Carlos Bivens that this was not a disciplinary action.

The DOC management has created an unconscionable public health crisis, and almost certainly guaranteed and accelerated the rampant spread of COVID-19 within the DOC facilities and the communities in which the staff live. Ms. Landerkin directly put the lives of the officers on the ERT in imminent danger. She did so without regard for their personal safety or that of the inmate population. In addition to being callous and reprehensible, her actions are in obvious violation of several provisions of the Collective Bargaining Agreement and are arguably illegal. The Agency is following absolutely no appropriate guidelines with regard to the safe handling and treatment of the front line staff or inmate population. The 50 at-risk inmates are housed two to a cell in “quarantine” status. They were extracted from cell blocks where they were housed more than one to a cell, and required to participate in recreation and other group activities. All of this is in violation of the Mayor’s Order 2020-048: Prohibition on Mass Gatherings During Public Health Emergency - Coronavirus (COVID-19). In addition, when asked by the ERT officers if the inmates with whom the 50 at-risk inmates were housed originally also should be quarantined, DOC management refused. Management’s response was that if they were not on the list, they were to be left in their unit.

As if this public health crisis created by Ms. Landerkin was not enough, DOC management clearly retaliated against Sgts. Alexander and Graham for their request for PPE. At the time of the order reassigning them, they were told it was not a disciplinary action. Management can call it whatever they choose; however, it is clearly retaliatory. The DOC ordered staff into a life-threatening situation without the proper equipment, and retaliated against them for asking for the proper PPE. The PPE requested was not unreasonable; it was exactly what is being recommended throughout the industry and the nation for handling of infectious individuals. There is absolutely no justification for not providing this equipment, especially upon request and in light of the fact that it was on hand. This treatment will not be tolerated.

I indicated in my email Request for Information sent earlier today to Eric Glover and Paulette Johnson that the Union's priority was to protect the health and safety of the staff. We will take immediate and decisive action to do so in the face of the deliberate and dangerous actions taken by DOC management today. One such action is to file a group grievance for multiple violations of the Collective Bargaining Agreement. A detailed email will follow with the exact provisions that have been violated. Please consider this official notice.

V/R,

Ann-Kathryn So

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Est. March 17, 2006

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EXHIBIT B

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

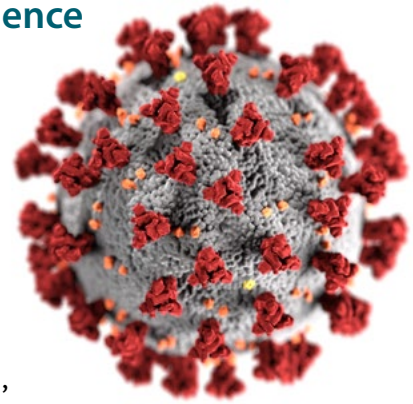
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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

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

In this guidance

Who is the intended audience for this guidance?



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

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

Why is this guidance being issued?

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

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

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

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

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

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

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

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

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

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

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

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

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

Personnel Practices

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

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

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

Operations & Supplies

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

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

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

- See CDC guidance optimizing PPE supplies.

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

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

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

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

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

Prevention

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

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

Operations

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

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

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

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

Cleaning and Disinfecting Practices

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

Hygiene

- √ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- √ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis.** Sample signage and other communications materials **are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
  - o **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.
  - o **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.
  - o **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
  - o **Avoid sharing eating utensils, dishes, and cups.**
  - o **Avoid non-essential physical contact.**
- √ **Provide incarcerated/detained persons and staff no-cost access to:**
  - o **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.
  - o **Running water, and hand drying machines or disposable paper towels for hand washing**
  - o **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).
  - o **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
    - Require the individual to wear a face mask.
    - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
    - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

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

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

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

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

Prevention Practices for Staff

- √ **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- √ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - o In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
  - o Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

Provide staff with up-to-date information about COVID-19 **and about facility policies on a regular basis, including:**

- o Symptoms of COVID-19 and its health risks
- o Employers' sick leave policy
- o **If staff develop a fever, cough, or shortness of breath while at work:** immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- o **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
- o **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

- √ **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
  - o Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).

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

Prevention Practices for Visitors

- √ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- √ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - o Staff performing temperature checks should wear recommended PPE.
  - o 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.**
  - o Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
  - o 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.
  - o 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:**
  - o Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
  - o Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
  - o 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.**
  - o If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
  - o Inform potential visitors of changes to, or suspension of, visitation programs.
  - o 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).
  - o If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

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

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

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

Management

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

Operations

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

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

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

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

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

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

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

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

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

Hygiene

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

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

Cleaning and Disinfecting Practices

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

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

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cleaning Spaces where COVID-19 Cases Spent Time

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

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

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

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

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

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

√ **Electronics cleaning and disinfection**

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

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

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

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

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

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

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

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

Quarantining Close Contacts of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

- √ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.
- √ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
  - o If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
  - o 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.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
  - o 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.**
  - o 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.**
  - o See above for definition of a close contact.
  - o Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

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

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

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

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

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

Clinical Care of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **N95 respirator**

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

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

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

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

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

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

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

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

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

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

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

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

- √ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**
  - *Today or in the past 24 hours, have you had any of the following symptoms?*
    - *Fever, felt feverish, or had chills?*
    - *Cough?*
    - *Difficulty breathing?*
  - *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*
- √ **The following is a protocol to safely check an individual's temperature:**
  - Perform hand hygiene
  - Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
  - Check individual's temperature
  - **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
  - Remove and discard PPE
  - Perform hand hygiene

EXHIBIT C

Fraternal Order of Police
Department of Corrections Labor Committee
711 4TH Street, Northwest
Washington, DC 20001

ANNOUNCEMENT TO DOC/FOP MEMBERS
MARCH 23, 2020

These are grave times at the District of Columbia Department of Corrections (DOC). There is no question that dire threats face our workforce. The Executive Board of the Fraternal Order of Police/Department of Corrections Labor Committee's (FOP/DOC LC) is committed to supporting and protecting the Union's membership, and is doing all that it can to do so. We all know we face serious threats both inside and outside of the DOC facilities. There is no question that each one of us puts our lives and our livelihoods on the line every time we report to work and man our post or take our seat at our desk.

We know your health and safety is at risk every day, and we want you to know it is our TOP priority to tackle the critical issues we all face with speed and effectiveness!!

In keeping with our priorities, this serves as official notice of three crucial actions the FOP DOC LC's Executive Board is taking to protect the membership.

COVID-19—DOC has not provided its employees a valid action plan in response to COVID-19. We hear more every day about the virus, yet the DOC has done very little to support the frontline officers and staff against COVID-19. The DOC's public website about COVID-19 has not been updated since at least March 14, 2020. Our attorneys sent a Request for Information on March 19, 2020, asking if the DOC had done what it promised to protect our members, and what future steps would be taken. No answer has been received as of March 23, 2020. DOC management has canceled our labor/management meetings at this critical time. Our attorneys also made the DOC aware of several violations they committed in the "quarantine" order DOC Management issued and had executed on March 19, 2020. This action led to a "No Confidence" vote by the Board. The DOC is up against its deadline to respond to that letter. We continue to work on getting that information to hold DOC Management accountable.

Officer Assault—One of our officers was viciously assaulted on March 13, 2020 by an inmate. DOC Management's response to this was to issue disciplinary action against two fellow officers, who responded as they should have to save the life of the assaulted officer. Due to DOC Management's incompetent presentation of the case to the U.S. Attorney's Office, no charges were made against the inmate for the unprovoked attack on our officer!!

We have instructed the HANNON LAW GROUP to investigate the incident, and we are confident they will do so fully. We anticipate that as a result of their efforts, HANNON LAW GROUP will re-present the case to the U.S. Attorney's Office for proper prosecution of the inmate. Mr. J. Michael Hannon is a former Assistant United States Attorney.

We are also contesting the removal of the officers who came to the aid of our colleague.

National FOP—We are working with the DC Lodge #1 Leadership and National Fraternal Order of Police (FOP) organization to advocate on YOUR behalf! We have made them aware of the failure of the DOC Management team to:

- ensure that proper protocols are followed with both staff, inmates and visitors at all DOC facilities;
- work with the Union on solutions as the COVID-19 situation evolves, and
- provide a safe working environment; and
- offer the proper equipment to ensure that the staff, inmates and visitors are protected.

We expect to present to the DOC our own set of protocols based on national standards being followed by other correctional institutions. If those protocols are not adopted, our members cannot work safely at the D.C. Jail.

We are prepared to take every action necessary to protect you and your family. We are prepared to escalate these issues as far as they need to go to obtain the attention of our citizens, the Mayor, and the courts if necessary.

EXHIBIT D

Gmail by Google

J. Michael Hannon <jhannon@hannonlawgroup.com>

Fwd: Request for Information on Potentially Dangerous Conditions at the DOC Facilities

1 message

Ann-Kathryn So <akso@hannonlawgroup.com> Mon, Mar 23, 2020 at 3:53 PM
To: "J. Michael Hannon" <jhannon@hannonlawgroup.com>

Here is his response to my first email. I have heard nothing about the second.

---------- Forwarded message ---------
From: **Glover, Eric (DOC)** <eric.glover@dc.gov>
Date: Fri, Mar 20, 2020 at 11:16 AM
Subject: RE: Request for Information on Potentially Dangerous Conditions at the DOC Facilities
To: Ann-Kathryn So <akso@hannonlawgroup.com>, Johnson, Paulette (DOC) <paulette.johnson@dc.gov>
Cc: Olubasusi, Benjamin R. (DOC) <benjamin.olubasusi@dc.gov>

Ms. So:

Thank you for contacting the District of Columbia Department of Corrections. DOC is preparing a response to your inquires and will contact you as soon as possible.

Regards,

Eric S. Glover

General Counsel

District of Columbia

Department of Corrections

2000 14th Street, N.W.

Seventh Floor

Washington, D.C. 20009

Phone: (202) 671-0088

Office Cell: (202) 286-8736

Fax: (202) 671-2514

From: Ann-Kathryn So [mailto:akso@hannonlawgroup.com]
Sent: Thursday, March 19, 2020 11:00 AM
To: Glover, Eric (DOC) <eric.glover@dc.gov>; Johnson, Paulette (DOC) <paulette.johnson@dc.gov>
Cc: Olubasusi, Benjamin R. (DOC) <benjamin.olubasusi@dc.gov>
Subject: Request for Information on Potentially Dangerous Conditions at the DOC Facilities

Good morning,

In light of the ever-changing landscape with respect to the pandemic, we would like to ensure that the Agency is doing everything it can to keep the staff, residents, and visitors as safe as possible from COVID-19. Swift effective action is critical as the numbers of suspected and confirmed cases rise exponentially. This is especially true for DOC staff members, who have regular contact with the inmate population. They must be protected!

The DOC has publicized a number of measures it has or will be taking. Please confirm the following DOC efforts:

- Have all in-person visits, programming and volunteer activities at all Agency facilities in fact been suspended?

- Have DOC officials established Incident Command Team? Who is on that team? Are any members of the Union on that team?

- Is the Medical Staff meeting with each housing unit and officer roll call? Please provide details as to time, place and frequency of the meetings that the Medical Staff is holding.

- What is the Agency's strategic communications plan with regard to COVID-19, and how has it been communicated to the staff? Is it updated and communicated regularly as this situation evolves? The last update on the DOC web page is dated March 14, 2020.

- What does "enhanced cleaning efforts" mean? Have those “enhanced cleaning efforts” been implemented, especially within common areas? How often is this level of cleaning being done?

- The Agency promised to order additional cleaning and sanitation supplies, including protective gloves, masks and clothing for staff. No information was provided about dispensing these items. Have these items been received and distributed? Are there any supplies you need that you do not have? Have sanitizing wipes been provided by the Agency? Is the staff permitted to bring personal sanitation material, other than wipes? Are inmates being provided safety materials that the staff is not?

- Was there a two-hour cleaning of the entire facility? How many times has this happened? Is this occurring daily/regularly?

- Please describe the Agency's efforts in partnering and/or sharing information with criminal justice partners?

- Are daily updates continuing to be sent via emails to the staff regarding COVID-19? Can you please make those available?

Most notable in the Agency's public response to COVID-19 is that there is nothing that addresses the procedures for the screening, quarantine and/or treatment of staff, inmates and/or anyone who comes into contact with either or both. Can you provide detailed information as to what those procedures are? Specifically:

- Have the DOC employees (officers and medical staff) been provided appropriate protective devices/material/training? Are staff members knowledgeable on and adequately equipped to prevent transmission, minimize spread and protect themselves and the inmate population from contacting COVID-19?

- Is the DOC working in close connection with the DC Department of Health? What medical support does the Agency have specifically for the virus?

- Are all incoming inmates, staff and other individuals with access to the DOC facilities questioned as to their level of risk?

- What is the procedure for processing all new inmates to the facilities?

- What is the procedure for assessing the risk to existing inmates?

- What testing is being offered to confirm a diagnosis of COVID-19?

- What procedures are in place if an inmate is symptomatic?

- What procedures are in place if an inmate tests positive?

- What procedures are in place for quarantines?

- Are there any of the following:

- Asymptomatic inmates currently housed at any of the facilities who are at high-risk for contracting COVID-19?

- Symptomatic inmates currently housed at any of the facilities? If so, what actions are being taken with regard to those individuals?

- Inmates currently housed at any of the facilities who have tested positive for COVID-19?

- What is being done to track any inmates, visitors, staff, or other individuals with access to any of the facilities who have been at any DOC facility within the

past two weeks, including any individuals who were held and released or transferred?

- What is the impact of the Agency's response to the Mayor's Order 2020-048: Prohibition on Mass Gatherings During Public Health Emergency - Coronavirus (COVID-19)?

Of a most critical nature, it has come to our attention that there may be one or more inmates currently housed within DOC facilities who are either symptomatic and/or tested positive for COVID-19. Please confirm if the Agency is aware of anyone housed at or with access to any of their facilities who either is symptomatic or has tested positive for COVID-19, and, if so, what actions have been taken and will be taken in response. Is the Agency following the CDC's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings or similar guidelines? Please provide the Union's Executive Management with your detailed emergency action plan.

Without question, this pandemic is a health and safety crisis. The District of Columbia has been in the forefront of a proactive response, and that must extend to the DOC. The entire DOC population is at higher risk than the general public, and every precaution and safety measure must be taken. It is the Union's priority to protect the staff, and it will take actions necessary to do so.

I look forward to hearing from you.

Thank you.

V/R,

Ann

--

Ann-Kathryn So
HANNON LAW GROUP, LLP
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(202) 745-6888, Direct
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For the latest information on the District Government's response to COVID-19 (Coronavirus), please visit coronavirus.dc.gov.

--

HANNON LAW GROUP
Est. March 17, 2006

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EXHIBIT E

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PARTNERS

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TALON R. HURST *§
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§ALSO ADMITTED IN NEW JERSEY
|| ADMITTED IN MARYLAND ONLY; UNDER SUPERVISION OF J. MICHAEL HANNON

March 25, 2020

VIA ELECTRONIC TRANSMISSION ONLY

Quincy L. Booth
Office of the Director
D.C. Department of Corrections

IMPLEMENTATION OF MAYOR'S ORDERS ON COVID-19

We present this letter on behalf of the bargaining unit for all D.C. Jail corrections officers, the Fraternal Order of Police Department of Corrections Labor Committee.

INTRODUCTION

Today the Mayor announced the number of positive COVID-19 infected persons in the District of Columbia increased by 46 new cases to a total of 183. Notably, of the new cases 13 are in their 20s, 12 are in their 30s, and only 7 are over the age of 60. The Mayor's update also reports the following:

> With ongoing community transmission, contact tracing is focused on positive cases associated with childcare facilities, schools and universities, healthcare facilities, senior care facilities, *correctional and detention centers*, and facilities serving individuals who are experiencing homelessness. Guidance will be published for healthcare providers, employers and the public to provide information on what to do if you have been diagnosed with or are a contact of someone who has COVID-19.

On March 19, our office sent an email to DOC regarding the quarantine of 50 inmates who came in contact with an infected U.S. Marshal at the Courthouse. (Attachment A). We received no response.

On the same date March 19, we sent a "Request for Information on Potentially Dangerous Conditions at the DOC Facilities" to DOC's General Counsel and to its HR Director. (Attachment B). The next morning, DOC's General Counsel responded: "DOC is preparing a response to your inquires and will contact you as soon as possible." We have received no response.

On March 23, 2020, the FOP/DOC Labor Committee delivered to the DOC leadership and posted throughout the D.C. Jail an Announcement regarding critical actions to be addressed

by the Labor Committee regarding COVID-19, as well as the failure to prosecute an inmate for the brutal beating of a corrections officer. (Attachment C).

Instead of communicating with the Union as requested on March 19, 2020, you issued a notice on the same date of March 23, announced at every roll call, falsely stating: "It has come to the agency's attention that employees of the DOC intend to engage in either a walkout and/or protest on the grounds of the DOC." Rather than communicating honestly with the Union on these critical conditions of work, you threatened the corrections officers with discipline. This action was clearly in retaliation for the Union presenting legitimate concerns about your failure to implement protections for inmates and corrections officers. This is not only an unfair labor practice and a prohibited personnel practice, but also a violation of the District of Columbia Whistleblower Reinforcement Act of 1998.

In the afternoon of yesterday, March 24, you summoned the FOP/DOC Labor Committee President Cpl. Benjamin Olubasusi to your office at the Reeves Center. Without notice to HANNON LAW GROUP, you put Deputy Mayor Kevin Donahue and Mayor Bowser on your speaker phone. The Mayor then falsely warned Cpl. Olubasusi that it is a "crime" for D.C. corrections officers "to walk out of the Jail." You asked Cpl. Olubasusi what the Union wants, as if our communications over the past 5 days were never read.

Also yesterday afternoon, HANNON LAW GROUP participated in a National Conference Call sponsored by the National Fraternal Order of Police on COVID-19. Speakers on the call included high-ranking experts from the Department of Homeland Security, FEMA, and the White House, as well as FOP State Representatives from all 50 states. The purpose of the call is to implement protocols for law enforcement officers and corrections officers nationwide. Highlights from the call are the following:

Increasing infections will reduce the number of officers on duty.

Loss of officers on duty will increase the work load on the uninfected officers.

The resultant lack of officers will lead to additional crime and risk in the corrections system.

PPE equipment is not being provided to officers nationwide.

Because "social distancing" is impossible in law enforcement, the infection rate among officers will be higher than the general population.

Coordination and Communication between and among political leaders and officers is the most important criteria to meet this challenge.

State health departments, which are in control of the distribution of PPE, must make law enforcement and corrections officers a priority group for receipt of PPE and education.

CONDITIONS AT THE D.C. JAIL

The FOP/DOC Labor Committee, its Shop Stewards, and its members walk the line in the D.C. Jail 24/7. You, Director Booth, are miles away at the Reeves Center, and your administrative staff remain behind glass walls and doors in the administrative section of the D.C. Jail, all in splendid isolation from the inmate population, with regular disinfection teams in gowns, gloves and masks. Here is the report of our members on conditions at the Jail:

1. There is no Communication and Coordination between DOC leaders and the FOP/DOC Labor Committee. Labor/Management meetings are repeatedly cancelled, including one meeting scheduled during this critical time period.

2. Inmates coming into the Jail are not screened for symptoms of COVID-19.

3. Corrections Officers receiving and discharging inmates have no PPE; however, they must have direct contact with these inmates.

4. Inmates continue to move within the Jail. Those inmates in the four restricted housing units must be escorted by hand by corrections officers without any PPE. Inmates in non-restricted housing units travel alone through the Jail as required for appointments. At latest count, there were 1,149 inmates in the Central Detention Facility and 509 in the Correctional Treatment Facility.

5. The corrections officers assigned to housing units have no masks, insufficient gloves, no gowns, no disinfectants, and no comprehensive cleaning occurs on a regular basis in these units. In each unit, one corrections officer is required to be out among the inmates at all times, without any protection.

6. Inmates are not required to engage in any of the behaviors which the Mayor recommends for the general population, such as “social distancing”, repeated hand-washing, and health monitoring.

7. Case workers must meet with inmates in small offices with no PPE or other distancing measures.

8. Inmates continue to engage in recreation in a common yard, also without social distancing or other protections from the spread of COVID-19.

9. Corrections officers enter the Jail three shifts a day. There is no distancing at entrances, no distancing at roll calls, no attempt to obtain or record health concerns of each officer.

10. When the D.C. Jail was forced to quarantine 65 inmates who were at risk to exposure to COVID-19 when they were at court, an ERT was designated to remove them from the general population to a “quarantine” housing unit. The

ERT members refused the assignment without provision of gowns and other appropriate PPE protection. They were ordered to remove the inmates with only masks and gloves. During the extraction, one of the members was spit upon by an inmate. Sgt. Alexander and Sgt. Graham were then removed from the ERT team and assigned to another post outside the Jail.

11. These inmates were not "quarantined" in any meaningful manner. They were housed two to a cell, and the corrections officers on the unit were not provided with any PPE or other means for protection against infections.

WHAT DO WE WANT?

Both you and the Mayor asked Cpl. Olubasusi "What do you want?" While this crisis should not be a time of legal technicalities, we choose to view this as a willingness by management to bargain over the terms and conditions of employment of our officers. The following is an enumeration of our requests. This list, as we all know, is subject to change as the pandemic changes.

1. A Daily Meeting among the Labor Committee, its Shop Stewards, its counsel and the DOC Director, Deputy Director, and its counsel to discuss conditions and responses to COVID-19;

2. A COVID-19 Protocol for officers and inmates including the following:

   Restricted movement of inmates

   Distancing among inmates/inmates, officers/officers, and officers/inmates

   Incident Reporting of officers and inmates' symptoms of illness

3. Regular Disinfection of the CDF and CTF

4. Priority for PPE for officers

5. Discontinuation of inmate transport for court appearances

6. 14-day Quarantine for new inmates

7. Establish a quarantine unit

8. Establish an on-site testing unit for those meeting CDC test criteria, including persons living in the household of a corrections officer

9. Treat COVID-19 among officers as duty-connected

In addition, we require production of all videotape and investigative reports of the assault on Officer Sulaimon T. Abiola so that we may investigate the assault and present it to the U.S. Attorney's Office for prosecution. Corporal Ayodeji Falade, Officer Olumide Popoola, Officer John Lewis, Officer Rahsard Roberts, Officer Abdou Alaguitouni and Corporal Damian Barnes and any other suspended officers must be returned to work pending your investigation into the assault.

CONCLUSION

We agree with Mayor Bowser's sentiment that these are difficult times, and we should all be pulling on the same rope. However, cooperation is a two-way street. We note with a great deal of concern that at today's news conference, the Mayor stated that corrections officers do not require PPE because they do not provide medical care.

The District of Columbia cannot treat its corrections officers as chattel. Already, the life expectancy among corrections officers nationwide is among the lowest in law enforcement.

Thank you for your courtesies.

Sincerely,

s/ J. Michael Hannon

J. Michael Hannon

EXHIBIT F

Fraternal Order of Police
Department of Corrections Labor Committee
711 4TH Street, Northwest
Washington, DC 20001

MANDATORY CDC COVID-19 PROTOCOL
MARCH 28, 2020

Introduction

The Department of Corrections and the Office of the Mayor have refused our repeated requests for communication regarding implementation of the CENTER FOR DISEASE CONTROL's COVID-19 Protocol for Corrections Facilities. HANNON LAW GROUP, therefore, at the Board's direction has participated in nationwide conferences to ascertain the appropriate COVID-19 Protocol for our members.

The following Protocol is based on CDC's "Interim Guidance on Management of Coronavirus 2019 (COVID-19) in Correctional and Detention Facilities," copies of which will soon be distributed throughout the CDF and CTF. HANNON LAW GROUP participated in a national conference on this topic sponsored by the National Fraternal Order of Police on March 24. HANNON LAW GROUP then participated in a national conference on this topic sponsored by the CDC on March 27.

These Protocols are Mandatory

These Protocols are based on guidance from the CDC as well as the Department of Homeland Security. The President's program of protection is also echoed by Orders issued by the Mayor of the District of Columbia. Therefore, any member who complies with these Protocols is following the directive of both the United States and the District of Columbia.

If you are ordered to violate any one of these Protocols by a supervisor, or if you are uncomfortable in the performance of your duties based on concern for exposure to symptomatic inmates or Members, immediately contact a Union Labor Committee Officer or Shop Steward who will come to your location. Should any disciplinary action be taken against you, the Union will provide you with representation through HANNON LAW GROUP.

Entrance to the Facilities

1. Distancing: Members must maintain more than 6' distance from any other person once arriving at the parking lot and throughout the shift, unless provided with appropriate PPE.

2. Members entering may bring personal protective gloves, eye protection, personal disinfectant, paper or N95 masks, and gowns if they have them. They should be placed in your clear carrying bag.

3. Members entering should not wear clothing over the uniform to facilitate visual search by the Members assigned to the entrance.

4. Members assigned to the entrance may not conduct a hand or wand search of an arriving Member if the assigned Member is not provided with a mask, gloves and gown.

5. Members entering must complete a COVID-19 report form and provide it to the Member posted at the entrance. If no medical staff is at the entrance to take the temperature of the entering Member, that Member must not enter the Jail.

6. Any Member who does not qualify for entrance based on answers to the COVID-19 report form must return home for 14-day self-quarantine. If a quarantined Member is not contacted by a DOC or DC medical professional within 3 days of returning home, that Member must contact an officer of the Labor Committee.

Working in Housing Units

1. Members should not accept assignment to a Housing Unit unless hand disinfectant, face masks, gloves, and disinfectant wipes are available in the bubble.

2. Members will not leave the bubble when inmates are on the floor of the unit. This means that 30-minute security checks will not take place during the time that inmates are on the floor.

3. Members may conduct security checks without PPE when inmates are in their cells.

4. Members may not deliver food trays to inmate cells without being provided face masks and gloves.

5. Members must routinely clean all surfaces in the bubble during their shift.

6. Case Managers may not report to their offices if face masks, gloves, hand disinfectant, and cleaning disinfectant is not available in the office.

7. Case Managers may not meet with inmates in their offices unless the inmate is provided and wears a face mask and gloves.

8. Case Managers must disinfect surfaces in the office before and after meeting with each inmate.

9. If a Member observes that the Housing Unit is not properly cleaned and disinfected, the Member should contact a supervisor and an Officer of the Labor Committee or Shop Steward.

Working in Quarantine Units

Members must not accept a post in a Quarantine Unit unless provided with an N95 or equivalent face mask, eye protection, gloves, gown, hand disinfectant, and cleaning disinfectant.

Working in Restricted Movement Housing Units

1. The protocol for working in a Housing Unit must be followed.

2. A Member may not escort an inmate without being provided with a face mask, eye protection, and gloves.

All Transportation Personnel

1. Members assigned to any form of inmate transport requiring contact with inmates may not report to post if not provided with face mask, gloves, hand disinfectant, cleaning wipes, and eye protection.

2. Members concerned that the vehicle has not been disinfected should request disinfectant of the vehicle from a supervisor and contact an Officer of the Labor Committee or Shop Steward, if not provided.

Other Posts

1. Members at any other post must engage in distancing.

2. No member may be required to contact an inmate unless provided with appropriate PPE, depending on whether the inmate is in general population (face mask, eye protection and gloves) or quarantined (face mask, eye protection, gloves and gown).

3. No Member may be required to escort or guard an inmate outside the Jail who is symptomatic or positive for COVID-19.

4. Any Member required to escort or guard an inmate outside the Jail who is not infected or symptomatic must be provided with face mask, eye protection and gloves.

FRATERNAL ORDER OF POLICE DOC LABOR COMMITTEE

Cpl. Benjamin Olubasusi (202) 699-2198
Cpl. Arnold Hudson (202) 445-4051
Sgt. Jannease Johnson (202) 436-1952
Cpl. Laurrine Ellis
Cpl. Naomi Namata (202) 615-4889

HANNON LAW GROUP: info@hannonlawgroup.com

Fraternal Order of Police
Department of Corrections Labor Committee
711 4TH Street, Northwest
Washington, DC 20001

PRESS RELEASE
MARCH 29, 2020

Today we learned that the 50-year-old wife of one of our corrections officers, a 29-year veteran, is infected with COVID-19. She is hospitalized in serious condition. Her husband, our officer and friend, has been tested for COVID-19, but his results are not available. We also learned that two inmates most recently testing positive at the Jail for COVID-19 are among the 65 inmates who were quarantined after exposure to a COVID positive U.S. Marshal at Superior Court. That quarantine lasted for only two days, when DOC's Public Information Officer Keena Blackman announced that the quarantine was being lifted without any of those inmates being tested. The reason given by Dr. Blackman follows:

> After sending out yesterday's Open Letter we learned through the Department of Justice (DOJ) and the DC Department of Health (DC Health) full investigation into the U.S. Marshal's contact tracing that none of the DOC residents were in contact with the individual. The quarantine has been lifted.

Our conclusion from this is that the "tracing" and "investigations" conducted by the DOC, by United Health at the D.C. Jail, and by the DC Department of Health are ineffective.

The FRATERNAL ORDER OF POLICE LABOR COMMITTEE for the D.C. Department of Corrections (FOP/DOC) is issuing this Press Release to correct and supplement information issued by various organizations regarding conditions at the D.C. Jail, namely: the Executive Office of the Mayor, the Department of Corrections, Deputy Mayor Kevin Donahue, Councilmember and Chair of the Public Safety Committee Charles Allen, the United States Attorney for the District of Columbia, the Public Defender Service for the District of Columbia, and various media.

Since early March, FOP/DOC and its counsel HANNON LAW GROUP have attempted to engage in a dialogue with the leadership at the D.C. Jail, with the Mayor, and with the City Council to assist in the management of the COVID-19 crisis at the Jail. Our efforts have been rejected. DOC long ago ceased its regular labor/management meetings.

Our conclusion is two-fold: (1) the City does not have the resources to combat COVID-19, and the Jail is the lowest priority among the health and safety community;

and, (2) the City wants to keep the truth from the public. The Mayor said as much at a recent press conference when she announced that corrections officers will not be provided with protective equipment because the officers do not provide medical care.

The Public Defender Service is correct that DOC is not following the "Guidance on Management of COVID-19 at Correctional and Detention Facilities", issued and updated regularly by the Center for Disease Control. Personal Protective Equipment (PPE) recommended by CDC is not present at the Jail for corrections officers or is in short supply and hoarded by supervisors under lock and key. Cleaning and disinfection of the Housing Units is inadequately performed by inmates, and the Department of Health has not conducted inspections of the Housing Units to our knowledge.

In the meantime, the administrative wing of the Jail, occupied by only a handful of DOC leadership, is disinfected daily by a team of workers in full protective clothing. The Director of the Jail, Quincy Booth, and his leadership staff actually do not even work at the Jail. They are at the Reeves Center in splendid isolation from the inmates, issuing directives to officers through texts and email.

DOC misleads the public in its reporting of positive cases of COVID-19 among inmates. Testing is inadequate at the D.C. Jail. Inmates are only tested when it is too late to protect other inmates, and the results take almost 6 hours. No testing is available for corrections officers. Any correction officer exposed to COVID-19 or with symptoms is sent home for 14-day self-quarantine. These officers and their family members are unable to obtain testing while on quarantine without going to a hospital with testing. More importantly, the DOC is not addressing the obvious: the rate of quarantine of corrections officers working in the Central Treatment Facility is already approximately 25% in the past 5 days and will increase significantly today after the announcement of two infected inmates in CTF. Already officers assigned to the Central Detention Facility are being re-assigned to CTF due to the number of CTF officers on quarantine. Soon the Jail will have no corrections officers.

Because COVID-19 testing in the Jail is only being used as a diagnostic tool, the rate of infection does not reflect the true level of infection at the Jail. The spread of all illnesses in a Jail population dramatically exceeds that in the general population. D.C.'s own statistics for newly infected persons show that almost a third of the 342 infected persons are in their 20s and 30s. Any expert in public health will tell you that there are untested COVID-19 infected inmates and infected corrections officers in the Jail today.

Yesterday, FOP/DOC unilaterally implemented its own Protocol for corrections officers and other members working at the Jail. In essence, because of the lack of PPE and other prophylactic cleaning measures, corrections officers will "shelter in place" in self-contained structures in the Jail called "bubbles." Corrections officers will not leave the bubble for contact work with inmates unless provided with the appropriate PPE. This includes conducting security checks while inmates are on the floor and delivering meals to cells.

FOP/DOC recognizes this is a crisis, and it is not unfair to say that the corrections officers who continue to report to work are doing so because of our leadership. However, the first principle for addressing this crisis – as emphasized by the CDC and the Department of Homeland Security with whom we are in consultation – is COMMUNICATION.

FRATERNAL ORDER OF POLICE DOC LABOR COMMITTEE

Cpl. Benjamin Olubasusi- Chairman
Cpl. Arnold Hudson Sr. Vice Chairman
Sgt. Jannease Johnson- Executive Secretary
Cpl. Laurrine Ellis - Recording Secretary
Cpl. Naomi Namata - Treasurer

FOR INFORMATION: J. Michael Hannon, jhannon@hannonlawgroup.com
Ann-Kathryn So, akso@hannonlawgroup.com
Cpl. Benjamin Olubasusi, Benjamin.Olubasusi@dc.gov

EXHIBIT H

Fraternal Order of Police
Department of Corrections Labor Committee
711 4TH Street, Northwest
Washington, DC 20001

FOP/DOC TO HOLD PRESS CONFERENCE*

8:30 A.M. WEDNESDAY
APRIL 1, 2020

PARKING LOT OUTSIDE THE D.C. JAIL
1901 D St SE, Washington, DC 20003

Members and Shop Stewards of the FOP/DOC Labor Committee along with their General Counsel, J. Michael Hannon, will speak and answer questions.

FOP/DOC will also be announcing its decision to participate in the lawsuit brought against the D.C. Jail by the Public Defender Service and the ACLU.

Media unable to attend in person may participate by registering tomorrow with Zoom:

https://zoom.us/webinar/register/WN_8pqgrjgbSxK0zRaQgPz6oA

* In response to the increasing requests for information from the media and citizens.

EXHIBIT I

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
CIVIL DIVISION

EDWARD BANKS, *et al.*,	:	
	:	
Plaintiffs-Petitioners,	:	
	:	
v.	:	No. 1:20-cv-849
	:	
QUINCY BOOTH, *et al.*,	:	
	:	
Defendants-Respondents.	:	

DECLARATIONS OF J. MICHAEL HANNON, ESQ. AND FRATERNAL ORDER OF POLICE /DEPARTMENT OF CORRECTIONS LABOR COMMITTEE

On this 2nd day of April, 2020, I, J. Michael Hannon, Esq., do hereby declare:

1. I am the founding partner at HANNON LAW GROUP, LLP, which represents Fraternal Order of Police/Department of Corrections ("FOP/DOC LC") in their Motion for Leave to File an *Amicus Curiae* brief filed in the above captioned case.

2. My firm, HANNON LAW GROUP, LLP, has served as Legal Counsel for the FOP/DOC LC from 2006 through the present in a variety of matters.

3. I submit this declaration in support of the FOP/DOC/LC's *Amicus Curiae* brief.

Educational Background and Professional Experience of J. Michael Hannon

4. After earning my Bachelor of Arts degree from Princeton University in 1972, I attended graduate school at the University of Michigan, where I earned a Masters in American Studies in 1976. I then earned my Juris Doctor degree from The Catholic University of America, Columbus School of Law in 1980.

5. I was admitted to the Bar of the District of Columbia in 1981 and the Bar of Maryland in 1982. I am also admitted to practice before the United States Supreme Court, the U.S. Court of Appeals for the District of Columbia Circuit, U.S. Court of Appeals for Veterans

Claims, U.S. Court of Appeals for the Federal Circuit, U.S. Court of Appeals for the Ninth Circuit, U.S. Court of Appeals for the Fourth Circuit, U.S. District Court for the District of Columbia, United States District Court for Maryland, and U.S. District Court for Colorado.

6. From 1980 to 1981, I served as Law Clerk to the Honorable Frank Q. Nebeker of the District of Columbia Court of Appeals.

7. From 1981 to 1988, I served as an Assistant United States Attorney for the District of Columbia where I investigated and prosecuted violent and white-collar offenders. From 1983 to 1985, I was responsible for the investigation and prosecution of homicide and sex offense cases in the Superior Court. I was promoted to the Special Prosecutions Section where I investigated and prosecuted racketeering, international fraud, and terrorism cases in the United States District Court for the District of Columbia.

8. In 1988, I entered private practice as a Partner at the law firm Thompson O'Donnell, LLP, where I practiced for 18 years. During that time, I argued the first appeal before the United States Supreme Court from the United States Court of Appeals for Veterans Claims in October of 1994. The Supreme Court ruled unanimously in favor of my veteran client, overturning a 70-year practice by the Department of Veterans Affairs of denying compensation to medically injured veterans. *See Brown v. Gardner*, 513 U.S. 115 (1994).

9. I founded HANNON LAW GROUP, LLP, in May of 2006, to expand the range of legal resources available to my clients.

10. I have participated in over 200 jury trials, bench trials, arbitrations, mediations, and other forms of litigation.

11. On March 27, 2020, I attended a national virtual conference hosted by the Department of Homeland Security and Centers for Disease Control (CDC) on the proper protocols for correctional facilities and personnel. The written guidelines are attached as Exhibit B to our *Amicus* brief.

12. Pursuant to these guidelines and in the absence of any guidance for inmates and staff with regard to modifying operations in the face of COVID-19, the FOP/DOC LC and their counsel developed a COVID-19 protocol in compliance with CDC guidelines on March 28, 2020.

13. The protocol included the following requirements:

a. All individuals in the facility must maintain more than 6' distance from any other person (for staff-once arriving at the parking lot and throughout the shift and for inmates throughout the facility), unless provided with appropriate personal protective equipment (PPE).

b. Physical searches of another person must not be conducted without the use of a mask, gloves, and if appropriate, gown.

c. Upon reporting for duty at any DOC facility entrance, Union members must complete a COVID-19 report form and provide it to the Member posted at the entrance who is conducting the temperature check. If no medical staff is at

the entrance to take the temperature of the entering Member, that Member must not enter the Jail.

d. Members should not accept assignment to a Housing Unit unless hand disinfectant, face masks, gloves, and disinfectant wipes are available in the bubble.

e. Members will not leave the bubble when inmates are on the floor of the unit. This means that 30-minute security checks will not take place during the time that inmates are on the floor.

f. Members may conduct security checks without PPE when inmates are in their cells.

g. Members may not deliver food trays to inmate cells without being provided face masks and gloves.

h. Members must routinely clean all surfaces in the bubble during their shift.

i. Case Managers may not report to their offices if face masks, gloves, hand disinfectant, and cleaning disinfectant is not available in the office.

j. Case Managers may not meet with inmates in their offices unless the inmate is provided and wears a face mask and gloves.

k. Case Managers must disinfect surfaces in the office before and after meeting with each inmate.

l. If a Member observes that the Housing Unit is not properly cleaned and disinfected, the Member should contact a supervisor and an Officer of the Labor Committee or Shop Steward.

m. Members must not accept a post in a Quarantine Unit unless provided with an N95 or equivalent face mask, eye protection, gloves, gown, hand disinfectant, and cleaning disinfectant.

n. A Member may not escort an inmate without being provided with a face mask, eye protection, and gloves.

o. Members assigned to any form of inmate transport requiring contact with inmates may not report to post if not provided with face mask, gloves, hand disinfectant, cleaning wipes, and eye protection.

p. Members concerned that the vehicle has not been disinfected should request disinfectant of the vehicle from a supervisor and contact an Officer of the Labor Committee or Shop Steward, if not provided.

q. Members at any post must engage in distancing.

r. No member may be required to contact an inmate unless provided with appropriate PPE, depending on whether the inmate is in general population (face mask, eye protection and gloves) or quarantined (face mask, eye protection, gloves and gown).

s. No Member may be required to escort or guard an inmate outside the Jail who is symptomatic or positive for COVID-19.

t. Any Member required to escort or guard an inmate outside the Jail who is not infected or symptomatic must be provided with face mask, eye protection and gloves.

The DOC had provided minimal guidance, and continues to refuse to offer proper health and safety protocols for the staff or the inmates.

Professional Experience of Benjamin Olubasusi

14. Benjamin Olubasusi is a Correctional Officer at the D.C. Department of Corrections (DOC), and has achieved the rank of Corporal. Cpl. Olubasusi has been an employee of the DOC for approximately ten (10) years.

15. Throughout his tenure, he has worked in various posts inside the DOC's Central Detention Facility (CDF), including Northwest One (NW1) (maximum security unit), Southwest Two (SW2) (maximum security unit), South One (1) (Restrictive Housing Unit).

16. Cpl. Olubasusi currently is serving as the Chairperson of the FOP/DOC LC, having been elected to that position in May, 2019.

17. Corporal Olubasusi has witnessed that social distancing is not be followed by the inmates in the quarantine unit, who are individuals identified as having had contact with an inmate who tested positive for COVID-19. As of March 31, 2020, there were approximately 50 inmates on one unit and approximately 40 on the other. In each of these units, the inmates were

required to go on recreation together in close proximity. They were guarded by only one officer, who had only a mask and gloves. The officer was required to stand in close proximity of potentially infected individuals.

18. Cpl. Olubasusi has witnessed personally that Union members assigned to the quarantine unit do not have gowns or face shields, when working in an area where inmates have come in close contact with COVID-19-infected inmates.

19. Cpl. Olubasusi has asked Director Booth for Labor/Management meetings to discuss the impact of and response to COVID-19 on staff and inmates in the DOC facilities, and has been refused at every request.

20. Cpl. Olubasusi requested that management of Unity Health Care and DOC medical staff, including Beth Jordan, M.D., meet with the FOP/DOC LC Executive Board to discuss the proper health protocols for staff and inmates for COVID-19, and has been refused to date.

Professional Experience of Arnold Hudson

21. Arnold Hudson is a Correctional Officer at the D.C. Department of Corrections (DOC), and has achieved the rank of Corporal. Cpl. Hudson has been an employee of the DOC for over 28 years.

22. Throughout his tenure, he has worked in various posts and positions, including at the Lorton, VA facilities from 1991 to 1997 in Maximum Security from 1991 to 1993, in South

One (S1) (Status Block) and South Three (S3) (Mental Health) from 1993 to 1997. In 1997, he began working in the CDF and from that time, he has been assigned to the Laundry division.

23. Cpl. Hudson currently is serving as the Vice-Chairperson of the FOP/DOC LC, having been elected to that position in May, 2019.

24. Cpl. Hudson has tested positive for COVID-19, and is on administrative leave. He has informed the DOC about his positive result, but to date has not been contacted for contact tracing for quarantine of either staff or inmates in close contact with him.

25. It has been reported to Cpl. Hudson as recently as April 2, 2020, that only one officer is assigned in the Special Management Unit – B (SMU-B), where all inmates who have tested positive for COVID-19 have been housed. The officer assigned to SMU-B is provided with disposable mask, gloves and gown, but is required to reuse the eye shield. The officer assigned to SMU-B is required to feed the infected inmates and take them for their showers.

Professional Experience of Jannease Johnson

26. Jannease Johnson is a Correctional Officer at the D.C. Department of Corrections (DOC), and has achieved the rank of Sergeant. Sgt. Johnson has been an employee of the DOC for over 28 years.

27. Throughout her tenure, she has worked in various posts and positions. She worked at the Youth Center in Lorton, VA from June, 1992 until it closed in 2000. From 2000 to date, she has worked at the CDF as Relief Officer, Count Book and Compliance Officer,

Southeast Two Officer-In-Charge (OIC), Command Center OIC, Major's Aide, and Adjustment Board Chair.

28. Sgt. Johnson currently is serving as the Executive Secretary of the FOP/DOC LC, having been elected to that position in June, 2018.

29. Sgt. Johnson personally has witnessed cleaning crews in the CDF that only clean the administrative side of the DOC facilities. The cleaners use the same rag to wipe down everything they are instructed to wipe down with bleach. All were wearing gloves; some had masks.

30. It was reported to Sgt. Johnson by a Correctional Officer assigned to escort the cleaning staff that Deputy Warden Landerkin had instructed that Officer not to take the cleaning crew to the infirmary. It was also reported to Sgt. Johnson that those cleaners use the bathroom while cleaning, and do not wash their hands before going back to cleaning duties.

31. Front line Correctional Officers have reported to Sgt. Johnson completely unsanitary conditions, complete lack of ventilation, and that they have to fight with management to get Personal Protective Equipment.

32. Sgt. Johnson has witnessed inmates, as recently as April 1, 2020, travelling within the facilities and during their assigned recreation periods without practicing any social distancing. The inmates were "elbow to elbow" in proximity to each other.

33. It has been reported to Sgt. Johnson that there are at least ten (10) inmates displaying symptoms in Southeast Two (SE2) with no PPE for the officers assigned there, no quarantine for the inmates, and no guidance from DOC medical staff.

Professional Experience of Lawanda Reddick

34. Lawanda Reddick is a Correctional Officer at the D.C. Department of Corrections (DOC), and has achieved the rank of Corporal. Cpl. Reddick has been an employee of the DOC for approximately twelve (12) years.

35. Throughout her tenure, she has worked in various posts inside the DOC's CDF. Currently, she is assigned to Receiving and Discharge (R&D), where Correctional Officers receive new intakes and court returns, and also send inmates out to other jurisdictions, court or other facilities.

36. Cpl. Reddick currently is serving as a Chief Shop Steward of the FOP/DOC LC, having been elected to that position in May, 2019.

37. The post to which she is currently assigned (R&D) has masks available, but only for incoming inmates. No Correctional Officers are provided masks. DOC Management (Deputy Warden Landerkin) has informed the staff assigned to R&D that masks are for incoming inmates and not for Correctional Officer use.

38. The City is not being truthful on how inmates coming into the facilities are processed. Inmates are having their temperatures taken only. No other procedures are in place to screen incoming inmates.

39. At Roll Call, Cpl. Reddick witnessed an entire shift of Correctional Officers being told by management (Deputy Warden Landerkin) that the Officers are exempt from the social distancing requirement imposed by the Mayor and CDC because they work for the DOC.

40. Correctional Officers also have been told that the risk of contracting COVID-19 is just part of their job, and that is why they have health insurance.

Professional Experience of Cherno Mballow

41. Cherno Mballow is a Correctional Officer at the D.C. Department of Corrections (DOC), and has achieved the rank of Corporal. Cpl. Mballow has been an employee of the DOC for approximately six (6) years.

42. Throughout his tenure, he has worked in various posts inside the CDF. Currently, he works DOC auxiliary posts and environmental. He assists in preparing the units for inspection by the D.C. Department of Health (DOH).

43. Cpl. Mballow currently is serving as a Chief Shop Steward of the FOP/DOC LC, having been elected to that position in May, 2019.

44. Cpl. Mballow has seen severe shortage in personal protective equipment, to include masks, gloves, gowns and eye shields.

Operational Activities at the DOC

45. As of the date of this declaration, the DOC continues to operate in many respects as business as usual. Very few changes to the daily operations have been implemented in preparation for and in response to COVID-19.

46. No actual changes in protocols for cleaning of individuals or physical locations, or distribution of cleaning, sanitizing or disinfecting products have been communicated clearly to the staff or inmates or executed.

47. No actual changes in protocols for cleaning of individuals or physical locations handling of inmate food preparation or distribution of food have been communicated clearly to the staff or inmates or executed.

48. There is no true quarantine. Cell mates of inmates who have tested positive for COVID-19 remain in General Population. The 65 inmates who had contact with the U.S. Marshal assigned to the D.C. Court and who tested positive initially were quarantined, but then two days later were released back to general population. Six of those 65 inmates have tested positive for COVID-19.

49. Inmates continue to meet with case managers and treatment specialists in violation of the social distancing requirements as of April 1, 2020, and without any protective equipment.

50. There was an Open Letter sent to the DOC staff on April 2, 2020 by Dr. Keena Blackmon. The letter was from Director Quincy Booth regarding COVID-19 testing for DOC staff. The letter states, in part, "Correctional Officers are highly encouraged to take advantage of the coronavirus (COVID-19) screenings and should contact the Infection Control Group at (202) 844-5994 or infection.control@dc.gov to schedule an appointment." Sgt. Johnson called upon receipt of the letter, and was informed, "I don't know why your agency told you to call the

number because we only service DC Fire and EMS." The representative also told Sgt. Johnson that the DOC should contact DOH. She was refused an appointment.

Responses to Declaration of Dr. Beth Jordan on April 2, 2020

Counsel for the FOP/DOC LC received the Declaration of Dr. Beth Jordan on April 2, 2020, and refutes the following representations made to this Court based on the personal knowledge of the above identified FOP/DOC members as communicated to him.

51. (Dr. Jordan Declaration #3) The DOC does not implement operational and medical procedures in response to COVID-19 based on guidance from the CDC.

52. (Dr. Jordan Declaration #5) Sgt. Johnson personally witnessed as recently as April 2, 2020, that the screening procedure outlined by Dr. Jordan is not what is occurring. The screening survey is a three-question form that is left on a table for individuals to complete; it is optional, not required. The DOC staff that screen entrants to the facility may or may not be wearing gloves and a mask. The thermometer is not being used properly, and often does not work. In addition, the logistical nature of the front entrance makes it impossible for employees to stand 6 feet apart.

53. (Dr. Jordan Declaration #6) At the Inmate Reception Center (IRC), the incoming inmates wait in a waiting room before being seen at a glass window, where they talk to the staff by phone. It is unknown if the inmates are practicing social distancing while waiting to be seen. Once the inmates are past that checkpoint, they are taken to at least three different stations (including having their photos taken and being strip searched) where there is contact with staff who are not protected with gloves or masks or gowns or eye protection.

54. (Dr. Jordan Declaration #7) All new inmates are assigned to South Two unit. The maximum time that new inmates were housed in that unit was 72 hours until on or about March 25, 2020, when the policy changed to 14 days. It was reported to Cpl. Hudson that as recently as April 2, 2020, that no new inmates have been placed in quarantine for 14 days. As of April 2, 2020, the longest any new inmate has been housed in South Two is eight days. Some of these new inmates were housed in a single cell and some have cellmates. The officers assigned to that unit do not have any PPE.

55. (Dr. Jordan Declaration #8) No members of the Union leadership have witnessed any meetings held by DOC's medical staff with staff and residents. Cpl. Olubasusi has requested a meeting with DOC's medical staff to include Dr. Jordan, but his requests have been ignored or refused. It is very unlikely that DOC's medical staff has met with DOC staff and residents on a regular basis. To do so, medical staff would have to enter 38 separate Housing Units. It is also unlikely because meeting with inmates in groups of ten would take days.

56. (Dr. Jordan Declaration #11) It was reported to Cpl. Olubasusi, Cpl. Hudson and Sgt. Johnson as recently as April 2, 2020, that there are only two units within the DOC facilities that are housing positive inmates—SMU-B and Medical 82. As of today, there were reported 13 inmates in SMU-B and two of the 12 inmates in Medical 82 have tested positive. The official number of inmates who have tested positive that has been released to the public is six. It has been reported to Sgt. Johnson that two inmates have been quarantined in the Protective Custody Housing unit, presumably for COVID-19-related symptoms. If as Dr. Jordan declared there are

22 inmates who have been tested, the whereabouts of all 22 is unknown. It has been reported to Sgt. Johnson that at least one of the inmates whose test results are pending is in general population. We do not know where all of these 22 inmates are at this time in the DOC facility. Per the Department of Health Director's public statements, individuals who have had COVID-19 exposure but have tested negative still should quarantine for 14 days. There is no evidence this is happening with the inmates who have tested negative or the ones with test results pending.

57. (Dr. Jordan Declaration #13) Based on the personal observations of Cpl. Olubasusi, Cpl. Hudson, Sgt. Johnson, Cpl. Reddick, Cpl. Mballow and the dozens of staff who have reported to them, the DOC is not providing either the staff or the residents access to necessary medical care or working to keep staff safe with regular (or any) prevention guidance or access to appropriate PPE.

Responses to Declaration of Warden Lennard Johnson on April 2, 2020

Counsel for the FOP/DOC LC received the Declaration of Warden Lennard Johnson on April 2, 2020, and refutes the following representations made to this Court.

58. (Warden Johnson Declaration #4) Cpl. Olubasusi, Cpl. Hudson, Sgt. Johnson, Cpl. Reddick, Cpl. Mballow are unaware of what the DOC Incident Command System is; however, there have been no meetings whatsoever with the FOP/DOC LC leadership (the union being a key detention stakeholder) to discuss COVID-19 preventative measures at the DOC's facilities. There have been no notices of any of the meetings referenced in this paragraph, and the FOP/DOC LC would like to participate in meetings regarding the working conditions for the staff. In addition, the FOP/DOC LC would like to be informed as to the details regarding,

minutes of and outcomes from any meetings of the DOC Incident Command Team and the daily meetings of the Criminal Justice Coordinating Council (CJCC) for the District of Columbia.

59. (Warden Johnson Declaration #5) The DOC has taken minimal steps to mitigate the spread of the COVID-19 virus; in fact, the measures taken are likely to result in the rapid spread of the virus. To date, the Mayor of the District of Columbia has released publicly that one DOC staff member has tested positive for COVID-19; however, this has not been communicated to the DOC staff. Cpl. Olubasusi, Cpl. Hudson and Sgt. Johnson are aware of at least three DOC staff members who have tested positive and alerted the DOC. No contact tracing has been done for at least one if not all of these staff members with regard to whether inmates or other staff should be quarantined.

60. (Warden Johnson Declaration #6) It was reported to Sgt. Johnson as recently as April 2, 2020, that the only scheduled sanitization that occurs is an announcement over the Public Address (PA) system that requests inmates to participate in cleaning their areas. The PA system is not designed to be heard throughout the facility and all Housing Units, and there are no clear instructions or policies for how inmates are supposed to clean their areas. There are no consequences for inmates who choose not to clean. There are no instructions given to inmates for what is considered a "high use" and "high touch" areas for special cleaning.

61. (Warden Johnson Declaration #7) It was reported to Cpl. Olubasusi and Sgt. Johnson as recently as April 2, 2020, that the cleaning materials for residents to clean their own cells are not generally available to the residents. They are under lock and key, and the residents

have to request them, if they are even aware that they exist. The ECOLAB Peroxide that is used may not be sufficient to ensure proper sanitization. It takes anywhere from 45 seconds to five minutes for the cleaning solution to kill germs effectively, depending on the concentration used. There is no evidence that any staff or inmates have been made aware of this requirement.

62. (Warden Johnson Declaration #8) Not all inmates have sinks in their cells. For those inmates who do not, they have to ask an officer to let them out of their cell to be able to use a sink. It is the personal experience of Cpl. Olubasusi and Sgt. Johnson that inmates do not regularly ask to do this. Given that inmates are currently allowed out of their cells only 2 ½ hours a day, there is likely very little inmate hand cleaning taking place for those inmates.

63. (Warden Johnson Declaration #9) The residents often carry their washcloths in and around their housing unit. There is no requirement to keep them in an individual cell. While the inmates can request that the washcloth be laundered, Cpl. Hudson's personal experience is that many do not. In addition, there is no requirement to wash the jumpsuits that the inmates wear. Many do not put out their jumpsuits for laundering, and are not required to do so.

64. (Warden Johnson Declaration #10) Hand sanitizer is available in CTF in a wall dispenser; however, any inmate that wishes to use it must be out of their cell to do so, which requires the inmate to ask and an officer to release them. High-risk staff may have "priority access" to hand sanitizer, but Cpl. Olubasusi and Sgt. Johnson are unaware of any staff who are aware of that fact. There is no "priority access" to proper PPE for any high-risk staff who come in contact with high risk residents, and what PPE there is completely insufficient. In SMU-B, for

example, the unit which houses inmates who test positive for COVID-19, the "protective" suits given to the staff are made out of paper and made only to protect from non-hazardous material and dry particulates. (http://www.cellucap.com/index.php?display=yes&productid=68). These are not CDC approved gowns.

65. (Warden Johnson Declaration #11) Some activities for the residents have been curtailed; however, they are allowed in-house recreation each day, and it occurs in groups, not individually. There is no social distancing encouraged.

66. (Warden Johnson Declaration #13) There was no attachment with a current list of COVID-19-related supplies. In any event, the FOP/DOC LC Executive Board is unaware of sufficient PPE, cleaning/disinfecting supplies or hand sanitizer for the staff or the residents. Cpl. Olubasusi, Cpl. Hudson and Sgt. Johnson are unaware of what the DOC's Operations Support Team is; however, repeated attempts by FOP/DOC LC officials to ascertain the inventory of the COVID-19-related supplies has been denied.

67. (Warden Johnson Declaration #13) On March 31, 2020, I J. Michael Hannon called the FEMA liaison to state governments. The FEMA liaison maintains data on the PPE shipped from the United States stockpile to each state. The FEMA liaison reported that the following were shipped to the District of Columbia from the stockpile: Surgical masks 314,601; N95 masks 132,437; Gloves 383,760; Gowns 55,657; Face shields 67,644; and Coveralls 3,550. HANNON LAW GROUP has monitored the Mayor's daily press briefings, and to our

knowledge the Mayor has never provided statistics as to the amount of PPE available to the District of Columbia.

I HEREBY SWEAR under the penalty of perjury that the foregoing is true and correct as to the knowledge attributed to me.

s/J. Michael Hannon

Cpl. Benjamin Olubasusi[1]

Cpl. Arnold Hudson, Sr.

Sgt. Jannease Johnson

Cpl. Lawanda Reddick

Cpl. Cherno Mballow

[1] Original signatures will be filed with the Court tomorrow.

Dated: April 2, 2020

Respectfully submitted,

HANNON LAW GROUP, LLP

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