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IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

JOAQUIN HERRERA-HERRERA,

Petitioner-Plaintiff,

v.

MICHAEL DOWNEY, in his individual capacity and official capacity as Sheriff of Kankakee County; CHAD KOLITWENZEW, Chief of Corrections of the Jerome Combs Detention Center; ROBERT GUADIAN, Field Office Director, Enforcement and Removal Operations, U.S. Immigration and Customs Enforcement; MATTHEW ALBENCE, Acting Director, U.S. Immigration and Customs Enforcement; and CHAD WOLF, Acting Secretary, U.S. Department of Homeland Security,

Respondents-Defendants.

Case No. _____

DECLARATION OF DR. HOMER VENTERS IN SUPPORT OF PETITIONER'S EMERGENCY PETITION FOR A WRIT OF HABEAS CORPUS

AND

COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

I, Homer Venters, hereby declare the following:

Background

1. I am a physician, internist, and epidemiologist with over a decade of experience in providing, improving, and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security. This work included and resulted in collaboration with U.S. Immigration and Customs Enforcement ("ICE") on numerous individual cases of medical release, the formulation of health-related policies, as well as testimony before U.S. Congress regarding mortality inside ICE detention facilities.

2. After my fellowship training, I became the Deputy Medical Director of the Correctional Health Services of New York City. This position included both direct care to people held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral, and emergency care. I subsequently was

promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health; addiction; quality improvement; re-entry, morbidity, and mortality reviews; and all training and oversight of physicians, nursing, and pharmacy staff. In these roles, I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacted almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection, and several other smaller outbreaks.

3. In March 2017, I left Correctional Health Services of New York City to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers.

4. In December 2018, I became the Senior Health and Justice Fellow for Community Oriented Correctional Health Services ("COCHS"), a nonprofit organization that promotes evidence-based improvements to correctional practices across the United States. In January 2020, I became the president of COCHS. I also work as a medical expert in cases involving correctional health, and I have written and published a book on the health risks of jail (*Life and Death in Rikers Island*) that was published in early 2019 by Johns Hopkins University Press.

5. A true and correct copy of my curriculum vitae is attached to this report as Exhibit A which includes my publications, a listing of cases in which I have been involved and a statement concerning my compensation.

6. In the previous four years, I have testified as an expert at trial or by deposition in the following cases:

a. *Benjamin v. Horn*, No. 75 Civ. 3073 (HB) (S.D.N.Y.) (2015), as expert for defendants;

b. *Rodgers v. Martin*, No. 2:16-cv-00216 (U.S.D.C. N.D. Tx.) (Oct. 19, 2017), as expert for plaintiffs;

c. *Fikes v. Abernathy*, No. 2017 7:16-cv-00843-LSC (N.D. Ala.) (Oct. 30, 2017), as expert for plaintiffs;

d. *Fernandez v. City of New York*, No. 17-CV-02431 (GHW)(SN) (S.D.N.Y.) (Apr. 10, 2018), as defendant in role as City Employee;

e. *Charleston v. Corizon Health Inc.*, No. 17-3039 (E.D. Pa.) (Apr. 20, 2018), as expert for plaintiffs;

f. *Gambler v. Santa Fe County*, No. 1:17-cv-00617 (WJ/KK) (Jul. 23, 2018) as expert for plaintiffs;

g. *Hammonds v. Dekalb County AL*, No. 4:16-cv-01558-KOB, as expert for plaintiffs;

h. *Mathiason v. Rio Arriba County NM*, No. D-117-CV-2007-00054 (Feb. 7, 2019), as expert for plaintiff;

i. *Hutchinson v. Bates et. al.*, No. 2:17-CV-00185-WKW- GMB (Mar. 27, 2019), as expert for plaintiff;

j. *Lewis v. East Baton Rouge Parish Prison LA*, No. 3:16-CV-352-JWD-RLB (E.D. La.) (Jun. 24, 2019), as expert for plaintiff;

k. *Belcher v. Lopinto*, No. 2:2018cv07368 (E.D. La. 2019) (Dec. 5, 2019), as expert for plaintiffs; and

l. *Imoerati v. Semple*, No. 3:18cv01847 (RNC) (D. Conn) (Mar. 11, 2020), as expert for plaintiffs.

Expert Assignment

7. Petitioner's Emergency Petition for a Writ of Habeas Corpus and Complaint for Injunctive and Declaratory Relief, Dkt. 1, alleges that the officials in charge of ICE detainees in the Jerome Combs Detention Center ("JCDC") in Kankakee, Illinois, are placing Petitioner Joaquin Herrera-Herrera at risk of significant harm or death due to COVID-19.

8. Petitioner's counsel has asked me to:

a. Evaluate whether existing policies and practices concerning ICE detainees in the JCDC comply with current, standard protocols for preventing the spread of coronavirus in detention facilities and for addressing prevention and treatment for detained people who are at high risk of serious illness or death from COVID-19; and

b. Evaluate whether existing policies and practices concerning ICE detainees in the JCDC create a risk that Mr. Herrera-Herrera will suffer significant harm or death from COVID-19 while detained in the facility.

COVID-19 in ICE Detention

9. Coronavirus disease of 2019 ("COVID-19") is a viral pandemic. This is a novel virus for which there is no established curative medical treatment and no vaccine.

10. COVID-19 infection rates are growing exponentially in the United States and Illinois. The number of cases is rising rapidly. The Governor of California predicted that over half of all residents will become infected with COVID-19[1] and the Commissioner of Health for New Jersey predicted, "I'm definitely going to get it. We all are. I'm just waiting."[2] The Centers for Disease Control and Prevention ("CDC") now reports COVID-19 cases in all 50 states, the District of Columbia, Guam, Puerto Rico, the Northern Mariana Islands, and the U.S. Virgin Islands.[3] The Illinois Department of Health reports that as of May 7, 2020, the number of people who have tested positive for COVID-19 in Illinois is 68,232 and 2,974 of these people have died from the disease so far.[4]

11. When COVID-19 impacts a community, it will also impact ICE detention facilities. Staff are likely to bring COVID-19 into a facility, based solely on their movement in and out every day.

12. ICE will not be able to stop the entry of COVID-19 into ICE facilities: the reality is that the infection is inside multiple facilities already. As predicted, COVID-19 has spread rapidly in immigration detention centers. ICE reported its first confirmed case of a detainee who tested positive in New Jersey on March 24, 2020.[5] As of May 7, 2020, there have been 705 ICE detainees in 37 facilities across 17 states, 39 ICE employees in 13 facilities across 8 states, and 102 ICE employees not assigned to a facility, who have all tested positive for COVID-19.[6] These statistics do not include third-party contractors who work in ICE facilities who have tested positive for COVID-19, as ICE has stated that this information "isn't something we have to provide."[7]

13. COVID-19 has already arrived at one Illinois jail where ICE detainees are housed. On April 9, 2020, three detainees and one correctional officer at the Pulaski County Jail in

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[1] Mark Saunders, *Newsom: 56 Percent of California Expect to Get Coronavirus*, ABC 10 NEWS (Mar. 19, 2020), https://www.10news.com/news/coronavirus/newsom-56-percent-of-california-expect-to-get-coronavirus.

[2] Tal Axelrod, *Top NJ health official: 'I'm definitely going to get' coronavirus, 'we all are'*, The Hill (Mar. 22, 2020), https://thehill.com/policy/healthcare/488828-top-nj-health-official-we-all-are-going-to-contract-coronavirus.

[3] *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, CENTERS FOR DISEASE CONTROL & PREVENTION (updated May 4, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[4] Illinois Department of Public Health, Coronavirus Disease 2019 (COVID 19), https://www.dph.illinois.gov/covid19 (last visited May 7, 2020).

[5] *ICE Detainee Tests Positive for COVID-19 at Bergen County Jail*, IMMIGRATION & CUSTOMS ENFORCEMENT (Mar. 24, 2020), https://www.ice.gov/news/releases/ice-detainee-tests-positive-covid-19-bergen-county-jail.

[6] *ICE Guidance on COVID-19*, IMMIGRATION & CUSTOMS ENFORCEMENT (updated May 7, 2020), https://www.ice.gov/coronavirus.

[7] Monique O. Madan, *Two Workers at ICE Detention Center in Miami Test Positive for Coronavirus*, MIAMI HERALD, Apr. 6, 2020, https://www.miamiherald.com/news/local/immigration/article241791511.html.

Illinois tested positive for COVID-19.[8] As of May 7, 2020, there were 14 detainees with confirmed cases.[9] ICE and local officials in Pulaski County refused to report the number of employees with COVID-19 for fear of jeopardizing the county's contract with ICE.[10]

14. This is likely just the tip of the iceberg in terms of the number of staff and detainees in facilities housing ICE detainees who are already infected but are unaware due to the lack of testing nationwide, and the fact that people who are infected can be asymptomatic for several days.

15. In New York, one of the areas of early spread in the United States, a large number of correctional officers and jail and prison inmates have become infected with COVID-19. The Legal Aid Society reports that the infection rate at Rikers was 9.54% as of May 6, compared to 2.12% in New York City and 1.68% in New York State.[11] The medical leadership in the NYC jail system announced that they are unable to stop COVID-19 from entering their facility and have called for release as the primary response to this crisis.[12]

16. The data from the NYC jail system illustrates the extremely rapid rate of COVID-19 infection spread in correctional settings. The facility went from zero confirmed infections on

[8] Molly Parker, *3 Detainees, 1 Correctional Officer of Pulaski County Detention Center Diagnosed with COVID-19*, The Southern Illinoisan, Apr. 9, 2020, https://thesouthern.com/news/local/3-detainees-1-correctional-officer-of-pulaski-county-detention-center-diagnosed-with-covid-19/article_8ce1ca7e-7b28-5884-8113-badf0e385a21.html.

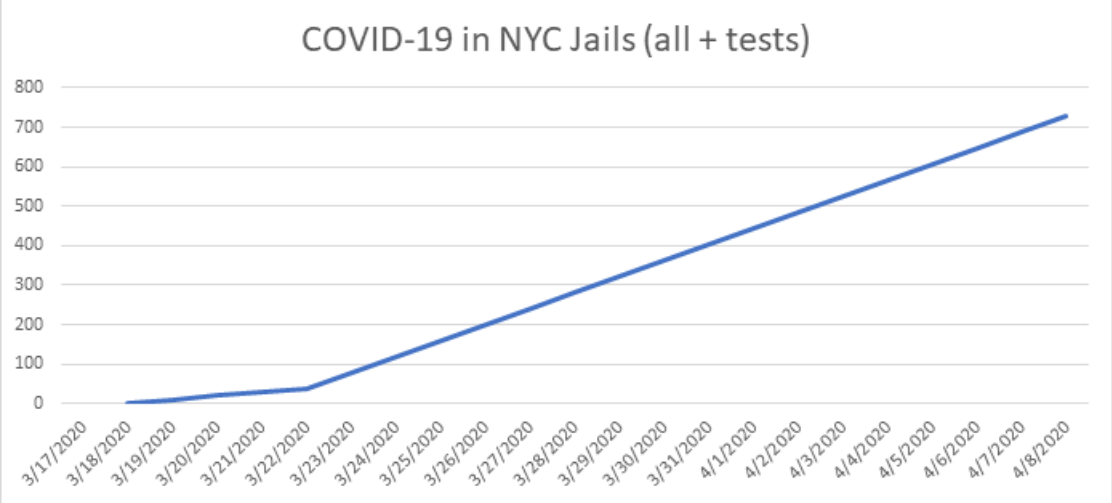
[9] *ICE Guidance on COVID-19*, IMMIGRATION & CUSTOMS ENFORCEMENT (updated May 7, 2020), https://www.ice.gov/coronavirus.

[10] Molly Parker, *Officials Tight-Lipped on Pulaski County Detention Center Outbreak as Detainees Fear for Their Lives*, The Southern Illinoisan, Apr. 25, 2020, https://thesouthern.com/news/local/officials-tight-lipped-on-pulaski-county-detention-center-outbreak-as-detainees-fear-for-their-lives/article_b1805d49-6d56-53c6-a650-229ed70aed4f.html

[11] *COVID-19 Infection Tracking in NYC Jails*, THE LEGAL AID SOCIETY (updated May 6, 2020), https://www.legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/.

[12] Meagan Flynn, *Top Doctor at Rikers Island Calls the Jail a "Public Health Disaster Unfolding Before Our Eyes,"* WASHINGTON POST (Mar. 31, 2020), https://www.washingtonpost.com/nation/2020/03/31/rikers-island-coronavirus-spread/.

March 17, 2020,[13] to 38 confirmed infections by March 22, 2020,[14] to 728 confirmed infections by April 8, 2020.[15]



17. Similarly, COVID-19 has spread rapidly in the Cook County Jail. In the two weeks after March 23, 2020, the number of confirmed cases of coronavirus in the jail multiplied from two detainees to 353 people—238 detainees and 115 staff.[16] As of May 6, 2020, there were 264 detainees, 98 correctional officers, and 30 other Cook County Sheriff's employees who tested positive for COVID-19, and 255 detainees who had been positive and were being monitored at the jail.[17] Seven detainees and two employees of the Cook County Jail died from

[13] Erin Durkin, *First Correction Officer Tests Positive As Worries Grow About Coronavirus Spread in Jails*, Politico, Mar. 18, 2020, https://www.politico.com/states/new-york/albany/story/2020/03/18/first-correction-officer-tests-positive-as-worries-grow-about-coronavirus-spread-in-jails-1267735; Vandana Rambaran, Rikers Island Inmate is First to Test Positive for Coronavirus, De Blasio Announces, Fox News, Mar. 19, 2020 https://www.foxnews.com/us/rikers-island-inmate-tests-positive-coronavirus-new-york-city.

[14] *Coronavirus: 38 Test Positive in New York City Jails, Including Rikers Island*, The Guardian, Mar. 22, 2020, https://www.theguardian.com/us-news/2020/mar/22/coronavirus-outbreak-new-york-city-jails-rikers-island.

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

[16] Timothy Williams and Danielle Ivory, *Chicago's Jail is Top U.S. Hot Spot as Virus Spreads Behind Bars*, New York Times, Apr. 8, 2020, https://www.nytimes.com/2020/04/08/us/coronavirus-cook-county-jail-chicago.html.

[17] Cook County Sheriff's Office, COVID-19 Cases at CCDOC, https://www.cookcountysheriff.org/covid-19-cases-at-ccdoc/ (last visited May 7, 2020).

the disease.[18]As of May 4, 2020, the Cook County Jail is one of the United States' largest known sources of coronavirus infection, with 970 associated cases.[19]

18. It is only a matter of time before COVID-19 arrives in the JCDC because the coronavirus is prevalent in Kankakee County, where the jail is located. The Illinois Department of Health reports that as of May 6, 2020, there are 416 known COVID-19 cases in Kankakee County and 27 deaths, making this one of the most hard-hit counties in all of Illinois.[20]

19. Once COVID-19 is inside a facility, ICE will be unable to stop the spread of the virus throughout the facility given long-existing inadequacies in ICE's medical care and because of how these facilities function. Newly released CDC guidance for correctional facilities makes clear that detention settings should plan for increased staffing shortages as COVID-19 impacts security and health staff.[21] Based on my experience in ICE facilities, ICE has faced longstanding challenges in maintaining adequate staffing of health care staff for many years, and the outbreak of this pandemic will dramatically worsen this problem.

20. I have been inside multiple ICE detention facilities, both county jails that house ICE detainees and dedicated facilities. My experience is that the densely packed housing areas, the manner in which health services, food services, recreation, bathroom and shower facilities for detained people, as well as the entry points, locker rooms, meal areas, control rooms for staff, all contribute to many people being in small spaces.

21. One of the most ubiquitous aspects of detention, the sally-port, or control port, a series of two locked gates that bring every staff member and detained person past a windowed control room as they stop between locked gates, provides but one example of this concern. The normal functioning of detention centers demands that during shift change for staff, or as the security count approaches for detained people, large numbers of people press into sally-ports as they move into or out of other areas of the facility. This process creates extremely close contact, and the windows in these sally-ports that are used to hand out radios, keys and other equipment to staff ensure efficient passage of communicable disease from the control rooms into the sally-port areas on a regular basis. Detention facilities are designed to force close contact between people and rely on massive amounts of movement every day from one part of the facility to another, e.g., for programming, access to cafeterias, commissary, medical care, just to name a few. This movement is required of detained people as well as staff.

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[18] *Id*.
[19] *See* New York Times, *Coronavirus in the U.S.: Latest Map and Case Count*, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited May 7, 2020).
[20] Illinois Dep't of Public Health, Coronavirus Disease 2019 (COVID-19), https://www.dph.illinois.gov/covid19 (last visited May 7, 2020).
[21] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html [hereinafter CDC Interim Guidance], attached as Exhibit F to this declaration.

22. My experience managing smaller outbreaks is that it is impossible to apply hospital-level infection control measures on security staff. In a hospital or nursing home, staff may move up and down a single hallway over their shift, and they may interact with one patient at a time. In detention settings, officers move great distances, are asked to shout or yell commands to large numbers of people, routinely apply handcuffs and operate heavy doors/gates, operate large correctional keys and are trained in the use of force. These basic duties cause the personal protective equipment they are given to quickly break and become useless. And even when in good working order, masks and other personal protective equipment may impede correctional staff's ability talk and be understood. As a result, correctional officers will generally not wear the protective equipment that is an important part of preventing spread of the virus.

23. ICE's protocols (addressed separately below) are simply insufficient to address the structural aspects of detention facilities that make transmission of COVID-19 so rapid.

24. For instance, data has shown that COVID-19 appears to be transmissible through aerosolized fecal matter. This is relevant because the plume of aerosolized fecal material that occurs when a toilet is flushed is not addressable by closing the lid of toilets in correctional and detention facilities, which lack a lid and often include a sink used for drinking and washing. This mode of transmission would pose a threat to anyone sharing a cell with a person who has COVID-19 and could occur before a person becomes symptomatic. This mode of transmission could also extend beyond cellmates, especially in circumstances where common bathrooms exist or where open communication between cells exists.[22]

25. ICE currently detains thousands of people with factors that increase their risk of death and serious complications from COVID-19, including long-lasting complications after recovery, such as fibrotic changes to the lung. The risk factors recognized by the CDC include being over the age of 65 and being of any age and having heart disease, lung diseases (including moderate-to-severe asthma), liver disease, a BMI over 40, diabetes, kidney disease, or an immune compromising condition, such as cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, or prolonged use of corticosteroids and other immune weakening conditions.[23] Additional risk factors include hypertension and a history of smoking. The CDC reports that the most common chronic health problem among people who are hospitalized for COVID-19 is hypertension.[24] In correctional settings, the age of 50 or 55 is often used to identify older patients, because of the extremely high

[22] Diana Swift, *Study: COVID-19 Is Also Spread by Fecal-Oral Route*, MEDPAGE TODAY (Mar. 9, 2020), https://www.medpagetoday.com/infectiousdisease/covid19/85315.
[23] *People Who Are at Higher Risk for Severe Illness*, CENTERS FOR DISEASE CONTROL & PREVENTION (updated Apr. 15, 2020) https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html.
[24] Centers for Disease Control & Prevention, Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID-NET, 14 States, March 1–30, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm (last visited May 11, 2020).

level of physical and behavioral health problems among this cohort of people.[25] In addition, recent data on the critical risk of smoking for serious illness and death from COVID-19 infection, combined with data that reveals the rates of smoking to be highest among detained people over 50, leads me to believe that the age of 50 should be applied to ICE detainees to identify individuals who have an increased vulnerability to COVID-19 based on their age for the same reason.[26]

ICE Guidelines Contradict or Omit Several Important CDC Guidelines

26. I have reviewed the following documents setting forth ICE policy and practice concerning COVID-19 in detention facilities where ICE detainees are housed:

a. ICE's March 6, 2020 Memorandum addressing COVID-19, a true and correct copy of which is attached to this declaration as Exhibit B ("ICE March 6 Memo").

b. ICE's March 27, 2020 Memorandum addressing COVID-19, a true and correct copy of which is attached to this declaration as Exhibit C ("ICE March 27 Memo").

c. The webpage that ICE has established concerning "ICE Guidance on COVID-19," which is located at https://www.ice.gov/coronavirus (last visited Apr. 15, 2020) ("ICE Guidance on COVID-19 webpage"), a true and correct copy of which is attached to this declaration as Exhibit G.

d. The April 4, 2020 guidance from ICE Enforcement and Removal Operations, a true and correct copy of which is attached to this declaration as Exhibit D ("ICE April 4 Guidance").

e. The April 10, 2020 U.S. Immigration and Customs Enforcement, Enforcement and Removal Operations, COVID-19 Pandemic Response Requirements ("April 10 ERO Pandemic Response Requirements"), much of which applies to JCDC and any setting where ICE detainees are held. A true and correct copy of the April 10 ERO Pandemic Response Requirements is attached to this declaration as Exhibit E.

[25] Kimberly A Skarupski et al., *The Health of America's Aging Prison Population*, 40 EPIDEMIOLOGIC REV. 157 (2018), https://academic.oup.com/epirev/article/40/1/157/4951841.
[26] Sara M. Kennedy et al., *Cigarette Smoking Among Inmates by Race/Ethnicity*, 18 NICOTINE & TOBACCO RESEARCH S73 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5100810/; Berkeley Lovelace, *CDC Says Diabetes, Lung or Heart Disease and Smoking May Increase Risk of Severe Coronavirus Illness*, CNBC.com, Mar. 31, 2020, https://www.cnbc.com/2020/03/31/cdc-says-diabetes-lung-disease-heart-disease-and-smoking-may-increase-risk-of-severe-coronavirus-illness.html.

f. It is my understanding that the JCDC does not have its own COVID-19 pandemic response plan. [27]

I refer to these information sources collectively as the "ICE COVID-19 protocols and guidance."

27. Collectively, the ICE COVID-19 protocols and guidance are deficient and at odds with CDC recommendations regarding detention settings in a manner that threatens the health and survival of ICE detainees, including the Petitioner in this action.

28. Social distancing: The ICE COVID-19 protocols and guidance fail to address one of the most important CDC key recommendations: the need for social distancing in detention facilities. The ICE March 27 Memo (Exhibit C) and the April 10 ERO Pandemic Response Requirements (Exhibit E) each briefly mention social distancing, but fail to address how ICE facilities will enact modified meal or recreation times to provide for social distancing. These protocols also fail to address the most common scenarios in which high-risk detainees find themselves in close quarters that make social distancing impossible, including shared cells, medication lines, bathroom facilities, common walkways, day rooms, sally-ports, and transportation. The ICE Guidance on COVID-19 webpage also fails to delineate how social distancing can be accomplished in settings like the JCDC. Again, because there is no cure for COVID-19, social distancing remains the primary means of prevention. Any guidance that treats it as merely recommended, rather than required at all times, remains inadequate to mitigate the spread of COVID-19. As of now, ICE has still failed to meaningfully implement this precaution into its guidance.

29. Screening: The April 10 ERO Pandemic Response Requirements (Exhibit E) identifies a list of conditions that place detainees at high risk of serious complications from COVID-19. Both this document and prior lists promulgated by ICE fail to provide a complete list of risk factors consistent with CDC guidelines.

a. The April 10 ERO Pandemic Response Requirements fail to identify pregnant or post-partum women and people with histories of smoking as people at high risk of serious illness from COVID-19.

b. The April 10 ERO Pandemic Response Requirements identify 65 as the onset of age-related heightened risk of serious illness from COVID-19, whereas the prior ERO guidance identified 60 as the triggering age. But based on correctional standards, the correct benchmark for when people in correctional or detention facilities begin experiencing age-related risk for serious illness or death from COVID-19 is 50. As discussed above, this is due to the extremely high degree of physical and behavioral health problems among people in correctional and detention institutions. In addition, data from U.S. COVID-19 cases have found a

[27] No such plan is referenced in a recent decision by the U.S. District Court for the Central District of Illinois ordering the release of a JCDC detainee at high risk of severe illness or death from COVID-19. *See Juan Manuel Hernandez v. Chad Kolitwenzew*, Case No. 20-cv-2088-SLD, Order, Dkt. #12 (C.D. Ill. Apr. 23, 2020).

higher hospitalization and intensive care admission rate for those between ages 50 and 64.[28]

c. The screening protocol provides that asymptomatic people with suspected COVID-19 contact or risk factors will be quarantined and monitored for 14 days. However, given the current prevalence of COVID-19, a majority of new admissions to detention will likely fit into this category. ICE or local facilities would have to expand medical capacity to monitor new detainees in accordance with this guideline, but have not indicated the intention to do so.

30. The April 10 ERO Pandemic Response Requirements appear to identify patients at high risk of serious illness from COVID-19 for the purpose of docket review, but critically fail to encourage or require any higher level of protection that facility officials must provide these detainees in order to protect them from contracting COVID-19.

a. The April 10 ERO Pandemic Response Requirements instruct facility staff to identify high-risk detainees and to email their names, location, medical issues, medications, and facility point of contact information to ICE headquarters. The purpose of this action appears to be to enable ICE to review the identified high-risk detainees in order to determine who to release. *See* Exhibit E at 14.

b. But the document provides little to no guidance, however, about the specific measures that facility staff must take to ensure that these high-risk patients are protected from coronavirus infection. It notes, "If cohorting of ill detainees is unavoidable, make all possible accommodations until transfer occurs 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 isolation room)." Exhibit E at 15. Nothing in the guidance requires their release or specific protective measures for high-risk detainees.

c. This guidance is entirely insufficient. It is not enough for ICE to identify some of the categories of detainees at increased risk of serious illness from COVID-19 and to delineate a process for ERO to identify these individuals. Instead, ICE must identify *all* high-risk detainees and establish clear protocols for increased surveillance of these individuals, including through twice daily symptom and temperature checks.

31. In addition to implementing active surveillance of high-risk patients, ICE should also immediately ensure daily review of all sick call requests for symptoms associated with COVID-19 by detainees in ICE custody. Sick call is the primary manner in which ICE detainees, including those with risk factors for severe illness and death from COVID-19, report their health

[28] Shikha Garg, et al., *Hospitalization Rates and Characteristics of Patients with Laboratory-Confirmed Coronavirus Disease 2019, March 1-30, 2020,* COVID-NET, 14 States, March 1–30, 2020. MMWR Morb Mortal Wkly Rep. ePub: 8 April 2020. DOI: http://dx.doi.org/10.15585/mmwr.mm6915e3external icon.

problems. ICE must ensure that facilities in which detainees are housed implement a structure by which officials review every sick call request made within 24 hours to detect the requests that concern a detainee with possible COVID-19 symptoms. As a correctional health official, I implemented this approach *in addition* to cohorting and active surveillance of high-risk patients during outbreak management, and it is essential to finding and treating ill and infectious patients as quickly as possible. My experience is that this approach must be clearly outlined and mandated. It is also my experience that it requires at least one additional nurse per facility to review sick calls and to act on high priority sick call requests concerning possible COVID-19 symptoms. Without this measure, patients will report symptoms of COVID-19 and wait days before they receive assessment or care. This is especially the case when they report their symptoms on Thursday or Friday and may be required to wait until Monday for sick call evaluation.

32. The April 10 ERO Pandemic Response Requirements (Exhibit E) create an unwieldy and unrealistic process for facilities to notify ICE headquarters about high-risk detainees.

a. As discussed above, the document contemplates a process by which each facility with ICE detainees will send emails to ERO with identifying information about detainees who have risk factors. But this process is unwieldy and unlikely to be effective.

b. Based on my experience creating surveillance tools for high-risk patients in multiple detention scenarios, several key elements of this process are problematic.

i. The process of emailing headquarters thousands of names with relevant information, or even hundreds of spreadsheets, tables and other documents, creates an unreliable and error-prone system for alerting ERO or tracking the most vulnerable detainees inside ICE facilities.

ii. The process identified by ICE is static, meaning that as detained people move from one facility to another, there will be no way for their location to be automatically updated with their high-risk status, requiring labor intensive and error-prone records reviews.

iii. The approach delineated by the April 10 ERO Pandemic Response Requirements will not allow ICE leadership to ensure day-to-day management of the high-risk population. The process does not establish an automatic notification process or ensure that ICE leadership will automatically be notified when people are released or become ill from non-COVID-19 reasons. Nor does the process establish an automatic cross-check process or ensure that emails to ERO regarding COVID-19 cases amongst ICE detainees will be automatically cross-checked against this initial batch of hundreds or thousands of emails from facilities identifying high-risk patients.

c. Instead of the system proposed by the April 10 ERO Pandemic Response Requirements, ICE should create a single portal into which every facility can enter data on ICE detainees who meet CDC criteria for being high risk. I employed such a portal as Chief Medical Officer of the NYC jail system. We relied on this system before and after the implementation of an electronic medical record as a way to identify high-risk patients and to track them as they moved from one facility to another. This type of approach is essential for ICE to meet its stated obligations to plan for the re-entry of people who are leaving amid the COVID-19 crisis and to coordinate with local and state public health partners.

d. The net effect of the April 10 Pandemic Response Requirements' cumbersome and inefficient process will be that far fewer high-risk detainees will be released than otherwise would be the case and more high-risk detainees will experience serious illness and death while in ICE detention.

33. The April 10 ERO Pandemic Response Plan fails to include vital elements of CDC guidance on preventing the spread of COVID-19 inside detention facilities.

a. Notably, the April 10 ERO Pandemic Response Requirements fail to mention or provide guidance on key aspects of social distancing including: how to ensure that staff and detainees maintain 6 feet of distance between themselves and others in

1. intake pens,
2. clinical and medication lines,
3. bathroom and shower areas,
4. sally-ports,
5. staff entry,
6. the symptom checking process,
7. locker room areas, and
8. other areas of crowded housing units.

b. The April 10 ERO Pandemic Response Requirements fails to include guidance on the importance of staff communication with detainees about changes to their daily routine and how they can contribute to risk reduction, both of which are explicitly identified by the CDC guidelines as necessary to protect the health and safety of people in detention facilities.

c. The April 10 ERO Pandemic Response Requirements fails to include many critical aspects of cleaning and disinfection outlined in CDC guidelines including the following:

i. CDC guidelines identify a higher level of intervention after a person has been identified as a suspected COVID-19 case. This common-sense approach requires any person cleaning spaces formerly occupied by a suspected COVID-19 patient to use PPE and wait for 24 hours after the patient vacates the area before cleaning. It also requires the facility to ensure that no people

come into contact with the area before it is cleaned. These steps are critical to ensuring that the most high-risk scenarios encountered by detainees and staff alike are addressed with an appropriate response.

ii. The April 10 ERO Pandemic Response Requirements instructs that vehicles should be cleaned after transport of a known/suspected case, and generically notes that "surfaces and objects that are frequently touched, especially in common areas," should be cleaned and disinfected "several times a day," (Exhibit E at 9–10) but fails to specifically instruct frequent cleaning and disinfection of all high-touch surfaces in the computers, equipment, and belongings of staff, and in detainees' housing area, cell, bunk, and personal belongings. This cleaning is in addition to any routine cleaning that occurs in common areas, and must occur as part of the response to any new known or suspected case.

iii. CDC guidelines indicate that in settings where people are held overnight, response to a known or suspected COVID-19 case should include closing off areas used by the person who is sick, opening outside doors and windows to increase air circulation in the area and waiting 24 hours (or as long as possible) before cleaning/disinfecting. If 24 hours is not feasible, wait as long as possible.[29]

iv. The April 10 ERO Pandemic Response Requirements fail to establish what PPE should be utilized by staff or detainees when cleaning areas occupied by a person known or suspected to have COVID-19.

d. The April 10 ERO Pandemic Response Requirements instructs that everyone in detention facilities must engage in hand washing for 20 seconds with soap and water, but fails to address how this can be accomplished in facilities that utilize metered faucets that make this process essentially impossible.

e. The April 10 ERO Pandemic Response Requirements fail to counsel against reliance on detainees for conducting critical environmental cleaning. Such reliance, without proper training, protection, or supervision, represents a gross deviation from correctional practices and will likely contribute to the spread of COVID-19 throughout the ICE detention system.

f. The April 10 ERO Pandemic Response Requirements fail to establish or mandate a respiratory protection program, which is a critical CDC guideline: "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

[29] CDC, Cleaning and Disinfection for Community Facilities, Coronavirus Disease 2019, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 15, 2020).

need within the scope of their responsibilities." Exhibit F at 8. Simply giving out N95 or other masks to staff and detainees but failing to train them on how to identify the high-risk tasks or scenarios they will encounter serves only to decrease the overall effectiveness of infection control, and increase the risk of serious illness and death of high-risk detainees in ICE facilities.

34. The April 10 ERO Pandemic Response Requirements fail to address what facilities must do to meet the re-entry needs of people leaving ICE custody. This is a critical failure given ERO's ongoing docket review, which should result in some releases of high-risk detainees. The requirements should follow the following CDC recommendations, which seek to protect the health and safety of detainees, staff, and the communities to which detainees return:

a. If an individual set for release does not clear the screening process, facilities should follow the protocol for a suspected COVID-19 case, including by providing a face mask to the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing;[30]

b. 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; and

c. 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.

35. Use of isolation: The ICE COVID-19 protocols and guidance specify that "isolation rooms" will be used to monitor people who are symptomatic with COVID-19. *See* Exhibit B. My experience in visiting and working in detention facilities across the nation is that each facility has one to four cells located in or near the medical clinic that meet this definition. When COVID-19 arrives in a facility, there will be many more people who meet this criteria of being symptomatic, and ICE will need to designate entire housing areas for this level of increased surveillance of symptomatic patients. This approach requires that empty housing areas be available, so that small numbers of symptomatic patients can be cohorted together away from those without symptoms. Facilities that are over 80% capacity will find this basic approach impossible once they start to see multiple symptomatic patients. Based on my experience visiting ICE detention facilities, this process will be essentially impossible.

[30] CDC, *Medical Isolation of Confirmed or Suspected COVID-19 Cases*, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Medicalisolation (last visited Apr. 14, 2020).

a. Each confirmed case results in loss of staff or isolation of detainees and quarantine of their close (housing area) contacts. Unless a detention setting is at less than 50% of capacity in terms of daily census, it is extremely improbable that the facility will be able to manage the physical separation of symptomatic and known COVID-19 patients, quarantine of their contacts for 14 days, and increased surveillance of people who are asymptomatic and have known risk factors. The maximum percentage capacity needed to allow proper quarantine and isolation may be even lower, depending on the physical layout of the facility and available staff capacity.[31]

b. While the ICE COVID-19 Guidance webpage indicates a desire to reduce the population of detention facilities to 70 percent or less,[32] none of the ICE COVID-19 protocols and guidance mandate that the JCDC ensures that the facility is at or below 50% capacity. In my opinion, it is necessary for facility to be at or below 50% capacity in order to permit the measures needed to provide sufficient space for proper isolation and quarantine of people with COVID-19 symptoms or known exposure to laboratory confirmed cases of COVID-19. To be clear, however, simply because a facility is at or below 50% capacity is not, in and of itself, sufficient to demonstrate that the facility is ensuring proper use of isolation or symptomatic and known COVID-19 patients, quarantine of their contacts for 14 days, and increased surveillance of people who are asymptomatic and have known risk factors.

c. Moreover, ICE should not employ isolation in locked cells as a primary means to protect either at-risk patients, or patients who are symptomatic. When patients are placed into locked cells, the level of monitoring is dramatically reduced. In addition, this practice causes new health problems in the form of risk for suicide and self-harm. Also, isolation units often drive increased physical interaction between staff and patients, in the form of increased handcuffing, escorting individuals to and from showers and other out of cell encounters, and increased uses of force due to the psychological stress these units cause.

d. In sum, it is my expert opinion, and that of other correctional experts, that the use of security isolation and/or lockdown is not a medically appropriate method for abating the substantial risk of harm from COVID-19.[33]

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[31] Note that ICE's guidance as to the proper percentage of reduction is inconsistent. ICE's April 10 Guidance, Exhibit E, specifies reduction to 75 percent capacity; ICE's website specifies reduction to 70 percent capacity. *See* ICE, ICE Guidance on COVID-19, https://www.ice.gov/coronavirus (last visited Apr. 14, 2020).

[32] ICE, ICE Guidance on COVID-19, https://www.ice.gov/coronavirus (last visited Apr. 14, 2020).

[33] David Cloud, et al., *The Ethical Use of Medical Isolation—Not Solitary Confinement—to Reduce COVID-19 Transmission in Correctional Settings*, Apr. 9, 2020, https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf.

36. Testing: The April 10 ERO Pandemic Response Requirements fails to address the lack of comprehensive COVID-19 testing in ICE facilities. There is no guidance for clinical staff on when to test patients for COVID-19, which leaves detained patients at a significant disadvantage. Without any clear guidance for testing, ICE will be unable to identify confirmed cases or take necessary precautions to contain the spread of COVID-19 in a timely manner. While the guidelines for testing may evolve over time, the protocol should create a structure for daily dissemination of testing criteria from ICE leadership, and time for daily briefings among all health staff at the start of every shift, to review this and other elements of the COVID-19 response. This briefing must include participation by epidemiologists tasked to a COVID-19 response who are also coordinating with local and federal COVID-19 activities.

37. Staffing: The ICE COVID-19 protocols and guidance fail to address the key CDC recommendation on the need for adequate staffing and training of staff. ICE's March 27 Memo simply states that "facilities are expected to be appropriately staffed," but provides no guidance whatsoever on how that can be accomplished in the context of existing staffing gaps, a decreased workforce, and increased needs resulting from steps required to screen, monitor and treat detainees for COVID-19. *See* Exhibit C at 2. CDC guidelines make clear the need for a concrete plan for ensuring adequate staffing as part of the COVID-19 response. These guidelines also make clear the need to orient staff to the critical need to stay home if and when they experience symptoms of COVID-19 infection. In sum, aside from the ICE March 27 Memo's "expectation" of appropriate staffing levels, ICE has not implemented any meaningful oversight system to ensure that appropriate staffing levels are met. Critically, appropriate staffing levels refers not only to a sufficient number of staff but also to a sufficient number of qualified staff.

a. In my experience, many facilities rely heavily on guards and Licensed Practical Nurses (LPNs) to do medical work that they are not qualified to do; likewise, many facilities rely on Registered Nurses (RNs) to do medical work that only doctors or physician-assistants are qualified to do. There is no indication whatsoever that ICE is implementing procedures in the JCDC to ensure not only sufficient numbers of staff but also sufficient numbers of qualified staff. The current shortages in staffing for health staff in particular, stretch across all communities, and staffing shortages represent a real emergency in many settings already. This is particularly concerning given that many ICE facilities are located in rural areas far from qualified medical professionals. This is a very serious defect that must be immediately remediated because access to qualified medical professionals is crucial during this rapidly evolving pandemic.

Lack of COVID-19 Mitigation Plan in Place for the Jerome Combs Detention Center

38. The April 10 ERO Pandemic Response Requirements mandate that every facility holding ICE detainees have a COVID-19 mitigation plan in place. The document specifies:

> "Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:

- To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
- To maintain essential functions and services at the facility throughout the pendency of the pandemic;
- To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
- To establish means to monitor, cohort, quarantine, and isolate the sick from the well."

Exhibit E at 4.

39. The key aspects of the CDC guidance regarding COVID-19 response involve active preparation before the arrival of COVID-19, and clear and evidence-based responses once cases are identified. Preparation includes communication with staff and inmates about risks of infection and infection control, and that reflect an evidence-based emergency COVID-19 mitigation plan that is widely disseminated. Once COVID-19 arrives, this plan is updated and may evolve, but the plan itself is a document that every person in the facility understands and is part of, much like a suicide prevention or sexual abuse reporting plan.

40. No COVID-19 mitigation plan appears to exist for JCDC based on the description of current practices in the facility. This represents a stark and dangerous departure from ICE's own policies and CDC guidelines.[34]

Review of JCDC Practices Based on the Declaration of Chad Kolitwenzew, Chief of Corrections

41. I have reviewed the Declaration of Chad Kolitwenzew, Chief of Corrections for the Kankakee County Sheriff's Office, filed on April 24, 2020 in *Favi v. Kolitwenzew*, No. 20-cv-2087 (C.D. Ill.), Dkt. 20-2 ("Kolitwenzew Declaration"), attached to this declaration as Exhibit H. Certain aspects of Chief Kolitwenzew's statement represent practices that are at odds with, or omit key elements of, the CDC guidance on COVID-19 response in detention settings, including the following:

a. As previously stated, there appears to be no unified COVID-19 mitigation plan in JCDC. There is reference to a "comprehensive set of precautionary measures to limit the risk of COVID-19 transmission," without a specific document or plan provided or referenced. A printout of the CDC guidelines and a generic law enforcement COVID-19 guide developed by the Illinois Department of Public health accompany this declaration, but no COVID-19 mitigation plan specific to JCDC.

[34] CDC, Resources for Correctional and Detention Facilities: Before and During an Outbreak, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html (last visited Apr. 14, 2020).

b. There is no health staffing from 11 pm to 7 am, representing an inability to conduct screenings of high-risk or quarantine patients during these times as well as an inability to maintain medical monitoring of isolation patients with COVID-19 symptoms. This lack of staffing is immediately problematic if and when a symptomatic patient arrives in the facility. The same declaration states: "If any ICE detainee presented any flu-like symptoms, such as coughing, fever, vomiting, diarrhea, nausea and/or dizziness, that detainee would be placed in a single cell for isolation and would be medically monitored by ICE medical personnel three to four times per day for the first five days of single cell isolated confinement." Exhibit H ¶ 13(B)(3). This level of monitoring would not be possible in the JCDC due to the lack of health staff overnight, and cannot be conducted by first responder security staff and thus, represents a significant gap in resources. The same gap exists for monitoring of quarantined patients.

c. Sick call is referenced without any mention as to whether COVID-19 symptoms reported in sick call requests result in a) prompt clinical evaluation or b) integration of these symptoms into the facility tracking of COVID-19 symptoms and outbreak.

d. New admission housing is described as lasting between 5 and 14 days, but the period needed to ensure lack of COVID-19 symptoms after initial contact is 14 days. Reliance on clearing patients out of new admission housing after less than 14 days represents a deficient practice that places staff and detainees at risk.

42. In sum, the description of practices set forth in Chief Kolitwenzew's declaration would be inadequate even if fully implemented. As noted below, however, my review of Mr. Herrera-Herrera's declaration indicates that some of the steps outlined by Chief Kolitwenzew's declaration have not been implemented.

Petitioner is at High-Risk if he Remains in ICE Custody

43. I have reviewed the Declaration of Petitioner Joaquin Herrera-Herrera in Support of Petitioner's Emergency Petition for a Writ of Habeas Corpus and Motion for a Temporary Restraining Order and/or Preliminary Injunction ("Herrera-Herrera Decl."). Mr. Herrera-Herrera is currently detained by ICE in JCDC. I have also reviewed the JCDC Facility Inspection Report from 2019.

44. Based on this information, I have specific concerns about the health status of the Petitioner and his lack of access to even the most basic infection control, and other COVID-19 measures included in basic CDC guidelines.

a. Based on his declaration, Mr. Herrera-Herrera has pre-existing medical conditions—notably, hypertension—which place him at heightened risk of serious illness or death should he contract COVID-19 infection. In addition, his reports of inconsistent medication administration during his detention by ICE, his high blood pressure readings, and JCDC staff's practice of only checking his blood

pressure once or twice per week raise concerns that his blood pressure is not adequately controlled or adequately monitored. Herrera-Herrera Decl. ¶¶ 6–11, 16.

b. Mr. Herrera-Herrera's report of staff indicating that they had "seen worse" blood pressure readings, and that his systolic elevation was not meaningful because his diastolic reading was not as elevated indicates that he is being cared for by staff who do not understand or use evidence-based practices in hypertension care. *Id.* ¶ 18. This is particularly relevant to COVID-19 risk since the CDC has expressly indicated that people with chronic diseases that are poorly controlled are at higher risk for serious illness and death than those with the same conditions under good control.

c. Mr. Herrera-Herrera's age (60 years) is another risk factor for serious illness or death from COVID-19.

d. In addition, Mr. Herrera-Herrera's report of morning fatigue, light-headedness and shortness of breath is extremely concerning. *Id.* ¶ 15. While some of these symptoms may relate to dehydration or side effects of his blood pressure medication, it is unusual for shortness of breath to occur, and shortness of breath is one of the danger signs for COVID-19. These symptoms are also consistent with viral, fungal and bacterial infections as well as renal and cardiac disease. It is extremely concerning that any patient would report these symptoms of serious disease and not receive prompt evaluation.

e. Mr. Herrera-Herrera reports a lack of social distancing and basic infection control measures within JCDC, including:

   i. Lack of any paper towels, which requires the use of clothes or personal towels to dry hands, *Id.* ¶ 53;

   ii. Lack of social distancing as prescribed by the CDC guidance for detention settings, including extremely close sleeping and eating quarters and living areas which make it impossible to stay six feet away from others and require close contact during medication administration, *Id.* ¶¶ 32, 40, 44, 45, 48;

   iii. Failure to provide detained people with masks or face coverings, *Id.* ¶¶ 41, 42, 57, 61;

   iv. Failure to ensure safe food handling, including placement of uncovered food trays directly on top of one another by food handlers not wearing gloves or masks, *Id.* ¶¶ 42, 43;

   v. Creation of a heightened risk for contracting COVID-19 specifically among high-risk patients due to close contact with others in medication lines, where high-risk patients are required to go, *Id.* ¶¶ 40, 48, 61; and

vi. Failure to provide adequate cleaning supplies and solutions, with wide variations from one day to the next in the strength and effectiveness of cleaning solutions provided to detained people for cleaning their housing areas, *Id.* ¶¶ 41, 52, 55–60.

f. Mr. Herrera-Herrera also reports a basic failure of JCDC health and security staff to communicate with detained people about the status of the COVID-19 outbreak and the facility plan for response, including social distancing and infection control. *Id.* ¶ 35. The CDC guidance regarding COVID-19 response in detention facilities requires active preparation before the arrival of COVID-19, and clear and evidence-based responses once cases are identified. Preparation includes: communication with staff and inmates about infection control; ensuring that environmental cleaning and access to hand washing is occurring per CDC guidelines; limiting large group events; initiating social distancing; communicating with local public health partners; identifying high risk patients; and creating an emergency COVID-19 mitigation plan. Once COVID-19 arrives, efforts should include screening, testing, identification, and tracking of new cases, quarantining of close contacts, continuation of infection control, staffing, and other aspects of the emergency plan, as well as increased coordination with the local health department, especially regarding testing, isolation, quarantining and hospitalization.[35]

45. Mr. Herrera-Herrera reports that some of his medical encounters have occurred in the security "bubble," the work station for correctional officers. *Id.* ¶ 13. This practice represents a gross deviation from basic correctional health practices and increases the risk to both the patient and the security staff who utilize this station.

46. Mr. Herrera-Herrera's observations contradict the claims made over a week earlier in Chief Kolitwenzew's declaration, including Chief Kolitwenzew's claims that:

a. Nurses make rounds of the cells twice a day and "pass medication to the ICE detainees in their cells," Exhibit H ¶ 7(A);

b. "[T]he JCDC conducts a daily disinfection routine three times a day, which includes door handles, toilets, showers and tables," *Id.* ¶ 13(D)(1); and

c. "At each . . . meal[] service, JCDC staff, wearing gloves, a hair net and face mask, verbally remind the detainees to maintain a distance of six feet from the detainee in front of them," *Id.* ¶ 8(C).

[35] CDC, Resources for Correctional and Detention Facilities: Before and During an Outbreak, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html (last visited Apr. 14, 2020).

47. The failure to implement a basic COVID-19 mitigation plan, and the omission in the JCDS of basic practices detailed in the CDC guidelines places people like Mr. Herrera-Herrera at a high risk of contracting COVID-19 and suffering serious complications—including death.

48. ICE and JCDC must release Mr. Herrera-Herrera to prevent his serious illness and/or death. The most recent ERO protocol (Exhibit E) makes clear that they do not plan to establish specific protections for high-risk patients and will wait for them to become symptomatic. This approach will result in preventable morbidity and mortality. Both the oversight authority of the NYC jail system, and the current medical director for geriatrics and complex care of the system have called for high-risk patients to be immediately transferred out of detention.[36] ICE faces a completely preventable disaster by keeping high-risk patients in detention as COVID-19 arrives in facilities where the virus will quickly spread, especially in settings like JCDC, which has failed to even develop and implement a COVID-19 mitigation plan or develop practices that are consistent with CDC guidelines. The basic limitations of the physical plant and looming staffing concerns make clear that this patient is in peril of serious illness or death if he remains in detention. In addition, transfer of this patient to other ICE detention facilities will only compound exposure and transmission of COVID-19. Mr. Herrera-Herrera must be released immediately.

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

Executed this 11th day in May 2020 in Port Washington, New York:

Homer Venters MD, MS

[36] Jennifer Gonnerman, *A Rikers Island Doctor Speaks Out to Save Her Elderly Patients from the Coronavirus*, NEW YORKER (Mar. 20, 2020), https://www.newyorker.com/news/news-desk/a-rikers-island-doctor-speaks-out-to-save-her-elderly-patients-from-the-coronavirus; *NYC Officials Call for Release of "Most at Risk" on Rikers Island as More Test Positive for Virus*, NBC4 NEW YORK (Mar. 18, 2020), https://www.nbcnewyork.com/news/local/nyc-officials-call-for-release-of-most-at-risk-on-rikers-prison-as-more-test-positive-for-virus/2333348/.

CERTIFICATE OF SERVICE

The undersigned, an attorney, certifies that on May 14, 2020, she caused a copy of the above and foregoing DECLARATION OF DR. HOMER VENTERS to be served on all counsel of record via the Court's electronic filing system (CM/ECF) and to the following:

By Summons Process Service:

Michael Downey, Sheriff
Sheriff of Kankakee County
3000 Justice Way
Kankakee, IL 60901

Chad Kolitwenzew
Chief of Corrections of the Jerome Combs Detention Center
3050 Justice Way
Kankakee, IL 60901

By US Certified Mail:

Robert Guadian
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
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Matthew Albence
Deputy Director and Senior Official Performing the Duties of the Director
of U.S. Immigration and Customs Enforcement
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Chad Wolf
Acting Secretary of Homeland Security
Office of Executive Secretary, MS 0525
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/s/ Rebecca K. Glenberg

Exhibit A

to Venters Decl.

Dr. Homer D. Venters

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HEALTH ADMINISTRATOR PHYSICIAN EPIDEMIOLOGIST

Professional Profile

- International leader in provision and improvement of health services to patients with criminal justice involvement.
- Innovator in linking care of the incarcerated to Medicaid, health homes, DSRIPs.
- Successful implementer of nations' first electronic health record, performance dashboards and health information exchange among pre-trial patients.
- Award winning epidemiologist focused on the intersection of health, criminal justice and human rights in the United States and developing nations.
- Human rights leader with experience using forensic science, epidemiology and public health methods to prevent and document human rights abuses.

Professional Experience

President, Community Oriented Correctional Health Services (COCHS), 1/1/2020-present.

- Lead COCHS efforts to provide technical assistance, policy guidance and research regarding correctional health and justice reform.
- Oversee operations and programmatic development of COCHS
- Serve as primary liaison between COCHS board, funders, staff and partners.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), 12/1/18-12/31/2018

- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Medical/Forensic Expert, 3/2016-present

- Provide expert input, review and testimony regarding health care, quality improvement, electronic health records and data analysis in detention settings.

Director of Programs, Physicians for Human Rights, 3/16-11/18.

- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.
- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

- Transitioned entire clinical service (1,400 staff) from a for-profit staffing company model to a new division within NYC H + H.
- Developed new models of mental health and substance abuse care that significantly lowered morbidity and other adverse events.
- Connected patients to local health systems, DSRIP and health homes using approximately $5 million in external funding (grants available on request).
- Reduced overall mortality in the nation's second largest jail system.
- Increased operating budget from $140 million to $160 million.
- Implemented nation's first patient experience, provider engagement and racial disparities programs for correctional health.

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.

- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from $115 million to $140 million.
- Established surveillance systems for injuries, sexual assault and mental health that drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.

- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.

- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

Clinical Attending Physician, Bellevue/NYU Clinic for Survivors of Torture, 10/07-12/11.

Clinical Attending Physician, Montefiore Medical Center Bronx NY, Adult Medicine, 1/08-11/09.

Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009
Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.
Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University7/2004- 5/2007.
M.D., University of Illinois, Urbana, 12/2003.
M.S. Biology, University of Illinois, Urbana, 6/03.
B.A. International Relations, Tufts University, Medford, MA, 1989**.**

Academic Appointments, Licensure

Clinical Associate Professor, New York University College of Global Public Health, 5/18-present.

Clinical Instructor, New York University Langone School of Medicine, 2007-2018.

M.D. New York (2007-present).

Media

TV
i24 Crossroads re Suicide in U.S. Jails 8/13/19.

i24 Crossroads re re *Life and Death in Rikers Island* 6/13/19.

Amanpour & Company, NPR/PBS re *Life and Death in Rikers Island* 4/15/19.

CNN, Christiane Amanpour re Forensic documentation of mass crimes against Rohingya. 7/11/18.

i24 Crossroads with David Shuster re health crisis among refugees in Syria. 7/6/18.

Canadian Broadcasting Corporation TV with Sylvie Fournier (in French) re crowd control weapons. 5/10/18

i24 Crossroads with David Shuster re Cholera outbreak in Yemen. 2/15/18.

China TV re WHO guidelines on HIV medication access 9/22/17.

Radio/Podcast
Morning Edition, NPR re Health Risks of Criminal Justice System. 8/9/19.

Fresh Air with Terry Gross, NPR re *Life and Death in Rikers Island*, 3/6/19.

Morning Edition, NPR re *Life and Death in Rikers Island*, 2/22/19.

LeShow with Harry Sherer re forensic documentation of mass crimes in Myanmar, Syria,

Iraq. 4/17/18.

Print articles and public testimony
Oped: Four ways to protect our jails and prisons from coronavirus. The Hill 2/29/20.

Oped: It's Time to Eliminate the Drunk Tank. The Hill 1/28/20.

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Oped: With Katherine McKenzie. Policymakers, provide adequate health care in prisons and detention centers. CNN Opinion, 7/18/19.

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Testimony: Venters HD, New York Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for juveniles in New York. July 10, 2014. NY NY.

Testimony: New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.
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Testimony: U.S. House of Representatives, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law: Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008.

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Venters H, *The Lancet* (2008) Who is Jack Bauer? 372 (9653).

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Kjome JR, Swenson KA, Johnson MN, Bordayo EZ, Anderson LE, Klevan LC, Fraticelli AI, Aldrich SL, Fawcett JR, **Venters HD**, Ala TA, Frey WH 2nd (1997) Inhibition of antagonist and agonist binding to the human brain muscarinic receptor by arachidonic acid. *J. Mol. Neurosci.* 10, 209-217.

Honors and Presentations (past 10 years)

Keynote Address, Academic Correctional Health Conference, April 2020, Chapel Hill, North Carolina.

TedMed Presentation, Correctional Health, Boston MA, March 2020.

Finalist, Prose Award for Literature, Social Sciences category for *Life and Death in Rikers Island*, February, 2020.

Keynote Address, John Howard Association Annual Benefit, November 2019, Chicago IL.

Keynote Address, Kentucky Data Forum, Foundation for a Healthy Kentucky, November 2019, Cincinnati Ohio.

Oral Presentation, Dual loyalty and other human rights concerns for physicians in jails an prisons. Association of Correctional Physicians, Annual meeting. 10/16, Las Vegas.

Oral Presentation, Clinical Alternatives to Punitive Segregation: Reducing self-harm for incarcerated patients with mental illness. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Analysis of Deaths in ICE Custody over 10 Years . American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Medication Assisted Therapies for Opioid Dependence in the New York City Jail System. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. American Public Health Association Annual Meeting, November 2014, New Orleans, LA.

Training, International Committee of the Red Cross and Red Crescent, Medical Director meeting 10/15, Presentation on Human Rights and dual loyalty in correctional health.

Paper of the Year, American Public Health Association. 2014. (Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.)

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. *American Public Health Association* Annual Meeting, New Orleans LA, 2014.

Oral Presentation, Human rights at Rikers: Dual loyalty among jail health staff. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health

Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, *American Public Health Association,* Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA,

November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award, Advocacy on behalf of detained immigrants. Legal Aid Society of New York, October 2009.

Oral Presentation, Deaths of immigrants detained by Immigration and Customs Enforcement. Venters H, Rasmussen A, Keller A, *American Public Health Association* Annual Meeting, San Diego CA, October 2008.

Poster Presentation, Death of a detained immigrant with AIDS after withholding of prophylactic Dapsone. Venters H, Rasmussen A, Keller A, *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Poster Presentation, Tuberculosis screening among immigrants in New York City reveals higher rates of positive tuberculosis tests and less health insurance among African immigrants. *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Daniel Leicht Award for Achievement in Social Medicine, Montefiore Medical Center, Department of Family and Social Medicine, 2007.

Poster Presentation, Case Findings of Recent Arestees. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Toronto Canada, April 2007.

Poster Presentation, Bringing Primary Care to Legal Aid in the Bronx. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Los Angeles CA, April 2006.

Poster Presentation, A Missed Opportunity, Diagnosing Multiple Myeloma in the Elderly Hospital Patient. Venters H, Green E., *Society of General Internal Medicine* Annual Meeting, New Orleans LA, April 2005.

Grants: Program

San Diego County: Review of jail best practices (COCHS), 1/2020, $90,000.

Ryan White Part A - Prison Release Services (PRS). From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/17 (Renewed since 2007). Annual budget $ 2.7 million.

Ryan White Part A - Early Intervention Services- Priority Population Testing. From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/18 (Renewed since 2013). Annual budget $250,000.

Comprehensive HIV Prevention. From HHS to Correctional Health Services (NYC DOHMH), 1/1/16-12/31/16. Annual budget $500,000.

HIV/AIDS Initiative for Minority Men. From HHS Office of Minority Health to Correctional Health Services (NYC DOHMH), 9/30/14-8/31/17. Annual budget $375,000.

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget $280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget $290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget $175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget $290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget $100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget $250,000.

Teaching

Instructor, Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, June 2015, June 2014, April 2019.

Instructor, Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture, Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo Egypt, September 20-23, 2014.

Doctors of the World, Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/05-11/18.

United States Peace Corps, Guinea Worm Educator, Togo West Africa, June 1990- December 1991.

-*Primary Project;* Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French

-*Secondary Project;* Malaria Prevention.

Books

Venters H. *Life and Death in Rikers Island*. Johns Hopkins University Press. 2/19.

Chapters in Books

Venters H. Mythbusting Solitary Confinement in Jail. In Solitary Confinement Effects, Practices, and Pathways toward Reform. Oxford University Press, 2020.

MacDonald R. and **Venters H.** Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

Membership in Professional Organizations

American Public Health Association

Foreign Language Proficiency

French	Proficient
Ewe	Conversant

Prior Testimony and Deposition

Benjamin v. Horn, 75 Civ. 3073 (HB) (S.D.N.Y.) as expert for defendants, 2015

Rodgers v. Martin 2:16-cv-00216 (U.S.D.C. N.D.Tx) as expert for plaintiffs, 10/19/17

Fikes v. Abernathy, 2017 7:16-cv-00843-LSC (U.S.D.C. N.D.AL) as expert for plaintiffs 10/30/17.

Fernandez v. City of New York, 17-CV-02431 (GHW)(SN) (S.D.NY) as defendant in role as City Employee 4/10/18.

Charleston v. Corizon Health INC, 17-3039 (U.S.D.C. E.D. PA) as expert for plaintiffs 4/20/18.

Gambler v. Santa Fe County, 1:17-cv-00617 (WJ/KK) as expert for plaintiffs 7/23/18.

Hammonds v. Dekalb County AL, CASE NO.: 4:16-cv-01558-KOB as expert for plaintiffs 11/30/2018.

Mathiason v. Rio Arriba County NM, No. D-117-CV-2007-00054, as expert for plaintiff 2/7/19.

Hutchinson v. Bates et. al. AL, No. 2:17-CV-00185-WKW- GMB, as expert for plaintiff 3/27/19.

Lewis v. East Baton Rouge Parish Prison LA, No. 3:16-CV-352-JWD-RLB, as expert for plaintiff 6/24/19.

Belcher v. Lopinto, No No. 2:2018cv07368 - Document 36 (E.D. La. 2019) as expert for plaintiffs 12/5/2019.

Fee Schedule

Case review, reports, testimony $500/hour.
Site visits and other travel, $2,500 per day (not including travel costs).

Exhibit B

to Venters Decl.

Immigration and Customs Enforcement
Washington, DC 20536

ICE Health Service Corps

Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)

ICE Health Service Corps (IHSC)

Version 6.0, March 6, 2020

WHAT'S NEW

Version 6.0

- Information added to convey that revised CDC guidance expands testing to a wider group of symptomatic patients. Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Information added to covey that testing is now available through LabCorp and other commercial laboratories.

Version 5.1

- Information added to emphasize that medical staff should educate detainees to include hygiene, covering coughs, and requesting sick call if ill.
- Add a link to Illness Prevention and Patient Education resources in multiple languages on SharePoint, including signage.
- Added a link to COVID-19 Questions and Responses on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses.
- Added a link to a 2019 Novel Coronavirus Resource Page on SharePoint.

Version 5.0

- Updates have been made for screening to identify detainees with revised CDC criteria for epidemiologic risk of COVID-19 exposure and to specify the start of the 14-day monitoring period from the date of initial DHS apprehension.
- Epidemiologic travel risk now includes travel from or through geographic areas with widespread or sustained community transmission.

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries. For the most current information, check the CDC information pages at https://www.cdc.gov/coronavirus/2019-ncov/index.html frequently for updates.

CDC interim guidance for health care professionals, including clinical criteria, is available at https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html.

ICE Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation.

1. ***During intake medical screening:***
   a. **Ask all detainees if they have had close contact[1] with a person with laboratory-confirmed COVID-19 in the past 14 days**
   b. **Ask all detainees what countries they have traveled from or through in the past two weeks**
      i. Check whether these countries include geographic area(s) with widespread or sustained community transmission.*
      ii. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.**
      iii. **If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b),** assess for fever and symptoms of respiratory illness.
         a. If the detainee has a fever and/or symptoms of respiratory illness, refer to #4 ISOLATION below.
         b. If the detainee does not have fever or respiratory illness, refer to #2 MONITORING, below.
         c. For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, *"Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.""* Click here for the eCW guide for adding a Global Alert.
   c. If the detainee has fever and/or symptoms or respiratory illness and has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see #3 ENCOUNTER below).

AILA Doc. No. 20031314. (Posted 3/13/20)

d. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
   i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

2. **MONITORING of detainees with exposure risk who do not present with fever or symptoms:**

a. See also IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
b. For detainees with travel history from or through geographic area(s) with sustained community transmission* in the past 14 days and/or detainees who have had close contact[1] with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension and observe daily for fever and/or symptoms of respiratory illness.
   i. ***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.**
c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.
d. Refer also to appendix A, Intake Screening Questions and Intake Screening and Early Management Algorithm on the 2019 Novel Coronavirus Resource Page.
e. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
f. Request a medical alert in following usual protocols stating that "the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission" Release the medical alert at the completion of the 14-day monitoring period.
g. During the 14-day monitoring period, if an asymptomatic detainee under monitoring must be released in the U.S., notify the local health department and provide information on the detainee including the intended address and telephone number of the detainee's intended destination.
h. Document any asymptomatic detainee under monitoring on the Lower Respiratory Illness Tracking Tool.
i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.

AILA Doc. No. 20031314. (Posted 3/13/20)

3. ***ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:***
   a. Ask all detainees what countries they have traveled from or through in the past two weeks.
      i. Check whether these countries include international area(s) with sustained transmission.*
      ii. *Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.
   b. If the detainee has traveled from or through area(s) with sustained community transmission*in the past 14 days, or if they have had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days
      i. → refer to #4 ISOLATION below.
   c. If the detainee has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days then
      i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
      ii. See #5 SPECIMEN COLLECTION AND LABORATORY TESTING below.
   d. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
      i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

4. ***ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through* geographic area(s) with widespread or sustained community transmission at *in the past 14 days or have had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:***
   a. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
   b. Place a tight-fitting surgical mask on the detainee.
   c. Promptly consult with a medical provider, preferably the Clinical Director or designee.

d. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
e. **Implement strict hand hygiene and standard, airborne and contact precautions, including use of eye protection.**
    i. **Increase hand hygiene and routine cleaning of surfaces.**
    ii. **Appropriate personal protective equipment includes gloves, gowns, N95 respirators, and goggles or face shields.**
f. Call the local and/or state health department for notification and guidance.
g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
    i. See #5 SPECIMEN COLLECTION AND LABORTORY TESTING below.
h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the room under airborne and contact precautions.
n. Document any ill detainee who is suspected of having COVID-19 on the Lower Respiratory Illness Tracking Tool.
o. The contagious period for COVID-19 is still undetermined.
    i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation.
    ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension.

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iii. See also IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
iv. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program

p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

5. SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19

a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page.**
i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. Infectious disease public health actions:

a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.
c. **Known exposure to a person with confirmed COVID-19**
i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact[1] with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee).
ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
iv. Discontinue cohorting when 14-day incubation period completes with no new cases.
d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact[1] with the ill detainee for the duration of the most recent incubation period.

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ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above.
v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).

e. Report cohorting through routine IHSC cohort reporting protocols.
f. Document any asymptomatic and afebrile detainees under monitoring for COVID-19 on the Lower Respiratory Illness Tracking Tool.
g. Recommend to Field Office Director or designee that detainees cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
   i. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
h. If a cohorted detainee must be released in the U.S., notify the local health department including the intended address and telephone numbers of the detainee's intended destination.

[1]**Close contact** is defined as:

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

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Resources and references

- 2019 Novel Coronavirus Resource Page on SharePoint
- Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- COVID-19 Questions and Responses on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- **Infection Control: Novel Coronavirus 2019 (COVID-19) | CDC**
- **Interim Guidance: Healthcare Professionals 2019-nCoV | CDC (including CDC website listing of geographic area(s) with widespread or sustained community transmission**
- CDC | Coronavirus Disease 2019 (COVID-19)
- 2019 Novel Coronavirus (2019-nCoV) | TDSHS
- nCOV2019 | CDPH
- Novel Coronavirus Outbreak 2020 | Washington State Department of Health

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- ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 (COVID-19)
- Coronavirus | NYC Health
- 2019 Novel (New) Coronavirus | NYDOH
- 2019 Novel Coronavirus (2019-nCoV) | Florida Department of Health
- NJ Department of Health | Communicable Disease Service | COVID-2019 (Novel Coronavirus)
- Pennsylvania Department of Health | Coronavirus
- 2019 Novel Coronavirus (2019 nCoV) | Frequently Asked Questions | IDPH

Points of contact for questions

- IHSC Staff: COVID-19 Questions and Responses on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
  - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief

- Facilities without IHSC Medical Staffing: Assigned Field Medical Coordinators

- Public health agencies: IHSC_InfectionPrevention@ice.dhs.gov

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Appendix A: Intake Screening Questions

Updated February 28, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
   - Last date you had contact with that person: mm/dd/yyyy

   OR
2. **What countries have you traveled from or through in the past two weeks?**
   - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days?
     - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**

3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days? (#2):
   - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
     - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
     - **If yes, implement standard, airborne, and contact precautions including eye protection,** isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
     - **If no, implement MONITORING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.

4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days AND no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
   - ***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**
   - Routine intake
     - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
     - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**

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Exhibit C

to Venters Decl.

Enforcement and Removal Operations

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

March 27, 2020

MEMORANDUM FOR: Detention Wardens and Superintendents

THROUGH: Field Office Directors

FROM: Enrique M. Lucero
Executive Associate Director
Enforcement and Removal Operations

SUBJECT: Memorandum on Coronavirus Disease 2019 (COVID-19) Action Plan, Revision 1

Background:

U.S. Immigration and Customs Enforcement (ICE) continues to monitor the spread of Coronavirus Disease 2019 (COVID-19) and to work in conjunction with select U.S. Department of Homeland Security (DHS) Component leadership and the Acting Secretary to implement a mitigation strategy.

To ensure a unified and preventative response, the ICE Enforcement and Removal Operations (ERO), ICE Health Service Corps (IHSC), Custody Management Division, and Field Operations are providing the following guidance. The combination of a dense and highly transient detained population presents unique challenges for ICE efforts to mitigate the risk of infection and transmission. Consequently, these measures were developed to reduce exposure to COVID-19, protect the detained population, and optimize employee health and availability for duty.

This memorandum only applies to IHSC-staffed and non-IHSC-staffed, ICE-dedicated facilities. For intergovernmental partners and non-dedicated facilities, ICE defers to local, state, tribal, territorial, and federal public health policies and authorities, including adherence with state laws on communicable disease reporting, but recommends actions contained in this memorandum be considered as best practices. Questions and concerns related to the following Action Plan can be addressed to: ICE_ERO_CMD@ice.dhs.gov.

Please see the recently-issued Centers for Disease Control and Prevention (CDC) Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities for additional information.

Action Plan:

STAFF HIRING: Wardens and facility staff should continue to meet any personnel staffing plan and staffing criteria outlined in the Performance Work Statement (PWS) and terms and conditions of their negotiated contract or agreement for medical staff and guard services. Facilities are expected to be appropriately staffed to meet established work schedules, rest periods, and to ensure the delivery of detainee medical and mental health care as it relates to the continually evolving impact of COVID-19.

LOGISTICS: Wardens and Facility Administrators should assess their inventories of food, medicine, cleaning supplies, personal protective equipment (PPE), and facility operational practices, and consistently maintain services and supplies to assure the safety, security, health, and well-being of ICE detainees. Facilities should have updated pandemic plans and policies as well as established quarantine and/or isolation areas within their facilities in the event they are needed. Alcohol-based hand sanitizer with at least 60 percent alcohol should be available in visitor entrances, exits, and waiting areas. In addition, alcohol-based hand sanitizer should be made available to staff and detainees in the secure setting to the maximum extent possible.

SOCIAL VISITATION/TELEPHONIC COMMUNICATION: As of March 13, 2020, social visits to/with ICE detainees at all detention facilities are suspended until further notice in order to mitigate the potential introduction of COVID-19 into the facilities. ICE recognizes the considerable impact of suspending personal visitation, and requests maximizing detainee use of teleconferencing, video visitation (e.g., Skype, FaceTime), email, and/or tablets, with extended hours where possible.

Detention facilities should make a timely effort to identify indigence in the detainee population. A detainee is considered "indigent" if he/she has less than $15.00 in his/her account for ten days. These detainees must be afforded the same telephone access and related privileges as other detainees. Each facility must ensure all detainees are able to make calls to the ICE-provided list of free legal service providers and consulates at no charge to the detainee or the receiving party, and that indigent detainees may request a call to immediate family or others in personal or family emergencies or on an as-needed basis to maintain community ties.

LEGAL VISITS: Detainee access to legal representatives remains a paramount requirement and should be accommodated to the maximum extent practicable. Legal visitation must continue unless determined to pose a risk to the safety and security of the facility.

Non-contact legal visitation (e.g., Skype or teleconference) should be offered first to limit exposure to ICE detainees, but in person contact should be permitted if determined essential by the legal representative. Prior to the in-person visit, the legal representative must undergo the same screening required for staff entry into the facility. The ultimate legal visit approving authority lies with the Warden or Facility Administrator; however, the facility should notify its local Field Office Director as soon as possible of any denied legal visits.

LEGAL RIGHTS GROUP PRESENTATIONS: Government-sponsored Legal Orientation Programs (LOPs), carried out by the Department of Justice Executive Office for Immigration Review (EOIR) and authorized by congressional appropriations, currently operate at a limited

number of detention sites, and may continue to conduct detainee presentations. No more than four LOP presenters may be allowed in the facility at any time and must undergo the same screening required for staff entry into the facility. Non-LOP legal rights group presentations offered by volunteers are suspended until further notice.

STAFF-DETAINEE COMMUNICATION VISITS: Field Office Directors should remain aware that detainees may experience increased feelings of fear and confusion during this time. Regular communication with staff is particularly important. Detainees should have frequent opportunities for informal contact with facility managerial and supervisory staff and with ERO field office staff.

Field Office Directors should monitor both facility staff and ERO officers to ensure they continue to interact with detainees. ICE staff-detainee communication may be conducted in-person (with appropriate risk reduction protocols to protect ERO officers, detainees, and facility staff) or through non-contact visitation using videoconferencing, phone calls, e-mail, or other communication services.

CONTRACTORS: Contractors performing essential services or maintenance on essential systems in ICE detention facilities must continue to be provided facility access and must undergo the same screening required for staff entry into the facility. Examples of essential services include medical and mental health services, telephone access, cleaning, laundry, waste disposal, and critical infrastructure repairs.

Facility annual inspections by the ICE inspections contractor, The Nakamoto Group, are suspended for 30 days from the issuance date of this memorandum.

VOLUNTEERS: Volunteer visits to ICE detention facilities are suspended until further notice unless approved by the Assistant Directors for Field Operations and Custody Management. The only exception is the facility Chaplain, who may continue to offer availability for individual and group pastoral care but must undergo the same screening required for staff entry into the facility. Other volunteers, contractors, and community groups that augment and enhance the religious program are suspended until further notice to reduce the risk of possible transmission of COVID-19 to detainees.

TOURS: Facility tours are suspended until further notice, excluding Members of Congress, Congressional Member Delegations (CODELs), and Congressional Staff Delegations (STAFFDELs) who will not be prevented from accessing facilities for the purpose of conducting oversight. To safeguard visitors, detainees, ICE and facility staff, congressional visitors may be subject to special screening procedures congruent with staff facility entry screening. Congressional visitors should be advised of standard hygiene practices to help prevent the spread of disease (i.e., washing hands, avoiding close contact) and should be made aware of available hand washing stations within the facility.

STAFF TRAINING: All ERO in-person staff training related to the ICE detention standards or facility compliance is suspended until further notice, including conferences, Contracting Officer Representative (COR) training, and Field Office Compliance Training. Wardens and Facility Administrators will determine the training schedule for facility staff. All staff licenses and certifications shall be maintained.

SCREENING OF FACILITY STAFF: Enhanced health screening of both ICE and facility staff should be implemented by ICE detention facilities in geographic areas with "sustained community transmission." These geographical areas are determined by the CDC and information is available at: https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html. Health screening includes self-reporting symptoms associated with COVID-19 infection and a temperature check.

Wardens and Facility Administrators in those geographical areas should collaborate with their Health Services Administrator to designate a trained staff member available on all shifts to conduct verbal screening and record temperature checks. It is not required that the trained staff member be medical personnel; however, the staff member must have documented training and protect the privacy of those being screened.

Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:

- 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 COVID-19 where you were not wearing the recommended proper personal protective equipment (PPE)?

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), gowns/coveralls, and a single pair of disposable gloves.
- Check the 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.

Staff who do not clear the screening process, or refuse the enhanced health screening must be denied entry and advised to follow CDC-recommended steps for persons who are sick with COVID-19 symptoms.

If PPE supply is limited, consider other PPE strategies based on CDC Guidance | Strategies for Optimizing the Supply of PPE.

If staff register a temperature greater than or equal to 100.4 degrees (Fahrenheit), they should be denied entry to the facility and placed on leave per the employer's administrative policies.

DETAINEE SCREENING: IHSC developed guidance for IHSC-staffed facilities to assist in the risk assessment and management of detained individuals with potential exposure to COVID-19, and guidance was disseminated to non IHSC-staffed ICE detention facilities for potential adoption of this guidance at their respective sites. This guidance addresses intake medical screenings, monitoring, encounters, laboratory testing, and public health actions. The CDC remains the authoritative source for information on how to protect individuals and reduce exposure to COVID-19. ICE continues to encourage facilities to follow CDC guidelines and those of their state and local health departments for non IHSC-staffed ICE detention facilities.

ICE requests that Wardens and Facility Administrators ensure ICE detainees are provided guidance and education in a language that they fully comprehend regarding basic hygiene and measures to maintain health. Links for detainee/patient education resources, in a variety of languages, are maintained in the IHSC guidance and information on the CDC website.

MODIFIED OPERATIONS: Wardens and Facility Administrators should implement modified operations to maximize social distancing in facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and recreation times in order to limit congregate gatherings. All community service projects are suspended until further notice.

CONSIDERATIONS FOR DETAINEE RELEASE: Upon notification of a detainee's pending release, a qualified health care provider will conduct a temperature screening:

- Temperature checks will be completed no more than 12 hours prior to facility departure and documented in the detainee medical record and transfer summary.
- Temperature checks must be completed and documented prior to providing ICE with transfer summary documents.

When considering the release of detainees into the United States with confirmed or suspected COVID-19, the following must be addressed for detainees exposed to an individual with confirmed or suspected COVID-19 or detainees under monitoring for having epidemiologic risk of exposure to COVID-19:

- If the detainee will be released prior to completion of the recommended medical isolation, cohorting, or monitoring period, the state or local health department in the facility jurisdiction should be notified of the detainee's release:
    - The health department should be provided with the detainee's name, intended address, email address, and all available telephone numbers.

- Facilitate safe transport, continued shelter, and medical care, as part of release planning:
    - Provide information regarding any potential community resources to promote continuity of care.
    - Attempt to facilitate transportation coordination through a family or friend.

- Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis.

- Provide the detainee the CDC's *What To Do if You Are Sick* fact sheet.

If this guidance creates any contractual issues, please contact your respective Contracting Officer Representative.

Exhibit D

to Venters Decl.

From: Berg, Peter B
To: [redacted]
Cc: [redacted]
Subject: Updated Guidance: COVID-19 Detained Docket Review-- Effective Immediately
Date: Saturday, April 4, 2020 5:17:40 PM

UPDATE: Please see the updated guidance below. The previous version of this guidance is rescinded.

This message is sent from Peter B. Berg, (a)Assistant Director, Field Operations

To: Field Office Directors and Deputy Field Office Directors

Subject: COVID-19 Detained Docket Review

Background:

U.S. Immigration and Customs Enforcement (ICE) has taken a number of significant and proactive measures in response to the Coronavirus Disease 2019 (COVID-19) pandemic, in order to mitigate the spread of COVID-19 to aliens detained in its custody, its workforce, and stakeholders at its detention facilities. As more becomes known about the virus, ERO will continue to update its practices and guidance in this regard. General ICE COVID-19 guidance is available here and will be updated and supplemented on an ongoing basis.

On March 18, 2020, you were directed to review the cases of aliens detained in your area of responsibility who were over the age of 70 or pregnant to determine whether continued detention was appropriate. The Centers for Disease Control and Prevention (CDC) has developed a list of categories of individuals identified as potentially being at higher-risk for serious illness from COVID-19. Expanding on that list, ERO has identified the following categories of cases that should be reviewed to re-assess custody:

- Pregnant detainees or those having delivered in the last two weeks
- Detainees over 60 years old
- Detainees of any age having chronic illnesses which would make them immune-compromised, including but not limited to:
  - Blood Disorders
  - Chronic Kidney Disease
  - Compromised immune system (e.g., ongoing treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications)
  - Endocrine disorders

- Metabolic disorders
- Heart disease
- Lung disease
- Neurological and neurologic and neurodevelopment conditions

As part of your ongoing application of the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (available here), please identify all cases within your AOR that meet any of the criteria above and validate that list with assistance from IHSC or your Field Medical Coordinator to ensure the conditions listed are still present and do result in the detainee potentially having a higher risk for serious illness from COVID-19. After identifying a case as meeting any of the above criteria, you should review the case to determine whether continued detention remains appropriate in light of the COVID-19 pandemic.

The presence of one of the factors listed above should be considered a significant discretionary factor weighing in favor of release. To be clear, however, it may not always be determinative. Field offices must remain cognizant of the requirements of mandatory detention. Section 236(c) of the Immigration and Nationality Act (INA) mandates the detention of certain categories of criminal and terrorist aliens during the pendency of removal proceedings. Such aliens may not be released in the exercise of discretion during the pendency of removal proceedings even if potentially higher-risk for serious illness from COVID-19. INA § 236(c); 8 C.F.R. § 236.1(c)(1)(i). Such aliens may only be released following a final order issued by an immigration judge, the Board of Immigration Appeals, or a federal court granting the alien relief, dismissing proceedings, or terminating proceedings. Similarly, pursuant to section 241(a)(2), certain criminal and terrorist aliens subject to a final order of removal may not be released during the 90-day removal period even if potentially higher-risk for serious illness from COVID-19. INA § 241(a)(2). For alien's subject to discretionary detention under section 236(a), please remember that release is prohibited, even if the alien is potentially higher-risk for serious illness from COVID-19, if such release would pose a danger to property or persons. 8 C.F.R. § 236.1(c)(8).

When reviewing cases of alien's subject to discretionary detention under 236(a), the following must be completed:

- **Cases involving any arrests or convictions for any crimes that involve risk to the public regardless of the date of arrest or conviction must be reviewed and approved by a Deputy Field Office Director (DFOD) or higher before a determination is made to release.**
    - Examples of crimes that involve a risk to the public include any crime that: involves any form of violence, driving while intoxicated, threatening behaviors, terroristic threats, stalking, domestic violence, harm to a child, or any form of assault or battery. This list is not intended to be

comprehensive. If there is any doubt whether a crime involves risk to the public, consult with your Office of the Principal Legal Advisor (OPLA) field location and your respective Deputy Assistant Director for Domestic Operations before a custody redetermination is completed.

- You may consider the age of an arrest or conviction as a mitigating or an aggravating factor, but the age of an arrest or a conviction does not automatically outweigh public safety concerns.

With regard to arriving aliens and certain other aliens eligible for consideration of parole from custody, under current circumstances and absent significant adverse factors, the fact that an alien is potentially higher-risk for serious illness from COVID-19, may form the basis for a determination that "continued detention is not in the public interest," justify release under 8 C.F.R. § 212.5(b)(5).

For other aliens for whom there is discretion to release, field offices remain responsible for articulating individualized custody determinations, taking into consideration the totality of the circumstances presented in the case. The fact that an alien is potentially higher-risk for serious illness from COVID-19 should be considered a factor weighing in favor of release. You may also consider alternatives to detention consistent with ICE ATD policies, if ATD is determined to sufficiently mitigate the risk of flight.

Any releases attributed to reviews of COVID-19 susceptibility shall be documented in the ENFORCE Alien Removal Module (EARM) under Special Class - COVID-19 Chronic Care Release. As previously communicated, these individuals should be placed on ATD if possible.

Please contact your local OPLA field location should you have any questions or concerns regarding your authority to release in any individual case.

For any questions on this guidance, please contact your respective Deputy Assistant Director for Domestic Operations.

Limitation on the Applicability of this Guidance. This message is intended to provide internal guidance to the operational components of U.S. Immigration and Customs Enforcement. It does not, is not intended to, shall not be construed to, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any person in any matter, civil or criminal.

Exhibit E

to Venters Decl.

ERO

U.S. Immigration and Customs Enforcement Enforcement and Removal Operations

COVID-19 Pandemic Response Requirements

U.S. Immigration and Customs Enforcement

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PURPOSE AND SCOPE

The U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. Consistent with ICE's overall adjustments to its immigration enforcement posture,[1] the ERO PRR builds upon previously issued guidance and sets forth specific mandatory requirements expected to be adopted by all detention facilities housing ICE detainees, as well as best practices for such facilities, to ensure that detainees are appropriately housed and that available mitigation measures are implemented during this unprecedented public health crisis. The ERO PRR has been developed in consultation with the Centers for Disease Control and Prevention (CDC) and is a dynamic document that will be updated as additional/revised information and best practices become available.

INTRODUCTION

As the CDC has explained:

> COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan Hubei Province, People's Republic of China (China).
>
> COVID-19 appears to spread easily and sustainably within communities. The virus is thought to transfer primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may transfer through contact with surfaces or objects contaminated with these droplets. There is also evidence of asymptomatic transmission, in which an individual infected with COVID-19 is capable of spreading the virus to others before exhibiting symptoms. The ease of transmission presents a risk of a surge in hospitalizations for COVID-19, which would reduce available hospital capacity. Such a surge has been identified as a likely contributing factor to the high mortality rate for COVID-19 cases in Italy and China.
>
> Symptoms include fever, cough, and shortness of breath, and typically appear 2-14 days after exposure. Manifestations of severe disease include severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. According to the [World Health Organization], approximately 3.4% of reported COVID-19 cases have resulted in death globally. This mortality rate is higher among older adults or those with compromised immune systems. Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease are also at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.

[1] *See, e.g.*, Attachment A, U.S. Immigration and Customs Enforcement, *Updated ICE statement on COVID-19* (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19.

Notice of Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060 (Mar. 26, 2020) (internal citations omitted).

Given the seriousness and pervasiveness of COVID-19, ICE is taking necessary and prompt measures in response. ICE is providing guidance on the minimum measures required for facilities housing ICE detainees to implement to ensure consistent practices throughout its detention operations and the provision of medical care across the full spectrum of detention facilities to mitigate the spread of COVID-19. The ICE detention standards applicable to all facilities used to house ICE detainees have long required that each such facility have written plans that address the management of infectious and communicable diseases, including, but not limited to, testing, isolation, prevention, treatment, and education. Those requirements include reporting and collaboration with local or state health departments in accordance with state and local laws and recommendations.[2] The measures set forth in the PRR, allow ICE personnel and detention providers to properly discharge their obligations under those standards in light of the unique challenges posed by COVID-19.

OBJECTIVES

The ERO PRR is designed to establish consistency across ICE detention facilities by establishing mandatory requirements and best practices all detention facilities housing ICE detainees are expected to follow during the COVID-19 pandemic. Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:

- To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
- To maintain essential functions and services at the facility throughout the pendency of the pandemic;
- To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
- To establish means to monitor, cohort, quarantine, and isolate the sick from the well.[3]

[2] *See, e.g.,* Attachment B, ICE National Detention Standards 2019, Standard 4.3, Medical Care, at II.D.2 (p. 114), https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf; Attachment C, 2011 ICE Performance-Based National Detention Standards (PBNDS), Revised 2016, Standard 4.3, Part V.C.1 (p. 261), https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf; Attachment D, 2008 ICE PBNDS, Standard 4-22, Medical Care, V.C.1 (pp. 5-6), https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.

[3] A *cohort* is a group of persons with a similar condition grouped or housed together for observation over a period of time. Isolation and quarantine are public health practices used to protect the public from exposure to individuals who have or may have a contagious disease. For purposes of this document, and as defined by the CDC, *quarantine* as the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic, from others who have not been

CONCEPT OF OPERATIONS

The ERO PRR is intended for use across ICE's entire detention network, applying to all facilities housing ICE detainees, including ICE-owned Service Processing Centers, facilities operated by private vendors, and facilities operated by local government agencies that have mixed populations of which ICE detainees comprise only a small fraction.

DEDICATED ICE DETENTION FACILITIES

All ICE dedicated detention facilities[4] *must:*

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally the Performance-Based National Detention Standards 2011 (PBNDS 2011).
- Comply with the CDC's *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Attachment E).
- Follow ICE's March 27, 2020 Memorandum to Detention Wardens and Superintendents on COVID-19 Action Plan Revision 1, and subsequent updates (Attachment F).
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the local ERO Field Office Director (or designee) and the Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
    - People aged 65 and older
    - People of all ages with underlying medical conditions, particularly if not well controlled, including:
        - People with chronic lung disease or moderate to severe asthma
        - People who have serious heart conditions
        - People who are immunocompromised

exposed, to prevent the possible spread of the communicable disease. For purposes of this document, and as defined by the CDC, *isolation* as the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from others to prevent the spread of the communicable disease.

[4] Dedicated detention facilities are facilities that house only ICE detainees. Dedicated facilities may be ICE-owned Service Processing Centers, privately owned Contract Detention Facilities, or facilities operated by state or local governments that hold no other detention populations except ICE detainees.

- Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification shall be made via e-mail from the facility's Health Services Administrator (HSA) (or equivalent) and contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical Point of Contact (POC) and phone number

NON-DEDICATED ICE DETENTION FACILITIES

All non-dedicated detention facilities and local jails housing ICE detainees must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally PBNDS 2011.
- Comply with the CDC *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*.
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the ERO Field Office Director (or designee) and Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
  - People aged 65 and older
  - People of all ages with underlying medical conditions, particularly if not well controlled, including:
    - People with chronic lung disease or moderate to severe asthma
    - People who have serious heart conditions
    - People who are immunocompromised

- Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification should be made via e-mail from the facility's HSA (or equivalent) and should contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." Other standardized means of communicating this information to ICE are acceptable. At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical POC and phone number

ALL FACILITIES HOUSING ICE DETAINEES

In addition to the specific measures listed above, all detention facilities housing ICE detainees must also comply with the following:

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 detainees about these preparations and how they may temporarily alter daily life.

- **Develop information-sharing systems with partners.**
  - Identify points of contact in relevant state, local, tribal, and/or territorial public health department before cases develop.
  - Communicate with other correctional and detention facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- **Review existing pandemic, influenza, all-hazards, and disaster plans, and revise for COVID-19, and ensure that they meet the requirements of ICE's detention standards.**

- **Offer the seasonal influenza vaccine to all detained persons (existing populations and new intakes) and staff throughout the influenza season, where possible.**

- **Staffing**
  - Review sick leave policies to ensure that staff can stay home when sick and determine which officials will have the authority to send symptomatic staff home. Staff who report for work with symptoms of COVID-19 must be sent home and advised to follow CDC-recommended steps for persons exhibiting COVID-19 symptoms.
  - Staff who test positive for COVID-19 must inform their workplace and personal contacts immediately. If a staff member has a confirmed COVID-19 infection, the relevant employers will inform other staff of their possible exposure to COVID-19 in the workplace consistent with any legal limitations on the sharing of such information. Exposed employees must then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).
  - Identify staff whose duties would allow them to work from home and allow them to work from home in order to promote social distancing and further reduce the risk of COVID-19 transmission.
  - Determine minimum levels of staff in all categories required for the facility to function safely.
  - Follow the Public Health Recommendations for Community-Related Exposure.[5]

- **Supplies**
  - Ensure that sufficient stocks of hygiene supplies (soap, hand sanitizer, tissues), personal protective equipment (PPE) (to include facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls), and medical supplies (consistent with the healthcare capabilities of the facility) are on hand, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.
  - Note that shortages of N95 respirators are anticipated during the COVID-19 response. Based on local and regional situational analysis of PPE supplies, face masks should be used when the supply chain of N95 respirators cannot meet the demand.
  - Follow COVID-19: Strategies for Optimizing the Supply of PPE.[6]
  - Soiled PPE items should be disposed in leak-proof plastic bags that are tied at the top and not re-opened. Bags can be disposed of in the regular solid waste stream.

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[5] Attachment G, Centers of Disease Control and Prevention, *Public Health Recommendations for Community-Related Exposure*, https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (last visited Apr. 9, 2020).

[6] Attachment H, Centers for Disease Control and Prevention, *Strategies to Optimize the Supply of PPE and Equipment*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ (last visited Apr. 9, 2020).

- Cloth face coverings should be worn by detainees and staff (when PPE supply is limited) to help slow the spread of COVID-19. Cloth face masks should:

    - fit snugly but comfortably against the side of the face
    - be secured with ties or ear loops where possible or securely tied
    - include multiple layers of fabric
    - allow for breathing without restriction
    - be able to be laundered and machine dried without damage or change to shape.

➢ **Hygiene**

- Reinforce healthy hygiene practices and provide and restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).
- Require all persons within the facility to cover their mouth and nose with their elbow (or ideally with a tissue) rather than with their hand when they cough or sneeze, and to throw all tissues in the trash immediately after use. Provide detainees and staff no-cost access to tissues and no-touch receptacles for disposal.
- Require all persons within the facility to maintain good hand hygiene by regularly washing their hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing their nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Provide detainees and staff no-cost, unlimited access to supplies for hand cleansing, including liquid soap, running water, hand drying machines or disposable paper towels, and no-touch trash receptacles.
- Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.
- Require all persons within the facility to avoid touching their eyes, nose, or mouth without cleaning their hands first.
- Post signage throughout the facility reminding detained persons and staff to practice good hand hygiene and cough etiquette (printable materials for community-based settings can be found on the CDC website). Signage must be in English and Spanish, as well as any other common languages for the detainee population at the facility.
- Prohibit sharing of eating utensils, dishes, and cups.
- Prohibit non-essential personal contact such as handshakes, hugs, and high-fives.

➢ **Cleaning/Disinfecting Practices**

- Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.[7]
- Several times a day using household cleaners and Environmental Protection Agency-registered disinfectants, clean and disinfect surfaces and objects that are frequently touched, especially in common areas (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment). The Environmental Protection Agency's (EPA) list of certified cleaning products is located here.
- Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
- Ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.
- Facility leadership will ensure that there is adequate oversight and supervision of all individuals responsible for cleaning and disinfecting these areas.

CDC Recommended Cleaning Tips

Hard (Non-porous) Surfaces

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective.
    - A list of products that are EPA-approved for use against the virus that causes COVID-19 is available here. Follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc.
    - Additionally, diluted household bleach solutions (at least 1000ppm sodium hypochlorite) can be used if appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least 1 minute, and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
        - Prepare a bleach solution by mixing:
            - 5 tablespoons (1/3 cup) bleach per gallon of water or
            - 4 teaspoons bleach per quart of water

Soft (Porous) Surfaces

[7] Attachment I, Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 9, 2020).

- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, 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 that are suitable for porous surfaces.[8]

Electronics

- For electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines, 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 sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, Clothing, and Other Items That Go in the Laundry

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- Wash 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. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

PREVENTION

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.

[8] Attachment J, U.S. Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*, https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 (last visited Apr. 9, 2020).

- **Perform pre-intake screening for all staff and new entrants for symptoms of COVID-19.**

  Screening should take place before staff and new intakes enter the facility or just inside the facility, where practicable. For new admissions, this should occur before beginning the intake process, in order to identify and immediately isolate any detainee with symptoms before the individual comingles with others or is placed in the general population. This should include temperature screening of all staff and new entrants, as well as a verbal symptoms check.

  - Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:
    - 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 COVID-19 where you were not wearing the recommended proper PPE?
  - If staff have symptoms of COVID-19 (fever, cough, shortness of breath): they must be denied access to the facility.
  - If any new intake has symptoms of COVID-19:
    - Require the individual to wear a face mask.
    - Ensure that staff interacting with the symptomatic individual wears recommended PPE.
    - Isolate the individual and refer to healthcare staff for further evaluation.
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective isolation and necessary medical care.
  - If an individual is a close contact of a known COVID-19 case or has traveled to an affected area (but has no COVID-19 symptoms), quarantine the individual and monitor for symptoms two times per day for 14 days.

- **Visitation**

  - During suspended (social) or modified (legal) visitation programs, provide access to virtual visitation options where available. When not possible, verbally screen all visitors on entry for symptoms of COVID-19 and perform temperature checks, when possible. ICE continues to explore opportunities to enhance attorney access while legal visits are being impacted. For facilities at which immigration hearings are conducted or where detainees are otherwise held who have cases pending immigration proceedings, this may include:

- Adding all immigration attorneys of record to the Talton Pro-bono platform.
- Requiring facilities to establish a process for detainees/immigration attorneys to schedule appointments and facilitate the calls.
- Leveraging technology (e.g., tablets, smartphones) to facilitate attorney/client communication.
- Working with the various detention contractors and telephone service providers to ensure that all detainees receive some number of free calls per week.

- Communicate with the public about any changes to facility operations, including visitation programs. Facilities are encouraged to prohibit or, at a minimum, significantly adopt restricted visitation programs, and to suspend all volunteer work assignments for detainees assigned to food service, and other assignments where applicable.

➢ **Where possible, restrict transfers of detained non-ICE populations to and from other jurisdictions and facilities unless necessary for medical evaluation, isolation/quarantine, clinical care, or extenuating security concerns.**

➢ **Consider suspending work release programs for inmates at shared facilities to reduce overall risk of introduction and transmission of COVID-19 into the facility.**

➢ **When feasible and consistent with security priorities, encourage staff to maintain a distance greater than six feet from an individual that appears feverish or ill and/or with respiratory symptoms while interviewing, escorting, or interacting in other ways, unless wearing PPE.**

➢ **Additional Measures to Facilitate Social Distancing**

- Although strict social distancing may not be possible in congregate settings such as detention facilities, all facilities housing ICE detainees should implement the following measures to the extent practicable:
  - Efforts should be made to reduce the population to approximately 75% of capacity.
  - Where detainee populations are such that such cells are available, to the extent possible, house detainees in individual rooms.
  - Recommend that detainees sharing sleeping quarters sleep "head-to-foot."
  - Extend recreation, law library, and meal hours and stagger detainee access to the same in order to limit the number of interactions between detainees from other housing units.
  - Staff and detainees should be directed to avoid congregating in groups of 10 or more, employing social distancing strategies at all times.

- Whenever possible, all staff and detainees should maintain a distance of six feet from one another.
- If practicable, beds in housing units should be rearranged to allow for sufficient separation during sleeping hours.

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.

ICE Custody Review for Potentially High-Risk Detainees

Upon being informed of a detainee who may potentially be at higher risk for serious illness from exposure to COVID-19, ERO will review the case to determine whether continued detention is appropriate.[9] ICE will make such custody determinations on a case-by-case basis, pursuant to the applicable legal standards, with due consideration of the public health considerations implicated.

- **Considerable effort should be made to quarantine all new entrants for 14 days before they enter the general population.**
  - To do this, facilities should consider cohorting daily intakes; two days of new intakes, or multiple days on new intakes, in designated areas prior to placement into the general population. Given the significant variance in facility attributes and characteristics, cohorting options and capabilities will differ across the various detention facilities housing ICE detainees. ICE encourages all facilities to adopt the most effective cohorting methods practicable based on the individual facility characteristics taking into account the number new intakes anticipated per day.

- **For suspected or confirmed COVID-19 cases:**
  - Isolate the individual immediately in a separate environment from other individuals. Facilities should make every possible effort to isolate persons individually. Each isolated individual should be assigned his or her own housing space and bathroom where possible. Cohorting should only be practiced if there are no other available options. Only individuals who are laboratory-confirmed COVID-19 cases should be isolated as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.
  - Ensure that the individual is always wearing a face mask (if it does not restrict breathing) when outside of the isolation space, and whenever another individual

[9] Attachment K, Assistant Director Peter Berg, Enforcement and Removal Operations, *Updated Guidance: COVID-19 Detained Docket Review* (Apr. 4, 2020).

enters the isolation room. Masks should be changed at least daily, and when visibly soiled or wet.

- If the number of confirmed cases exceeds the number of individual isolation spaces available in the facility, then ICE must be promptly notified so that transfer to other facilities, transfers to hospitals, or release can be coordinated immediately. Until such time as transfer or release is arranged, the facility must be especially mindful of cases that are at higher risk of severe illness from COVID-19. Ideally, ill detainees should not be cohorted with other infected individuals. If cohorting of ill detainees is unavoidable, make all possible accommodations until transfer occurs 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 isolation room).

- Review the CDC's preferred method of medically isolating COVID-19 cases here depending on the space available in a particular facility. 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.

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

  - At least 7 days have passed since the date of the individual's first positive COVID-19 test and he or she has had no subsequent illness.

- Meals should be provided to COVID-19 cases in their isolation rooms. Isolated cases should throw disposable food service items in the trash in their 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 must clean their hands after removing gloves.
- Laundry from a COVID-19 case can be washed with other individuals' laundry.
  - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard gloves after each use, and clean their hands after handling.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing the virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

ATTACHMENTS

ATTACHMENT LETTER	DOCUMENT NAME AND CITATION
A	U.S. Immigration and Customs Enforcement, *Updated ICE statement on COVID-19* (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19.
B	ICE National Detention Standards 2019, Standard 4.3, Medical Care, https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf.
C	2011 ICE Performance-Based National Detention Standards, Revised 2016, Standard 4.3, https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf.
D	2008 ICE Performance-Based National Detention Standards, Standard 4-22, Medical Care, https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.
E	Centers of Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf.
F	Memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, *Memorandum on Coronavirus 2019 (COVID-19) Action Plan, Revision 1* (Mar. 27. 2020).
G	Centers of Disease Control and Prevention, *Public Health Recommendations for Community-Related Exposure*, https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (last visited Apr. 9, 2020).
H	Centers for Disease Control and Prevention, *Strategies to Optimize the Supply of PPE and Equipment*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ (last visited Apr. 9, 2020).
I	Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 9, 2020).

J	U.S. Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*, https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 (last visited Apr. 9, 2020).
K	Assistant Director Peter Berg, Enforcement and Removal Operations, *Updated Guidance: COVID-19 Detained Docket Review* (Apr. 4, 2020).

Exhibit F

to Venters Decl.

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

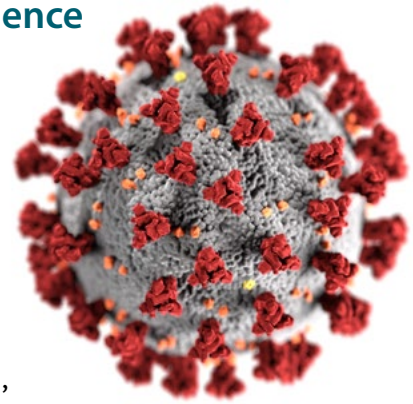
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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.

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

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

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

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

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

Prevention Practices for Incarcerated/Detained Persons

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

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

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

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

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

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

Prevention Practices for Staff

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

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

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

Prevention Practices for Visitors

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

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

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

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

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

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

√ **Promote non-contact visits:**

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

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

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

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

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

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

Management

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

Operations

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

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

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

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

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

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

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

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

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

Hygiene

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

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

Cleaning and Disinfecting Practices

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

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

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cleaning Spaces where COVID-19 Cases Spent Time

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

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

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

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

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

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

√ **Electronics cleaning and disinfection**

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

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

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

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

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

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

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

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

Quarantining Close Contacts of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

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

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

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

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

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

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

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

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

Management Strategies for Staff

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

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

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

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

Infection Control

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

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

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

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

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

Clinical Care of COVID-19 Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **N95 respirator**

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit G

to Venters Decl.

Official Website of the Department of Homeland Security

ICE

Report Crimes: Email or Call 1-866-DHS-2-ICE

NOTICE

Click here for the latest ICE guidance on COVID-19

ICE Guidance on COVID-19

Overview & FAQs | Confirmed Cases | Previous Statements

Introduction

U.S. Immigration and Customs Enforcement (ICE) is working closely with the Department of Homeland Security (DHS) and other federal, state, and local agencies to facilitate a speedy, whole-of-government response in confronting Coronavirus Disease 2019 (COVID-19), keeping everyone safe, and helping detect and slow the spread of the virus. To keep the public, media and family members of those in custody and other stakeholders informed, we will update this site frequently during this extremely fluid situation.

Expand All Collapse All

GENERAL

What is ICE doing to safeguard its employees/personnel during this crisis?

The ICE Occupational Safety and Health (OSH) Unit continues to work diligently to ensure employees are operating under the safest and most practical conditions to reduce the risk of exposure and prevent further spreading of COVID-19 during the course of ongoing daily operations. The OSH Unit regularly provides guidance regarding integrating administrative controls such as social distancing in law enforcement settings, and the appropriate choice and use of personal protective equipment when administrative controls cannot be implemented. Besides providing information through an employee website, OSH officials have held conference calls, responded to emails, and spoken personally with employees who have safety questions. At all levels, ICE employees have access to the most current CDC and DHS guidance and assistance in this rapidly changing environment.

ICE is reviewing CDC guidance daily and will continue to update protocols to remain consistent with CDC guidance.

Updated 03/18/2020 4:28pm

What is ICE doing in response to the COVID-19 virus?

Law enforcement agencies across the country, to include ICE, are paying close attention to this pandemic. While our law enforcement officers and agents continue daily enforcement operations to make criminal and civil arrests, prioritizing individuals who threaten our national security and public safety, we remain committed to the health and safety of our employees and the general public. It is important for the public to know that ICE does not conduct operations at medical facilities, except under extraordinary circumstances. ICE policy directs our officers to avoid making arrests at sensitive locations – to include schools, places of worship, and health care facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities – without prior approval for an exemption, or in exigent circumstances. See our FAQ for more.

Consistent with federal partners, ICE is taking important steps to further safeguard those in our care. As a precautionary measure, ICE has temporarily suspended social visitation in all detention facilities.

The health, welfare and safety of U.S. Immigration and Customs Enforcement (ICE) detainees is one of the agency's highest priorities. Since the onset of reports of Coronavirus Disease 2019 (COVID-19), ICE epidemiologists have been tracking the outbreak, regularly updating infection prevention and control protocols, and issuing guidance to ICE Health Service Corps (IHSC) staff for the screening and management of potential exposure among detainees.

ICE continues to incorporate CDC's COVID-19 guidance, which is built upon the already established infectious disease monitoring and management protocols currently in use by the agency. In addition, ICE is actively working with state and local health partners to determine if any detainee requires additional testing or monitoring to combat the spread of the virus.

Updated 03/15/2020 2:38pm

IMMIGRATION ENFORCEMENT and CHECK-INS

I have a scheduled check-in, what should I do?

Individuals should contact their local field office for additional guidance prior to their scheduled appointment.

Updated 03/17/2020 5:00pm

Has ICE modified enforcement efforts during COVID-19?

To ensure the welfare and safety of the general public as well as officers and agents in light of the ongoing COVID-19 pandemic response, U.S. Immigration and Customs Enforcement (ICE) will temporarily adjust its enforcement posture beginning today, March 18, 2020. ICE's highest priorities are to promote life-saving and public-safety activities.

ICE Enforcement and Removal Operations (ERO) will focus enforcement on public-safety risks and individuals subject to mandatory detention based on criminal grounds. For those individuals who do not fall into those categories, ERO will exercise discretion to delay enforcement actions until after the crisis or use alternatives to detention, as appropriate.

Homeland Security Investigations will continue to carry out mission critical criminal investigations and enforcement operations as determined necessary to maintain public-safety and national security. Examples include investigations into child exploitation, gangs, narcotics trafficking, human trafficking, human smuggling, and continued participation on the Joint Terrorism Task Force. This work will be conducted based on ability to coordinate and work with prosecutors from the Department of Justice and intake at both the U.S. Marshals Service and Bureau of Prisons.

Consistent with its sensitive locations policy, during the COVID-19 crisis, ICE will not carry out enforcement operations at or near health care facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities, except in the most extraordinary of circumstances. Individuals should not avoid seeking medical care because they fear civil immigration enforcement.

Updated 03/18/2020 7:45pm

Is ICE making arrests at hospitals?

ICE does not conduct enforcement operations at medical facilities, except under extraordinary circumstances. Claims to the contrary are false and create unnecessary fear within communities. Individuals should continue to seek medical care.

Updated 03/15/2020 2:38pm

Has ICE revised the process for filing the Form I-246, "Application for Stay of Deportation of Removal?"

ICE will temporarily permit the filing of Form I-246, "Application for Stay of Deportation or Removal," through the mail accompanied by money orders, certified funds, or requests for fee waivers only.

Updated 03/18/2020 5:18pm

Has ICE revised the timeline for aliens to report for their initial check-in with a local field office?

Aliens released from the Southwest Border will now be scheduled for initial reporting to a local field office 60 days after release, versus the current practice of scheduling such reporting in 30 days or less. Individuals should contact their local field office for additional guidance prior to their scheduled appointment.

Updated 03/18/2020 10:39am

BONDS

I need to pay a bond, has ICE made any adjustments to its payment process?

ICE will limit the acceptance of bonds to locations with "bond windows" or other appropriate barriers that will limit exposure to staff. Generally, only the individual appearing to post the bonds will be permitted to enter the office. Anyone accompanying such individuals, including children accompanied by another adult, will be asked by security not to enter the building.

Updated 03/18/2020 10:39am

DETENTION

What has ICE done to protect detainees in ICE custody?

In March, ICE's Enforcement and Removal Operations (ERO) convened a working group between medical professionals, disease control specialists, detention experts, and field operators to identify additional enhanced steps to minimize the spread of the virus. ICE has since evaluated its detained population based upon the CDC's guidance for people who might be at higher risk for severe illness as a result of COVID-19 to determine whether continued detention was appropriate. Of this population, ICE has released nearly 700 individuals after evaluating their immigration history, criminal record, potential threat to public safety, flight risk, and national security concerns. This same methodology is currently being applied to other potentially vulnerable populations currently in custody and while making custody determinations for all new arrests. Additionally, ERO has limited the intake of new detainees being introduced into the ICE detention system. ICE's detained population has dropped by more than 4,000 individuals since March 1, 2020 with a more than 60 percent decrease in book-ins when compared to this time last year.

Updated 04/15/2020 11:02am

What is ICE doing to ensure detainees in custody are well-cared for during this crisis?

Currently, the CDC advises self-monitoring at home for people in the community who meet epidemiologic risk criteria, and who do not have fever or symptoms of respiratory illness. In detention settings, cohorting serves as an alternative to self-monitoring at home.

Comprehensive protocols are in place for the protection of staff and patients, including the appropriate use of personal protective equipment (PPE), in accordance with CDC guidance. ICE has maintained a pandemic workforce protection plan since February 2014, which was last updated in May 2017. This plan provides specific guidance for biological threats such as COVID-19. ICE instituted applicable parts of the plan in January 2020 upon the discovery of the potential threat of COVID-19. The ICE Occupational Safety and Health Office is in contact with relevant offices within the Department of Homeland Security, and in January 2020, the DHS Workforce Safety and Health Division provided DHS components additional guidance to address assumed risks and interim workplace controls. This includes the use of N95 masks, available respirators, and additional personal protective equipment.

ICE testing for COVID-19 complies with CDC guidance. IHSC updates and shares its COVID-19 guidance with field units on a real-time basis. Subjects selected for testing follow CDC's definition of a person under investigation.

Updated 03/15/2020 2:38pm

How does ICE screen new detainees for COVID-19?

ICE instituted screening guidance for new detainees who arrive at facilities to identify those who meet CDC's criteria for epidemiologic risk of exposure to COVID-19. IHSC isolates detainees with fever and/or respiratory symptoms who meet these criteria and observe them for a specified time period. IHSC staff consult with the local health department, as appropriate, to assess the need for testing. Detainees without fever or respiratory symptoms who meet epidemiologic risk criteria are monitored for 14 days. ERO has also encouraged facilities to isolate new admissions into the detention network for 14 days before placing them into general population.

Updated 04/06/2020 1:27pm

Is ICE testing detainees for COVID-19 at ICE detention centers, or sending detainees somewhere for testing?

Detainees are being tested for COVID-19 in line with CDC guidance. In some cases, medical staff at ICE detention facilities are collecting specimens from ICE detainees for processing at a commercial or public health lab. In other cases,including when a detainee requires a higher level of care, they are sent to a local hospital and may be tested at the discretion of the treating provider at the hospital.

Updated 03/24/2020 2:15pm

Can detainees attend medical appointments?

Asymptomatic detainees in isolation can attend all appointments. Symptomatic detainees in isolation must wear a tight-fitting surgical mask to attend essential medical appointments. ICE also notifies the medical provider about the detainee's status ahead of the appointment to coordinate care and protect staff and other patients.

Updated 03/15/2020 2:38pm

How does ICE mitigate the spread of COVID-19 within its detention facilities?

Detainees who meet CDC criteria for epidemiologic risk of exposure to COVID-19 are housed separately from the general population. ICE places detainees with fever and/or respiratory symptoms in a single medical housing room, or in a medical airborne infection isolation room specifically designed to contain biological agents, such as COVID-19. This prevents the spread of the agent to other individuals and the general public. ICE transports individuals with moderate to severe symptoms, or those who require higher levels of care or monitoring, to appropriate hospitals with expertise in high-risk care. Detainees who do not have fever or symptoms, but meet CDC criteria for epidemiologic risk, are housed separately in a single cell, or as a group, depending on available space.

ICE reviews CDC guidance daily and continues to update protocols to remain consistent with CDC guidance.

Updated 03/15/2020 2:38pm

Will someone who presents symptoms or tests positive for COVID-19 be released from immigration custody?

ICE only has authority to detain individuals for immigration purposes. ICE cannot hold any detainee ordered released by a judge. If ICE must release an ill or isolated detainee, health staff immediately notify the local public health agencies to coordinate further monitoring, if required.

Updated 04/06/2020 1:27pm

Do ICE facilities have necessary sanitary products to help guard against the virus?

In addition to providing detainees with soap for the shower and hand soap for sink handwashing, ICE provides alcohol-based sanitizer in visitor entrances, exits, waiting areas and to staff and detainees in the secure setting whenever possible. ICE also provides soap and paper towels that are present in bathrooms and work areas within the facilities. Everyday cleaning supplies such as soap dispensers and paper towels are routinely checked and are available for use. Detainees are encouraged to communicate with local staff when additional hygiene supplies or products are needed.

Performance-Based National Detention Standards (PBNDS) 2008 and PBNDS 2011, require that facilities operating under these respective standards have written plans that address the management of communicable diseases, which should include isolation and management of detainees exposed to communicable diseases. The Centers for Disease Control and Prevention (CDC) remains the definitive source for information about how to protect individuals and reduce exposure to the virus, so ICE continues to encourage facilities to follow CDC guidelines as well as those of their state and local health departments.

Updated 04/02/2020 6:05pm

How are ICE detention facilities engaging in social distancing?

In March, ICE's Enforcement and Removal Operations (ERO) convened a working group between medical professionals, disease control specialists, detention experts, and field operators to identify additional enhanced steps to minimize the spread of the virus. As a result of the working group, ERO decided to reduce the population of all detention facilities to 70 percent or less to increase social distancing. Detention facilities may also increase social distancing by having staggered meals and recreation times in order to limit the number of detainees gathered together. All community service projects are suspended until further notice.

Updated 04/06/2020 1:27pm

How will family members communicate with each other?

ICE recognizes the substantial impact of temporarily curtailing personal visitation, but the agency has determined it necessary to maintain the safety and security of the facility, the detainees and those who work at the facility. ICE continues to facilitate communication with families in the absence of visitation through extended access to telephones, teleconferencing, video visitation and email with extended hours where possible.

Updated 04/02/2020 6:05pm

Are detainees able to make outside phone calls?

All detainees are afforded telephone access and can make calls to the ICE-provided list of free legal service providers and consulates at no charge to the detainee or the receiving party. Additionally, detainees who cannot afford to call family members may request a call to immediate family or others in personal or family emergencies or on an as-needed basis to maintain community ties.

Updated 04/02/2020 6:05pm

VISITATION AT DETENTION FACILITIES

My family member or friend is currently in ICE custody, will visitation to the facility still be allowed?

ICE has temporarily suspended social visitation in all of its detention facilities. ICE recognizes the considerable impact of suspending personal visitation and has requested wardens and facility administrators maximize detainee use of teleconferencing, video visitation (e.g., Skype, FaceTime), email, and/or tablets, with extended hours where possible. ICE will continue to collaborate with the CDC, IHSC, and its network of health care providers to provide updates and revise procedures as necessary.

Updated 04/02/2020 6:05pm

How will family members communicate with each other?

ICE recognizes the substantial impact of temporarily curtailing personal visitation, but the agency has determined it necessary to maintain the safety and security of the facility, the detainees and those who work at the facility. ICE continues to facilitate communication with families in the absence of visitation through extended access to telephones, teleconferencing, video visitation and email with extended hours where possible.

Updated 04/02/2020 6:05pm

Will individuals in ICE custody be able to meet with their legal representatives?

Detainee access to legal representatives remains a paramount requirement and should be accommodated to the maximum extent practicable. Legal visitation must continue unless determined to pose a risk to the safety and security of the facility.

Non-contact legal visitation (e.g., Skype or teleconference) should be offered first to limit exposure to ICE detainees, but in person contact should be permitted if determined essential by the legal representative. Prior to the in-person visit, the legal representative must undergo the same screening required for staff entry into the facility. The ultimate legal visit approving authority lies with the Warden or Facility Administrator; however, the facility should notify its local Field Office Director as soon as possible of any denied legal visits.

Updated 04/02/2020 6:05pm

Are Legal Orientation Programs continuing in ICE detention facilities?

Government-sponsored Legal Orientation Programs (LOPs), carried out by the Department of Justice Executive Office for Immigration Review (EOIR) and authorized by congressional appropriations, currently operate at a limited number of detention sites, and may continue to conduct detainee presentations. No more than four LOP presenters may be allowed in the facility at any time and must undergo the same screening required for staff entry into the facility. Non-LOP legal rights group presentations offered by volunteers are suspended until further notice.

Updated 04/02/2020 6:05pm

Will members of Congress be able to visit ICE detention facilities?

Facility tours are suspended until further notice, excluding Members of Congress, Congressional Member Delegations (CODELs), and Congressional Staff Delegations (STAFFDELs) who will not be prevented

from accessing facilities for the purpose of conducting oversight. To safeguard visitors, detainees, ICE and facility staff, congressional visitors may be subject to special screening procedures congruent with staff facility entry screening. Congressional visitors should be advised of standard hygiene practices to help prevent the spread of disease (i.e., washing hands, avoiding close contact) and should be made aware of available hand washing stations within the facility.

Updated 04/02/2020 6:05pm

IMMIGRATION COURT

Is immigration court still taking place in-person at ICE detention facilities?

Individuals attending immigration court in-person are encouraged to contact the Executive Office for Immigration Review for any additional requirements or changes to procedures.

Updated 04/02/2020 6:05pm

REMOVALS

Does ICE medically screen detainees before they board a removal flight to their home country?

The ICE Air flight medical provider conducts a visual screening consistent with current ICE policy and procedures on those detainees lacking medical summary information (new apprehensions) who are delivered to the aircraft. Those detainees who are not “new apprehensions” are brought to the aircraft with medical clearance. Any ICE detainee who fails to pass screening by a flight medical provider and/or is suspected of having a health-risk condition potentially contagious to other detainees, staff and/or third parties, will be denied boarding and referred to an ICE approved facility for screening.

In addition to recently issued IHSC guidance, for ICE Air charter removals, there will be a temperature screening at the flight line, prior to boarding. In accordance with IHSC guidance, any detainee with a temperature of 100.4 degrees or higher will be immediately referred to a medical provider for further evaluation and observation.

Updated 03/15/2020 2:38pm

STAKEHOLDER ENGAGEMENT

Is ICE continuing to hold in-person stakeholder meetings?

ICE will eliminate non-mission critical meetings with the public and use video-teleconferencing and other technology to conduct stakeholder meetings, to the extent practicable. ERO case officers will notify attorneys and those with upcoming scheduled appointments of the temporary change in procedures.

Updated 03/18/2020 10:39am

EMPLOYMENT VERIFICATION (I-9)

If I am hiring and onboarding workers to work remotely at this time, do I need to verify their identity and employment authorization documents in person?

If there are no employees present at a work location and a new employee is working remotely due to COVID-19, employers will not be required to review the employee's identity and employment authorization documents in the employee's physical presence. However, employers must inspect the Section 2 documents remotely (e.g., over video link, fax or email, etc.) and obtain, inspect, and retain copies of the documents, within three business days for purposes of completing Section 2. Employers also should enter "COVID-19" as the reason for the physical inspection delay in the Section 2 Additional Information field once physical inspection takes place after normal operations resume. Once the documents have been physically inspected, the employer should add "documents physically examined" with the date of inspection to the Section 2 additional information field on the Form I-9, or to section 3, as appropriate. These provisions may be implemented by employers for a period of 60 days from the date of this notice OR within 3 business days after the termination of the national emergency, whichever comes first. Click here to read the full guidance and requirements.

Updated 04/08/2020 2:15pm

NONIMMIGRANT STUDENTS AND SEVP-CERTIFIED SCHOOLS

Expand All Collapse All

Guidance Documents

The Student and Exchange Visitor Program (SEVP) has issued the following guidance to stakeholders:

- Broadcast Message: COVID-19 and F and M Nonimmigrants (Jan. 2020)
- Broadcast Message: COVID-19 and Potential Procedural Adaptations for F and M Nonimmigrant Students (Mar. 2020)
- COVID-19: Scenarios for SEVP-certified Schools for Emergency Procedures (Mar. 2020)
- Optional COVID-19 School Reporting Template that schools can use to report temporary procedural adaptations (Mar. 2020)

Updated 03/20/2020 5:45pm

Frequently Asked Questions

SEVP continues to receive COVID-19-related stakeholder questions about SEVP-certified schools and nonimmigrant students. Download this PDF to read answers to Frequently Asked Questions about COVID-19. This list is regularly updated – please note the timestamp of the most recent document update.

Updated 04/14/2020 5:20pm

Last Reviewed/Updated: 04/16/2020

Exhibit H

to Venters Decl.

E-FILED
Friday, 24 April, 2020 04:13:32 PM
Clerk, U.S. District Court, ILCD

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS

DELOME OSTIAN JOHANNES FAVI,

Petitioner,

v. Case No. 20-cv-2087

CHAD KOLITWENZEW,

Respondent, and

THE UNITED STATES OF AMERICA,

Interested Party.

DECLARATION OF CHAD KOLITWENZEW

I, Chad Kolitwenzew (Chad), pursuant to Title 28 U.S.C. § 1746, hereby declare under penalty of perjury that the following is true and correct:

My Training and Background

1. I am the Chief of Corrections of the Jerome Combs Detention Center (JCDC) operated by the Kankakee County, Illinois Sheriff's Department (KCSD), located in Kankakee County, Illinois.

A. I graduated from Illinois State University in 1999 with a Bachelor's Degree in Criminal Justice. My professional corrections training includes the following:

(1) In 2000, I graduated from the five week basic Corrections Officer Training provided by the University of Illinois Police

Training Institute.

(2) In 2008, I attended the five-month long Police Staff and Command program provided by Northwestern University in Chicago, Illinois.

(3) In 2012, I attended the National Jail Leadership Command Academy provided by the American Jail Association and Sam Houston State University outside of Houston, Texas.

2. I have has been assigned to the KCSD's JCDC since it opened in 2004.

JCDC's Detainee Population Includes 63 Male U.S Immigration and Customs Enforcement (ICE) Detainees

3. The JCDC facility has 450 beds.

A. The total female population is usually about 25 female detainees, and the total male population is usually 395 detainees.

B. As of Wednesday, April 22, 2020, the total detainee JCDC population of 344 detainees includes 63 ICE male detainees. There are no female ICE detainees.

C. Since March 19, 2020, 92 male ICE detainees have been released from the JCDC, and April 3, 2020, is the most recent date that the JCDC has accepted an ICE detainee. Also, the JCDC has not refused to accept any ICE detainees.

D. Clearly, this inmate population of 344 detainees is not near the maximum capacity population of 450 beds, showing that the JCDC inmate population is not overcrowded.

The JCDC's Medical Facility and Its Contract for the Care of JCDC's ICE Detainees

4. The JCDC is a single floor facility, and its medical clinic is about a quarter of the way down the main hallway on the right side next to the classification housing unit.

A. The clinic space in the JCDC consists of a locked pharmacy where the medication is kept, a store-room, three exam rooms, an area to draw labs, a work space for the medical staff, with the work space being like a nurse's station, and a biohazard room.

B. Each exam room is a typical exam room that you would encounter in a doctor's office that includes an exam table, a telephone with a language line for persons who do not speak English that is provided by the federal government, blood pressure equipment, cabinets with medical supplies, a sink, and pulse and temperature checking equipment, and other items.

C. The JCDC healthcare medical clinic staff consists of its medical director, who is a physician; one physician's assistant; ten full-time registered nurses and one part-time registered nurse; two licensed practical nurses; a nurse practitioner; and two on-call registered nurses.

D. The JCDC medical director, who is a physician, comes to the JCDC one day each week. A physician's assistant and a nurse practitioner both come to the JCDC five days per week. These individuals also are on call seven days per week.

(1) The JCDC also is staffed at all times with at least one trained JCDC First Responder. Prior to becoming a First Responder, each person receives medical training that at a minimum is the medical training required for a person to be classified as an Emergency Medical Technician (EMT). This training allows each trained First Responder to perform temperature and blood pressure readings, complete medical questionnaire sheets, and to assess the detainee's immediate and general medical needs. This First Responder, who is in the JCDC for 24 hours per day, for every

day of the year, has the authority to immediately summon ambulance and other emergent care to the JCDC for its detainees and staff as needed. The KCSD has 21 such First Responders who serve both the JCDC and the KCSD's downtown correctional facility.

E. The staffed hours of the JCDC medical clinic are from 7 a.m. to 3 p.m., seven days per week, and there is an on-site registered nurse from 7:00 am. to 11:00 p.m. every day. From 11:00 p.m. to 7:00 a.m., the first responders are immediately available and can summon emergency medical assistance as needed.

F. If a medically trained person at JCDC believes that a detainee in the JCDC needed immediate medical assistance or attention, that detainee can be taken to the emergency room at one of two local hospitals.

The JCDC Mental Health Staff

5. The KCSD has (1) a clinical PhD psychologist, who is the head of the KCSD Mental Health Unit, and (2) two mental health professionals (a) a licensed professional counselor (LPC) with a master's degree in professional counseling with twenty years of clinical experience and (b) a second licensed professional counselor (LPC) with a master's degree in professional counseling who also is a Qualified Mental Health Professional (QMHP).

These mental health professionals also provide these services to the detainees in the JCDC. These professionals go to the individual housing units at least twice per week for mental health wellness checks and detainee observation. Although group counseling has been put on hold as of at least March 9, 2020 because of the COVID-19 virus, these mental health professionals provide individual counseling to the JCDC detainees. A JCDC detainee can request mental health counseling through the above-recited sick call procedure and can make this request during the mental health visits to the cellblocks. Independently, if JCDC correctional staff (all of whom have had the required mental health training in compliance with the Illinois County Jail Standards) observe anyone in the JCDC, including

its detainees, exhibiting signs of or needing mental health assistance, the staff member immediately reports this to the on-site medical staff, who then triage the individual for further medical and/or mental health treatment.

The Contract

6. By written contract between the U.S. Immigration and Customs Enforcement ("ICE") and the JCDC, this facility detains persons on behalf of ICE. For purposes of this Declaration, I refer to these detained individuals as "ICE detainees."

A. All outside non-emergency medical care provided outside of the JCDC to ICE detainees must be pre-approved by the ICE. In the event of an emergency, the KCSD and JCDC proceed immediately with the necessary medical treatment. In such an event, the KCSD and JCDC notify ICE immediately regarding the nature of the ICE detainee's illness or injury as well as the types of treatment provided.

B. Consequently, the KCSD and JCDC provide to the ICE detainees in JCDC custody the full range of medical care inside the JCDC at its own expense, and the level of care is the same for ICE detainees contracted to the county as it is for all of its other federal, state and local detainees in the county's custody.

C. ICE preapproves all non-emergency medical care requested to be provided outside of the JCDC to its ICE detainees, and after said non-emergency outside medical care is approved in advance by ICE, ICE pays for said non-emergency outside medical care provided to its ICE detainees outside of the JCDC.

JCDC Sick Call

7. ICE detainees have daily access to sick call in a clinical setting.

A. There are paper and electronic forms for the ICE detainees To fill out to request, either in paper or electronically, various

services, within the JCDC, including medical requests. Each ICE detainee's request is triaged by the medical staff, to determine the priority for medically seeing the patient in the clinic. Each detainee also independently can personally communicate with a nurse when the nurse makes these visit rounds, and pass medication to the ICE detainees in their cell blocks, twice per day.

ICE Detainees Are Housed In Rooms For Either Two or a Maximum of Four ICE Detainees

8. ICE detainees are housed in a section of the JCDC that is separate from other detainees. ICE detainees do not mix with the rest of the JCDC population.

A. ICE detainees are held either two detainees to a room or to 4 detainees in rooms with separate doors and with access to a shared living space. Consequently, there is a shared living space for two detainees in a two person room, and there is a shared living space for four persons in a four person room.

B. ICE detainees are only allowed into these rooms after completion of their quarantine time, described in more detail below, and only after being cleared by medical.

C. When food trays come into the common area of the housing unit, twice per day, for lunch and dinner, the detainees line up to receive their food trays. At each of these meals service, JCDC staff, wearing gloves, a hair net and face mask, verbally remind the detainees to maintain a distance of six feet from the detainee in front of them.

D. Detainees can elect to eat either of these two meals by sitting at tables in the common area or by sitting at the table either in the cellblock common area or at the table in their individual cell. Breakfast is only served within each individual cellblock. The posters attached hereto as Exhibit 2 are posted in the common room area, as reminders to remain six feet apart from others, including when eating at a table. These signs also are posted in the common area of each cell block.

The JCDC Has Tested Detainees for the COVID-19 Virus, and No JCDC Detainee or Staff Member Has Either Tested Positive for COVID-19 Or Is Known To Have Been Exposed To the Virus

9. No JCDC detainee (including no ICE detainee) or staff member has either tested positive for COVID-19 or is known to have been exposed to the virus. In addition, the JCDC staff has tested detainees for the presence of the COVID-19 virus, and all tests have come back negative. The test swabs are taken in the detainee's cellblock and are sent by JCDC staff to a private off-site testing facility, who has contracted with the JCDC's two area hospitals for conducting these COVID-19 virus tests.

JCDC Precautionary Measures to Limit the Risk of COVID-19 Transmission

10. I have provided to each staff member and to every non-detainee who enters the JCDC, the two page Illinois Department of Public Health COVID-19 Quick Reference for Law Enforcement that is attached hereto as Exhibit 1.

A. The first page explains the history, transmission, symptoms, rules of thumb for officer safety, recommended basic Personal Protective Equipment (PPE), when PPE is recommended and where to obtain more information regarding this virus.

B. The second page provides risk assessment questions, response considerations (what to do) regarding reporting, precautions, cleansing and sanitizing regarding encounters with an individual suspected of having the virus, and officer safety and reporting in connection with this virus.

11. The JCDC has established a comprehensive set of precautionary measures to limit the risk of COVID-19 transmission into and inside the JCDC. The JCDC is committed to providing all necessary precautionary measures and supportive therapies to avoid an outbreak of COVID-19, including taking all of the preventative actions advised by the Centers for Disease Control and Prevention (CDC) and by the Illinois Department of

Public Health regarding the COVID-19 virus.

(1)
This Includes Compliance With the Attached CDC Guidance on Management of COVID-19 in Correction and Detention Facilities

12. This includes JCDC's compliance with the CDC Guidance on Management of COVID-19 in Correction and Detention Facilities that is attached hereto as Exhibit 2 and substantively incorporated herein.

(2)
Additional Action Taken by the JCDC as of March 9, 2020 In Response to the COVID-19 Virus

13. The JCDC officials have substantial experience ensuring that viral outbreaks do not occur at their facilities. They recognize the unique threat posed by the transmission of viruses inside a jail or other corrections facility. That being said, health and prison officials recognize that COVID-19 carries an increased risk of transmission, carries a higher fatality rate than many other viruses, and has resulted in a state of emergency nationwide. Accordingly, commencing either on or before March 9, 2020, and continuing until the COVID-19 virus threat has subsided, the JCDC has begun employing the following:

A. Social and Attorney Visitation.

The JCDC by no later than March 9, 2020, has placed a temporary hold on all social visits, such as visits from friends and family, to limit the number of people entering the JCDC and interacting with detainees, and on in-person detainee attorney visits.

(1) Detainees can conduct social visitation via video equipment.

(2) In-person attorney visits have also been temporarily suspended. Attorney visits are to be conducted through the detainee's I-Pads or telephones. In direct response to this virus, the JCDC has

increased its number of I-Pads that are available to attorneys to communicate with their detainee clients.

(3) The only in-person visits allowed during this time are visits with medical staff.

(4) There are no group gatherings, and all classes and religious events have been cancelled.

B. Detainees Entering the Facility.

The JCDC houses both state, ICE and other federal detainees. However, over the past several weeks, fewer detainees have been entering the facility.

(1) The JCDC has suspended accepting inmates sentenced to weekends, work release, or any intermittent sentence.

(2) The JCDC received its most recent ICE detainee on April 3, 2020. Every detainee received on April 3, 2020, was medically screened, as recited below in ¶9 C, per ICE policy.

(3) If any ICE detainee presented any flu-like symptoms, such as coughing, fever, vomiting, diarrhea, nausea and/or dizziness, that detainee would be placed in a single cell for isolation and would be medically monitored by ICE medical personnel three to four times per day for the first five days of single cell isolated confinement. The detainee remains in this single cell for the duration of any such illness, and then remains in this single cell until after five days have passed with the detainee being symptom free. No detainee has been released into the population until cleared by the appropriate medical staff.

(4) No potential JCDC detainee is accepted into the JCDC until after the JCDC staff confirm that this person, while still inside the transporting vehicle, does not have a fever. No potential detainee with a fever is allowed inside the JCDC.

C. Screening Procedures.

(1) In the few instances in which a new detainee enters the JCDC, KCSD First Responders screen each new detainee immediately upon admission by taking vitals of temperature, blood pressure, physical complaints, current medications, suicidal tendencies, drug usage and other factors.

(2) Currently, each new detainee is seen by either a registered nurse, a nurse practitioner or a physician's assistant routinely within 24 hours of admission for a more thorough intake medical examination. The ICE detainee's responses and the results of medical assessments dictate whether to monitor or isolate the ICE detainee.

(3) Also, each new detainee is placed into a separate pod immediately upon arrival. This detainee then must remain there from between five and fourteen days, until the detainee is cleared by the JCDC medical staff.

(4) There is screening for all non-detainees entering the JCDC. Beginning not later than March 9, 2020, all JCDC staff, contractors, volunteers, and vendors immediately are temperature-checked, upon entry into the JCDC, and are required to wear a mask, upon entry to the facility.

D. Sanitation and Hygiene.

(1) Detainees are provided with soap to wash their hands at any time throughout the day. Approximately four bottles of alcohol-free disinfectant are stocked in all housing units, that only provide one such bottle at a time for use by the detainees and staff. In addition, the JCDC conducts a daily disinfection routine three times a day, which includes door handles, toilets, showers and tables. Non-alcoholic hand sanitizer is stocked in every housing unit. Detainee restraints are disinfected after each use.

(2) No contractors, other than in case of emergency, may enter a detainee area, including an ICE detainee area, before all detainees have been removed from that area. Then after that person leaves, and before detainees are allowed to return to that area, the area is sanitized with approved echo-lab chemicals.

(3) All detainees receive handouts regarding hygiene and sanitization, in English and Spanish, and these handouts are included in Exhibit 2 to this Declaration.

(4) The JCDC staff also are provided with disinfectants, non-alcoholic hand sanitizer, soap and masks.

(5) The five pages attached hereto as Exhibit 3 are individually posted throughout the detainee housing units in the JCDC, including (a) in each individual cellblock, (b) on the computer screens on the electronic kiosks that are available to the detainees; (c) on the computer screens of the individual computer tablets that the detainees can purchase within the JCDC and (d) in the individual document binders in each of the cellblocks in the JCDC.

(6) The first page states "Wash Your Hands" in the languages recited in that document.

(7) The second page is COVID-19 information in English and in Spanish.

(8) The third page explains "Stop the Spread of Germs" in English and Spanish by recommending at the top left "Wash your hands often with soap and water for at least 20 seconds;" at the top right "Cover your cough or sneeze with a tissue, then throw the tissue in the trash.;" at the bottom left "Avoid touching your eyes, your nose, and mouth.;" and at the bottom right "Clean and disinfect frequently touched objects and surfaces." Each cell block has toilet paper and paper towels that can be used as tissues, and nonalcoholic sanitizer.

(9) The fourth and fifth pages recite in English and Spanish the same "Housing unit clean up and disinfectant info and procedures" to be used in cleaning the individual cellblock housing units, that also contain disinfectant cleaners, shower cleaners, floor cleaners and cleaning equipment, including mops, squeegees, brooms, dust pans, and ample trash storage containers with lids.

E. Quarantine.

The JCDC follows the CDC guidelines regarding testing for COVID-19 and isolation of individuals with symptoms and/or risk exposure factors. Should a detainee exhibit any of the above-recited flu-like symptoms, that detainee will be isolated, in the manner that is also recited above. If a detainee exhibits COVID-19 symptoms, including those recited in Exhibit 1, he will be isolated in a negative pressure room (air is not circulated to the other parts of the facility) for further observation and treatment by the facility's medical staff. If any ICE detainee presented any flu-like symptoms, including those recited above, that detainee would be placed in a single cell for isolation and would be medically monitored by ICE medical personnel three to four times per day for the first five days of single cell isolated confinement. Asymptomatic inmates with exposure risk factors also are quarantined.

(1) If an ICE Detainee is Asymptomatic after Being Exposed to An Individual Testing Positive for COVID-19.

If any JCDC detainee, including an ICE detainee, would be exposed to an individual who tests positive for COVID-19 but is asymptomatic, that detainee's movement will be restricted for the duration of the most recent incubation period (at least 14 days after most recent exposure to an ill individual). During the incubation period, the resident will be housed with other residents, who were also potentially exposed to the individual with COVID-19. This 14-day incubation period is to avoid the detainee from becoming an undetected source patient, since he or she may already be contagious with COVID-19 before becoming symptomatic. The detainee also will be monitored daily for fever and for symptoms of

respiratory illness.

(2) If An ICE Detainee Exhibits COVID-19 Symptoms.

If an ICE, or other JCDC, detainee exhibits COVID-19 symptoms, the detainee will be isolated in a one-person negative pressure room (air is not circulated to the other parts of the facility) for further observation and treatment by the facility's medical staff. The detainee will also be monitored daily for fever and symptoms of respiratory illness. If the resident shows the onset of fever and/or respiratory illness, he or she will be referred for evaluation to the onsite medical provider. If the resident is then diagnosed with COVID-19, per ICE guidance, the resident will be quarantined in accordance with CDC, as well as, state and local health department guidelines.

F. Correctional Officers.

Although correctional officers will need to enter and re-enter the facility, they have been ordered to call from home and to not come to the JCDC if they have any of the above-recited flu symptoms. Enhanced health screening of staff has been implemented in areas with "sustained community transmission," as determined by the CDC. Such screening includes self-reporting and temperature checks. For three weeks now, all correctional officers and health care workers have been wearing masks at all times, while in the secured portion of the JCDC facility In addition, detainees are issued masks when they go to court and to medical.

G. The ICE Detainee Unit.

JCDC health care workers wearing masks visit the ICE detainee unit twice a day to check detainees for COVID-19 symptoms, as determined from time to time by the federal government's CDC, including temperature checks of each detainee twice per day. They monitor each detainee to see if that detainee is displaying any symptoms or behavior warranting immediate referral to the in-house heath care provider for evaluation and treatment, as appropriate.

Also, correctional officers visit the ICE detainee unit every 25 minutes and check for any possible COVID-19 symptoms such as sneezing or coughing, to see if they are displaying any symptoms or behavior warranting immediate referral to the in-house health care provider for evaluation and treatment, as appropriate.

To date, none of these personnel have noted any JCDC detainee exhibiting such symptoms.

Pursuant to 28 U.S.C. § 1746, I hereby declare that the foregoing is true and correct. Executed on April 24, 2020.

/s/Chad Kolitwenzew
Chad Kolitwenzew
Chief of Corrections
Jerome Combs Detention Center
Kankakee County Sheriff's Office

2019 Novel Coronavirus (COVID-19) Quick Reference for Law Enforcement

This quick reference is intended as a guide for law enforcement personnel who may respond to, or come in contact with, individuals potentially exposed to and/or infected with the COVID-19 virus.

History
CDC is closely monitoring an outbreak of respiratory illness caused by a novel (new) coronavirus (named "COVID-19") that was first detected in Wuhan City, Hubei Province, China and which continues to expand.

Transmission
COVID-19 is a viral illness and can be spread from person-to-person among close contacts (about 6 feet). Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. It's currently unclear if a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes.

Symptoms
Patients with COVID-19 have reportedly had mild to severe respiratory illness with symptoms of:
- Fever
- Cough
- Shortness of breath

Symptoms may appear 2-14 days after exposure.

Rules of Thumb
Officer safety is the most important consideration
- Be smart, be careful
- Respiratory droplets can infect you
- Fear and ignorance about COVID-19 is widespread
- Avoid close contact with people who are sick

Basic Personal Protective Equipment (PPE) Recommendations for Infection Control
- Contact: gloves
- Airborne: N-95 or higher level filtering face piece respirator
- Eye protection (goggles or face shield)
- Disposable isolation gown or single use/disposable coveralls (If unable to wear a disposable gown or coveralls because it limits access to duty belt and gear, ensure duty belt and gear are disinfected after with contact individual)

When is PPE recommended
- For lifesaving medical treatment
- Direct contact with an individual experiencing symptoms
- Per department policy and protocol

For more information
CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html
IDPH: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus
Illinois 24/7 Hotline: 1-800-889-3931 or email **dph.sick@illinois.gov**

Developed by the Illinois Department of Public Health

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For more information
CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html
IDPH: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus
Illinois 24/7 Hotline: 1-800-889-3931 or email **dph.sick@illinois.gov**

Developed by the Illinois Department of Public Health

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2019 Novel Coronavirus (COVID-19) Quick Reference for Law Enforcement

Risk Evaluation Questions

If PSAP (911/Dispatch) has not made an initial COVID-19 assessment, responding law enforcement personnel should attempt to determine the following, if you suspect the individual displays any of the symptoms of COVID-19, while utilizing protective guidelines provided on the front of this quick reference.

- Have you traveled out of the country to a geographic area affected with COVID-19 in the last 14 days?
- Have you had contact with anyone who has traveled to an area that is experiencing an active COVID-19 outbreak?
- Have you had any contact with a COVID-19 patient?
- Are you feeling ill? What are your symptoms? How long have you been ill or had symptoms?

If the answer to any of these questions is YES, notify PSAP (911/Dispatch) secure the scene and minimize additional exposure pending EMS arrival.

Response Considerations (WHAT TO DO)

- Most response situations will warrant the usual level of precaution against respiratory pathogens. Follow department protocol/policy.
- If PSAP call takers advise that the individual is suspected of having COVID-19 law enforcement personnel should wear recommended PPE.
- Avoid direct contact with a symptomatic individual's body fluid and secretions.
  -To minimize potential exposure, it may be prudent to perform the initial screening from at least 6 feet away from the individual.
- If direct contact with a symptomatic individual or their respiratory secretions is necessary, follow the department's First Responder Blood-borne Pathogen policy/protocol.
- Wash hands vigorously with soap and water for at least 20 seconds (or hand sanitizer ≥ 60% alcohol) after removing PPE or after close contact with an ill person and/or with body fluids or surfaces that may be contaminated.
- Report potential exposure following department policy/protocol.

Officer Safety is the Most Important Considerations

- Emergency medical treatment should be provided through local EMS/911 services.
- If an officer is confronted with a medical situation requiring immediate life saving attention (i.e., CPR, trauma, etc.) follow the department's medical policy/protocol.
- If an officer comes into direct contact with respiratory droplets from an individual with suspected COVID-19, the officer should wash the affected skin surfaces immediately with soap and water for at least 20 seconds and report potential exposure following department policy/protocol.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Report exposure to on scene EMS personnel and follow department policy/protocol as appropriate.

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Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Coronavirus Disease 2019 (COVID-19)

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

Printer friendly version

PowerPoint Presentation: Managing COVID-19 in Correctional and Detention Facilities [25 pages, 1 MB]

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

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the CDC website periodically for updated interim guidance.

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

Who is the intended audience for this guidance?

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

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

Why is this guidance being issued?

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

- Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heigh potential for COVID-19 to spread once introduced.

PENGAD-Bayonne, N. J.
GOVERNMENT EXHIBIT 2
JCDC DEC.

- 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

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- 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.

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- **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.

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- Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.

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

Personnel Practices

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

- **Identify staff whose duties would allow them to work from home.** Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.
  - Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
  - Put systems in place to implement work from home programs (e.g., time tracking, etc.).

- **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.
  - Allow staff to work from home when possible, within the scope of their duties.
  - Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
  - Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
  - Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.

- **Consider offering revised duties to staff who are at higher risk of severe illness with COVID-19.** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
  - Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.
- **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.

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

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

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Operations & Supplies

- **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**
  - Standard medical supplies for daily clinic needs
  - Tissues
  - Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
  - Hand drying supplies
  - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
  - Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19
  - Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s. Visit CDC's website for a calculator to help determine rate of PPE usage.
  - Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

- **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**
  - See CDC guidance optimizing PPE supplies.

- **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.
- **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)
  - Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.

- **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**
- **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

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

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

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Operations

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

Cleaning and Disinfecting Practices

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

Hygiene

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- **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis. Sample signage and other communications materials are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
  - **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
  - **Practice good hand hygiene:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
  - **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
  - **Avoid sharing eating utensils, dishes, and cups.**
  - **Avoid non-essential physical contact.**

- **Provide incarcerated/detained persons and staff no-cost access to:**
  - **Soap** – Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
  - **Running water, and hand drying machines or disposable paper towels** for hand washing
  - **Tissues** and no-touch trash receptacles for disposal
- **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.
- **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

- **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process**, in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).
  - **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath)**:**
    - Require the individual to wear a face mask.
    - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
    - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.
  - **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**
    - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

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- **Implement social distancing** strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms). Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:
  - **Common areas:**
    - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
  - **Recreation:**
    - Choose recreation spaces where individuals can spread out
    - Stagger time in recreation spaces
    - Restrict recreation space usage to a single housing unit per space (where feasible)
  - **Meals:**
    - Stagger meals
    - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
    - Provide meals inside housing units or cells
  - **Group activities:**
    - Limit the size of group activities
    - Increase space between individuals during group activities
    - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
    - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
  - **Housing:**
    - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
    - Arrange bunks so that individuals sleep head to foot to increase the distance between them
    - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
  - **Medical:**
    - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
    - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.
- **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**
- **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**
- **Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.**
- **Provide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis, including:**
  - Symptoms of COVID-19 and its health risks
  - Reminders to report COVID-19 symptoms to staff at the first sign of illness
- **Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.**

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Prevention Practices for Staff

- **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
  - Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
  - Symptoms of COVID-19 and its health risks
  - Employers' sick leave policy
  - **If staff develop a fever, cough, or shortness of breath while at work**: immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
  - **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
  - **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
  - Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).
- **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.**
- **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

- **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - Staff performing temperature checks should wear recommended PPE.
  - Exclude visitors and volunteers who do not clear the screening process or who decline screening.
- **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**
- **Provide visitors and volunteers with information to prepare them for screening.**
  - Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
  - If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.

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- Display signage outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.

- **Promote non-contact visits:**
  - Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
  - Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
  - Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.
- **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**
  - If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
  - Inform potential visitors of changes to, or suspension of, visitation programs.
  - Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
  - If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons' physical health and the health of the general public. However, visitation is important to maintain mental health. If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. See above suggestions for promoting non-contact visits.

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

Management

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

Operations

- **Implement alternate work arrangements deemed feasible in the Operational Preparedness**
- **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**
  - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.

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- **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.
- **When possible, arrange lawful alternatives to in-person court appearances.**
- **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**
  - Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
    - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
    - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
    - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.
- Coordinate with state, local, tribal, and/or territorial health departments.
  - When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below.
  - When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below.
  - Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See Facilities with Limited Onsite Healthcare Services section.

Hygiene

- **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)
- **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

- **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)
- **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

- **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**
- **Keep the individual's movement outside the medical isolation space to an absolute minimum.**

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- 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.

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- **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.
- **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**
- **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:
  - **Cover** their mouth and nose with a tissue when they cough or sneeze
  - **Dispose** of used tissues immediately in the lined trash receptacle
  - **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.
- **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria.**
  - **For individuals who will be tested to determine if they are still contagious:**
    - The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
    - The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
    - The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart
  - **For individuals who will NOT be tested to determine if they are still contagious:**
    - The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
    - The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
    - At least 7 days have passed since the first symptoms appeared
  - **For individuals who had a confirmed positive COVID-19 test but never showed symptoms:**
    - At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
    - The individual has had no subsequent illness
- **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**
  - If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

- **Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note – these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.**
  - Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
  - Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).
- **Hard (non-porous) surface cleaning and disinfection**
  - If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.

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

- **Soft (porous) surface cleaning and disinfection**
  - For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
    - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
    - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.
- **Electronics cleaning and disinfection**
  - For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
    - Follow the manufacturer's instructions for all cleaning and disinfection products.
    - Consider use of wipeable covers for electronics.
    - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

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

- **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)
- **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- **Laundry from a COVID-19 cases can be washed with other individuals' laundry.**
  - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.
- **Consult cleaning recommendations above to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

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

- **Incarcerated/detained persons who are close contacts of a confirmed or suspected COVID-19 case (whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**
  - If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.
- **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**
  - Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time **OR**
  - Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

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

- **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**
  - Provide medical evaluation and care inside or near the quarantine space when possible.
  - Serve meals inside the quarantine space.
  - Exclude the quarantined individual from all group activities.
  - Assign the quarantined individual a dedicated bathroom when possible.
- **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.
  - If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation
  - If an entire housing unit is under quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
  - Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.
  - If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.
- **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.)
- **In order of preference, multiple quarantined individuals should be housed:**
  - Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
  - Separately, in single cells with solid walls but without solid doors
  - As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
  - As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door

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- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements (NOTE – Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

- **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see PPE section and Table 1)**:**
  - If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
  - If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
  - All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
  - Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.
- **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).
  - Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.
- **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical Isolation section above.)
  - See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- **If an individual who is part of a quarantined cohort becomes symptomatic:**
  - **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
  - **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

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

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

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

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

Management Strategies for Staff

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

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

- **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
  - See above for definition of a close contact.
  - Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

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

- **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates.**
  - Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
  - Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).
- **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).
- **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

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

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- **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**

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- **Guidance in the event of a shortage of eye protection**
- **Guidance in the event of a shortage of gowns/coveralls**

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

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Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Staff handling laundry or used food service items from a COVID-19 case or case contact				X	X
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X

Classification of Individual Wearing PPE

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.
** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

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

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

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

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