IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICKY PRICE and KEVIN CONWAY, Plaintiffs, v. FEDERAL BUREAU OF PRISONS; MICHAEL CARVAJAL, Director of the Federal Bureau of Prisons; RUSSELL HEISNER, Warden of the Metropolitan Correctional Center; ZAIDA NDIFE, Health Administrator of the Metropolitan Correctional Center, Defendants.	)	Case No.

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs Ricky Price and Kevin Conway, by their attorneys, on their own behalf and on behalf of a Class consisting of all persons confined or to be confined in the Chicago Metropolitan Correctional Center ("MCC") (the "Class"), and two Subclasses, one consisting of pretrial detainees at MCC (the "Pretrial Subclass"), and one consisting of post-conviction MCC residents (the "Post-conviction Subclass"), complain against Defendants Federal Bureau of Prisons; Michael Carvajal, Director of the Federal Bureau of Prisons; Russell Heisner, Warden of the Metropolitan Correctional Center; and Zaida Ndife, Health Administrator of the Metropolitan Correctional Center, as follows:

Introduction and Background

1. MCC is run by the Federal Bureau of Prisons ("BOP") and currently houses between 500 and 550 federal detainees and prisoners in a space designed for 400. Its inhabitants and staff cannot socially distance. Residents are almost entirely dependent upon Defendants for protection against the novel coronavirus, SARS-CoV-2, and the disease it causes, COVID-19.

2. Defendants have already failed not once, but twice, to protect the people in their custody. As of May 4, 2020, MCC had the fourth highest reported number of coronavirus infections of any BOP facility in the country—between 20% and 25% of the resident population. The real infection rate was certainly higher since the reported cases were the result of systematic testing on only some of MCC's residential floors. In November 2020, reported cases started to surge again. Public health experts had repeatedly warned of this risk for fall and winter. Despite months to plan for a better outcome, Defendants resorted once again to the failed strategies of the spring, which did not stop the disease then and did not stop it the second time. This included lockdowns, poorly implemented and incomplete isolation and quarantine processes, slovenly disinfection, and a blind eye turned to staff who do not wear masks (although staff are the ones who go in and out of the facility every day). Now, months after testing has become routinely and widely available, and "surveillance testing" is practiced by other correctional systems, Defendants still rely on the observation and self-reporting of symptoms—for a disease universally known to have many asymptomatic carriers—to identify when an outbreak has begun. They fail to care properly even for those they know to be sick. Residents are terrified and depressed. The BOP COVID-19 webpage now reports that this facility, housing some 500 to 550 people, has had some 300 resident cases of COVID-19 since the start of the pandemic.

3. Defendants' persistent failure to protect MCC residents from COVID-19 is likely to cause harm in any congregate setting, but is particularly shocking because MCC residents, like all carceral populations, suffer disproportionately from medical conditions and history of disease that place them at high risk of serious injury or death from COVID-19 as compared to the general population.

4. MCC residents and staff need early access to a COVID-19 vaccine, although this measure by itself will not immediately protect them. As of January 16, 2021, the Bureau of Prisons reported that it had vaccinated a fraction of its staff and an even smaller number of residents at some of its facilities—some 20% of staff had received one dose of a two-shot vaccine, while barely 4% of residents had received their first shot. It also reported that this had used 97% of its existing supply.[1] Last week, reportedly some staff and a very few MCC residents were offered the vaccine—how many actually accepted is unknown. And while vaccination mitigates the severity of COVID-19, it has not been shown to prevent asymptomatic infection and transmission of the coronavirus.

5. Defendants must have an effective plan to educate and encourage the people in its custody at MCC, as well as its staff, to accept vaccination. But even with vaccination, it will be at least months, and maybe longer, before a facility like MCC can safely abandon the critically important preventative measures against COVID-19 at which Defendants have so far failed.

6. The pandemic is not over, and COVID-19 remains a cruel and sometimes fatal illness. Now even more contagious strains of the virus have emerged. Only a multi-layered approach, which includes not just vaccination, but also routine and effectively implemented testing, masking, sanitation, and use of isolation and quarantine, can keep the residents of MCC from being exposed, over and over again, to the same risks of serious harm they have already endured. Defendants had time and did not use it. They have failed their responsibilities under federal law, the Constitution, and their own regulations. It is now time to order them to protect Plaintiffs and the Class.

[1] Federal Bureau of Prisons, *COVID-19 Vaccination Efforts Commended*, updated (Jan. 16. 2021), https://www.bop.gov/resources/news/20210116_covid_vaccine_efforts_commended.jsp.

I. JURISDICTION AND VENUE

7. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because it arises under the Constitution and laws of the United States.

8. Plaintiffs' claims for declaratory and injunctive relief are authorized by the Declaratory Judgment Act, 28 U.S.C. §§ 2201–02; by Rules 57 and 65 of the Federal Rules of Civil Procedure; by the Administrative Procedure Act, 5 U.S.C. §§ 702, 706; and by the inherent equitable powers of this Court.

9. Venue is proper under 28 U.S.C. § 1391(e)(1)(B). Defendants are United States agencies or officers sued in their official capacities, and the events and omissions giving rise to this Complaint have and will continue to occur in this judicial district.

II. PARTIES

10. Plaintiff Ricky Price is currently in BOP custody at MCC, where he is at risk of death or serious injury if exposed to COVID-19. He is being held in pre-trial custody and is presumed innocent. Like other pre-trial detainees at MCC, Mr. Price shares a cell with another detainee on one of MCC's cell floors. Approximately 90% of MCC's population are pre-trial detainees like Mr. Price.

11. Plaintiff Kevin Conway is currently in BOP custody at MCC, where he is at risk of death or serious injury if exposed to COVID-19. He is being held post-conviction. Until the past week, Mr. Conway has continuously been housed in "dormitory" housing on one of MCC's dormitory floors. Approximately 10% of MCC's population are post-conviction residents, like Mr. Conway.

12. Defendant Federal Bureau of Prisons "was established in 1930 to provide more progressive and humane care for federal inmates, to professionalize the prison service, and to

ensure consistent and centralized administration of federal prisons." It is responsible for the safety of, and all care and services for, the persons in its custody.

13. Defendant Michael Carvajal is the Director of the Federal Bureau of Prisons. As Director, Defendant Carvajal is responsible for all BOP policies implemented at MCC, including those pertaining to resource distribution and factors that BOP facility leadership should consider in determining an incarcerated individual's eligibility for early release. His responsibilities include ensuring the safety of all in the BOP system and ensuring that its institutions operate in an orderly fashion. Director Carvajal has adopted and enforced policies that leave Plaintiffs and all those similarly situated exposed to infection, severe illness, and death due to COVID-19. Defendant Carvajal is named in both individual and official capacities.

14. Defendant Russell Heisner is MCC's Warden. He is in charge of MCC operations and is responsible for the welfare of MCC inmates. Defendant Heisner is named in both individual and official capacities.

15. Defendant Zaida Ndife is MCC's Health Administrator. Ndife is responsible for formulating and implementing administrative policies and programs essential to medical and dental operations at MCC. Ndife also manages and directs the MCC laboratory, pharmacy, and the medical records departments. Defendant Ndife is named in both individual and official capacities.

III. FACTS

16. The global COVID-19 pandemic remains a grave threat with no certain conclusion. As of January 27, 2021, worldwide there were over 99 million reported COVID-19

cases and two million confirmed deaths.[2] On January 19, 2021, the United States suffered its 400,000th death from COVID-19, with an official from the U.S. Centers for Disease Control and Prevention ("CDC") predicting 500,000 by February.[3] In Illinois, there have been over one million confirmed or probable cases of COVID-19 and 20,000 deaths.[4] Chicago alone has seen over 230,000 cases and 4,500 deaths.[5]

17. COVID-19 is now the leading cause of death in the United States. BOP itself has acknowledged that "[a]pproximately 20 percent of cases will have severe or life-threatening illness and up to two to three percent of patients will die. Some experts . . . estimate the mortality rate may be 10 times higher than that of seasonal influenza."[6]

18. As is now fully evident, the arrival of COVID-19 vaccines does not mean that the pandemic is over or will be over within a few weeks or months. The pace of vaccine distribution in the U.S. has already fallen behind schedule. As of January 7, 2021, the CDC reported that the total number of people "initiating vaccination (1st dose received)" stood a little above 5.9 million—far short of the 21 million doses that had been distributed—and as of January 28, it reported that only 4.2 million people had received the full two doses.[7] On the same date, the

---

[2] World Health Org., *Coronavirus disease (COVID-19) pandemic*, https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last accessed January 27, 2021).

[3] Jamie Yuccas, *U.S. expected to have 500,000 COVID-19 deaths by February, CDC official warns*, CBS News (Jan. 19, 2021), https://www.cbsnews.com/news/covid-death-toll-united-states-expected-500k-february/.

[4] Ill. Dep't of Pub. Health, *Coronavirus Disease 2019*, http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus (last accessed January 27, 2021).

[5] *Id.*

[6] Federal Bureau of Prisons, *COVID-19 Pandemic Response Plan Overview* (Aug. 31, 2020), p. 2, https://www.bop.gov/foia/docs//Overview_of_COVID_Pandemic_Response_Plan_08312020.pdf.

[7] Ctrs. For Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19), CDC COVID Data Tracker/COVID-19 Vaccinations in the United States*, https://covid.cdc.gov/covid-data-tracker/#vaccinations (last accessed January 28, 2021).

Johns Hopkins Coronavirus Resource Center reported that Illinois had "fully vaccinated" only 1.25% of its population.[8]

19. In addition, vaccine resistance and hesitancy are impinging on public health efforts to quell SARS-CoV-2 by immunization. BOP itself reported that, as of January 16, 2021, "roughly half" of the staff to whom vaccine had been offered had "opted to vaccinate."[9] But epidemiologists agree that more than 70% of the United States population must have immunity to achieve "herd immunity."; When this might occur for COVID-19 is unknown and unpredictable.[10]

20. Finally, the virus continues to mutate. An important new development in the evolution of the COVID-19 pandemic and the SARS-CoV-2 virus has been the emergence of the B.1.1.7 mutant in the United Kingdom that has been identified in Colorado, New York, and California, and is believed to be widely circulating across the United States. As of January 16, 2021, the B.1.1.7 mutant had been identified in Chicago by laboratories at Northwestern University. Both laboratory testing and epidemiologic data strongly indicate greater transmissibility of this agent compared to the original form of the SARS-CoV-2 virus. Recent estimates project that 80% vaccination or greater is required for herd immunity against this mutant.[11]

21. The CDC has estimated that 50% of SARS-CoV-2 infections come from asymptomatic patients. Consequently, the familiar measures to limit the spread of the virus

---

[8] *Coronavirus Resource Ctr.*, Johns Hopkins Univ. & Medicine, https://coronavirus.jhu.edu/vaccines (last visited Jan. 28, 2021).
[9] Federal Bureau of Prisons, *COVID-19 Vaccination Efforts Commended* (Jan. 16, 2021), https://www.bop.gov/resources/news/20210116_covid_vaccine_efforts_commended.jsp.
[10] Donald G. McNeil, Jr., *How Much Herd Immunity is Enough?* N.Y. Times (Dec. 24, 2020), https://www.nytimes.com/2020/12/24/health/herd-immunity-covid-coronavirus.html.
[11] *Id.*

(social distancing; using personal protective equipment (especially masks); avoidance of large groups and of indoor gatherings except with household members or those who are members of a "bubble;" and practicing vigilant hygiene, including frequently and thoroughly washing hands with soap and water and cleaning and disinfecting high-touch surfaces) will continue to be essential for the foreseeable future to stem transmission of SARS-CoV-2.

22. Although older people and people with certain pre-existing conditions are the most vulnerable to serious illness or death from the virus, even younger people may suffer serious cases of COVID-19 or die. A recent study reported 12,000 excess deaths among the young (defined as adults ages 25 to 44) in the U.S. in the period from March through the end of July 2020—a trend that was continuing into the fall and winter.[12]

23. As the pandemic has continued, there have been more and more reports of long-term, sometimes disabling effects of the disease. The CDC reports fatigue, chest and joint pain, and shortness of breath among "common" long-term symptoms; others are intermittent fever, heart palpitations, depression, and difficulty with thinking and concentration.[13] There are graver long-term effects as well, including inflammation of the heart muscle (myocarditis), lung function abnormalities, and acute kidney injury.[14] BOP itself notes that "[c]ellular damage from SARS-CoV-2 may cause long-term health consequences, including multiple organ injury."[15]

---

[12] Jeremy Samuel Faust, Harlan M. Krumholz and Rochelle P. Walensky, *People Thought COVID-19 Was Relatively Harmless for Younger Adults. They Were Wrong.* N.Y. Times (Dec. 16, 2020), https://www.nytimes.com/2020/12/16/opinion/covid-deaths-young-adults.html.
[13] Ctrs. For Disease Control and Prevention, *COVID-19, Long-Term Effects of COVID-19*, updated (Nov. 13, 2020), https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html.
[14] *Id.*
[15] Federal Bureau of Prisons, *COVID-19 Pandemic Response Plan Overview* (Aug. 31, 2020), p. 2, https://www.bop.gov/foia/docs//Overview_of_COVID_Pandemic_Response_Plan_08312020.pdf.

24. These long-term effects are not unusual or confined to the elderly or ill. As of September 2020, a series of medical studies had already reported that substantial numbers of COVID-19 sufferers had long-term symptoms, including, according to one study of patients with mild symptoms who had not been hospitalized, one-quarter of the patients aged 18 to 34 years old.[16]

25. From the outset of the global pandemic, experts warned that people in confined spaces such as correctional facilities—where people live, eat, sleep, and work in close proximity—faced increased danger of contracting COVID-19.[17] The close quarters and limited freedom of movement inherent in correctional facilities make social distancing and other preventive measures difficult or impossible for their residents. Moreover, the ability of incarcerated people to adopt preventative measures is almost completely subject to the dictates of correctional officials who control the housing, schedules, sanitary and personal protective equipment supplies, and nearly every other aspect of their lives. BOP has acknowledged that the disease "presents unique challenges for management in the confined correctional environment."[18]

[16] Rita Rubin, *As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts*, JAMA 324(14) (Sept. 23, 2020) https://jamanetwork.com/journals/jama/fullarticle/2771111.
[17] Timothy Williams, Benjamin Weiser and William K. Rashbaum, *'Jails are Petri Dishes': Inmates Freed as the Virus Spreads Behind Bars*, N.Y. Times, (Mar. 30, 2020), https://www.nytimes.com/2020/03/30/us/coronavirus-prisons-jails.html.
[18] Federal Bureau of Prisons, *COVID-19 Pandemic Response Plan Overview* (Aug. 31, 2020), p. 2, https://www.bop.gov/foia/docs//Overview_of_COVID_Pandemic_Response_Plan_08312020.pdf.

26. In addition, as is well known, jail and prison populations suffer from higher levels of chronic conditions, history of disease, and other health impairments that make individuals more vulnerable to serious illness and death from COVID-19.[19]

27. Defendants have failed to take the necessary steps to address the severe risks faced by Plaintiffs and the Class. Defendants have opposed and continue to oppose motions for early release or home confinement; the U.S. Department of Justice Office of the Inspector General found that BOP had been "slow to use . . . authority" given to it by the U.S. Attorney General to expeditiously consider medically vulnerable people for home confinement or other release "to mitigate the effects of COVID-19."[20] Defendants are thus themselves responsible for the crowded conditions that enable rapid spread of the virus within MCC, whose population remains well above "design capacity" and which has large numbers of residents packed into dormitory housing. Defendants' failures not only endanger people incarcerated at MCC, they put MCC's staff, their family members, local health care workers, and the broader community at risk.

28. COVID-19 has predictably overwhelmed MCC, a 27-floor prison skyscraper, not once but twice.

29. The building, a unique triangular design, was structured to have inmate housing occupying floors 13 to 26.[21] Four floors (21 to 24) were originally designated for immigration

[19] Laura M. Maruschak, et al., *Medical Problems of State and Federal Prisoners and Jail Inmates*, 2011-12, U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Statistics (Feb. 2015, revised Oct. 4. 2016), https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.
[20] Michael E. Horowitz, *Top Management and Performance Challenges Facing the Department of Justice—2020*, U.S. Dep't of Justice, Off. Of the Inspector Gen., 12 (Oct. 16, 2020) https://oig.justice.gov/sites/default/files/reports/2020.pdf.
[21] Robert Bruegmann and Kathleen Murphy Skolnick, *The Architecture of Harry Weese* 178 (2010).

detainees who were regarded as not "need[ing] the security of a private room" and "were typically held for only brief periods of time," and thus were housed in "dormitory units" planned to have 62 beds.[22] The remaining residential floors were built with cells, distributed around the perimeter of the triangle in two tiers, 44 cells total, with "mini-lounges" for four groups of 11 cells located in the common area in the middle.[23] The standard cell size on cell floors is 7 feet by 10 feet.[24] The design capacity of the building was approximately 400.[25] The "tightly organized space" of the design "was intended as a safeguard against future overcrowding."[26] Over the years, this has been thwarted by the addition of double bunks to many of the rooms and increased numbers of beds on the "dormitory" floors. Over 100 residents are currently crammed onto at least one of the dormitory floors.

30. On March 9, 2020, the Governor of Illinois declared all counties in Illinois a "disaster area" because of COVID-19. Defendants barred visitors (lawyers in addition to family and others) on March 13, 2020, but took few other steps to protect MCC's population.

31. Internally, reports that staff were ill with COVID-19 began circulating early in March. On March 27, 2020, the BOP website acknowledged that two MCC staff had tested positive for COVID-19.[27] Around the same time, staff placed a large number of cots outside the gym, which was subsequently used for quarantine. But MCC still carried on "business as usual" in many respects. Inmates with jobs circulated throughout the facility to and from their jobs,

---

[22] *Id.*
[23] *Id.*
[24] *Id.*, figure p. 177, 178.
[25] *Id.*
[26] *Id.* p. 179.
[27] Federal Bureau of Prisons, *COVID-19 Coronavirus* (Mar. 27, 2020), http://web.archive.org/web/20200328112539/bop.gov/coronavirus/.

including in the kitchen. Staff did not wear masks or use gloves, and residents were not provided with masks.

32. By the first part of April, the number of staff acknowledged to have tested positive was growing—three as of April 7, 2020 to six as of April 10, 2020. The BOP website reported no resident cases, but within MCC, word of mouth said otherwise. Nonetheless, it was not until mid-to-late April that MCC screened residents on its crowded and vulnerable dormitory floors, where bunk beds sit barely three feet apart.

33. On April 14, 2020, BOP acknowledged the first resident COVID-19 case at MCC. Finally, more than one month after Illinois was declared a "disaster area," MCC stopped sending residents to their jobs within the facility.

34. Testing quickly revealed widespread infection among those tested, and the numbers escalated rapidly. By May 6, 2020, almost one quarter of MCC's population—133 residents—were acknowledged to have contracted the virus. Eight were hospitalized.

35. Once resident cases were finally acknowledged within MCC, Defendants compounded their errors through gross mismanagement of isolation and quarantine. On March 23, 2020, the CDC had issued the first version of its guidance on the management of COVID-19 for prisons and jails.[28] Within a secure facility, proper management of isolation and quarantine is an essential tool in managing an outbreak of infectious respiratory disease. The CDC Guidance was clear from the beginning of the pandemic that known COVID-19 cases must be medically isolated, while "close contacts" and others under investigation must be quarantined.[29] "Ideally,"

[28] Ctrs. For Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), https://stacks.cdc.gov/view/cdc/86821.
[29] *Id.* p. 4.

the Guidance specified, "cases should be isolated individually, and close contacts should be quarantined individually"; however, if facility space did not permit this, then "cohorting" could be used—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."[30]

36. Defendants have never implemented effective isolation, quarantining or cohorting procedures at MCC—not in the spring of 2020 and not thereafter.

37. Initially, Defendant Heisner used the "secure housing unit" ("SHU") for isolation and/or quarantine—a unit typically used for disciplinary purposes. The conditions in the SHU are, by design, austere. Detainees and prisoners in the SHU are housed in small dark cells with a solid door with a "chuck hole" through which the food is passed. The unit is dirty and noisy. Defendant Heisner did not change the conditions in the SHU when converting it to the isolation/quarantine unit for people with known or suspected SARS-CoV-2 infection.

38. Predictably, by using the SHU for isolation/quarantine, Defendant Heisner incentivized MCC residents to hide their symptoms—a problem obvious to correctional managers and one that BOP, when it issued its own COVID-19 guidance, frankly acknowledged.[31] MCC took this approach despite the recognition that security isolation should *not* be used to abate coronavirus transmission.[32] Since MCC, in accordance with BOP policy and practice, relied on symptom self-reporting by residents to determine when an outbreak was

---

[30] *Id.* p. 3.

[31] Federal Bureau of Prisons, *COVID-19 Pandemic Response Plan, Module 4: Medical Isolation and Quarantine* (Sept. 8, 2020), p. 5, https://www.bop.gov/foia/docs//Mod_4_Inmate_Isolation_and_Quarantine_of_COVID_Pandemic_Response_Plan_08312020.pdf.

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

occurring, Defendants' misuse of security isolation disabled COVID-19 detection and mitigation in the facility from the start.

39. As the number of COVID-19 cases among residents increased, Defendant Heisner moved numerous residents among the floors of MCC, enabling further spread of the virus. Individuals who were feeling sick or had tested positive were moved to floors with residents not yet under suspicion of infection: stickers were placed on their doors indicating that they were "quarantined." Nevertheless, these individuals used the same showers and phones as others on the floor who were not "quarantined," and shared the common air space.

40. The spring outbreak was, unsurprisingly, worst on the dormitory floors. In or around mid-to-late April, Defendant Heisner had everyone on the 21st and 23rd floors tested. A very large number of those housed on these floors tested positive, but not all. COVID-19 management processes outlined by the CDC (and common sense) dictated that individuals who tested positive for the coronavirus should be separated (isolated) from individuals who tested negative, and that those who tested negative should be cohorted and kept under 14-day observation (quarantined). Defendants did not take these steps during the spring 2020 outbreak. Residents who tested positive and negative alike remained housed together on floors 21 and 23 and were only later separated.

41. On the cell floors not being used for isolation/quarantine, despite having testing available, Defendants continued to rely on symptom self-reporting to detect cases of COVID-19 among residents. Defendants elected to rely on symptom self-reporting in spite of the well-known and widely reported fact that a large percentage of SARS-CoV-2 transmission takes place through asymptomatic carriers, and despite the fact that Defendants' use of punitive isolation settings for people with coronavirus infection or exposure created strong disincentives for

residents to self-report. Even MCC's symptom self-reporting was implemented in a haphazard way not likely to work. A nurse would walk through the cell floors, performing a "drive-by" tap on the cell doors and calling out "are you okay?"

42. But admitting symptoms was also not enough to receive testing and medical attention. Residents who clearly should have been tested and isolated during the spring 2020 coronavirus outbreak at MCC were not, even though they begged for attention.

43. In the early summer, in an incident witnessed by Mr. Price, a resident on the 19th floor, perhaps in his early 30s, was spitting up blood. Responding staff—correctional officers and lieutenants—arrived in about 30 minutes; it appeared that no medical staff came with them. When the responders tried to put a mask on the resident, he took off the mask and said he could not breathe. Soon after, a lieutenant took a used garbage bag from a nearby garbage can and put the garbage bag over the resident's upper body—with some garbage still inside. The resident was moving around under the garbage bag and fell on the stairs as staff were escorting him. Staff picked him up and put him on the elevator. One of the resident's family members, also detained on the 19th floor, said that other family members reported that his relative had been transported to Northwestern Memorial Hospital where he was put on a ventilator.

44. The haphazard and insufficient measures that led to the spring 2020 COVID-19 outbreak at MCC continued even after the outbreak. In the late summer, BOP issued its apparently first version of pandemic guidance (dated August 31, 2020 to September 28, 2020.) This directed facility management to "[p]eriodically throughout the outbreak and at the conclusion of it [] review the implementation of your [] institution's COVID-19 Pandemic

Response Plan to identify what has worked well . . . [or] what has not . . . [I]dentify areas for improvement . . ..”[33]

45. At MCC, nothing changed. Basic isolation and quarantine rules were still violated; persons who had tested positive were housed with those who had not. MCC continued to rely on symptom self-reporting to identify sick residents, but as in the spring, some individuals did not report symptoms because they did not want to be relocated within MCC to the SHU or security isolation elsewhere. Others, however, begged for attention and testing but were ignored.

46. Unsurprisingly, and as warned by public health experts, a second COVID-19 outbreak overtook MCC in mid-November 2020. At its height, at the start of December, BOP reported that 127 MCC detainees and prisoners were once again sick—again over 20% of the population. These numbers understate the extent of the outbreak since universal testing is still not in place. Only once infection has spread within a floor are MCC residents widely tested, and by then it is too late.

47. Defendants’ reliance on symptom self-reporting—and its decision to eschew routine surveillance testing of staff and residents—was ill-advised in the early stages of the pandemic and is unforgivable now. In the spring, the availability of COVID-19 testing was widely reported to be limited, although, on information and belief, MCC has had two Abbott lab testing machines since the spring. Regardless, there is no longer a dearth of testing and testing supplies for COVID-19 in Illinois. During the week of April 11-17, 2020, the number of tests reported daily by the Illinois Department of Public Health (“IDPH”) ranged from a low of 4,848 to a high of 7,956; during the week of November 11-17, 2020, the number of tests reported daily

[33] Federal Bureau of Prisons, *COVID-19 Pandemic Response Plan Overview* (Aug. 31, 2020), p. 7, https://www.bop.gov/foia/docs//Overview_of_COVID_Pandemic_Response_Plan_08312020.pdf.

by IDPH ranged from a low of 84,831 to a high of 106,540. Moreover, at all times, MCC has had available to it federal resources for COVID-19 testing not available to state or municipal governments. The BOP Pandemic Plan issued in late summer observes that "[w]ith the increased availability of testing supplies and the increased understanding of the epidemiology of transmission, expanded TESTING STRATEGIES have become an important tool in the prevention and management of COVID-19 infections. . . ."[34]

48. Routine surveillance testing of staff and residents, like that mandated for long-term care facilities, is now an established method to help keep SARS-CoV-2 out of crowded correctional settings and to create an "early warning" system to identify resident infections. Other correctional systems have implemented surveillance testing, including the California Department of Corrections and Rehabilitation and the New Jersey Department of Corrections, which instituted its program in July 2020 after a major spring outbreak in its prisons.

49. Despite this, and ongoing surges in COVID-19 cases in its facilities throughout the country, BOP has not instituted surveillance testing, and Defendants have not done so at MCC in spite of two major outbreaks at the site and the evidence that symptom self-reporting is insufficient.

50. MCC has also failed at other, simpler measures. One of the most familiar means to combat the spread of infectious disease is routine cleaning and sanitation. Since the very beginning of the pandemic, handwashing and regular cleaning and disinfection of shared surfaces have been among the staples of public health advice to prevent the spread of COVID-19.

[34] Exhibit A to Government's Opposition to Defendant's Motion for Compassionate Release From Incarceration, *United States of America v. Pantone*, No. 16-cr-10018 (D. Mass. Nov. 12, 2020), ECF 59-1.

51. Providing residents with the means to keep themselves and their spaces clean—one of the few ways in which they can, however minimally, help control their fates—would seem straightforward, but Defendants have failed this challenge as well. Bar soap—the recommended method of hygiene by the CDC—has been, and continues to be, limited at MCC. Residents are supposed to receive one small bar of soap each week; especially with frequent handwashing, this bar will not last a week, and the bars sometimes run out before they are distributed to everyone. More soap can be purchased from commissary (two additional small bars every two weeks), but all residents do not have funds.

52. Residents on the cell floors are responsible for cleaning their own cells, but cleaning supplies have also been in short supply. Recently laundry services have been sporadic as well, with bedding going unwashed for weeks—and even months—at a time, forcing residents to wash their own sheets in trash buckets and hang them out to dry.

53. Liquid hand sanitizer is only permitted in dispensers in certain common locations, accessible primarily to staff and not to residents. These dispensers are often empty.

54. The cleaning of common areas is also haphazard. Most of these areas—showers, phones, computers used to email family or iPads used for FaceTime calls—are in heavy use, frequently touched by dozens of residents in the course of a single day. On the 23rd floor, for instance, there are four showers and four toilets shared by over 100 men. Showers are cleaned after a large group has used them, not after each use. Phones and computers are likewise not cleaned regularly in spite of BOP directives.

55. On the dormitory floors (21st and 23rd), residents are assigned to four sections within the floor. Around the beginning of May, Defendant Heisner installed make-shift plexiglass dividers between the sections. Residents nonetheless move freely between the sections

and have described the plexiglass dividers as additional surfaces that accumulate pathogens. These surfaces are also not regularly cleaned.

56. Disinfection is so poor that, in the middle of a viral pandemic, the 23rd floor, a dormitory floor, also experienced an outbreak of MRSA (Methicillin-resistant Staphylococcus aureus) starting in the summer of 2020. On information and belief, more than a dozen individuals on the floor had infections. One infection was so serious and so resistant to treatment that the patient had multiple hospitalizations before he was transferred out of MCC. This outbreak is still ongoing in January 2021.

57. Finally, Defendants' policies, practices, and deployment of another straightforward preventative measure—masks—has also been systematically inadequate. Masks are universally recognized as one of the most important coronavirus transmission prevention measures and have been so for months, but Defendants have also failed to use this tool to protect the residents of MCC.

58. Early in the pandemic, MCC residents were provided with some disposable masks. Later, they were provided cloth masks. But regular distribution of cloth masks ceased sometime in fall 2020.

59. Even more unconscionable, Defendants have failed to ensure staff compliance with masking rules, although staff are the ones who go in and out of MCC on a daily basis into a community whose positivity rate has been as high as 10% or more recently. Staff pull down their masks to talk to residents or other staff, or wear them under their noses or pulled down beneath their chin.

60. At MCC, where visits have been suspended and the facility has been on restricted movement since March 2020, Defendants' failure to ensure staff compliance with PPE usage

rules has enabled the transmission of COVID-19 amongst residents and continues to put the Plaintiffs and Class at risk of serious harm.

61. Defendants' last failed measure to contain COVID-19 has damaged residents psychologically and has failed to prevent coronavirus transmission. MCC has been on lockdown since mid-March. Although the intensity of lockdown has varied over time, at its worst—and recently—already fearful residents are locked in their cells for 23 or 24 hours a day, coming out 20-30 minutes three times each week for showers or phone calls to family, and often forced to choose between them due to the shortness of time. When the 23rd floor was put on lockdown again recently, one individual immediately attempted suicide. Nevertheless, the lockdowns have not stopped rapid spread of COVID-19 throughout MCC.

62. Staff are also hard to find, increasing the anxiety and isolation of residents. During the spring outbreak, they would creep onto floors via staircase entrances that were shielded from view of residents, so as to avoid interactions or answering questions. Case managers and other personnel who should be on every residential floor regularly are scarce. Plaintiffs Price and Conway have not seen the Warden in months, and other senior staff are rarely in evidence.

63. MCC's deplorable handling of COVID-19 is compounded by its generally inadequate healthcare, which has become worse during the pandemic and further compounds residents' anxiety. Routine healthcare requests are not attended to. A resident of the 23rd floor—a dormitory housing floor, with beds a few feet apart—who tested positive for tuberculosis had no follow-up tests and slept among all the other residents on this crowded floor.

64. Mr. Price has gone without his blood pressure medicine, sometimes for weeks, during the pandemic despite the fact that medical experts recognize that hypertension places

individuals at increased risk for severe COVID-19 and that poorly controlled chronic health problems further elevate that risk.[35]

65. Finally, when residents do fall ill, the care they receive is shameful. Locked in isolation, a nurse may come by once a day. The only medication offered is Tylenol. The failure to monitor and properly treat ongoing cases of COVID-19 increases the likelihood of serious illness and death.

66. Now that vaccines are available, the residents of MCC, like those of other detention and correctional facilities, deserve early access to the vaccine; this is especially the case since Defendants have shown themselves incapable and unwilling to implement the measures to mitigate the spread of the virus urged by public health authorities from the very start of the pandemic, many months ago. But supplies are scarce, and even when MCC residents are offered the vaccines, the protective measures set forth above, at which Defendants have so far failed, will continue to be essential for the foreseeable future—at least months and perhaps longer. It is currently unknown whether the Pfizer-BioNTech and Moderna vaccines render their recipients, in whole or even in part, unable to transmit the virus to others. Vaccine acceptance, both inside and outside of MCC, may take some time to achieve. In the meantime, in addition to the other protective measures that must remain in place, Defendants must undertake a robust program of vaccination education to ensure that MCC residents and staff understand and accept these new vaccines. Lack of such a program already has damaged residents' trust of the vaccines.

[35] Ctrs. For Disease Control and Prevention, *COVID-19, People with Certain Medical Conditions*, updated (Dec. 29, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

Class Allegations

67. Pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure, Plaintiffs bring this action as a Class consisting of all persons confined or to be confined in MCC, including as Subclasses: (A) persons confined pre-trial ("Pre-trial Subclass"), and (B) persons confined pursuant to a judgment of conviction ("Post-conviction Subclass"). Plaintiffs reserve the right to amend the Class definition or establish Subclasses as appropriate if discovery or further investigation reveals the Class should be expanded or otherwise modified.

68. Numerosity (Rule 23(a)(1)): The Class is so numerous that joinder is impracticable. Based upon information reported by BOP, the size of the Class is between 500 and 600 people and is therefore so numerous that joinder is inherently impracticable for that reason alone. Similarly, the Pre-trial Subclass consists of around 90% of all MCC residents—around 450 or more people. The Post-conviction Subclass also satisfies numerosity because, at any given moment, there are between 40 and 100 MCC residents who are in the facility post-conviction. Joinder is also inherently impracticable for other, independent reasons. The Class and each Subclass includes unnamed, future Class members who cannot by definition be joined. Further, proposed Class members are highly unlikely to file individual suits on their own, as all are incarcerated and many are indigent, and thus have limited access to their retained or court-appointed counsel, are currently incarcerated, fear retaliation from filing suits against Defendants, and lack access and financial resources to obtain qualified counsel to bring such suits.

69. Commonality (Rule 23(a)(2)): The claims of the Class and Subclasses share common issues of fact and law, including but not limited to whether Defendants' policies and procedures (or lack thereof) as to the prevention, mitigation, and management of COVID-19 in

MCC—policies and procedures that affect all proposed Class members—put the Class at substantial risk of serious harm and violate the Fifth and Eighth Amendments to the United States Constitution and the Administrative Procedure Act. The resolution of these questions will drive the outcome of the litigation.

70. Typicality (Rule 23(a)(3)): The claims of Plaintiffs are typical of those of the Class as a whole, because each Plaintiff is currently in Defendants' custody and Plaintiffs' claims arise from the same policies and procedures (or lack thereof) that provide the basis for all proposed Class members' claims.

71. Adequacy (Rule 23(a)(4)): Plaintiffs are adequate Class representatives who meet all of the requirements of Rule 23(a)(4). They have no conflicts of interest in this case with other Class members. They will fairly and adequately represent the interests of the Class and Subclasses. Mr. Price is a member of the Pre-trial Subclass, and Mr. Conway is a member of the Post-conviction Subclass. Each Plaintiff understands the responsibilities of a Class and Subclass representative. Counsel for Plaintiffs will vigorously prosecute the interests of the Class and Subclasses and include attorneys with extensive experience with the factual and legal issues involved in representing jail and prison inmates, in asserting constitutional rights, and/or in pursuing class actions.

72. Rule 23(b)(2): The proposed Class and Subclasses satisfy the requirements of Federal Rule of Civil Procedure 23(b)(2) in that Defendants' policies and procedures (or lack thereof) as to the prevention, mitigation, and management of COVID-19 in MCC constitute action and refusal to act on grounds generally applicable to the Class and each Subclass, and final injunctive relief and corresponding declaratory relief are appropriate respecting the Class as a whole and each Subclass.

COUNT I

Administrative Procedure Act, 5 U.S.C. §§ 702, 706(2)—Violation of 18 U.S.C. § 4042(a)(2) and Implementing Regulations

(Plaintiffs and the Class Against Defendant Federal Bureau of Prisons for Injunctive and Declaratory Relief)

73. Plaintiffs incorporate all of the preceding paragraphs as if fully set forth herein.

74. Plaintiffs and the Class are entitled to care and safekeeping while in BOP custody. 18 U.S.C. § 4042(a)(2) requires BOP to "provide for the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States. . . ."

75. BOP regulation requires the agency to "manage infectious diseases" in its facilities "through a comprehensive approach which includes testing, appropriate treatment, prevention, education, and infection control measures." 28 C.F.R. § 549.10.

76. BOP regulation also prohibits detainees and prisoners "with infectious diseases transmitted through casual contact . . . from work assignments in any area until fully evaluated by a healthcare provider. 28 C.F.R. § 549.13(a). The same regulation prohibits the disciplinary action against an individual in BOP custody solely on the basis of a positive result for an infectious disease . *Id.* § 549.13(c). BOP regulation also requires each facility's clinical director to assess residents with infectious diseases for appropriate programming, duty, and housing. *Id.* § 549.13(a).

77. Despite these directives, Defendant has failed, and continues to fail, to provide an adequate level of care and safekeeping to Plaintiffs and the Class as evidenced, inter alia, by the fact that MCC has had not one but two major outbreaks of COVID-19 causing physical suffering and psychological distress to Plaintiffs and the Class.

78. Moreover, Defendant's failure to follow BOP regulations contributes to the failure to provide for the safekeeping and care of Plaintiffs and the Class. Defendant allowed individuals who had confirmed cases of COVID-19 or who were suspected of having COVID-19 to continue their work assignments. Defendant also disciplined residents by placing them in the secure housing unit solely because they had COVID-19 or were suspected of having COVID-19. Defendant continues to engage in these practices contrary to BOP regulations.

79. Defendant has also failed to follow BOP regulations requiring a comprehensive approach to the management of infectious disease, which includes testing, appropriate treatment, prevention, education, and infection control measures by: suppressing testing and failing to ensure routine, surveillance testing of staff and residents; failing to provide appropriate treatment; failing to ensure consistent use of masks and other PPE by staff and residents; failing to educate staff, inmates, and visitors about precautions they could take to avoid transmission; failing to implement proper isolation and quarantine procedures; failing to sanitize and maintain the physical plant in order to prevent spread of infection; failing to institute early and comprehensive vaccination of residents and staff; and failing to deploy robust vaccination and PPE use campaigns, and other measures.

80. To the extent Defendant has acted at all, the ineffective measures BOP has deployed to manage the virus at MCC have not only failed to contain it, but inflicted and continue to inflict grave psychological injury on all residents as well as needless pain and suffering on those who have contracted COVID-19.

81. As a consequence of Defendant's past and continuing failure to follow its statutory obligations and its own regulations, Mr. Price, Mr. Conway and members of the Class face an ongoing risk of severe harm from COVID-19.

82. BOP's failure to follow its own regulations is arbitrary, capricious, an abuse of discretion, and otherwise unauthorized by law in violation of the Administrative Procedure Act. 5 U.S.C. § 706(2).

COUNT II

Fifth Amendment—*Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320 (2015)

(Plaintiff Price and the Pre-Trial Subclass Against All Defendants)

83. Plaintiffs incorporate all of the preceding paragraphs as if fully set forth herein.

84. The Fifth Amendment to the United States Constitution guarantees pretrial detainees a due process right to conditions of reasonable health and safety, which requires protection from risks of serious harm and adequate medical care for serious health needs.

85. The Fifth Amendment also prohibits the punishment of pre-trial detainees.

86. The conditions at MCC pose substantial risks of serious harm to Plaintiff Price and the members of the Pre-trial Subclass, and Defendants' conduct as to this risk of harm is objectively unreasonable and evidences purposeful, knowing, or reckless disregard of the consequences. *Miranda v. County of Lake*, 900 F.3d 335 (7th Cir. 2018); *Hardeman v. Curran*, 933 F.3d 816 (7th Cir. 2019). Defendants have failed to develop and implement effective policies and procedures for preventing and mitigating coronavirus transmission in MCC, and have failed to implement and enforce those policies and procedures which they do have, to protect Mr. Price and the Pre-trial Subclass from known risks of serious harm, both physical and psychological. Ten months into the pandemic, Defendants have failed meaningfully to modify and improve their infection prevention and mitigation procedures, which has now led to not one but two major outbreaks of COVID-19 at MCC. In addition, Defendants' months-long reliance on lockdowns, which have proved unable to stop the spread of COVID-19 through MCC, have caused and will

continue to cause depression, anxiety, and other damaging physical and psychological effects for Mr. Price and the Pre-trial Subclass.

87. Defendants also fail to provide adequate care for those who have contracted COVID-19 at MCC. In this as well, their conduct is objectively unreasonable and evidences purposeful, knowing, or reckless disregard of the consequences.

88. As a result of Defendants' unconstitutional actions and inactions, Plaintiff Price and the Pre-trial Subclass are suffering irreparable injury.

COUNT III

Eighth Amendment—*Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320 (2015)

(Plaintiff Conway and the Post-Conviction Subclass Against All Defendants)

89. Plaintiffs incorporate all of the preceding paragraphs as if fully set forth herein.

90. The Eighth Amendment to the United States Constitution protects Plaintiff Conway and members of the Post-conviction Subclass from cruel and unusual punishment.

91. Prison conditions (1) which pose "an unreasonable risk of serious damage" to a prisoner's health and (2) to which prison officials have acted with deliberate indifference constitute the infliction of cruel and unusual punishment. *Helling v. McKinney*, 509 U.S. 25, 33–35 (1993).

92. The SARS-CoV-2 virus and the disease it causes poses substantial risks of serious harm to Plaintiff Conway and the members of the Post-conviction Subclass, who are typically housed on MCC's dormitory housing floors. To the extent Defendants have acted at all, the ineffective measures Defendants have deployed to manage the virus have not only failed to contain the coronavirus, exposing Mr. Conway and the Post-conviction Subclass to substantial risks of serious harm, but also have inflicted and continue to inflict grave psychological injury.

In addition, Defendants have inflicted needless pain and suffering on those who have contracted COVID-19 by their failure to provide minimally adequate medical care, and exposed them to further risks of harm as a result.

93. Defendants are aware of these risks but have acted with deliberate indifference to them by failing to implement effective policies and procedures, and failing to implement and enforce those policies and procedures which they do have, to protect Plaintiff Conway and the Post-conviction Subclass from known risks of serious harm, both physical and psychological. Further, ten months into the pandemic, and despite two outbreaks of COVID-19, Defendants have persisted in courses of action which they know to be ineffective to prevent the entry of the virus into MCC or to stop the spread of the virus once inside the facility.

94. As a result of Defendants' actions, Plaintiff Conway and the Post-conviction Subclass are suffering irreparable injury.

COUNT IV

Eighth Amendment—Bivens

(Plaintiff Conway and the Post-Conviction Subclass Against Defendants Carvajal, Heisner, and Ndife)

95. Plaintiffs incorporate all of the preceding paragraphs as if fully set forth herein.

96. The Eighth Amendment to the United States Constitution protects Plaintiff Conway and members of the proposed Post-conviction Subclass from cruel and unusual punishment.

97. The Supreme Court has recognized *Bivens* theories in the context of Eighth Amendment deliberate indifference to serious medical needs. *Carlson v. Green*, 446 U.S. 14 (1980).

98. The Seventh Circuit has recognized that plaintiffs may seek injunctive relief through a *Bivens* claim. *Bunn v. Conley*, 309 F.3d 1002, 1009 (7th Cir. 2002); *see also Robinson v. Sherrod*, 631 F.3d 839, 842 (7th Cir. 2011) (prospective relief is available in a *Bivens* action); *Glaus v. Anderson*, 408 F.3d 382, 389 (7th Cir. 2005).

99. Prison conditions (1) which pose "an unreasonable risk of serious damage" to a prisoner's health and (2) to which prison officials have acted with deliberate indifference constitute the infliction of cruel and unusual punishment. *Helling v. McKinney*, 509 U.S. 25, 33–35 (1993).

100. The SARS-CoV-2 virus and the disease it causes poses substantial risks of serious harm to Plaintiff Conway and the members of the Post-conviction Subclass, who are typically housed on MCC's dormitory housing floors. To the extent Defendants have acted at all, the ineffective measures Defendants have deployed to manage the virus have not only failed to contain the coronavirus, exposing Mr. Conway and the Post-conviction Subclass to substantial risks of serious harm, but also have inflicted and continue to inflict grave psychological injury. In addition, Defendants have inflicted needless pain and suffering on those who have contracted COVID-19 by their failure to provide minimally adequate medical care, and exposed them to further risks of harm as a result.

101. Defendants are aware of these risks but have acted with deliberate indifference to them by failing to implement effective policies and procedures, and failing to implement and enforce those policies and procedures which they do have, to protect Plaintiff Conway and the Post-conviction Subclass from known risks of serious harm, both physical and psychological. Further, ten months into the pandemic, and despite two outbreaks of COVID-19, Defendants

have persisted in courses of action which they know to be ineffective to prevent the entry of the virus into MCC or to stop the spread of the virus once inside the facility.

102. As a result of Defendants' actions, Plaintiff Conway and the Post-conviction Subclass are suffering irreparable injury.

IV. PRAYER FOR RELIEF

Wherefore, Plaintiffs and the Class members respectfully request that the Court order the following relief:

A. Enter a declaratory judgment that Defendants have failed to provide an adequate level of care and safekeeping to Plaintiffs and the Class in violation of 18 U.S.C. § 4042(a)(2) and 5 U.S.C. § 702;

B. Enter a declaratory judgment that Defendants' policies and practices at MCC violate the Fifth Amendment right to conditions of reasonable safety, including protection against harm and to adequate medical care with respect to Plaintiff Price and the Pre-trial Subclass;

C. Enter a declaratory judgment that Defendants' policies and practices at MCC violate the Eighth Amendment right to be free of cruel and unusual punishment with respect to Plaintiff Conway and the Post-conviction Subclass;

D. Order Defendants to create and implement a mitigation plan for prevention and treatment of COVID-19 at MCC that includes:

1. Education to promote COVID-19 vaccination for all MCC residents and staff, in collaboration with local, state, and federal health officials, to maximize vaccine uptake;

2. Development of a vaccination plan for MCC residents in order of decreasing risk of severe illness, starting with residents age 55 and older and those with co-morbidities;

3. Vaccination of all MCC residents and staff as soon as possible;

4. Aggressive testing using an Abbott antigen test (*Ag*) with rapid test results within 12-24 hours for screening of symptomatic detainees (and employees); and the use of a highly sensitive PCR test (*PCR)* for asymptomatic screening with a <48 hour turnaround for results of:

a. All 550 residents, once (PCR);

b. All new residents, at intake, in a separate and safe space (PCR);

c. All staff, weekly, with frequency of testing determined by the % positive (PCR);

d. All symptomatic residents and staff (Ag);

e. Implementation of a simple Information Technology system to maintain testing data safely and reliably for ongoing monitoring and reporting;

5. Isolation of all COVID-positive MCC residents in a separate ward or block of rooms;

6. Quarantine of all symptomatic MCC residents who are SUIs (Suspects under investigation), in a separate ward or block of rooms, apart from the COVID-positive MCC residents and the general MCC population;

7. Rapid identification, diagnosis, isolation, delivery of, or transfer for, the appropriate level of medical care for MCC residents with moderate-severe COVID-19 illness;

8. Hiring an infectious disease/public health expert to advise and monitor COVID control efforts;

9. Transparency of all COVID-19 data, plans, and guidance for and staff to offer timely information, e.g. with daily or weekly updates on a website;

10. Universal masking, and procedures to enforce mask wearing and to launder or sterilize masks in order to maintain a supply of clean masks;

11. Reliable symptom screening of MCC residents to identify selected residents for rapid COVID testing and movement into SUI cohort housing;

12. Mental health measures to address isolation, depression, self-harm and suicidal ideation in MCC residents in conjunction with greater access to phones, e-visits, and yard or exercise time;

13. Hand washing and/or sanitation with widely available soap and water, or hand sanitizer stations, throughout the facility, and signage to reinforce frequent hand washing, together with regular laundry services;

14. Systematic cleaning and surface sanitation of all common points of contact, i.e. door knobs, public phones, multi-use tablets, bannisters, faucets, toilet handles, etc.;

15. Consultation with infection control expert engineers regarding feasible improvements in HVAC ventilation and filtration systems, and in cohort analysis of stool for COVID-19 positive housing areas.

E. Certify this case as a class action, including by certifying the Class defined above, *supra* ¶ 67, the Subclass of MCC pre-trial detainees defined above, *supra* ¶ 67(A), and the Subclass of post-conviction MCC residents defined above, *supra* ¶ 67(B);

F. Award Plaintiffs attorneys' fees and costs, as provided by statute and law; and

G. Award such other relief as the Court deems just, proper, and equitable.

Dated: January 29, 2021

Respectfully submitted,

/s/ Camille E. Bennett

Camille E. Bennett
Nusrat Jahan Choudhury
Allyson M. Bain
Emily Hirsch
Roger Baldwin Foundation of ACLU, Inc.
150 N. Michigan Ave., Ste. 600
Chicago, IL 60601
(312) 201-9740
cbennett@aclu-il.org
nchoudhury@aclu-il.org
abain@aclu-il.org
ehirsch@aclu-il.org

Attorneys for Plaintiffs