IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, JULIO CESAR MEDEIROS NEVES, and all those similarly situated,

Petitioners-Plaintiffs,

v.

THOMAS HODGSON, Bristol County Sheriff in his Official Capacity; STEVEN J. SOUZA, Superintendent Bristol County House of Corrections in his Official Capacity; TODD LYONS, Boston Field Office, Acting Director, Immigrations and Customs Enforcement in his Official Capacity;
CHAD F. WOLF, Acting Secretary, Department of Homeland Security, in his Official Capacity; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director for U.S. Immigration and Customs Enforcement, in his Official Capacity; and U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT,

Respondents-Defendants.

Civil Action No.

PETITION FOR WRIT OF HABEAS CORPUS PURSUANT TO 28 U.S.C. 2241 AND COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

INTRODUCTION

1. This case presents a request for immediate relief on behalf of a putative class of highly vulnerable Petitioner-Plaintiffs ("Plaintiffs") – civil immigration detainees held by Respondents-Defendants ("Defendants") at the Bristol County House of Corrections and C. Carlos Carreiro Immigration Detention Center ("Carreiro") in North Dartmouth, Massachusetts (hereinafter collectively "Bristol County Immigration Detention Facilities") – who are at imminent risk of contracting COVID-19, the lethal virus that is sweeping the globe and that feeds on precisely the unsafe, congregate conditions in which Plaintiffs are being held.

2. The coronavirus that causes COVID-19 infection – and death – has produced an unprecedented global pandemic. In only a few months, 529,093 people worldwide have been diagnosed with COVID-19 and more than 23,956 have died.[1] The virus is highly contagious and lethal. By the time this Court reads this complaint, there will be more diagnoses, and more death, with no end in sight.

3. Despite repeated pleas from Plaintiffs and community advocates, and despite clear evidence that the dangerous conditions in the Bristol County Immigration Detention Facilities where Plaintiffs are confined will imminently result in the uncontrolled spread of COVID-19 and the likely death of many detainees including Plaintiffs, Defendants have continued to confine detainees in close proximity, without adequate soap, toilet paper, and other daily necessities; admit new detainees without COVID-19 testing or screening; deny access to testing and medical care for Plaintiffs and other detainees; and refuse to release even the most vulnerable detainees with medical conditions that heighten their risk for infection, sickness, and death.

4. These actions by Defendants are the result of two egregious errors: Defendants' flawed policies and decision-making surrounding COVID-19; and the conditions and structure of immigration detention and confinement at Bristol County Immigration Detention Facilities.

5. Plaintiffs are subject to imminent infection, illness, and death because of their civil immigration detention – literally trapped, with no safe alternative available to them. Facility staff have rebuffed their inquiries about COVID-19 risks and precautions. Their confinement conditions and detention treatment have created a dangerous and hazardous situation that imminently threatens their lives, as well as the well-being of guards and others in the surrounding community, and the

[1] John Hopkins University, Coronavirus Resource Center (March 26, 2020), https://coronavirus.jhu.edu/map.html; World Health Organization, *Coronavirus Disease 2019 (COVID-19) Situation Report* (Mar. 26, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200326-sitrep-66-covid-19.pdf?sfvrsn=81b94e61_2.

general public. Immediate relief is necessary before the coronavirus ignites the tinderbox that is BCHOC and irreversible damage is done.

6. As putative class members have repeatedly expressed in pleas for help to Defendants, they are afraid for their lives. The only known effective measures to reduce the risk of COVID-19 are social distancing and hygiene. Yet "social distancing" is a meaningless term in BCHOC, where detainees are in constant close contact with each other and with Bristol County Immigration Detention Facilities staff. Hygiene is similarly unavailable and unavailing under the conditions at Bristol County Immigration Detention Facilities.

7. Plaintiffs are not being detained pursuant to a conviction. Rather, they are in civil detention awaiting the completion of immigration proceedings. Immigration and Customs Enforcement ("ICE") has significant discretion to release immigration detainees, *see* 8 U.S.C. 1226(a), and has a long-standing practice of releasing for humanitarian reasons even those whose detention has been mandated under particular immigration detention statutes, *see* 8 U.S.C. 1182(d)(5); 1225(b); 1226(c). ICE regularly uses alternatives to detention to maintain custody and control over non-citizens in immigration proceedings, such as supervised release, electronic ankle monitors, home confinement, and telephonic monitoring.

8. The risks and consequences of COVID-19 cannot be understated. In the United States alone, 83,507 cases of infection have been reported and 1,201 people have died.[2]

9. The disease itself does not discriminate between the old and young. People of all ages, with and without preexisting conditions, have died.

[2] John Hopkins University, Coronavirus Resource Center (March 26, 2020), https://coronavirus.jhu.edu/map.html; World Heath Organization, *Coronavirus Disease 2019 (COVID-19) Situation Report* tbl. 1 (Mar. 26, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200326-sitrep-66-covid-19.pdf?sfvrsn=81b94e61_2.

10. At the time of this filing there were 2,417 reported cases in Massachusetts[3] including persons confined or working in correctional institutions.

11. At the time of this filing there were 1,012 reported cases in Connecticut.[4] Many immigration detainees are brought to BCHOC from Connecticut.

12. There is no vaccine against COVID-19.

13. There is no known cure for COVID-19.

14. No one and no place is immune from COVID-19 infection, illness, and death.

15. The Centers for Disease Control and Prevention ("CDC") reports that "[t]he best way to prevent illness is to avoid being exposed to this virus." The CDC advises that COVID-19 is thought to spread mainly from person-to-person, between people who are in close contact with one another (within about 6 feet), and through respiratory droplets produced when someone speaks, coughs, or sneezes, including the touch of shared surfaces.[5]

16. States have taken extraordinary and unprecedented measures to ensure that residents practice "social distancing" in order to halt the spread of COVID-19. On March 23, 2020, Massachusetts Governor Charlie Baker ordered the closure of all non-essential businesses and advised residents to shelter in place.

17. The projections for those who contract the virus and those who succumb to the illness are startling and grave. The CDC has suggested that between 160 million and 210 million Americans could contract the disease. Based on mortality data and current hospital capacity, the number of deaths under the CDC's estimates range from 200,000 to as many as 1.7 million. The

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[3] State of Massachusetts, *COVID-19 Cases, Quarantine, and Monitoring* (Mar. 26, 2020), https://www.mass.gov/info-details/covid-19-cases-quarantine-and-monitoring.
[4] State of Connecticut, *COVID-19 Update March 26, 2020* (Mar. 26, 2020), https://portal.ct.gov/-/media/Coronavirus/CTDPHCOVID19summary3262020.pdf?la=en.
[5] World Health Organization, Rolling updates on coronavirus disease (COVID-19) (Updated Mar. 20, 2020) https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen. 4 As of March 21, 2020 at 7:06 p.m. EST. See COVID-19 CORONAVIRUS PANDEMIC, WORLDOMETER (Mar. 21, 2020), https://www.worldometers.info/coronavirus/. 5 Id. 6 As of March 21, 2020 at 3:10p.m. EST.

CDC projects that as many as 21 million people might need hospitalization, a daunting figure in a nation with just about 925,000 hospital beds.

18. Recognizing the urgency of present circumstances, judges, prosecutors and correctional authorities across the country have been ordering releases to protect individuals and the public health. Such releases not only protect the people with the greatest vulnerability to serious illness and death from COVID-19 from transmission of the virus, they also contribute to greater risk mitigation for all people in custody or working in a prison, jail, or detention center, and reduce the burden on the surrounding region's limited hospitals and health care infrastructure, as they lessen the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.[6]

19. Law enforcement and jail officials in Los Angeles, Oakland, New Jersey, New York City, Cleveland, Nashville, Houston, San Antonio, Charlotte, and numerous other jurisdictions are releasing thousands of individuals - both civil detainees and, in many cases, people serving sentences for criminal convictions or pre-trial detainees, because of the threat COVID-19 poses inside jails.

20. Several recent court rulings have explained the health risks—to inmates, guards, and the outside community at large—created by large prison populations. See, e.g., *Jimenez v. Wolf*, No. 18-10225-MLW (D. Mass. Mar. 26, 2020) (ordering release of immigrant detainee in the midst of the COVID-19 pandemic and noting that "being in a jail enhances risk" and that in jail "social distancing is difficult or impossible"); *United States v. Stephens*, No. 15-cr-95-AJN, 2020 WL 1295155, at *2 (S.D.N.Y. Mar. 19, 2020) (ordering the release of inmate in Federal Bureau of Prisons custody due, in part, to risk posed by COVID-19 in the facility); *In the Matter of the Extradition of Alejandro Toledo Manrique*, Case No. 19-mj-71055, 2020 WL 1307109, at *1 (N. D. Cal. March 19, 2020) (ordering change to conditions of bail for an individual to postpone incarceration, in part in light of

[6] There are only four hospitals located in the entirety of Bristol County.

risk of vulnerability to the coronavirus) *United States v. Barkman*, No. 3:19-cr-0052-RCJ-WGC, 2020 U.S. Dist. LEXIS 45628 (D. Nev. Mar. 17, 2020). On March 22 the New Jersey Supreme Court issued a consent order for the presumptive release of approximately 1,000 persons by March 26.

21. Despite the directives from the CDC, the extraordinary measures being taken by government officials to ensure social distancing, and the lack of adequate medical and cleaning supplies, Defendants have failed to protect one of the most vulnerable populations: civil immigration detainees.

22. Defendants' response to the threats the pandemic poses to immigrants has been abysmal and haphazard. Following public outcry, on March 17, 2020, ICE issued a statement that it would modify its enforcement efforts in apparent recognition of the need for alternatives to detention to protect public health.

23. The next day, however, in response to a lawsuit for the release of vulnerable ICE detainees in Washington state, the agency again demonstrated its failure to appreciate the threats the COVID-19 pandemic presents, stating that "Plaintiffs' assertion that detention *per se* poses an increased risk of health complications or death from COVID-19 is purely speculative."[7] ICE's head-in-the-sand response to the threats of this pandemic will prove deadly to immigrant detainees if it is not remedied through this Court's intervention.

24. On March 19, 2020, two medical subject matter experts for the Department of Homeland Security's Office of Civil Rights and Civil Liberties blew the whistle to Congress, writing "regarding the need to implement immediate social distancing to reduce the likelihood of exposure to detainees, facility personnel, and the general public, ***it is essential to consider releasing all***

[7] Respondents—Defendants' Opposition at 8, Dawson v. Asher, ECF No. 28, Case No. 20-0409 (W.D. Wash. Mar. 18, 2020).

detainees who do not pose an immediate risk to public safety."[8] On multiple occasions since at least February 25, 2020, these experts had sounded the alarm within the agency on the imminent risks to the health of immigrant detainees and the public at large presented by COVID-19 unless swift mitigation measures, including decreasing the number of immigrant detainees, are taken.

25. Instead, Defendant Hodgson, the Sheriff of Bristol County, issued a statement on March 19, 2020 noting that although 80% of the individuals detained at BCHOC are immunocompromised, and thus particularly vulnerable to exposure to COVID-19, he refused to take *any* measures to release anyone from custody.

26. Inside Bristol County Immigration Detention Facilities, Defendants are not consistently taking even the less aggressive precautionary measures the Department of Homeland Security ("DHS") claims it is taking. To take one critical example, Defendants are introducing daily new detainees in with the general population without any mandatory quarantine period.

27. This echoes a concern of the two DHS medical experts, who say that "the track record of ICE facilities implementing [early screening, testing, isolation and quarantine] protocols historically has been inconsistent." Moreover even if ICE was consistently taking these precautions, the DHS experts have explained that they "won't be enough" without rapidly "releas[ing] those who do not pose an immediate danger to public safety." Defendants stubbornly refuse to heed the advice of public health experts, including their own.

28. No "social distancing" has taken place in Defendants' facilities – and it cannot. Plaintiffs are unaware of any meaningful safety measures enacted by Defendants since the inception of this crisis.

[8] Letter from Scott A. Allen, MD and Josiah Rich, MD, MPH to Congressional Committee Chairpersons, dated Mar. 19, 2020, available at https://assets.documentcloud.org/documents/6816336/032020-Letter-From-Drs-Allen-Rich-to-Congress-Re.pdf (emphasis in original).

29. Currently, there are approximately 57 immigration detainees at BCHOC in Unit B, and an unknown additional number of immigration detainees in Correira. All of them are at imminent risk. Their confinement conditions are a tinderbox, that once sparked will engulf the facility.

30. The inevitable viral spread in confined and crowded areas has already been evidenced by the rapid spread of COVID-19 in nursing homes and cruise ships. Detention facilities pose the same risk. "'It's a vulnerable situation,' John Sandweg, an acting head of ICE during the Obama administration, told CBS News. 'You have the exact situation everyone is cautioning against. You have a bunch of people contained in a very small environment.'…'[c]an you imagine if you get an outbreak in these detention facilities? It's going to spread like wildfire,' Sandweg added. "[9]

31. Plaintiffs, who are not subject to any form of punitive detention, are at risk because of Defendants' flawed choices and the conditions in Bristol County Immigration Detention Facilities. Their failure to follow public health guidance endangers the lives of those Defendants have chosen to detain. Inevitably, one detainee will contract COVID-19, and its spread throughout the facility will be impossible to contain. The only way to effectively inhibit the spread of COVID-19 and to protect Plaintiffs and others is to immediately release Plaintiffs, such that they can actually adhere to guidance from public health authorities and take the steps recommended by the government and medical professionals, and bar future immigrant admissions to the dangerous conditions at The only way to effectively inhibit the spread of COVID-19 and to protect Plaintiffs and others is to immediately release Plaintiffs, such that they can actually adhere to guidance from public health authorities and take the steps recommended by the government and medical

[9] Camilo Montoya-Galvez, *"Powder Kegs": Calls Grow for ICE to Release Immigrants to Avoid Coronavirus Outbreak*, CBS News (Mar. 19, 2020), https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak.

professionals, and bar future immigrant admissions to the dangerous conditions at Bristol County Immigration Detention Facilities.

32. Defendants cannot justify continuing to subject Plaintiffs to extraordinary risk of illness and death with any legitimate government objective, particularly in light of the alternatives available to them to maintain custody and control over Plaintiffs. The danger posed by Plaintiffs' detention during the current outbreak of COVID-19 is "so grave that it violates contemporary standards of decency to expose anyone unwillingly to such a risk" and violates their constitutional right to safety in government custody. *Helling v. McKinney*, 509 U.S. 25, 36 (1993). Plaintiffs bring this action on behalf of themselves and all other immigration detainees at Bristol County Immigration Detention Facilities, to remedy grave violations of their constitutional rights that imminently threaten them with serious illness and death.

33. Unless this Court intervenes to order the release of the Plaintiffs, they, along with many other detained individuals and outside communities, will face dramatically increased chances of contracting COVID-19, becoming seriously ill, and dying.

PARTIES

34. Petitioner-Plaintiff MARIA ALEJANDRA CELIMEN SAVINO is an immigration detainee in Correira. Ms. Celimen Savino suffers from asthma, a condition for which she has been previously hospitalized. She is at high risk for severe illness, exacerbated by the imminent risk of exposure to COVID-19 and the lack of safety precautions taken by Bristol County Officials or ICE.

35. Petitioner-Plaintiff JULIO CESAR MEDEIROS NEVES is a Brazilian national and immigration detainee in BCHOC. Mr. Medeiros Neves suffers from extreme depression and anxiety which has been exacerbated by the imminent risk of exposure to COVID-19 and the lack of safety precautions taken by BCHOC or ICE. He is one of the signatories to repeated pleas to ameliorate the situation made to Defendants by persons confined in Unit B.

36. Respondent-Defendant THOMAS HODGSON is named in his official capacity as Sheriff of Bristol County where he maintains supervision and control over Bristol County Immigration Detention Facilities which detains named Plaintiffs and other civil immigration detainees.

37. Respondent-Defendant STEVEN J. SOUZA is sued in his official capacity as the Superintendent of Bristol County House of Corrections. He has custody of Plaintiffs because ICE contracts with Bristol County House of Corrections to house immigration detainees, including Plaintiffs.

38. Respondent-Defendant TODD LYONS is sued in his official capacity as the acting Boston Field Office Director for U.S. Immigration and Customs Enforcement. He has responsibility for and authority over the detention and removal of noncitizens within the Boston Region, which includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

39. Respondent-Defendant CHAD WOLF is named in his official capacity as the acting Secretary of the U.S. Department of Homeland Security. Defendant Wolf is responsible for enforcing federal laws concerning, for example, border control and immigration, including the INA provisions at issue in this case. Defendant Wolf has direct authority over ICE, which is responsible for the civil detention of immigrants in the United States.

40. Respondent-Defendant MATTHEW T. ALBENCE is named in his official capacity as the acting Deputy Director and Senior Official Performing Duties of the Director for ICE. Defendant Albence oversees civil detention of immigrants in the United States.

VENUE

41. Venue in the District Court for the District of Massachusetts is proper under 28 U.S.C. § 1391(b) because Respondent-Defendant Hodgson resides in this District, Petitioners-Plaintiffs are detained in this District, and this District is the site of the injury at issue.

JURISDICTION

42. Defendant-Respondent Hodgson and all Plaintiffs reside within the jurisdiction of this Court.

43. This case arises under the Fifth Amendment to the United States Constitution and the Rehabilitation Act, 29 U.S.C. § 794(a).

44. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331, 1346, 2201-02, and § 2241, and Article 1, Section 9, clause 2 of the United States Constitution.

45. The United States has waived sovereign immunity for this action for declaratory and injunctive relief against one of its agencies and that agency's officers are sued in their official capacities. See 5 U.S.C. § 702.

FACTS

The COVID-19 Pandemic is Spreading Quickly and Poses Grave Risk of Serious Illness and Death

46. The outbreak of COVID-19 has reached pandemic status.

47. COVID-19 is easily transmitted and the numbers of confirmed cases and deaths are expected to grow exponentially.

48. All human beings share an equal risk of contracting and, upon contraction, transmitting the virus that causes COVID-19. Any adult who contracts the virus may experience life-threatening symptoms and death.

49. New information regarding COVID-19 risk factors is released daily by public health authorities. Beyond the extreme risks to all, the categories of individuals who may have conditions or characteristics that predispose them to complications from COVID-19 are growing – and not fully identified by medical experts.

50. The COVID-19 virus can severely damage lung tissue, which requires an extensive period of hospitalization and rehabilitation, and in some cases, can cause a permanent loss of respiratory capacity. More is learned each passing day about the extent of permanent injury that may be caused by COVID-19.

51. COVID-19 may also target the heart muscle, causing a medical condition called myocarditis, or inflammation of the heart muscle. Myocarditis can affect the heart muscle and electrical system, reducing the heart's ability to pump. This reduction can lead to rapid or abnormal heart rhythms in the short term, and long-term heart failure that limits exercise tolerance and the ability to work.

52. People of all ages and medical backgrounds who have experienced serious cases of COVID-19 describe painful symptoms, including vomiting, severe diarrhea, relentless shivering, and suffocating shortness of breath.

53. Emerging evidence suggests that COVID-19 can also trigger an over-response of the immune system further damaging tissues in a cytokine release syndrome that can result in widespread damage to other organs, including permanent injury to the kidneys and neurologic injury.

54. These complications can manifest at an alarming pace. Individuals can show the first symptoms of COVID-19 infection in as little as two days after exposure, and their condition can seriously deteriorate in five days or sooner.

55. People can also spread COVID-19 but be asymptomatic making testing or seclusion of only those who are symptomatic an ineffective solution.

56. Most people who develop serious illness will need advanced support. This level of supportive care requires highly specialized equipment that is in limited supply, even in non-detention settings, and an entire team of dedicated medical care providers.

57. People who experience serious cases of COVID-19 who do not die should expect a prolonged recovery, including the need for extensive rehabilitation for profound reconditioning, loss of digits, neurologic damage, and the loss of respiratory capacity.

58. There is no vaccine against COVID-19, nor is there any known medication to prevent or treat infection. The only known effective measures to reduce the risk for vulnerable people from illness, injury or death from COVID-19 are to prevent them from being infected in the first place, and to limit community spread. Social distancing or remaining physically separated from known or potentially infected individuals, and vigilant sanitation and hygiene, including repeatedly and thoroughly hand washing with soap and water, are the only known effective measures for protecting people from COVID-19

59. Nationally, projections by the CDC indicate that over 200 million people in the United States could be infected with COVID-19 over the course of the epidemic without effective public health intervention with as many as 1.5 million deaths in the most severe projections.

60. In recent days, the number of reported cases of infection in many parts of the country, including the Boston metropolitan area, have shown a frightening and exponential increase, and numerous media outlets and public officials estimate that the reported number of deaths could soon follow suit.

People Detained at Bristol County House of Corrections are at an Elevated Risk of COVID-19 Transmission, Infection and Illness.

61. Bristol County Immigration Detention Facilities confine civil immigration detainees in BCHOC Unit B, and the Correira.

62. Currently there are approximately 57 detainees held on civil immigration violations in Unit B, and an additional unknown number of civil immigration detainees in Correira.

63. As Plaintiff Medeiros Neves and numerous other BCHOC Unit B detainees wrote to Defendant Hodgson and others in a March 18, 2020 letter (See Exhibit A), the most recent detainee was admitted on March 17, 2020 – well within the time when Defendants and the general public were well aware of the rapid spread of COVID-19.

64. As Plaintiff Medeiros Neves and other detainees also pointed out in their March 18, 2020 plea for help, a note was posted in Unit B by Defendant Hodgson's office explicitly stating that "…Given the close quarters and need for daily contact, our correctional facilities and jail are extremely vulnerable for residents, staff, volunteers and visitors to be infected." *Id.* This concession is unsurprising given the grim realities of BCHOC.

65. In institutional settings with close quarters such as BCHOC, people are at imminent risk of severe COVID-19 infection, illness and death. Immigration detention facilities are "congregate environments," places where people live and sleep in close proximity.

66. Infectious diseases that are communicated by air or touch are more likely to spread in these confined settings and crowded environments. This presents an imminent danger for the spread of COVID-19 to Plaintiffs.

67. The conditions of immigration detention facilities pose a heightened public health risk for the spread of COVID-19 that is even greater than non-carceral institutions. Immigration detention facilities have even greater risk of infectious spread because of overcrowding, the high proportion of vulnerable people detained, limited access to hygiene products, and scant medical resources. People live in close quarters and cannot achieve the social distancing needed to effectively prevent the spread of COVID-19. Plaintiffs will find it impossible to maintain the recommended distance of 6 feet from others. They must also share or touch objects used by others.

68. As Petitioner-Plaintiff Medeiro Neves and other civil detainees detailed in the March 23 letter (See Attached Exhibit B):

a. Beds in the facility where detainees sleep are situated only 3 feet apart.

b. Meals are inadequate and eaten in close quarters.

c. Symptomatic guards have entered the premises and interacted with detainees.

69. On information and belief, no meaningful changes to the hygienic or sanitary policies, products or facilities have been made since the March 23 letter.

70. On information and belief, BCHOC facilities lack adequate soap, toilet paper, and medical resources and infrastructure to address the spread of infectious disease or to treat people most vulnerable to illness.

71. Detention centers are integral components of the public health systems in the communities in which they are located. If detainees contract COVID-19 in such a facility, they will require hospitalization in the community threatening to overwhelm local resources. This problem is particularly acute in smaller communities, such as North Dartmouth, Massachusetts, where the Bristol County detention facility is located. Surrounding communities will be unable to provide adequate medical treatment to infected persons.

72. Moreover, as a result of profound stress and helplessness, immigrant detainees are at risk of having suppressed immune systems putting them at higher risk than the general population of contracting and potentially having more serious infections. Stress and its link to immunosuppression are well documented in the medical literature.

73. The physical and mental health and well-being of detained immigrants, independent of age or underlying conditions, is worsened and severely harmed by continued immigration detention during the COVID-19 pandemic. All immigrant detainees are at high risk of developing severe, disabling psychological symptoms and distress as a result of their continued immigration detention during the COVID-19 pandemic.

74. Individuals with underlying mental health conditions are at a high risk of harm from coronavirus. Individuals suffering from mental health conditions including depression, anxiety, schizophrenia and posttraumatic stress disorder (PTSD) are at particularly high risk of worsening of their symptoms as a result of being detained amid the coronavirus pandemic.

75. For instance, Harlan Perez is an immigration detainee in Unit B at BCHOC who suffers from schizophrenia, anxiety and depression. *See Perez v. Souza*, No. 1:20-cv-10414-PBS (D.Mass.), ECF No. 1 at ¶ 2. Such exacerbation of psychological symptoms can result in severe harm. For example, individuals with depression are at increased risk of suicidality.

ICE's Responses to COVID-19 and Its Inadequate Healthcare System Will Not Protect Plaintiffs

76. ICE issued an "Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)" and has established a webpage entitled "ICE Guidance on COVID- 19." These documents (collectively the "ICE Protocols") will not protect Plaintiffs. The protocols also do not address: imminent shortages of medical supplies and staffing or education of detained people and staff about the virus, amongst other critical issues.

77. Further, there is substantial evidence that ICE's COVID-19 protocols are not being followed in detention centers throughout the country, including Bristol County Immigration Detention Facilities, and that ICE is otherwise failing to provide an adequate response, which exacerbates the risk of harm to Plaintiffs.

78. Evidence further establishes that these serious defects are far from anomalous, but rather systemic in nature. Indeed, the attached declarations paint an alarming picture of ICE's inadequate responses to COVID-19 across the entire country, including failures to: test for COVID-19, provide basic and necessary sanitation supplies such as hand sanitizer, check symptoms, provide necessary education about COVID-19 to detained people and staff, provide people with protective gear (e.g., masks), increase medical staffing, respond to sick calls, and assess medically vulnerable detained people and increase precautionary measures. As a direct consequence, medically vulnerable people feel like they are "sitting ducks" and are "scared for [their] life.".

79. Importantly, the COVID-19 pandemic—and ICE's unreasonable response to it—will significantly strain ICE's already broken medical care system. Long before the COVID-19 outbreak, numerous reports (including by DHS itself) have identified serious and substantial flaws in ICE's medical care system. For example, a 2017 OIG report that assessed care at certain ICE facilities identified "long waits for the provision of medical care[.]"[10] Other reports echo these alarming findings about substandard medical care in ICE facilities.[11]

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[10] Off. of Inspector Gen., Off. of Homeland Sec., OIG-18-32: Concerns About ICE Detainee Treatment and Care at Detention Facilities, at 7 (Dec. 11, 2017), https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf.

[11] See, e.g., U.S. Gov't Accountability Off. GAO-16-23: Additional Actions Needed to Strengthen Mgmt. and Oversight of Detainee Med. Care (Feb. 2016), https://www.gao.gov/assets/680/675484.pdf; Human Rts. Watch, Am. Civil Liberties Union, Nat'l Immigr. Just. Ctr. & Det. Watch Network, Code Red: The Fatal Consequences of Dangerously Substandard Med. Care in Immigr. Det, at 15, 19, 25, 46 (June 2018), https://www.hrw.org/sites/default/files/report_pdf/us0618_immigration_web2.pdf; Human Rts. First, Prisons and Punishment: Immigr. Det. in Cal., at 10-13 (Jan. 2019), https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf; J. David McSwane, ICE Has Repeatedly Failed to Contain Contagious Diseases, Our Analysis Shows. It's a Danger to the Pub., PROPUBLICA (Mar. 20, 2020), available at https://www.propublica.org/article/ice-has-repeatedly-failed-tocontain-

The Only Way to Reduce the Risk of A COVID-19 Outbreak at BCHOC is to Immediately Reduce the Population at the Facility by Release.

80. Risk mitigation is the only known strategy that can protect people from COVID-19, and Defendants through actions and statements have demonstrated that they are unwilling and unable to implement meaningful risk mitigation measures. Accordingly, public health experts with experience in immigration detention and correctional settings have recommended that detention centers immediately reduce their populations.

81. Furthermore, the routine practice of transferring immigrant detainees from one facility to another, throughout the nationwide immigration detention network, makes the likelihood of COVID-19 spread and infection even more likely. Given such conditions and practices, one would be hard-pressed to think of a more effective means for the spread of COVID-19 infection than immigration detention.

82. Plans for separating suspected COVID-19 exposed or infected individuals within a given facility or by transferring to specialized quarantine facilities is neither effective nor feasible as a response to the threat of infection or infectious spread within a detention facility.

83. As per CDC guidelines, when individuals become symptomatic and considered "at risk" of being infected with/contagious to others for COVID-19, they are supposed to self-isolate, not isolate within groups. Putting individuals with symptoms in a group-like isolation setting risks to those who were not infected with COVID-19, despite having similar symptoms to those who may be infected. In other words, for individuals who did not have COVID-19 before being placed in be infected. In other words, for individuals who did not have COVID-19 before being placed in group

contagious-diseases-our-analysis-shows-its-a-danger-to-the-public (analysis of DDRs demonstrates that ICE facilities have "long histories of mishandling infectious diseases that can rapidly spread outside their walls.").

isolation, many may contract COVID-19. This is exacerbated by substantial and increasing limitations on access to testing, even for those who have symptoms of COVID-19, because of a major shortage of testing materials. It would be unlikely that in these immigration detention facilities, all who are symptomatic could be tested prior to any form of group isolation.

Class Action and Representative Habeas Allegations

84. Respondent-Defendants have continued to hold and admit civil immigration detainees to BCHOC despite the warnings of the CDC and medical community and despite their inability to manage an outbreak if one were to occur.

85. All individuals in BCHOC and Carreiro are subject to this same disregard for health and safety and are subject to the same policies of confinement and hygiene.

86. Petitioner-Plaintiffs Celimen Savino and Medeiro Neves seek certification of a class under Federal Rule of Civil Procedure 23, to challenge Defendants' detention of civil ICE detainees at BCHOC during the current COVID-19 pandemic, or in the alternative certification of the proposed class as a representative habeas class. *See United States ex rel. Sero v. Preiser*, 506 F.2d 1115 (2d Cir. 1974)

87. Plaintiffs Celimen Savino and Medeiro Neves seek certification of a class consisting of all individuals who are now or will be held in civil immigration detention in BCHOC. -Plaintiffs satisfy all of the requirements of Rule 23(a)—numerosity, commonality, typicality, and adequacy—as well as those of Rule 23(b)(2).

88. **Numerosity -** The proposed representative class is sufficiently numerous as to make joinder impracticable. The numerosity requirement imposes only a "low threshold," *Garcia-Rubiera v. Calderon*, 570 F.3d 443, 460 (1st Cir. 2009), such that "a class size of forty or more will generally suffice in the First Circuit." *Reid v. Donelan*, 297 F.R.D. at 189. There are substantially more than forty civil immigration detainees currently being held at BCHOC.

89. **Commonality -** The proposed representative class presents common questions of law and fact, including (1) whether civil detention in a manner likely to result in the life-threatening infection of detainees violates constitutional protections; and (2) whether in the face of the COVID-19 pandemic, the conditions of confinement at BCHOC fail to ensure the detainees' safety and health in a manner that amounts to punishment.

90. **Typicality -** Plaintiffs Celimen Savino and Medeiro Neves' claims are typical of the representative class they seek to represent. Like all class members, both Ms. Celimen Savino and Mr. Medeiro Neves are currently (1) civilly detained in immigration detention in Bristol County Immigration Detention Facilities; (2) subject to the close confinement and lack of hygiene that characterize immigration detention at Bristol County Immigration Detention Facilities and; (3) subject to infection, illness, and death from COVID-19 were it to spread.

91. **Adequacy -** Petitioner-Plaintiffs are able to fairly and adequately protect the interests of the proposed representative class. Undersigned counsel at Lawyers for Civil Rights and the Jerome N. Frank Legal Services Organization at Yale Law School have extensive experience litigating complex civil rights matters, immigration cases, and class action lawsuits.

92. Defendants have acted or refused to act on grounds that apply generally to the class. Moreover, because members of the proposed representative class all seek the same relief, this relief is appropriate respecting the class as a whole to ensure that members of the proposed are given consistent relief and to satisfy the health and safety standards at the core of their challenge.

93. Plaintiffs and members of the proposed class seek a *writ of habeas* corpus to remedy their unconstitutional detention in life-threatening conditions at Bristol County Immigration Detention Facilities.

STATEMENT OF RELATED CASE

94. Petitioners Celimen Savino and Medeiro Neves state that, pursuant to Local

Rule 40.1(g), this Petition for a Writ of Habeas Corpus and Complaint for Declaratory and Injunctive Relief is related to *Reid v. Donelan*, No. 3:13-cv-30125-PBS (D. Mass.) and *Brito v. Barr*, No. 1:19-cv-11314-PBS (D. Mass.).

95. Per Local Rule 40.1(g)(1), "some or all of the parties are the same." The Director of the Boston Field Office of Immigration and Customs Enforcement and the current Bristol County Sheriff, Thomas M. Hodgson, are defendants in *Reid* and in the present petition, and the Superintendent of BCHOC Souza, the Secretary of DHS, and the Director of ICE are defendants in *Brito.*

96. Additionally, this case involves "the same or similar claims or defenses," Local Rule 40.1(g), as those at issue in *Reid* and *Brito*, including allegations that the incarceration of civil immigration detainees in Massachusetts violates the Fifth Amendment.

97. In addition, some members of the *Brito* and *Reid* classes, and persons who will vest into the *Reid* class when their detention lasts six months, are detained now at BCHOC, and as such are members of the proposed class herein as well.

CLAIMS FOR RELIEF

Count I (Violation of Fifth Amendment Right to Due Process--Unlawful Punishment; Freedom from Cruel Treatment and Conditions of Confinement as to All Defendants)

98. Plaintiffs reallege and incorporate by reference each and every allegation contained in the preceding paragraphs as if set forth fully herein.

99. The Fifth Amendment to the U.S. Constitution guarantees that civil detainees, including all immigrant detainees, may not be subjected to punishment. The government violates this substantive due process right when it subjects civil detainees to treatment and conditions of confinement that amount to punishment or does not ensure the detainees' safety and health.

100. Defendants have subjected Plaintiffs to conditions of confinement that include the imminent risk of contracting COVID-19, for which there is no vaccine, known treatment, or cure.

101. Defendants are subjecting Plaintiffs to imminent risk of physical, emotional and mental harm in violation of Plaintiffs' rights under the Due Process Clause.

102. Defendants continue to admit new ICE detainees to Bristol County Immigration Detention Facilities, in reckless disregard of and deliberate indifference to the dangerous conditions there and the inability of Bristol County Immigration Detention Facilities to provide minimal protection against COVID-19.

103. As public health experts in correctional medical care and infectious disease agree, individuals and families in immigration detention are at grave risk of COVID-19 infection.

104. Alternatives are available that would preserve and protect both Plaintiffs' health and well-being and that of the broader community. Release either on personal recognizance or subject to monitoring or supervision would cause no burden on Defendants and would place Plaintiffs at substantially lower risk of contracting COVID-19, with all of its attendant threats to health and life.

105. Accordingly, Defendants are subjecting Plaintiffs to detention conditions that amount to punishment and that fail to ensure their safety and health.

Count II (Violation of the Rehabilitation Act – Failure to Provide Reasonable Accommodation to Persons with Disabilities)

106. Section 504 of the Rehabilitation Act requires federal agencies to provide "reasonable accommodations" to individuals with disabilities so they can fully participate in benefits administered by these agencies. 29 U.S.C. § 794(a).

107. DHS regulations implementing the Rehabilitation Act mandate that "[n]o qualified individual with a disability in the United States, shall, by reason of his or her disability, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the Department." 6 C.F.R. § 15.30; see also 29 U.S.C. § 794(a).

108. The regulations implementing Section 504 prohibit entities receiving federal financial assistance from utilizing "criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons." 34 C.F.R. § 104.4(b)(4).

109. The removal proceedings are a benefit or program administered by DHS and Plaintiffs are entitled to participate in the removal process. The services, programs, and activities within the detention centers where DHS detains Plaintiffs receive substantial federal financial assistance.

110. Plaintiffs' underlying medical conditions, and those of other members of the proposed class of all immigration detainees who are or will be held at Bristol County Immigration Detention Facilities, qualify as disabilities for purposes of the Rehabilitation Act. 29 U.S.C. § 705(2)(B); 42 U.S.C. § 12102.

111. By exposing them to a heightened risk of contracting COVID-19, Defendants are preventing Plaintiffs from participating in the removal process by reason of their disability.

112. By failing to take account of their special vulnerability to severe illness or death if they were to contract COVID-19, Defendants are preventing Plaintiffs from participating in the removal process by reason of their disability.

113. By failing to provide Plaintiffs adequate protection from COVID-19 through the only effective means to reduce the risk of severe illness or death, Defendants have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of removal proceedings and the services, programs, and activities within the detention centers with respect to Plaintiffs.

114. The only available "reasonable accommodation" that would mitigate Plaintiffs' disability is release from detention. Defendants have failed to implement this reasonable accommodation, which would not be unduly burdensome nor require a fundamental alteration in the removal process or the programs and activities of the detention center.

115. Defendants' ongoing detention of Plaintiffs constitutes discrimination because it is either disparate treatment of, or at the very least has a disparate impact on, people with qualifying disabilities who are at severe risk of serious illness or death if they were to contract COVID-19.

116. For these reasons, Defendants' ongoing detention of Plaintiffs violates the Rehabilitation Act.

PRAYER FOR RELIEF

Plaintiffs respectfully request this Court to:

1. Issue a Writ of Habeas Corpus and order the immediate release of Plaintiffs or placement in community-based alternatives to detention such as conditional release, with appropriate precautionary public health measures, on the ground that their continued detention violates the Due Process Clause and/or the Rehabilitation Act;

2. In the alternative, issue injunctive relief ordering the immediate release of Plaintiffs and all similarly situated detainees in Bristol County Immigration Detention Facilities with appropriate precautionary measures.

3. Immediately order Defendants to implement public health guidance and protocols designed to prevent the transmission of COVID-19;

4. Prohibit the placement of new detainees in Bristol County Immigration Detention Facilities until all public health protocols designed to prevent the transmission of COVID-19 have been implemented;

5. Require Defendants to immediately effectuate the release of Plaintiffs and all similarly situated detainees as BCHOC upon the posting of the appropriate bond, if bond was previously set by ICE or an Immigration Judge;

6. Declare that Defendants' detention of Plaintiffs is unconstitutional in violation of the Fifth Amendment and/or the Rehabilitation Act;

7. Award Plaintiffs their costs and reasonable attorneys' fees; and

8. Grant such further relief as the Court deems justice to require.

/s/Oren Nimni
Oren Nimni (BBO #691821)
Oren Sellstrom (BBO #569045)
Ivan Espinoza-Madrigal†
Lawyers for Rights
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B. Rey, Law Student Intern*
Megan Yan, Law Student Intern*
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Phone: (203) 432-4800
michael.wishnie@ylsclinics.org

† Motion for admission *pro hace vice* forthcoming.

* Motion for Law Student Appearance forthcoming.

JS 44 (Rev. 06/17)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

MARIA ALEJANDRA CELIMEN SAVINO,
JULIO CESAR MEDEIROS NEVES

(b) County of Residence of First Listed Plaintiff Bristol
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Oren Nimni -Lawyers for Civil Rights - 61 Batterymarch Street 5th floor - (617) 988-0606 (additional counsel on attachment)

DEFENDANTS

THOMAS HODGSON, Bristol County Sheriff in his Official Capacity; STEVEN J. SOUZA, Superintendent Bristol County House of Corrections in his Official Capacity; TODD LYONS, Boston Field

County of Residence of First Listed Defendant Bristol
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ❒ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ❒ 2 U.S. Government Defendant
- ❒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	❒ 1	❒ 1	Incorporated *or* Principal Place of Business In This State	❒ 4	❒ 4
Citizen of Another State	❒ 2	❒ 2	Incorporated *and* Principal Place of Business In Another State	❒ 5	❒ 5
Citizen or Subject of a Foreign Country	❒ 3	❒ 3	Foreign Nation	❒ 6	❒ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
❒ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	❒ 625 Drug Related Seizure of Property 21 USC 881	❒ 422 Appeal 28 USC 158	❒ 375 False Claims Act
❒ 120 Marine	❒ 310 Airplane	❒ 365 Personal Injury - Product Liability	❒ 690 Other	❒ 423 Withdrawal 28 USC 157	❒ 376 Qui Tam (31 USC 3729(a))
❒ 130 Miller Act	❒ 315 Airplane Product Liability	❒ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	❒ 400 State Reapportionment
❒ 140 Negotiable Instrument	❒ 320 Assault, Libel & Slander	❒ 368 Asbestos Personal Injury Product Liability		❒ 820 Copyrights	❒ 410 Antitrust
❒ 150 Recovery of Overpayment & Enforcement of Judgment	❒ 330 Federal Employers' Liability	PERSONAL PROPERTY		❒ 830 Patent	❒ 430 Banks and Banking
❒ 151 Medicare Act	❒ 340 Marine	❒ 370 Other Fraud	LABOR	❒ 835 Patent - Abbreviated New Drug Application	❒ 450 Commerce
❒ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	❒ 345 Marine Product Liability	❒ 371 Truth in Lending	❒ 710 Fair Labor Standards Act	❒ 840 Trademark	❒ 460 Deportation
❒ 153 Recovery of Overpayment of Veteran's Benefits	❒ 350 Motor Vehicle	❒ 380 Other Personal Property Damage	❒ 720 Labor/Management Relations	SOCIAL SECURITY	❒ 470 Racketeer Influenced and Corrupt Organizations
❒ 160 Stockholders' Suits	❒ 355 Motor Vehicle Product Liability	❒ 385 Property Damage Product Liability	❒ 740 Railway Labor Act	❒ 861 HIA (1395ff)	❒ 480 Consumer Credit
❒ 190 Other Contract	❒ 360 Other Personal Injury		❒ 751 Family and Medical Leave Act	❒ 862 Black Lung (923)	❒ 490 Cable/Sat TV
❒ 195 Contract Product Liability	❒ 362 Personal Injury - Medical Malpractice		❒ 790 Other Labor Litigation	❒ 863 DIWC/DIWW (405(g))	❒ 850 Securities/Commodities/ Exchange
❒ 196 Franchise			❒ 791 Employee Retirement Income Security Act	❒ 864 SSID Title XVI	❒ 890 Other Statutory Actions
				❒ 865 RSI (405(g))	❒ 891 Agricultural Acts
					❒ 893 Environmental Matters
					❒ 895 Freedom of Information Act
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	IMMIGRATION	FEDERAL TAX SUITS	❒ 896 Arbitration
❒ 210 Land Condemnation	☒ 440 Other Civil Rights	Habeas Corpus:	❒ 462 Naturalization Application	❒ 870 Taxes (U.S. Plaintiff or Defendant)	❒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
❒ 220 Foreclosure	❒ 441 Voting	❒ 463 Alien Detainee	❒ 465 Other Immigration Actions	❒ 871 IRS—Third Party 26 USC 7609	❒ 950 Constitutionality of State Statutes
❒ 230 Rent Lease & Ejectment	❒ 442 Employment	❒ 510 Motions to Vacate Sentence			
❒ 240 Torts to Land	❒ 443 Housing/ Accommodations	❒ 530 General			
❒ 245 Tort Product Liability	❒ 445 Amer. w/Disabilities - Employment	❒ 535 Death Penalty			
❒ 290 All Other Real Property	❒ 446 Amer. w/Disabilities - Other	Other:			
	❒ 448 Education	❒ 540 Mandamus & Other			
		❒ 550 Civil Rights			
		❒ 555 Prison Condition			
		❒ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ❒ 2 Removed from State Court ❒ 3 Remanded from Appellate Court ❒ 4 Reinstated or Reopened ❒ 5 Transferred from Another District *(specify)* ❒ 6 Multidistrict Litigation - Transfer ❒ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
1331 - Violation 5th & 8th Amendme of U.S. Constitution

Brief description of cause:
Current Conditions in Bristol County violate 5th am. rights of civil detainees

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ❒ Yes ❒ No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE C.J. Saris DOCKET NUMBER 3:13-cv-30125-PBS; 1:19-cv-1

DATE 03/27/2020

SIGNATURE OF ATTORNEY OF RECORD Oren Nimni

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

ATTACHMENT – ADDITIONAL COUNSEL CIVIL COVER SHEET

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Reena Parikh†
Michael Wishnie (BBO# 568654)
Jerome N. Frank Legal Services Organization
P.O. Box 209090
New Haven, CT 06520
Phone: (203) 432-4800

† Motion for admission *pro hace vice* forthcoming.
* Motion for Law Student Appearance forthcoming.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

1. **Title of case (name of first party on each side only)** MARIA ALEJANDRA CELIMEN SAVINO v. THOMAS HODGSON

2. **Category in which the case belongs based upon the numbered nature of suit code listed on the civil cover sheet. (See local rule 40.1(a)(1)).**

☐ **I.** **160, 400, 410, 441, 535, 830*, 835*, 850, 891, 893, R.23, REGARDLESS OF NATURE OF SUIT.**

☑ **II.** **110, 130, 190, 196, 370, 375, 376, 440, 442, 443, 445, 446, 448, 470, 751, 820*, 840*, 895, 896, 899.**

☐ **III.** **120, 140, 150, 151, 152, 153, 195, 210, 220, 230, 240, 245, 290, 310, 315, 320, 330, 340, 345, 350, 355, 360, 362, 365, 367, 368, 371, 380, 385, 422, 423, 430, 450, 460, 462, 463, 465, 480, 490, 510, 530, 540, 550, 555, 560, 625, 690, 710, 720, 740, 790, 791, 861-865, 870, 871, 890, 950.**

***Also complete AO 120 or AO 121. for patent, trademark or copyright cases.**

3. **Title and number, if any, of related cases. (See local rule 40.1(g)). If more than one prior related case has been filed in this district please indicate the title and number of the first filed case in this court.**

Reid v. Donelan, No. 3:13-cv-30125-PBS (D. Mass.); Brito v. Barr, No. 1:19-cv-11314-PBS (D. Mass.)

4. **Has a prior action between the same parties and based on the same claim ever been filed in this court?**

YES ☑ **NO** ☐

5. **Does the complaint in this case question the constitutionality of an act of congress affecting the public interest? (See 28 USC §2403)**

YES ☐ **NO** ☑

If so, is the U.S.A. or an officer, agent or employee of the U.S. a party?

YES ☐ **NO** ☐

6. **Is this case required to be heard and determined by a district court of three judges pursuant to title 28 USC §2284?**

YES ☐ **NO** ☑

7. **Do all of the parties in this action, excluding governmental agencies of the United States and the Commonwealth of Massachusetts ("governmental agencies"), residing in Massachusetts reside in the same division? - (See Local Rule 40.1(d)).**

YES ☑ **NO** ☐

A. **If yes, in which division do all of the non-governmental parties reside?**

Eastern Division ☑ **Central Division** ☐ **Western Division** ☐

B. **If no, in which division do the majority of the plaintiffs or the only parties, excluding governmental agencies, residing in Massachusetts reside?**

Eastern Division ☐ **Central Division** ☐ **Western Division** ☐

8. **If filing a Notice of Removal - are there any motions pending in the state court requiring the attention of this Court? (If yes, submit a separate sheet identifying the motions)**

YES ☐ **NO** ☑

(PLEASE TYPE OR PRINT)

ATTORNEY'S NAME Oren Nimni

ADDRESS 61 Batterymarch Street 5th Floor

TELEPHONE NO. (617) 988-0606

EXHIBIT A

U.S. Immigration and Customs Enforcement I.C.E.
Office of Detention and Removal
U.S. Department of Homeland Security
10 New England Executive Park
Burlington, MA 01803

BRISTOL COUNTY SHERIF'S OFFICE
Sheriff Thomas M. Hodgson
400 Faunce Corner Road
North Dartmouth, MA 02747

CPS Correctional Healthcare
Bristol County Correctional Center
400 Faunce Corner Road
North Dartmouth, MA 02747

Massachusetts Department of Health
250 Washington Street
Boston, MA 02110

A.C.L.U.
American Civil Liberties Union Foundation Massachusetts
Att. Kathleen Navin, Esq.
211 Congress Street
Boston, MA 02110

North Dartmouth, March 18, 2020

To whom it might concern:

The I.C.E. detainees of unit B of the Bristol County Correctional Center, individually and collectively would like to highlight serious concerns about the outbreak of the COVID-19 Virus within the facility of Bristol Correctional Center.
The facility safety conditions and the conditions of it's personnel, in light of two recent and separate episodes have raised the concern into a very serious matter.
Specifically, on March 14, 2020 a Correctional Officer was observed to be symptomatic of the COVID-19 Virus during his shift followed by another C.O. on March 16, 2020 that was later on repleced by a collegue.
Two separate and serious episodes recently occurred and have alarmed the entire detainee population of unit B and prompted a number of detainees to file their own Sick Call /Medical Encounter Request.
Unit B in comprised of sixty-six (66) beds, fifty-seven (57) of them occupied, one of them filled as recently as 24 hours ago.

Two major concerns are expressed in this letter:

1 The reckless behaviur of the two separate Correctional Officers that reported for duty showing symptoms of the COVID-19 Virus created extreme alarm and anxiety among all detainees;

2 The overcrowded living conditions of the detainees in unit B, fifty-seven (57) to be precise is in net contrast with State mandatory guidelines of max 25 and Federal guidelines of a max of 10. This is unacceptable to the health and wellbeing of all detainees.
On March 15, 2020 a note was posted in the unit by Sheriff Thomas M. Hodgson's office stating among other the following: "...Given the close quarters and need for daily contact, our correctional facilities and jail are extremely vulnerable for residents, staff, volunteers, and visitors to become infected."
The three (3) feet distance between bunk beds is in net contrast with the mandatory six (6) feet safety distance between individuals.

3 Today at around 12:00pm medical personell in their unofficial vest stated that the infection of the whole ICE facility population is inevitable and will occur within the next 30 days.
Such statement spreaded faster than the virus itself among detainees that are now extremely agitated and panicking.

Accordingly, it is imperative that the following measures should be implemented effectively immediately:

1 Detainees with serious medical condition should be released immediately;

2 Detainees considered low risk (without aggravated felonies), or detainees who have not had their bond hearing should be released immediately;

3 Detainees with scheduled hearings that gets rescheduled shall qualify for immediate bond hearing/release;

4 Detainees who consented to be deported, yet still present at the facility shall depart the U.S. within five (5) business days.

If you have any further question please address your correspondence to TEAM B attention Darcy McMenamin Bristol County Correctional Center, ICE B, 400 Faunce Corner Road North Dartmouth, MA 02747

Respectfully submitted and signed by 51 detainees. Original is attached.
The remaining six inmates refused to sign the petition in fear of retaliation.

ID # 198710 Firma
ID #196670 Arreaga Marvin
ID # 198234 Elmer Gomez Gomez
#196644 Carlos Menjivar Rojas
#198722 Jose CALDAS
#198811 Oscar Alvarez
#197021 Diego Isacl Amador Galindo
198647
198280 Morale Figueroa Julio
19809 Manuel CHUN
Rodriguez Oseguera Erik
197694 — Bonilla Garcia DARWIN
197273 — Julian Mesa Franco
198225 Segundo Armijos
198810 — Jose H. Beltran Araujo
198213 DIEGO GUALIAN TIXI
198657 —
Sandro Vera
198627 — Alarcon Mercedes
198656 — Francisca Ortiz
198744 MARCO BATTISTOTTI
198734 Juline Lema

Team Letter

BED #	ID #	NAME
1	VACANT	
2	196586	Victor Reguera - Vasquez
3	VACANT	
4	198275	SEGUNDO ARMIJOS
5	198213	GUAMAN TIXI DIEGO
6	198744	MARCO BATTISTOTTI
7	198210	Eduardo Tejada
8	194843	[illegible] Cuns
9	1685302	Miguel Lucas Ixc
10	198234	Elmer Gomes Gomes
11	198792	Jose CAIPAS
12	197021	Diego Isael Amado, Galindo
13	VACANT	
14	198318	Ricardo Flores
15	197934	Mario Ivan Pilco Morocho
16	196566	Sanchez Lopez Victor Manuel
17/20	19-5847	Abdoulaye Fall
18	193495	Pascual Montes Santos
19	198718	German Miranda T.
~~20~~ 17	———	
21	198810	Jose Beltran Araujo

Team Letter

22	198647	Julio C. Figueroa Morales
23	198627	Alarcon Mercedes
24	197919	Kevin Colato
25	NA	No Bed
26	NA	No Bed
27	191813	GARANG LUAL
28	198315	Osvaldo Matte
29	198636	REHSE JIMENEZ JEREZ
30	—	
31	198681	Julio Jmio
32	—	
33	VACANT	
34	196784	Lloyd Wafula
35	198651	Sandra Vera
36	197273	Julian Mesa Franco
37	198299	JUAN CARLOS ILLICACHI
38	196670	Arreaga G. Marvin
39	198280	Manuel Chun
40	196644	Carlos Menjivar
41	198654	Jesus Mato
42	196815	Conroy Lewis
43	198634	Donovan Smith

		Team Letter
	918233	
44	918233	Hussion Hussion
45	VACANT	
46	—	
47	198656	Francisco Ortiz
48	197694	Bonilla Garcia DARWIN
49	198134	Jaime Lopez
50	198459	Rodriguez Oseguera, Erik
51	197695	Edy Ramirez
52	154243	Cesar F. Vargas Vasquez
53	VACANT	
54	—	
55	197826	AHMED HASSAN
56	195606	Harlen Perez
57	VACANT	
58	197734	AARON SOL
59	198811	Oscar Nieto
60	197559	Edson Martin
61	VACANT	
62	197670	Doug Clem
63	VACANT	
64	195838	Flavio Prado
65	198259	Javier Lorenzo Mata
66	198195	ABEL PROMOTOR DOMINGUEZ
67	198586	Ricardo Ortega Vazquez
68	—	

NOTE:

WE ARE HOPING THAT YOU WILL MOBILIZE ON OUR BEHALF BY CONTACTING YOUR LOCAL CONGRESSMAN AND ANY AND ALL TV AND MEDIA OUTLET, ALONG WITH YOUR LOCAL AMERICAN CIVIL LIBERTIES UNION FOUNDATION (U.C.L.U.) AT THE ADDRESS POSTED ON OUR LETTER.

WE ARE TRAPPED INSIDE A STORAGE AND IN FEAR FOR OUR LIFE. PLEASE HELP!

THANK YOU. TEAM B

EXHIBIT B

DETAINEE'S LETTER #2

U.S. Immigration and Customs Enforcement I.C.E.
Office of Detention and Removal
U.S. Department of Homeland Security
10 New England Executive Park
Burlington, MA 01803

U.S. Senator Elizabeth Warren
15 New Sudbury Street, Suite 2400
Boston, MA 02203

BRISTOL COUNTY SHERIF'S OFFICE
Sheriff Thomas M. Hodgson
400 Faunce Corner Road
North Dartmouth, MA 02747

U.S. Senator Ed Markey
218 Russell Senate Office Building
Washington, DC 20510

CPS Correctional Healthcare
Bristol County Correctional Center
400 Faunce Corner Road
North Dartmouth, MA 02747

U.S. Representative Joseph Kennedy III
8 North Main Street, Suite 200
Attleboro, MA 02703

Massachusetts Department of Health
250 Washington Street
Boston, MA 02110

U.S. Representative Bill Keating
128 Union Street, Suite 103
New Bedford, MA 02740

A.C.L.U.
American Civil Liberties Union Foundation Massachusetts
Att. Kathleen Navin, Esq.
211 Congress Street
Boston, MA 02110

Consulates of jurisdiction of each detenees.

North Dartmouth, March 23, 2020

(1)

To whom it might concern:

The I.C.E. detainees of unit B of the Bristol County Correctional Center, individually and collectively would like to highlight serious concerns about the outbreak of the COVID-19 Virus within the facility of Bristol Correctional Center. The facility safety conditions and the conditions of it's personnel, in light of two recent and separate episodes have raised the concern into a very serious matter.
Specifically, on March 14, 2020 a Correctional Officer was observed to be symptomatic of the COVID-19 Virus during his shift. He never returned to unit B leaving all detainees very worried. The second C.O. that showed symptoms was on March 16, 2020 and was later replaced by a collegue to then return with coughing and sneezing.
Those two separate and serious episodes recently occurred have alarmed the entire detainee population of unit B and prompted a number of detainees to file their own Sick Call/Medical Encounter Request.
On March 22, 2020 C.O. Aylwart during a conversation with one of the detainees stated the following: "You don't get it, this [coronavirus] is nothing more than a flu" missing the gravity of the situation entirely. Once told the current situation the Italy is experiencing he dismissed the topic entirely. This naive behavior is of a grave concern of us. How can we be sure that this CO adheres the Federal recommendations when he totally ignores the existence of the Covid-19? His behavior was reckless to say the least.

Unit B in c, omprised of sixty-six (66) beds, fifty-seven (57) of them occupied, one of them filled as recently as less than a week ago.

Our concerns are the following:

1 The reckless behavior of the two separate Correctional Officers that reported for duty showing symptoms of the COVID-19 Virus created extreme alarm and anxiety among all detainees.

2 The naive behavior of C.O. Aylwart created fear and anxiety among us and should not be permitted.

3 The lack of reassurance from top management that those officers posed no risk to us is unacceptable. We need for ICE to assure us all that we are safe here.

4 The overcrowded living conditions of the detainees in unit B, fifty-seven (57) to be precise is in net contrast with State mandatory guidelines of max 25 and Federal guidelines of a max of 10. This is unacceptable to the health and wellbeing of all detainees.
On March 15, 2020 a note was posted in the unit by Sheriff Thomas M. Hodgson's office stating among other the following: "...Given the close quarters and need for daily contact, our correctional facilities and jail are extremely vulnerable for residents, staff, volunteers, and visitors

to become infected."
The three (3) feet distance between bunk beds is in net contrast with the mandatory six (6) feet safety distance between individuals.
On March 22, 2020 Sec. of Homeland Security Chad Wolf in a televised interview stated the following when referring to ICE detention centers: "There is a serious danger for the officers" as if detenees are somehow immune from contractig the Covid-19 through correctional officers as vehicle.

5 On March 18, 2020 at around 12:00pm medical personell in their unofficial vest stated that the infection of the whole ICE facility population is inevitable and will occur within the next 30 days.
Such statement spreaded faster than the virus itself among detainees that are now extremely agitated and panicking.

Accordingly, it is imperative that the following measures should be implemented effectively immediately:

1 Detainees with serious medical condition should be released immediately.
Our survey collected a total of 28 inmates that have conditions such as:
Hernia
Pacemaker
Herniated disk
Falsimia (Leukemia)
High blood pressure
Complex tear of the upper meniscus (right knee)
Healing bone fracture
Fractured rib
Atsma
Cancer survivor
Urinal track infection
Heart problem
Severe back spinal injury
High blood pressure
Diabete
Low white blood cell count
Tested positive for TB
Recovering from broken shoulder
High cholesterol
Kidney stones
Dental
Back pain
Ceasures
Severe COPD/Emphyzema
70% lung function
Double desection of main neck arteries
Stroke (recent)
Recent internal bleeding

Diagnosed with weak immune system
Mental health issues
Fear and anxiety
Depression
Stress
Headaches
Difficult in sleeping
PTSD
Bypolar depression
Schitzophrenia
Double personality disorder

2 Detainees considered low risk (without aggravated felonies), or detainees who have not had their bond hearing should be released immediately;

3 Detainees with scheduled hearings that gets rescheduled shall qualify for immediate bond hearing/release;

3/23/20 2:00 AM
41
36
14
10
51
50
deported

4 Detainees who consented to be deported, yet still present at the facility shall depart the U.S.within five (5) business days. Our survey shows that eleven (11) detainees have a final deportation order, some of them as old as of July 2019. Those detainees are now being held hostage by ICE.

In the meantime, in no particular order:

5 The current chow is inadequate for us all, it is weak and does not provide us enough nutrients to fight even a simple disease, nevertheless to say a Civid-19. We are respectfully asking the following:
Chow should have more nutrients, we should have red meat, more vegetable, more fruit and more variety. We eat rice and potatoes at least seven (7) times/week. This regime is borderline punitive.
We are detainees and not prisoners nor hostages.

6 The facility must be decontaminated as stated by the Sheriff. It has not been despite his televised message last week.

7 The above mentioned televised message should be distributed in writing in the spanish language.

8 We need to be reassured that both CO (Salvator and Santos) are in healthy conditions.

9 Starting immediately all non-detainees personell entering the ICE facility should wear gloves and mask at all times as implemented in ICE court. This is non-negotiable.

10 Clergy should be allowed to visit us. Yesterday a group of clergy from PEAR were not allowed to meet with us and they were forced

to return back to Boston without meeting with us.

11 Please do not open or take our mail. Our mail should reach the intended person in its original format.

12 Same as above for the greviance. Third party only (no Liutenants) should retrieve greviance.

13 Please provide us with a free/unlimited use of the phone (including international calls) for the next four (4) weeks.

14 Please provide us with accurate informations regarding officers/personell/prisoners and or detainees that have been tested positive for the Covid-19 Virus in real time.

15 Starting immediately, ICE detainees should not have any contact with prisoners when in the medical facility, or in any other facilities.

16 Starting immediately the scanning device in booking facility should be disinfected after each scan.

17 Provide hand sanitizer at point of egress.

18 Provide assurance that the soap in our bathroom kills 99.9% of germs and bacteria and has not been diluted.

19 Provide cleaning workers with yellow rubber gloves, adequate scrubber/floor brush to clean bathrooms.

20 Provide us with adequate product to disinfect the phone after each use.

We are looking forward to address all the above on March 23, 2020 with ICE major.

Respectfully submitted and signed by 52 detainees.
The remaining five inmates refused to sign the petition in fear of retaliation.

- Team B

LT will take use of cleaning products

UNITED STATES DISTRICT COURT
for the
DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, ET AL.

Plaintiff

v.

THOMAS M. HODGSON, ET AL.

Defendant

Civil Action No.: **1:20−CV−10617−PBS**

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) −−− or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) −−− you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ROBERT M. FARRELL

CLERK OF COURT

/s/ − Leonardo Topanotti Vieira

Signature of Clerk or Deputy Clerk

ISSUED ON 2020−03−27 09:45:12.0, Clerk USDC DMA

Civil Action No.: **1:20−CV−10617−PBS**

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for (name of individual and title, if any) _____ was received by me on (date)_____.

☐ I personally served the summons on the individual at (place)_____ _____on (date)_____ ; or

☐ I left the summons at the individual's residence or usual place of abode with (name)_____ _____, a person of suitable age and discretion who resides there, on (date) _____ , and mailed a copy to the individual's last known address; or

☐ I served the summons on (name of individual)_____ , who is designated by law to accept service of process on behalf of (name of organization)_____ _____ on (date) _____; or

☐ I returned the summons unexecuted because_____ ; or

☐ Other (specify) :

My fees are $ _____ for travel and $_____ for services, for a total of $_____.

I declare under penalty of perjury that this information is true.

_____ Date

_____ *Server's Signature*

_____ *Printed name and title*

_____ *Server's Address*

Additional information regarding attempted service, etc:

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et al.*, *Petitioners-Plaintiffs,* v. Thomas Hodgson, Bristol County Sheriff in his Official Capacity, *et al.*, *Respondents-Defendants*.	Case No. 1:20-cv-10617 March 27, 2020

NOTICE OF APPEARANCE

Pursuant to Local Rule 83.5.2, please enter the appearance of Oren M. Sellstrom of Lawyers for Civil Rights on behalf of Petitioners-Plaintiffs Maria Alejandra Celimen Savino, Julio Cesar Medeiros Neves, and all those similarly situated in the above-captioned action.

Date: March 27, 2020

Respectfully submitted,

/s/ Oren Sellstrom

Oren Sellstrom (BBO# 569045)
Lawyers for Civil Rights
61 Batterymarch Street, Fifth Floor
Boston, MA 02110
(617) 988-0608
osellstrom@lawyersforcivilrights.org

Counsel for Petitioners-Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020 a copy of the foregoing document was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of this court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the court's CM/ECF system.

Date: March 27, 2020

Respectfully submitted,

/s/ Oren Sellstrom

Oren Sellstrom (BBO# 569045)
Lawyers for Civil Rights
61 Batterymarch Street, Fifth Floor
Boston, MA 02110
(617) 988-0608
osellstrom@lawyersforcivilrights.org

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et al*.,	
Petitioners-Plaintiffs,	
v.	Case No. 1:20-cv-10617 WGY
Thomas Hodgson, Bristol County Sheriff in his Official Capacity, *et al.*,	
Respondents-Defendants.	

NOTICE AND MOTION FOR TEMPORARY RESTRAINING ORDER

Please take notice that, as soon as they may be heard, Plaintiff-Petitioners hereby move, pursuant to Fed. R. Civ. P. 65, for a temporary restraining order and humanitarian release for themselves and all those similarly situated – specifically, all current and future civil immigration detainees held by Respondents-Defendants at the Bristol County House of Corrections and C. Carlos Carreiro Immigration Detention Center in North Dartmouth, Massachusetts. The following relief is requested:

1. Release of plaintiffs and all similarly situated detainees in Bristol County Immigration Detention Facilities on their own recognizance with appropriate precautionary public health measures, or, in the alternative, release plaintiffs and all similar situated detainees in Bristol County Immigration Detention Facilities into community-based alternatives to detention, such as conditional release, supervision or electronic monitoring, with appropriate precautionary public health measures;
2. [In the alternative,] implementation of public health guidance and protocols designed to prevent the transmission of COVID-19;

3. Ceasing placing new detainees in Bristol County Immigration Detention Facilities until all public health protocols designed to prevent the transmission of COVID-19 have been implemented; and
4. Effectuating the release of Plaintiffs and all similarly situated detainees at Bristol County Immigration Detention Facilities upon the posting of the appropriate bond, if bond was previously set by ICE or an Immigration Judge.

This motion is supported by an accompanying Memorandum of Law, Petition for Writ of Habeas Corpus and Complaint for Injunctive and Declaratory Relief, and by declarations of the named Plaintiffs, other similarly situated detainees, relatives of detainees, attorneys working on their behalf, and leading medical and public health experts.

Notice – As further detailed in the Declaration of Oren Sellstrom in Support of Temporary Restraining Order, filed concurrently herewith, on March 27, 2020 at approximately 9:00 a.m., counsel for Plaintiffs sent an e-mail to Attorney Robert Novack, Assistant U.S. Attorney Eve Piemonte, Assistant U.S. Attorney Michael Sady, and Assistant U.S. Attorney Rayford Farquhar to advise of the emergency reasons requiring them to seek a temporary restraining order and attaching copies of the Complaint. At approximately 7:30 p.m. on March 27, 2020, counsel for Plaintiffs emailed the above-referenced counsel advising them that Plaintiffs were preparing to file the temporary restraining order and attaching all documents to be filed.

Dated: March 27, 2020

Respectfully Submitted,

/s/ Oren Sellstrom
Oren Nimni (BBO #691821)
Oren Sellstrom (BBO #569045)
Lauren Sampson (BBO #704319)
Ivan Espinoza-Madrigal†

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New Haven, CT 06520
Phone: (203) 432-4800
michael.wishnie@ylsclinics.org

† Motion for admission *pro hace vice* forthcoming.

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren Sellstrom

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et al*., *Petitioners-Plaintiffs,* v. Thomas Hodgson, Bristol County Sheriff in his Official Capacity, *et al.*, *Respondents-Defendants*.	Case No. 1:20-cv-10617-WGY

MEMORANDUM IN SUPPORT OF MOTION
FOR TEMPORARY RESTRAINING ORDER

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INTRODUCTION

Petitioners-Plaintiffs ("Plaintiffs") are civil immigration detainees held by Respondents-Defendants ("Defendants") at the Bristol County House of Corrections ("BCHOC") and C. Carlos Carreiro Immigration Detention Center ("Carreiro") (collectively, "Bristol County Immigration Detention Facilities"), who respectfully seek emergency relief—humanitarian release and a temporary prohibition against new immigration admissions—from this Court because they are at imminent risk of contracting COVID-19. This extraordinary request is amply supported by life-threatening conditions of confinement, and the unprecedented circumstances surrounding the cascade of infections and death caused by the current global pandemic. Plaintiffs are kept in close quarters, are not provided with adequate medical care, are not able to distance themselves from others exhibiting symptoms, and are not equipped with materials to practice adequate hygiene to protect themselves. They seek relief on behalf of themselves and all other persons who are now – or will be in the future – held by Defendants in civil immigration detention in the Bristol County Immigration Detention Facilities.

Despite the overwhelming consensus of public health authorities and experts—including doctors contracted by the U.S. Department of Homeland Security[1]—Defendants have repeatedly and unjustifiably refused to take critical and urgent steps to safeguard Plaintiffs' health and to prevent the spread of COVID-19.

Recognizing the urgency of present circumstances, judges, prosecutors and correctional authorities across the country have been ordering humanitarian releases to protect individuals and the public health. Such releases not only protect the people with the greatest vulnerability to serious illness and death COVID-19 from transmission of the virus, they also contribute to

[1] Letter from Scott A. Allen, MD and Josiah Rich, MD, MPH to Congressional Committee Chairpersons, dated Mar. 19, 2020, available at https://assets.documentcloud.org/documents/6816336/032020-Letter-From-Drs-Allen-Rich-to-Congress-Re.pdf.

greater risk mitigation for all people in custody or working in a prison, jail, or detention center, and reduces the burden on the surrounding community's limited medical and health care infrastructure, as it lessens the likelihood that an overwhelming number of people will become seriously ill from COVID-19 at the same time.

Defendants stand apart from law enforcement and jail officials in Los Angeles, Oakland, New Jersey, New York City, Cleveland, Nashville, Houston, San Antonio, Charlotte, and countless other jurisdictions that are actively releasing thousands of individuals —both civil detainees and, in many cases, people serving sentences for criminal convictions —because of the imminent threat COVID-19 poses inside jails.

Every day, more court rulings explain the health risks—to inmates, guards, and the outside community at large—present in large prison populations. *See, e.g.*, *Jimenez v. Wolf*, No. 18-10225-MLW (D. Mass. Mar. 26, 2020) (ordering release of immigrant detainee in the midst of the COVID-19 pandemic and noting that "being in a jail enhances risk" and that in jail "social distancing is difficult or impossible"); *United States v. Stephens*, No. 15-cr-95-AJN, 2020 WL 1295155, at *2 (S.D.N.Y. Mar. 19, 2020) (ordering the release of inmate in Federal Bureau of Prisons custody due, in part, to risk posed by COVID-19 in the facility); *In the Matter of the Extradition of Alejandro Toledo Manrique*, No. 19-mj-71055, 2020 WL 1307109, at *1 (N. D. Cal. March 19, 2020) (ordering change to conditions of bail for an individual to postpone incarceration, in part, in light of risk of vulnerability to the coronavirus); *United States v. Barkman*, No. 3:19-cr-0052-RCJ-WGC, 2020 U.S. Dist. LEXIS 45628 (D. Nev. Mar. 17, 2020). On March 22, the New Jersey Supreme Court also issued a consent order for the presumptive release of approximately 1,000 persons by March 26.

Just this morning, on March 27, 2020, Judge Alison Nathan from the Southern District of New York granted a similar temporary restraining order filed by immigration detainees seeking humanitarian release in *Coronel v. Decker*, No. 20-cv-2472 (AJN) (S.D.N.Y. Mar. 27, 2020) (finding "likelihood of success on the[ ] claim the Government's actions constitute deliberate indifference to Petitioners' medical needs" and on procedural due process claim). So did Judge Analisa Torres, in a separate action on behalf of a different group of immigration detainees seeking humanitarian release. *Basank v. Decker*, No. 20-cv-2518 (AN) (S.D.N.Y. Mar. 27, 2020) (finding likelihood of success, granting TRO, and ordering immediate release on recognizance of petitioners).

This series of favorable rulings makes sense because the pandemic presents the paradigmatic situation in which emergency relief is necessary. The Eighth Amendment protects all those in detention against "a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). As civil immigration detainees, Plaintiffs enjoy even greater constitutional protections than those outlined in *Helling* because their confinement is meant to be non-punitive; they are merely awaiting the conclusion of pending immigration proceedings. The widespread presence of the virus has materially changed detention conditions as to renders Plaintiffs' ongoing civil immigration detention unconstitutional. Conditions that may not have been likely to cause serious illness before the COVID-19 outbreak are now breeding grounds for the virus, and Defendants failure to take steps to mitigate this risk increase the likelihood that such harms will occur. Therefore, Plaintiffs respectfully urge this Court to follow the prevailing precedent and to order their immediate humanitarian release, and that of the other members of the class

they propose to represent, because of the life-threatening conditions in Bristol County Immigration Detention Facilities.

In the alternative, Plaintiffs respectfully request that the Court temporarily restrain Defendants from admitting new detainees in the Bristol County Immigration Detention Facilities, and grant the immediate release of the most medically vulnerable detainees, including the named Plaintiffs, until such a time as an expedited hearing on a preliminary injunction can be held on behalf of the full class. Plaintiffs also urge that Defendants be required to thoroughly and professionally disinfect and sanitize the Bristol County Immigration Detention Facilities. Finally, because there is no likelihood of harm to Defendants, Plaintiffs respectfully request that the Court dispense with any requirements for security.

FACTS[2]

I. The COVID-19 Pandemic is Spreading Quickly and Poses Grave Risk of Serious Illness and Death

Since January 21, 2020, when the first case was reported in the United States, COVID-19 has spread like wildfire into every region of this country. Declaration of Oren Sellstrom ("Sellstrom Decl."), Exhibit A. A respiratory illness that spreads from person to person contact, transmitted mainly between people who are in close contact with one another, Declaration of Gregg Gonsalves ("Gonsalves Decl."), ¶ 15, but may also be carried on "surface[s] or object[s]

[2] The information described below is based on public reports from the Center for Disease Control ("CDC"), World Health Organization ("WHO") and the accompanying declarations of two medical and public health experts: Allen S. Keller, MD, who has extensive experience reporting on conditions of detention in ICE facilities, Declaration of Allen Keller (Keller Decl.), ¶¶ 2-3, and Gregg S. Gonsalves, Ph.D., an epidemiologist at the Yale School of Medicine and School of Public Health. The descriptions of conditions at Bristol County House of Corrections are drawn from March 18, 2020 and March 23, 2020 letters by Plaintiffs and similarly situated detainees to Defendant Hodgson (ECF 1, Exhibits A and B), as well as declarations from Plaintiff Julio Cesar Medeiros Neves, Plaintiff Maria Alejandra Celimen Savino, immigration attorney Ira Alkalay, who has multiple immigration clients housed in Bristol County, putative class members Cesar Francisco, Carlos Menjivar-Rojas, and Cesar Francisco Vargas Vasquez, as well as Cristina Oritz Ortiz and Yesenia Leyva, who are family members of putative class member Francisco Ortiz Ortiz.

that ha[ve] the virus on them," the virus produces mild to severe symptoms that can include fever, coughs, and shortness of breath. Sellstrom Decl., Ex. A. But in over 15% of cases, the illness is severe or deadly. Gonsalves Decl., ¶ 3. For thousands of patients, hospital-grade respirators are required to take any breaths, as the virus can progress from a mere fever to "life-threatening pneumonia," or septic shock, multi-organ failure, and death. *Id*, ¶ 2-3**.** As of March 27, 2020, there is neither a vaccine for COVID-19 nor a specific antiviral treatment. Sellstrom Decl., Ex. A. No one is immune. Gonsalves Decl., ¶ 5**.** Indeed, even young and healthy individuals have been found shockingly susceptible, as those between the ages of 20 and 44 represent 20% of all COVID-19 hospitalizations in the United States. *Id.*

COVID-19 was declared a global pandemic by the World Health Organization (WHO) on March 12, 2020. The United States leads the world in confirmed coronavirus cases, with 68,440 infections and 994 deaths, as of March 26, 2020. Sellstrom Decl., Exhibit C at 2. COVID-19 is present in all fifty states, as well as the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. *Id.* In Massachusetts, since the first confirmed case on February 1, 2020, the number of infections has grown exponentially, with 2,417 confirmed cases of COVID-19 in the Commonwealth as of March 26, 2020, to say nothing of the "thousands of people" who are unable to be tested and are likely "carrying a potentially fatal disease that is easily transmitted." Gonsalves Decl., ¶¶ 10, 11.

In response to the pandemic, Governor Charlie Baker declared a state of emergency on March 10, 2020 and issued subsequent emergency orders on March 15, 2020 and March 23, 2020 to close schools until May 4, 2020, close all nonessential businesses, and prohibit gatherings of more than 10 people. *Id*., ¶ 12. The purpose of these measures was to encourage

residents to "practice social distancing at all times . . . to limit the spread of this highly contagious and deadly virus." *Id*.

Globally, the WHO has reported that as of March 26, 2020, there are 462,684 confirmed cases (49,219 in the previous 24 hours) and 20,834 deaths (2,401 in the previous 24 hours). Sellstrom Decl., Exhibit D, at 1. Those over the age of 50, as well as those who are immuno-compromised or have pre-existing medical conditions, ranging from diabetes to chronic respiratory disease, are especially at risk of serious symptoms or death. *Id*. at 10.

Without a single known immunity, treatment, vaccine, or cure, the only available effective measure to prevent serious illness or death from COVID-19 is to "prevent individuals from being infected with the virus." Gonsalves Decl., ¶ 5. Accordingly, since the inception of the virus, infectious disease experts and epidemiologists have consistently recommended individuals and institutions engage in key preventative measures to limit viral transmission, including "maintaining physical distances," avoiding individuals with "fever or respiratory symptoms," performing hand hygiene, and cleaning and disinfecting objects and surfaces. Sellstrom Decl., Exh. D at 2; *see also* Gonsalves Decl., ¶ 17 (observing that because "community spread" is at "the root" of the pandemic, containment and social distancing, including "not touching common surfaces," staying "at least 6-12 feet from other people," and "identifying and isolating people who are ill," are among "the best methods of prevention").

II. Detention Facilities and Other Institutions that Harbor Individuals in Close Contact Are Especially Susceptible to a Deadly Outbreak of the Virus.

Despite these recommendations from public health experts around the world, basic hygienic and social distancing measures are largely absent in overcrowded, ill-managed prisons and other places of detention. In general, detention facilities, which are designed to "maximize control" over the incarcerated population, rather than to "minimize disease transmission or to

efficiently deliver health care," are enclosed environments, akin to the nursing homes and cruise ships that have formed the epicenters of multiple COVID-19 outbreaks in the United States and abroad. Gonsalves Decl., ¶ 16. Unsurprisingly, jails and prisons have been loci for historical viral outbreaks, including during the 2009 H1N1 epidemic and a 2012 influenza outbreak in Maine. *Id.* ¶¶ 16, 25. This pattern is already being repeated across the world. In China alone, over 500 cases of COVID-19 were reported across four detention facilities in both correctional officers and detainees. *Id.* ¶ 27. Inmates have also tested positive in county jails in both New Jersey and New York. *Id.* ¶ 28.

On March 15, 2020, the WHO Regional Office for Europe published Interim Guidance on "Preparedness, prevention, and control of COVID-19 in prisons and other places of detention." Sellstrom Decl., Exhibit E. In particular, the WHO highlighted that detained individuals are "likely to be more vulnerable to the coronavirus disease . . . because of the confined conditions in which they live together for prolonged periods of time," and that prisons, jails, and similar settings "may act as a source of infection, amplification and spread of infectious disease within and beyond prisons," such that "[p]rison health is therefore widely considered as public health." *Id*. at 1. The WHO emphasized that the provision of health care for people in places of detention is a "State responsibility" as well as that detained individuals should "enjoy the same standards of health care that are available in the outside community, without discrimination on the grounds of their legal status." *Id*. at 3. The WHO made numerous recommendations for reducing the risk of a spread of coronavirus within a detention facility, including the "provision of adequate space between people, adequate air exchange, and routine disinfection of the environment (preferably at least once daily)," as well as "distributing food in room/cells instead of a common canteen" and supplying soap, water, and personal towels in

"rooms/cells night and day." *Id.* at 9 and 13. These recommendations are echoed by the Center for Disease Control's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, Sellstrom Decl., Exhibit F, which has called for, among other things, signage through facilities communicating the symptoms of COVID-19 and hand hygiene instructions that is "understandable for non-English speaking persons," encouraging staff to stay home when sick, and providing "sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies." *Id*. at 6, 7.

Beyond these preventative measures, there are continued calls to release detainees in order to promote greater social distancing, provide sufficient numbers of hygienic supplies, and prevent burnout and overloading among detention staff. For example, in Iran, amidst reports the pandemic had spread to Iranian prisons, Secretary of State Mike Pompeo has called for the immediate release of detained U.S. citizens on the ground their detention "amid increasingly deteriorating conditions defies basic human decency." Gonsalves Decl., ¶ 27. Additionally, in acknowledgment of the "serious public health risks posed by prisons and detention centers," the United Nations High Commissioner for Refugees has urged governments to "release prisoners and detainees" in the name of public health and safety. *Id*., ¶ 31.

In accordance with recommendations from public health experts and epidemiologists, law enforcement and jail officials from around the country are releasing individuals —both civil detainees and, in many cases, people serving sentences for criminal convictions —because of the threat COVID-19 poses inside jails and the vulnerability of these individuals. *See, e.g.,* Maura Dolan, et al., *California releases more jail inmates amid coronavirus crisis*, L.A. Times (March 20, 2020), https://www.latimes.com/california/story/2020-03-20/california-releases-more-jail-inmates-amid-coronavirus-crisis?; Quinn Wilson, *KCSO: Inmate releases based on mitigating*

spread of COVID-19, reserved for non-violent offenders, Bakersfield Californian (March 19, 2020), https://www.bakersfield.com/news/breaking/kcso-inmate-releases-based-on-mitigating-spread-of-covid-/article_10ffc8a2-6a3d-11ea-b7b5-7b06de300554.html; *see also* Board of Correction City of New York, Letter from BOC re NYC Jails and Covid-19 (March 19, 2020) available at https://www1.nyc.gov/assets/boc/downloads/pdf/News/covid-19/Letter- from-BOC-re-NYC-Jails-and-COVID-19-2020-03-21.pdf.

III. Conditions in Bristol County Detention Facilities Pose a Considerable Risk to the Health of Detainees and to Public Health At Large.

As of March 27, 2020, detainees in Bristol County Facilities are subject to living conditions that violate nearly every recommendation of infectious disease experts across the globe—including the CDC and WHO—and, as such, are susceptible to a deadly outbreak of COVID-19. As reported by Ira Alkalay, an attorney with multiple clients who are presently Immigrations and Customs Enforcement (ICE) detainees at Bristol County House of Corrections (BCHOC), bunk beds in Unit B, a unit housing up to sixty-six immigration detainees, are located "between one and three feet apart," leaving detainees without "adequate space to practice social distancing, which requires keeping six feet apart." Declaration of Ira Alkalay, ¶ 4. Detainees eat meals off of plastic rays, which are "passed through three or four individuals before reaching a detainee for meals." *Id.*, ¶ 4. There are only four operational showers and two urinals for sixty-six detainees, and soap is "watered down and inadequate for proper hygiene." *Id*., ¶ 7.

Perhaps most startlingly, there appear to be no policies in place to separate healthy inmates from those who are ill and potentially exposed; detainees have been assigned bunks next to individuals who have "test[ed] positive for tuberculosis," or who must wait weeks to receive medical appointments, even when suffering from breathing issues. *Id*., ¶¶ 9-11. Plaintiff Julio Cesar Medeiros Neves, who is presently detained in Unit B, is currently held in "the same room

as 49 other people," and so has no opportunity to separate himself from other detainees to slow or stop any viral spread. Declaration of Julio Cesar Medeiros Neves ("Neves Decl."), ¶¶ 2-6. Even amidst the presence of correctional officers with flu-like symptoms, as well as other detainees who are critically ill, detainees like Mr. Neves have not received basic hygienic supplies such as "sanitizer, disinfectant, or antiseptic" products. *Id.* ¶¶ 12, 14-15; *see also* Declaration of Yessenia Leyva, ¶ 4 (noting that at least two guards have come into the facility with coronavirus symptoms, including one guard who coughed incessantly). Despite Bristol County's awareness of the horrifying conditions in their facilities—indeed, a March 23 letter signed by 52 detainees housed in Unit B highlighted the issue of multiple ill guards, overcrowded living conditions, a lack of signage in any language, and a lack of decontamination procedures—the facilities have failed to implement basic protocols to protect these vulnerable populations. ECF 1, Exhibit B; *see also* Declaration of Carlos Menjivar-Rojar, ¶¶ 7-9 (reporting that in Unit B, there is "no toilet paper, no napkins" and that without proper soap, bleach, or disinfectant, detainees are "pretty much just washing our hands with water."). By contrast, in a display of naked cruelty, Defendants' only response to the pandemic was to end visits by family members to individuals inside of the facility—despite the fact that families never had physical contact, but spoke over the phone or through glass, as well as that correctional officers continue to arrive at the jail. Declaration of Cristina Oritz Ortiz, ¶ 5.

These conditions occur through Bristol County's facilities. According to Plaintiff Maria Alejandra Celimen Savino, who is detained in Alley EB in the C. Carlos Carreiro Immigration Detention Center, detainees lack access to basic necessities like toilet paper and standards for sanitation are "very poor," with all cleaning in the unit conducted by detainees. Declaration of Maria Alejandra Celimen Savino ("Savino Decl."), ¶ 8, 10. Ms. Savino, who has suffered from

asthma since she was a child, is at especially high risk for COVID-19, but due the conditions of her civil detention, she is unable to engage in any kind of social distancing or preventative hygiene. *Id.*, ¶ 5-7, 11-13. Other detainees, who are living with health conditions that place them at increased risk of severe COVID-19 symptoms, including weak immune systems, leukemia, diabetes, tuberculosis, emphysema and chronic obstructive pulmonary disease (COPD), are precluded from taking even basic steps to protect themselves because of the policies imposed and perpetuated by Defendants. ECF 1, Exh. B, at 6. For example, despite having asthma and only one working lung, Cesar Francisco Vargas Vasquez has been denied protective gear, as well as access to toilet paper and disinfectant. Declaration of Cesar Francisco Vargas Vasquez, ¶¶ 3, 5, 10. Mr. Vasquez has even been deprived of basic medical necessities, including an unexpired inhaler and medical attention for his injured hand. *Id*., ¶¶ 3-4; *see also* Ortiz Declaration, ¶¶ 4, 6 (describing conditions endured by her detained brother who suffers from respiratory difficulties, asthma and hernias and has a pacemaker, but is denied food beyond bread, coffee, and crackers as well as "supplies for personal cleaning.").

As indicated above, medical experts have been clear that the conditions of confinement in facilities such as Bristol County are "unsafe and pose a danger to detained immigrants" in the midst of the present COVID-19 pandemic. Declaration of Allen Keller, ¶ 5. Dr. Allen Keller, an Associate Professor at New York University School of Medicine in the Departments of Medicine and Population Health with over 25 years of experience evaluating and treating vulnerable populations and evaluating prison conditions, has opined that the fatal combination of poor health conditions, insufficient hygiene, psychological stress, and close confinement has rendered immigration detention facilities "unsafe environments for immigrant detainees" such that

"continued detention in these facilities poses an immediate risk and danger to their health and well-being and to the community." *Id.*, ¶¶ 1, 34.

LEGAL ARGUMENT

For a temporary restraining order, the plaintiff "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The standard for issuing a temporary restraining order is substantially similar as that for a preliminary injunction. *Largess v. Supreme Judicial Court for State of Massachusetts*, 317 F. Supp. 2d 77, 81 (D. Mass. 2004). Relief depends on: (i) the likelihood that the movant will succeed on the merits; (ii) the possibility that, without an injunction, the movant will suffer irreparable harm; (iii) the balance of relevant hardships as between the parties; and (iv) the effect of the court's ruling on the public interest. *See id.; see also Alongi v. AMCO LLC,* 2015 WL 12766154 at *1 (D. Mass. Sept. 23, 2015) (granting preliminary injunction where issuance of order would "not cause undue inconvenience or loss" to defendant); *CellInfo, LLC v. Am. Tower Corp.*, 352 F.Supp. 3d 127 (D. Mass. 2018) (granting preliminary injunction); *Westenfelder v. Novo Ventures (U.S.), Inc.*, 797 F.Supp. 2d 188, 191 (D. Mass. 2011) (same); *United Parcel Service, Inc. v. Local 25 of Intern. Broth. Of Teamsters, Chauffeurs, Warehousemen and Helpers of America (Local 25)*, 421 F.Supp. 452, 458-59 (D. Mass. 1976); *accord Monga v. Nat'l. Endowment for Arts*, 323 F.Supp. 3d 75, 95-96 (D. Me. 2018) (granting TRO of immigrant high school student based on citizenship-based eligibility rule for national poetry reading competition; in relevant part, court observed one-time

opportunities "constitute irreparable harm" that outweighed order's impingement on discretionary program administration with "generalized goals"); *Cirelli v. Town of Johnston School District*, 888 F.Supp. 13, 16 (D. R.I. 1995) (granting TRO enjoining defendants from violating plaintiff's First Amendment rights and noting even "temporary restraint on expression may constitution irreparable injury").

In this case, as discussed below, all four factors overwhelmingly favor Plaintiffs.

I. In The Absence of Emergency Relief and Humanitarian Release, Medical Experts Confirm That Plaintiffs Will Suffer Infection, Illness, and Death.

Medical and public health experts confirm that Defendants' actions will cause severe injury and harm to Plaintiffs. This harm, serious illness or even death, is irreparable, as it "cannot adequately be compensated for either by a later-issued permanent injunction, after a full adjudication on the merits, or by a later-issued damages remedy." *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 76 (1st Cir. 2005). Immediate relief and humanitarian release are essential to address the imminent hazards of COVID-19 on Plaintiffs.

When Plaintiffs contract COVID-19 as a result of their close confinement they will have contracted an illness with no known cure. Gonsalves Decl., ¶ 5. This is true for all civil immigration detainees as the disease does not discriminate based on age or health status. *Id.*, ¶¶ 5, 7. It is particularly true for Plaintiffs Celimen Savino and Medeiros Neves because they suffer from asthma, depression, and anxiety—all medical conditions that place them at much higher risks of developing serious and possibly lethal medical complications if they become infected. *Id.* ¶¶ 4, 7. Moreover, due to the close confinement conditions in Bristol County Immigration Detention Facilities, if one Plaintiff or detained person were to contract the virus, it is highly likely that it would spread to all Plaintiffs, subjecting them to the serious harm this illness would cause. *See* Keller Decl., ¶ 13. Judges Nathan and Torres in the Southern District of New York

readily found irreparable harm for groups of civil immigration detainees, and for similar reasons, so should this Court.

Thus, the imminent infection, illness, and death that Plaintiffs face constitutes irreparable harm that this Court can help prevent.

II. Plaintiffs are likely to succeed on the merits of their claims.

Immigrant detainees, whether or not they have prior criminal convictions, are unquestionably civil detainees held pursuant to civil immigration laws. *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001). The Due Process Clause of the Fifth Amendment, which provides significantly greater protection than the Eighth Amendment's ban on cruel and unusual punishment, safeguards the rights of civil detainees while in custody. However, even the Eighth Amendment imposes on the Government an affirmative duty to provide conditions of reasonable health and safety to those in its custody:

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

DeShaney v. Winnebago County Dept. of Soc. Servs., 489 U.S. 189, 199-200 (1989). Conditions that pose an unreasonable risk of imminent harm violate the Eighth Amendment's prohibition against cruel and unusual punishment, even if that harm has not yet come to pass. Thus, prison authorities cannot "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." *Helling*, 509 U.S. at 33. For example, the Supreme Court has held that inmates cannot be comingled with others experiencing illness such as hepatitis or venereal disease. *Hutto v. Finney*, 437 U.S. 678, 682 (1978). An

Eighth Amendment violation is established even though the plaintiff cannot yet "prove that he is currently suffering serious medical problems caused by" the exposure. *Helling*, 509 U.S. at 32.

While Plaintiffs would clearly succeed on a claim under the Eighth Amendment, the Due Process Clause of the Fifth Amendment provides even greater protection to civil immigrant detainees. While the Eighth Amendment prohibits punishment that is "cruel and unusual," civil detention and the Fifth Amendment's due process protections prohibit "punishment." *Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979) ("Due process requires that a pretrial detainee not be punished."). Civil detainees are entitled to "more considerate treatment" than their criminal counterparts. *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982). And while convicted persons must show "deliberate indifference" on the part of prison officials to establish a violation of the Eighth Amendment, *Farmer v. Brennan*, 511 U.S. 825, 828 (1994), there is no such requirement for civil detainees challenging their conditions of confinement. If placing an inmate in a situation creating an elevated risk of potentially lethal infection constitutes "cruel and unusual punishment" in violation of the Eighth Amendment – as was found in *Hutto* – placing civil immigration detainees in life-threatening conditions with an imminent risk of lethal COVID-19 infection amounts to a clear violation of the Fifth Amendment. Plaintiffs are precisely in this untenable and unconstitutional position.

In a decision issued today in *Basank v. Decker*, the Court stated well the due process analysis:

> Immigration detainees can establish a due process violation for unconstitutional conditions of confinement by showing that a government official "knew, or should have known" of a condition that "posed an excessive risk to health," and failed to take appropriate action. *Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017); *Charles v. Orange Cty.*, 925 F.3d 73, 87 (2d Cir. 2019) ("Deliberate indifference . . . can be established by either a subjective or objective standard: A plaintiff can prove deliberate indifference by showing that the defendant official recklessly failed to act with reasonable care to mitigate the risk that the condition posed to the pretrial detainee even though the

> defendant-official knew, *or should have known*, that the condition posed an excessive risk to the plaintiff's health or safety." (internal quotation marks, citation, and alterations omitted)). The risk of contracting COVID-19 in tightly-confined spaces, especially jails, is now exceedingly obvious. It can no longer be denied that Petitioners, who suffer from underlying illnesses, are caught in the midst of a rapidly-unfolding public health crisis. The Supreme Court has recognized that government authorities may be deemed "deliberately indifferent to an inmate's current health problems" where authorities "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year," including "exposure of inmates to a serious, communicable disease," even when "the complaining inmate shows no serious current symptoms." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). Petitioners need not demonstrate that "they actually suffered from serious injuries" to show a due process violation. *Darnell*, 849 F.3d at 31; *see Helling*, 509 U.S. at 33. Instead, showing that the conditions of confinement "pose an unreasonable risk of serious damage to their future health" is sufficient. *Phelps v. Kapnolas*, 308 F.3d 180, 185 (2d Cir. 2002) (quoting *Helling*, 509 U.S. at 35) (alteration omitted).

Basank, slip op., at 11-12 (footnote omitted).

Alarmingly, Defendants' guards have reported to work with coronavirus symptoms. Neves Decl., ¶ 12. Just two days ago, in the midst of the public health crisis and contagion, a new immigration detainee was brought into the facility. *Id.* at ¶ 14. The new detainee "got very sick. He was very sick all night, and [Defendants] took him out." *Id.* Even after this illness and sickness, Plaintiffs "have not received any protection. No sanitizer, disinfectant or antiseptic." *Id.*, ¶ 15. In fact, there are no sanitation or decontamination crews, the cleaning is done by inmates. Savino Decl., ¶ 10 ("The standards of sanitation are very poor, and I am forced to touch things that are potentially contaminated by diseases, including tables, chairs, dishes, and cutlery."). Plaintiffs cannot wash their hands frequently with soap. They cannot engage in social distancing – maintaining a distance of six feet from other persons – because the Bristol County Immigration Detention Facilities "do not provide [ ] the space for that." *Id.*, ¶ 11. Plaintiffs must sleep merely feet apart from other individuals in detention, who have not been tested for COVID-19, and may even be exhibiting symptoms. Plaintiffs cannot engage in the preventative measures that those outside of detention can undertake to thoroughly protect themselves from

coming into contact with the virus, nor can they control whom they come in to contact with on a daily basis, since guards, contractors, and vendors regularly enter the facility, Keller Decl., ¶ 14, and other detained individuals are transported between immigration detention facilities regularly. *Id.* ¶ 11.

Under these circumstances, the question is not if the unconstitutionally dangerous conditions in the Bristol County Immigration Detention Facilities will lead to the spread of COVID-19, but when, how quickly, and how many will die. Plaintiffs are literally being held in tinderboxes waiting to be ignited. Defendants know and should know that Plaintiffs and members of the putative class are at grave peril and risk of death due to their confinement in close quarters and without adequate space to distance themselves from each other, not to mention the arrival of new admissions and the lack of adequate soap, toilet paper, and other necessities of virus-preventing hygiene. Since exposure to lethal COVID-19 infection is imminent – and clearly banned by the Fifth Amendment – Plaintiffs are highly likely to succeed on the merits of their claim.

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

Both the balance of equities and the public interest heavily favor the Plaintiffs. In normal times, crowding and close quarters, the sharing of toilets, sinks, and showers, and communal food preparation and service may be considered uncomfortable. However, these conditions present a deadly threat to Plaintiffs lights in light of COVID-19. This threat is compounded daily, as guards come through the facility after being in contact with outside communities, and as other detainees are transferred in to Bristol County Immigration Detention Facilities. The threat and exceptional risk COVID-19 poses to Plaintiffs vastly outweighs any interest Defendants may have in maintaining Plaintiffs' detention.

Since immigration proceedings are civil and non-punitive, "[t]here is no sufficiently strong special justification . . . for indefinite civil detention." *Zadvydas*, 533 U.S. at 690. In fact, Immigration and Customs Enforcement ("ICE") has significant discretion to release immigration detainees, see 8 U.S.C. § 1226(a), and has a long-standing practice of releasing for humanitarian reasons even those whose detention has been mandated under particular immigration detention statutes, see 8 U.S.C. § 1182(d)(5); § 1225(b); § 1226(c). ICE regularly uses alternatives to detention to maintain custody and control over non-citizens in immigration proceedings, such as supervised release, electronic ankle monitors, home confinement, and telephonic monitoring. Since Defendants can and have routinely released immigration detainees for humanitarian reasons, they cannot object to the reasonableness of such relief under the life-threatening conditions in the Bristol County Immigration Detention Facilities.

CONCLUSION

Plaintiffs' motion for a temporary restraining order should be granted.

March 27, 2020

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren M. Sellstrom

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et. al.*, Petitioners-Plaintiffs, v. THOMAS HODGSON, *et. al.*, Respondents-Defendants.	Civil Action No. 1:20-cv-10617-PBS

DECLARATION OF ALLEN S. KELLER, M.D.

I, Allen S. Keller, M.D., hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge.

RELEVANT BACKGROUND AND QUALIFICATIONS

1. I am an Associate Professor at New York University School of Medicine (NYUSoM) in the Departments of Medicine and Population Health, and a Medicine Attending Physician at Bellevue Hospital in New York City. In 1995, I co-founded Bellevue/NYU Program for Survivors of Torture (PSOT) in New York City and from 1995-December 2018 served as PSOT's Director. I am co-founder and Director of the NYU Center for Health and Human Rights (CHHR). I have over 25 years of experience evaluating and treating vulnerable populations including asylum seekers and victims of severe trauma such as torture.

2. I have over 25 years of experience evaluating prison conditions. From 2009 to 2016, I Co-Chair of the Immigration Detention Health Advisory Group for the U.S. Department of Homeland Security Immigration and Customs Enforcement NGO working group. In this role I also was part of several delegations visiting ICE detention facilities throughout the United States. I continue to conduct research on the conditions of detention and related health consequences. I am the author, coauthor and editor of nearly 100 scholarly publications on the evaluation and treatment of victims of trauma/human rights abuses; and prison conditions, including the health consequences of immigration detention.[1]
To date, I have visited over 20 immigration detention facilities throughout the United States.

3. I have served as a medical expert on various investigations of immigration detention facilities. In 2004, I was appointed as an expert by the U.S. Commission on International Religious Freedom (USCIRF) for their congressionally mandated study on the expedited removal process for asylum seekers, which examined all aspects of the process including

[1] *See e.g.*, Granski, Megan; Keller, Allen; Venters, Homer, Death Rates among Detained Immigrants in the United States. International journal of environmental research & public health. 2015 Nov 12; 12(11):14414-14419.

immigration detention.[2] In 2017, I served as a medical expert for a review conducted by Human Rights Watch on medical care and deaths of immigrants in detention entitled "Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention."[3]

4. In preparing this affidavit, I reviewed the following materials:
   - Letters by ICE Detainees at Bristol County House of Correction;
   - ICE's National Detention Standards (Revised 2019);
   - ICE Guidance on COVID-19[4];
   - ICE's Enforcement and Removal Operations, National Detainee Handbook; Custody Management (April 2016);
   - The President's Coronavirus Guidelines for America.[5]
   - Massachusetts Dept. of Health Coronavirus Infection Statistics

Dangerous Conditions of Confinement in Immigration Detention Related to COVID-19

5. It is my professional opinion that in the midst of the COVID-19 pandemic the conditions of confinement in immigration detention facilities such as Bristol County are unsafe and pose a danger to detained immigrants.

6. Immigration detention facilities, such as Bristol County, both in design and functioning, are typically comparable to maximum-security prisons. For example, immigration detention facilities are heavily guarded, secured with barbed wire and multiple security check points, including electronic bars. Detainees, who must wear jail uniforms, are constantly monitored by corrections officers. Immigration detainees are often subjected to restricted visitation and recreational time, restricted access to the law library, and the use of segregation for punitive reasons. Lockdowns are common, including when head counts are conducted. Bristol County House of Correction is well-known for the Sheriff there taking pride in "tough" conditions in his jail.

7. Detained immigrants are housed in small, confined bunk-like quarters commonly referred to as "pods." They often sleep with many detainees in close quarters. In recent letters from ICE Detainees, which I reviewed, Detainees repeatedly raised concerns about overcrowded conditions at Bristol. Meals are served in cafeterias to a large number of detainees at a time. Recreation typically occurs in central courtyards with large numbers of immigrant detainees at any given time.

8. These immigration detention practices occur in enclosed, prison-like facilities putting detainees in close contact around the clock. "Social Distancing COVID-19 Guidelines," as per the CDC and the White House COVID-19, cannot be effectively and safely

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[2] *Report on Asylum Seekers in Expedited Removal, available at* https://www.uscirf.gov/reports-briefs/special- reports/report-asylum-seekers-in-expedited-removal (accessed Mar. 23, 2020).

[3] *Available at* https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care- us-immigration-detention (accessed Mar. 23, 2020).

[4] Available at https://www.ice.gov/covid19 (accessed Mar. 23, 2020).

[5] See https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf (accessed Mar. 23, 2020).

implemented in immigration detention.

9. My review of allegations included in the letters submitted by immigration detainees at the Bristol County House of Corrections and reports regarding the facility leads me to conclude that the conditions at that facility are substantially similar to those of other immigration detention facilities I have visited and inspected.[6]

10. As such, the risk of COVID-19 infection and spread in immigration detention facilities, including Bristol County, is extremely high. Massachusetts Dept. of Health statistics about Coronavirus infections make this clear. On March 11, 2020, there were no confirmed Coronavirus infections in Bristol County and a total of 41 confirmed cases throughout the state. As of March 26, 2020 (2 weeks and 1 day later) there are 90 confirmed Coronavirus cases in Bristol County and 2,417 throughout the state. A significant number of individuals infected with the Coronavirus require admission to an intensive care unit. The total number of ICU beds in Bristol County is 96. Given the rapid increase of Coronavirus infections in the county, there is a substantial risk that the county will have inadequate ICU beds to care for all in need.

11. Furthermore, the routine practice of transferring immigrant detainees from one facility to another, and adding new prisoners each day throughout the nationwide immigration detention network, makes the likelihood of COVID-19 spread and infection far more likely, including at Bristol County. In a recent letter, Bristol County immigrant detainees noted that a new detainee was placed in an already overcrowded bunk before he was medically screened. Given such conditions and practices, one would be hard-pressed to think of a more effective means for the spread of COVID-19 infection than immigration detention.

12. The recent clustering of Coronavirus cases following a Biogen Employee meeting held in late February 2020 in Boston, which is attributed at least in part for the rapid rise of cases in Boston, is a sobering example of how a cluster of cases can rapidly multiply.

13. Plans for separating suspected COVID-19 exposed or infected individuals within a given facility or by transferring to specialized quarantine facilities is neither effective nor feasible as a response to the threat of infection or infectious spread within a detention facility. As per CDC guidelines, when individuals become symptomatic and considered "at risk" of being infected with/contagious to others for COVID-19, they are supposed to self-isolate, not isolate within groups. This prevents spread of COVID-19 from infected patients to those who are not infected, despite having similar symptoms. Putting both groups together, risks infecting the uninfected, symptomatic individuals. In other words, for individuals with symptoms who did not have COVID-19 before being placed in group isolation, many will likely contract COVID by being in contact with COVID infected patients.

14. This is exacerbated by substantial and increasing limitations on access to testing, even for those who have symptoms of COVID-19, because of a major shortage of testing materials. It would be unlikely that in these immigration detention facilities, all who are symptomatic

[6] *See e.g.*, WGBH Boston, Why is the suicide rate in Bristol County jails so high?, May 8, 2017 https://www.wgbh.org/news/2017/05/08/news/why-suicide-rate-bristol-county-jails-so-high; The Sun Chronicle, Jail Tales: A glimpse at life inside, April 12, 2019, https://www.thesunchronicle.com/news/local_news/jail-tales-a-glimpse-at-life-inside/article_cbe6a01c-36c3-5c8a-9b85-d3cdeb98d6f6.html.

could be tested prior to any form of group isolation.

15. Immigration detention staff, as well as contractors and vendors, are at risk of unknowingly spreading COVID-19 infection that was acquired in the community, given the daily back and forth routines of staff, contractors, and vendors, and the lack of available tests. In letters from Bristol County immigrant detainees, they raised concerns about guards who had to leave work because they had fevers.

16. All of the above risks of COVID-19 infection are further increased given the substantial period when individuals may be asymptomatic, but still shedding the virus and contagious.

17. It is my professional opinion that health care provided in immigration detention facilities such as Bristol County under normal conditions is often unsafe, and there are serious inadequacies in hygiene and sanitation. This conclusion is supported by numerous governmental,[7] non- governmental,[8] and investigative reports over the past decade which have found evidence of substandard medical care in immigration detention facilities, deficiencies in hygiene and sanitation, and a lack of oversight and accountability.

18. For example, The U.S. Government Accountability Office in 2016 reported that ICE lacked the tools to monitor the medical care in detention facilities. Human Rights Watch, in a 2017 report, documented deaths in detention resulting at least in part from substandard care. The DHS Office of the Inspector General has documented unclean and unsanitary detention facilities which do not meet ICE standards. In its 2019 review, the California Department of Justice found that, across the immigration detention facilities in the state, there were failures in medical record- keeping, "nurses practicing outside their legal scope of practice, superficial medical examinations, delayed or inadequate medical care, inadequate mental health staffing and services, and unsafe suicide watch and disciplinary

[7] California Department of Justice, "Immigration Detention in California," Feb. 2019, https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2019.pdf (accessed May 21, 2020); DHS Office of the Inspector General, "Concerns About ICE Detainee Treatment and Care at Four Detention Facilities," June 3, 2019, https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf (accessed May 21, 2020); US Government Accountability Office, "Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care," February 2016, http://gao.gov/products/GAO- 16-231. http://www.gao.gov/assets/680/675484.pdf (accessed May 21, 2020); US Department of Homeland Security, Office of Inspector General, "Management Alert on Issues Requiring Immediate Action on Theo Lacy Facility in Orange, California," March 6, 2017, https://www.oig.dhs.gov/sites/default/files/assets/2017/OIG-17-43- MA-030617.pdf (accessed March 21, 2020).

[8] Human Rights Watch, "Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention," May 2017, https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard- medical-care-us-immigration-detention (accessed May 20, 2020); Human Rights Watch, "Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention," June 2018, https://www.hrw.org/sites/default/files/report_pdf/us0618_immigration_web2.pdf (accessed May 20, 2020); New York Lawyers for the Public Interest, "Health in Immigration Detention," February 2016, http://www.nylpi.org/wp- content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report_2017.pdf (accessed May 20, 2020); Southern Poverty Law Center, "Shadow Prisons: Immigrant Detention in the South," November 2016, https://www.splcenter.org/news/2016/11/21/new-splc-report-uncovers-abuse-and-neglect-immigrant-detention- centers-south (accessed May 20, 2020); American Civil Liberties Union, Detention Watch Network, and National Immigrant Justice Center, "Fatal Neglect: How ICE Ignores Deaths in Detention," February 2016, https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention (accessed May 21, 2020).

isolation (solitary confinement) practices."

19. In numerous ICE facilities, the medical care is provided largely by low-level medical professionals unqualified or underqualified for the care they are responsible to provide. This may include licensed vocational nurses (or licensed practical nurses), certified medical assistants, and registered nurses, often with very limited experience. Many of these health care professionals are asked to make decisions that are beyond their areas of expertise or skill level. There is also typically high turnover among health professionals in immigration detention facilities.

20. Access to healthcare for chronic conditions including HIV, hypertension and other illnesses can be challenging in immigration detention facilities including Bristol County. This in part is because the jail-like facilities where immigrants are held are intended for short-term rather than prolonged detention. As a result, they are often geared to providing temporary, short-term acute care rather than longer-term care and management of chronic health disorders. Thus, health conditions that may have been well-controlled outside of detention, such as diabetes and hypertension, are likely not only to be exacerbated by detention, but also to be inadequately treated. Facilities may have inadequate health staff and difficulty recruiting local health providers to provide care for their detainees.

21. The Public Health Service through the ICE Health Service Corps (IHSC) has some role governing the health care provided at detention centers even where it is not the health care provider. It is my professional opinion, however, where IHSC is not providing direct health care, as is the case in Bristol County House of Correction, there is typically some discontinuity of care and insufficient oversight of the work of private health care providers.

22. It is my professional opinion that IHSC also lacks the resources to monitor the quality of health care delivered to ICE detainees at any facility. IHSC lacks the appropriate clinical, non-clinical and monitoring staff to both provide and oversee the health care of immigration detainees. Instead, ICE often relies on contracts with non-governmental for-profit vendors to conduct formal monitoring, and this has been inadequate.

23. ICE has established national detention standards which govern the facilities the agency operates.[9] However, for its county contractors and private detention providers, ICE has rarely held detention contractors accountable when they fail to meet the performance standards, even where their failures resulted in severe harm to detainees.[10]

24. The healthcare capacity in immigration detention facilities will be easily overwhelmed by the COVID-19 pandemic. Furthermore, many ICE detention facilities are located in remote, isolated areas, with limited health system capacity as well, which will easily be overwhelmed.

Vulnerability of Plaintiffs to Severe Effects of COVID-19

[9] ICE detention center contracts establish the governing standards: the 2000 National Detention Standards (NDS) or 2008 and 2011 Performance Based National Detention Standards.

[10] See DHS Office of the Inspector General, "ICE Does Not Fully Use Contracting Tools To Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards," Jan. 29, 2019, https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf (accessed March 21, 2020).

25. People over the age of 50 years old and people with underlying medical conditions are at greater risk of harm from COVID-19 and developing more serious illnesses and dying should they become infected with coronavirus. Underlying medical conditions which increase the risk of harm from COVID-19 infection include individuals who are immunosuppressed or HIV+, or who have hypertension, diabetes, coronary artery disease, chronic pulmonary conditions including Chronic Obstructive Pulmonary Disease (COPD) and asthma.[11]

26. Individuals in ICE custody at the Bristol County House of Corrections are at risk of harm from COVID-19. The CDC reported that 38% of individuals that were hospitalized between February 12 and March 16 as a result of complications arising from COVID-19 were between the ages of 20 and 54.[12]

27. New information regarding COVID-19 risk factors is coming out daily. Other individual plaintiffs not named here may have conditions that predispose them to complications from COVID-19, but are not yet identified by the medical literature. For example, the CDC published a new list on March 22, 2020 which expanded the previously identified groups of individuals vulnerable to the virus.

28. In addition, individuals who are "immunocompromised" are at high risk of severe illness, and this could include a large number of individuals, depending on the medication they are taking, their past drug/alcohol abuse,[13] and other medical conditions. My conclusions above rest on currently available information, and do not discount the possibility that other factors may increase the severity of COVID-19.

29. For instance, as a result of profound stress and helplessness, immigrant detainees are at risk of having suppressed immune systems putting them at higher risk than the general population of contracting and potentially having more serious infections. Stress and its link to immunosuppression are well documented in the medical literature.[14]

Harmful Psychological Impact of COVID-19 on Immigrant Detainees

30. It is my professional opinion that physical and mental health and well-being of detained immigrants, independent of age or underlying conditions, is worsened and severely harmed by continued immigration detention during the COVID-19 pandemic. All immigrant detainees are at high risk of developing severe, disabling psychological symptoms and distress as a result of their continued immigration detention during the COVID-19 pandemic.

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[11] Coronavirus-19. People who are at higher risk for severe illness. Centers for Disease Control, National Center for Immunization and Respiratory Diseases. March 22, 2020

[12] Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020, March 26, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm

[13] https://www.ncbi.nlm.nih.gov/pubmed/19630706.

[14] Glaser R and Kiecolt-Glaser JK. 2005. Stress-induced immune dysfunction: implications for health. *Nat Rev Immunol* 5: 243-251; Segerstrom SC and Miller GE. 2004. Psychological stress and the human immune system: a meta-analytic study of 30 years of inquiry. *Psychol Bull* 130: 601-630; Johnson JD, Campisi J, Sharkey CM, Kennedy SL, Nickerson M, Greenwood BN and Fleshner M. 2005. Catecholamines mediate stress-induced increases in peripheral and central inflammatory cytokines. *Neuroscience* 135: 1295-1307.

31. Based on my over 20 years of evaluating and examining the impact of immigration on psychological symptoms, the vast majority of immigrant detainees suffer from psychological symptoms, including depression and anxiety, caused by their immigration detention. These individuals already suffering from psychological symptoms related to their immigration detention will likely experience substantial worsening of these symptoms in the context of a devastating pandemic. Furthermore, it is likely that even those immigrant detainees who did not have psychological symptoms before Coronavirus will develop such symptoms as a result of profound fear and helplessness. It is worth noting, that prior reports have documented that Bristol County Jail even before the Coronavirus infection has had an unusual high number of suicides compared to other county jails in the state.

32. Individuals with chronic medical conditions are at a particularly high risk of developing (if they did not have previously) significant symptoms of psychological distress, including anxiety, sleep disorders and depression. It is likely and predictable that such individuals with chronic health conditions are appropriately frightened of increased risk of harm by remaining in detention, which will, in turn, result in symptoms of anxiety and depression.

33. It is my professional opinion that individuals with underlying mental health conditions are at a high risk of harm from coronavirus. Individuals suffering from mental health conditions including depression, anxiety, schizophrenia and posttraumatic stress disorder (PTSD) are at particularly high risk of worsening of their symptoms as a result of being detained amid the coronavirus pandemic. Such exacerbation of psychological symptoms can result in severe harm. For example, individuals with depression are at increased risk of suicidality.

34. It is my professional opinion that as a result of the COVID-19 pandemic, immigration detention facilities are unsafe environments for immigrant detainees and continued detention in these facilities poses an immediate risk and danger to their health and well-being and to the community.

Date: March 26, 2020

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Allen S. Keller, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren M. Sellstrom

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et. al.*, Petitioners-Plaintiffs, v. THOMAS HODGSON, *et. al.*, Respondents-Defendants.	Civil Action No. 1:20-cv-10617-PBS

DECLARATION OF GREGG GONSALVES

I, **GREGG S. GONSALVES**, upon my personal knowledge, and in accordance with 28 U.S.C. § 1746, declare as follows:

1. I am an epidemiologist at the Yale School of Medicine and School of Public Health. I have worked at the schools of medicine and public health since 2017. Attached as Exhibit A is my CV.

2. COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a virus closely related to the SARS virus. In its least serious form, COVID-19 can cause illness including fever, cough, and shortness of breath. However, for individuals who become more seriously ill, a common complication is bilateral interstitial pneumonia, which causes partial or total collapse of the lung alveoli, making it difficult or impossible for patients to breathe. Thousands of patients have required hospital-grade respirators, and COVID-19 can progress from a fever to life-threatening pneumonia with what are known as "ground-glass opacities," a lung abnormality that inhibits breathing.

3. In about 16% of cases of COVID-19, illness is severe including pneumonia with respiratory failure, septic shock, multi organ failure, and even death.

4. Certain populations of people are at particular risk of contracting severe cases of COVID-19. People over the age of fifty are at higher risk, with those over seventy at serious risk. As the Center for Disease Control and Prevention has advised, certain medical conditions increase the risk of serious COVID-19 for people of any age. These medical conditions

include: those with lung disease, heart disease, diabetes, blood disorders, chronic liver or kidney disease, inherited metabolic disorders, developmental delays, those who are immunocompromised (such as from cancer, HIV, autoimmune diseases), those who have survived strokes, and those who are pregnant.[1]

5. There is no vaccine against COVID-19 and there is no known cure. No one is immune. The only known effective measures to prevent injuries or deaths resulting from COVID-19 are to prevent individuals from being infected with the virus. In fact, young and healthy individuals may be more susceptible than originally thought. New data from the CDC show that up to one-fifth of infected people ages 20-44 have been hospitalized, including 2%-4% who required treatment in an intensive care unit.[2]

6. The number of people infected is growing exponentially. The death toll in, for instance, the nation of Italy, which began experiencing this epidemic about a week earlier than the first diagnosed American cases, rose by 30% overnight in the 24 hours between March 5, 2020 and March 6, 2020.[3] On March 17, 2020, Italy reported 345 new coronavirus deaths in the previous 24 hours, an increase in the death toll of 16%.[4] Experts predict similar rapid growth will soon occur in the United States. Without effective public health interventions, a COVID-19 response team at the Imperial College in the United Kingdom projected 2.2 million or more deaths in the United States.[5]

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

8. Based on data collected by the Centers for Disease Control and Prevention, World Health Organization, and National Center for Biotechnology Information on the speed at which

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[1] Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): People Who May Be at Higher Risk for Severe Illness*, https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html (last accessed Mar. 18, 2020).

[2] Centers for Disease Control and Prevention, Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020 (Mar. 26, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w
Sharon Begley, New analysis breaks down age-group risk for coronavirus — and shows millennials are not invincible (March 18, 2020)
https://www.statnews.com/2020/03/18/coronavirus-new-age-analysis-of-risk-confirms-young-adults-not-invincible/

[3] Worldometer, Italy, https://www.worldometers.info/coronavirus/country/italy/ (last accessed Mar. 26, 2020).

[4] *Id.*

[5] Imperial College COVID-19 Response Team, *Impact of non-pharmaceutical Interventions (NPIs) to reduce COVID-19 mortality and healthcare demand* (Mar. 16, 2020), https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf.

SARS-CoV-2 has spread since it is first known to have infected a human in November 2019, the virus is estimated to be twice as contagious as influenza.[6] Unlike influenza, there are no known vaccines or antiviral medications to prevent or treat infection from COVID-19. Because the coronavirus that causes COVID-19 is passed through respiratory droplets and also appears to be able to survive on inanimate surfaces, it can be transmitted even when an infected person is no longer in the immediate vicinity. Data from China indicates that the average infected person passes the virus on to 2-3 other people at distances of 3-6 feet.[7] Everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus.

9. The current estimated incubation period of COVID-19 is between 2 and 14 days, meaning that a patient who begins showing symptoms today may have been contagious for as long as two weeks prior. The time course of the disease once symptoms appear can be very rapid. A patient's condition can seriously deteriorate in as little as five days (perhaps sooner) following initial detection of symptoms. The current estimated rate for life-threatening complications is approximately 20%, with a fatality rate estimated at between 1% and 5%. All of these risk assessment numbers, however, appear to be rising.

10. It is clear that, currently, the numbers of people diagnosed reflect only a portion of those likely infected; very few people have been tested, and many are asymptomatic, so they do not even know they should be tested. As a result, thousands of people are likely living day to day and carrying a potentially fatal disease that is easily transmitted—and no one is aware of it.

11. The Massachusetts ("MA") Department of Public Health announced the first confirmed COVID-19 case in the state on February 1, 2020.[8] As of March 26, the MA Department of Public Health has confirmed 2,417 cases of COVID-19 in the state.[9] As of March 24, 2,l47 residents of Massachusetts were under state-imposed quarantine following exposure to COVID-19 in community-based settings.[10] According to the MA Department of Public Health, 1,655 additional residents have completed monitoring after possible exposure from group settings.[11] In the last few weeks, several entire nations have declared lockdowns, and cities and institutions across the United States are closing public events,

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[6] Brian Resnick & Christina Animashaun, *Why Covid-19 is worse than the flu, in one chart*, Vox (Mar. 18, 2020), https://www.vox.com/science-and-health/2020/3/18/21184992/coronavirus-covid-19-flu-comparison-chart.

[7] Knvul Sheikh, Derek Watkins, Jin Wu & Mika Gröndahl, *How Bad Will the Coronavirus Outbreak Get? Here are 6 Key Factors*, NEW YORK TIMES (Feb. 28, 2020), https://www.nytimes.com/interactive/2020/world/asia/china-coronavirus-contain.html.

[8] Joe Dwinell, Lisa Kashinsky & Stefan Geller, *UMass Boston student first confirmed case of coronavirus in Massachusetts*, BOSTON HERALD (Feb. 1, 2020), https://www.bostonherald.com/2020/02/01/first-case-of-coronavirus-confirmed-in-massachusetts-dph/.

[9] Massachusetts Department of Public Health, *COVID-19 cases in Massachusetts* (Mar. 26, 2020), https://www.mass.gov/doc/covid-19-cases-in-massachusetts-as-of-march-26-2020/download.

[10] Massachusetts Department of Public Health, *Massachusetts residents subject to COVID-19 quarantine,* https://www.mass.gov/info-details/covid-19-cases-quarantine-and-monitoring#massachusetts-residents-subject-to-covid-19-quarantine- (last accessed Mar. 26, 2020).

[11] *Id.*

workplaces, and schools in order to curb spread of COVID-19 by limiting person-to-person transmission in group settings.

12. On March 10, 2020 Governor Charlie Baker of Massachusetts declared a state of emergency, announcing aggressive recommendations to curb the spread of COVID-19 and finding the importance of taking steps to address the potentially disastrous impacts of the disease on the health, safety, and security of the public.[12] On March 13, 2020 President Donald J. Trump announced a national state of emergency in response to the disease's outbreak.[13] On March 15, 2020, Governor Baker closed schools for three weeks, banned on-premise consumption of food or drinks at bars and restaurants, and limiting all gatherings to 25 individuals.[14] On March 23, 2020, Governor Baker issued an emergency order closing all nonessential businesses, prohibiting gatherings of more than ten people, and urging everyone to remain in their homes as much as possible and to "practice social distancing at all times. . . to limit the spread of this highly contagious and deadly virus."[15] On March 25, 2020, Governor Baker extended school closures until May 4.[16]

13. On March 11, 2020, the World Health Organization declared a global pandemic based on COVID-19. Citing "deep[] concern[] both by the alarming levels spread and severity, and by the alarming levels of inaction," it called for countries to take "urgent and aggressive action."[17]

14. As of March 26, 2020, according to the World Health Organization, over 462,684 people in over 200 countries and territories have been diagnosed with coronavirus and 20,834 people have died as a result.[18] And as of March 26, according to the Center for Disease

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[12] Massachusetts Department of Public Health, *COVID-19 State of Emergency*, Exec. Order No. 591 (Mar. 10, 2020), https://www.mass.gov/executive-orders/no-591-declaration-of-a-state-of-emergency-to-respond-to-covid-19.

[13] President Donald Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (Mar. 13, 2020), https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

[14] Massachusetts Department of Public Health, *COVID-19 State of Emergency: Updates, Emergency Orders and Guidance*, https://www.mass.gov/info-details/covid-19-state-of-emergency (last accessed Mar. 17, 2020).

[15] Office of the Governor, Commonwealth of Massachusetts, *Order Assuring Continued Operation of Essential Services in the Commonwealth, Closing Certain Workplaces, and Prohibiting Gatherings of More Than 10 People*, https://www.mass.gov/doc/march-23-2020-essential-services-and-revised-gatherings-order/download (last accessed Mar. 26, 2020).

[16] CBS Boston, *Coronavirus Closures: Gov. Baker Orders All Mass. Schools Stay Closed Until May 4* (Mar. 25, 2020), https://boston.cbslocal.com/2020/03/25/coronavirus-massachusetts-schools-closed/.

[17] World Health Organization, *WHO Director-General's opening remarks at the media briefing on COVID-19* (Mar. 11, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[18] World Health Organization, *Coronavirus disease 2019: Situation Report – 66* (Mar. 26, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200326-sitrep-66-covid-19.pdf?sfvrsn=81b94e61_2.

Control (CDC), 68,440 people have been diagnosed in the United States, with 994 deaths confirmed. 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have confirmed positive tests.[19]

15. The virus is thought to be transmitted mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or sneezes. It also may be possible that 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. What doctors and experts are calling "community spread" is at the root, and "containment" and "social distancing" are being enforced as the best methods of prevention. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill. Social distancing means, in essence, isolating oneself from other people as much as possible: working from home, avoiding travel, avoiding crowds and contact with others, not touching common surfaces, and generally staying at least 6-12 feet from other people as much as possible.

16. In light of COVID-19, individuals in detention facilities are at risk of serious harm. Detention facilities are designed to maximize control of the incarcerated population, not to minimize disease transmission or to efficiently deliver health care. These facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Detention facilities have even greater risk of infectious spread than other enclosed environments because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources. During the H1N1 influenza ("Swine Flu") epidemic in 2009, jails and prisons were sites of severe outbreaks of viral infection.[20]

17. People incarcerated in detention facilities live in close quarters and cannot achieve the "social distancing" needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Spaces are poorly ventilated, which promotes highly efficient spread of diseases through droplets.

18. Many detention facilities lack the supplies and staff needed to perform cleaning procedures such as regular disinfection of high-touch surfaces, which is essential to preventing virus spread. Facilities often do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced

[19] Centers for Disease Control and Prevention, *COVID-19: U.S. at a Glance*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html (last accessed Mar. 26, 2020).

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

and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings.

19. Many detention facilities lack the medical care infrastructure necessary to treat infected individuals and prevent the exponential spread of infection. For example, many detention facilities use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals. Detention facilities are also ill-equipped to provide sufficient personal protective equipment, such as gloves, masks, gowns, and eye-shields, for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

20. The medical facilities at jails and prisons are almost never sufficiently equipped to handle widespread outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. As an outbreak spreads, medical personnel become sick and do not show up to work. Facilities can become dangerously understaffed with healthcare providers.

21. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

22. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions may not be able to receive the care they need. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

23. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, can result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

24. As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

25. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities

in Maine, resulting in two inmate deaths.[21] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the swine flu outbreak in 2009, jails and prisons experienced a disproportionately high number of cases.[22] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

26. Due to the crowded conditions and scarcity of sanitary and medical resources, transmission of infectious diseases in jails and prisons, including the Bristol County House of Corrections, is incredibly common. These risks are magnified for those diseases, like COVID-19, that are transmitted by respiratory droplets. An outbreak of COVID-19 in detention facilities would be devastating.

27. The experiences of other nations fighting COVID-19 outbreaks demonstrate the particular risk of COVID-19 transmission present in detention facility settings. Prisons in China reported more than 500 cases of COVID-19 spread across four facilities, and these cases affected both correctional officers and incarcerated people.[23] Secretary of State Mike Pompeo has called for Iran to release U.S. citizens detained there because of "deeply troubling" "[r]eports that COVID-19 has spread to Iranian prisons," noting that "[t]heir detention amid increasingly deteriorating conditions defies basic human decency."[24]

28. Of the 2,417 confirmed cases in the state of Massachusetts, 90 of those cases have been in Bristol County.[25] It is only a matter of time before we become aware of COVID-19 cases in the Massachusetts detention system, including Bristol County House of Corrections, in which inmates live in close quarters, with subpar infection control measures in place, and whose population represents some of the most vulnerable. On March 24, 2020, ICE announced that a detainee in Bergen County Jail in New Jersey had

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[21] *Influenza Outbreaks at Two Correctional Facilities – Maine, March 2011,* Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.
[22] David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few,* PRISON LEGAL NEWS (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/.
[23] Evelyn Cheng & Huileng Tan, *China says more than 500 cases of the new coronavirus stemmed from prisons*, CNBC (Feb. 20, 2020), https://www.cnbc.com/2020/02/21/coronavirus-china-says-two-prisons-reported-nearly-250-cases.html.
[24] Michael R. Pompeo, *United States Calls for Humanitarian Release of All Wrongfully Detained Americans in Iran,* U.S. Dep't of State (Mar. 10, 2020), https://www.state.gov/united-states-calls-for-humanitarian-release-of-all-wrongfully-detained-americans-in-iran/.
[25] Massachusetts Department of Public Health, *COVID-19 cases in Massachusetts* (Mar. 26, 2020), https://www.mass.gov/doc/covid-19-cases-in-massachusetts-as-of-march-26-2020/download.

tested positive for COVID-19.[26] COVID-19 has already entered the detention systems of several other states.[27] In this setting, we can expect the spread of COVID-19 in a manner similar to that at the Life Care Center of Kirkland, Washington, at which over 50% of residents have tested positive for the virus and over 20% have died in the past month. Such an outbreak would further strain the community's health care system.

29. COVID-19 threatens the well-being of detained individuals, the corrections staff who shuttle between detention facilities and outside communities, and members of those outside communities. Staff, visitors, contractors, and vendors who pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Strains on the medical systems of detention facilities have implications for the outside hospitals and emergency departments on which detention facilities already depend for intensive medical care services. Prison health is public health.

30. The only viable public health strategy available is risk mitigation. In my opinion, from an epidemiological perspective, the Court should immediately take the steps necessary to provide for the release of any detainees in Bristol County House of Corrections, absent extraordinary circumstances. Such steps are necessary for the safety of detained individuals and the broader community as we address the rapid global outbreak of COVID-19.

31. Releasing detainees has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff such that they can continue to ensure the safety of detainees. The United Nations High Commissioner for Refugees, recognizing the serious public health risks posed by prisons and detention centers, has urged governments to release prisoners and detainees in order to protect their safety and as part of larger efforts to quell the spread of the virus.[28]

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[26]News Release, U.S. Immigration and Customs Enforcement, ICE detainee tests positive for COVID-19 at Bergen County Jail (March 24, 2020) (https://www.ice.gov/news/releases/ice-detainee-tests-positive-covid-19-bergen-county-jail).

[27] *See, e.g., Rikers Inmate Tests Positive for Coronavirus,* Spectrum News NY1 (Mar. 18, 2020), https://www.ny1.com/nyc/all-boroughs/coronavirus/2020/03/18/rikers-inmate--correction-officer-test-positive-for-coronavirus; *Rikers officer infected with coronavirus,* Fox 5 NY (Mar. 18, 2020), https://www.fox5ny.com/news/rikers-officer-infected-with-coronavirus; Mark Sundstrom, *Inmate at Nassau County jail tests positive for coronavirus: officials*, Pix 11 (Mar. 16, 2020), https://www.pix11.com/news/coronavirus/inmate-at-nassau-county-jail-long-island-tests-positive-for-coronavirus-officials.

[28] Michelle Bachelet, UN High Commissioner for Refugees, Urgent action needed to prevent COVID-19 "rampaging through places of detention" (Mar. 25, 2020) (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx).

32. The public health crisis requires each and every one of us to re-evaluate how we conduct our lives and care for one another. Institutions responsible for the care and custody of vulnerable populations must take unique steps to "flatten the curve" and slow the spread of this virus. Incarcerating as few individuals as possible will help mitigate the harm from a COVID-19 outbreak.

33. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my information and belief.

Assistant Professor of Epidemiology (Microbial Diseases)
Yale School of Public Health
350 George Street
New Haven, CT 06511
gregg.gonsalves@yale.edu

Date: March 26, 2020

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren M. Sellstrom

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et. al.*, Petitioners-Plaintiffs, v. THOMAS HODGSON, *et. al.*, Respondents-Defendants.	Civil Action No. 1:20-cv-10617-WGY

DECLARATION OF IRA ALKALAY

I, Ira Alkalay, hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge.

1. I am a private attorney who practices in Massachusetts specializing in immigration law, criminal appeals, and post-conviction relief. I have multiple clients who are currently Immigration and Customs Enforcement (ICE) detainees at Bristol County House of Corrections (BCHOC).

2. I most recently visited clients at BCHOC on March 25, 2020. I also visited clients on March 20, 21, and 23. My clients are worried about exposure to COVID-19 inside the facility.

3. I currently have no-contact visits with my clients, so as not to risk carrying infection to them. I meet with my clients in the visitor's bay where we sit in a glass-partitioned booth. From this vantage point I can see into one of the ICE detainee housing units, known as Unit B.

4. Up to 66 people can be housed in Unit B at one time. The beds are bunk beds located between one and three feet apart. Eating tables are clustered at one end of the room. The Unit contains a small area of space where detainees can walk around. Other than a few hours outside each day, the detainees spend all hours of the day inside Unit B, where they eat, sleep, and socialize. From my observation of the Unit, detainees do not have adequate space to practice social distancing, which requires keeping six feet apart.

5. My clients have informed me that they eat their meals off of plastic trays, which have been passed through three or four individuals before reaching a detainee for meals.

6. To the best of my knowledge, at least one corrections officer, who has been in physical contact with the outside community, is present on the Unit at all times.

7. My clients have informed me that the Unit has access to six showers, of which four are currently operational. Additionally, they have access to four urinals, of which two are operational. My clients have told me that soap is watered down and inadequate for proper hygiene.

8. My clients and the other Unit B detainees are responsible for cleaning the unit. My clients have informed me that until the past few days, they were not allocated bleach, adequate scrub-brushes, or sufficient soap for this purpose. Despite this recent improvement, my clients do not believe they have the training or supplies necessarily to disinfect their living space to prevent spread of COVID-19.

9. On March 26, 2020, I spoke with two currents clients and an additional prospective client regarding a new detainee booked into Unit B. This new detainee is, based on my client's description, in his late twenties The new detainee related that he was arrested on March 25 and placed in New Bedford District Court lockup in close proximity to a man wearing a mask who was obviously sick. The new detainee posted bail, was immediately picked up by ICE, and put straight into Unit B without screening for COVID-19. He was assigned a bunk next to a detainee who tests positive for tuberculosis. The new detainee spent the night coughing and vomiting without intervention from BCHOC officials. On the morning of March 26, he was taken to medical. This intake process and placement of an obviously ill and potentially exposed detainee demonstrates how Bristol and ICE put detainees at risk of outside infection.

10. I have a client who is being transferred from BCHOC to Strafford County Department of Corrections in New Hampshire overnight on March 26, 2020. This client was exposed to the ill detainee described in paragraph 9. This transfer could spread the illness, if it is COVID-19, from BCHOC to ICE units at Strafford.

11. My clients have complained about inadequate medical attention at BCHOC. For example, I have a client who experiences breathing problems due to allergies and headaches due to hypertension. He has been detained for nine months at BCHOC. He has repeatedly needed medical attention, but tells me it takes days to a week to receive an appointment. It can take an additional week following the appointment to receive medications aside from his daily medications for hypertension and allergies, such as Tylenol for his severe headaches. His eyeglasses, when broken, were not replaced for approximately two months.

12. Based on my observations, my clients and their fellow ICE detainees are not resilient to infection. In addition to underlying health conditions, they are impacted by the stress of living in Unit B, sometimes for a year or more.

13. In my estimation, 65-75% of ICE detainees in Unit B at any given time speak Spanish. I speak Spanish, and almost all of my Spanish-speaking clients do not speak adequate English to understand facility instructions unless those instructions are provided in Spanish.

Date: March 26, 2020

Ira Alkalay

CERTIFICATE OF SERVICE

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, et al., Petitioners-Plaintiffs, v. THOMAS HODGSON, et al., Respondents-Defendants.	Case No. 1:20-cv-10617-WGY

Declaration of Carlos Menjivar-Rojas

I, Carlos Menjivar-Rojas, hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge:

1. My name is Carlos Menjivar-Rojas and I am detained in Bristol County, Unit B.

2. I'm afraid of getting infected. I have asthma and I heard on the news that the coronavirus is much worse for people with asthma.

3. People have no space here and if anyone gets sick, it is a huge problem. I am one of 47 individuals detained in a very crowded room. We are always really close together. The beds, for example, are maybe 1 or 2 feet away from each other.

4. I also have anxiety and depression. Being here and being so afraid of the coronavirus has made my anxiety and depression much worse. Every day, I look at the news – the total number of deaths keeps rising; the total number of people being exposed keeps rising.

5. It gives me a lot of stress – all I'm thinking about every day is coronavirus. What if the numbers never stop going up? Where I am, people are right next to each other all day. We cannot distance from each other.

6. The conditions are nasty. The walls are dirty. There's dust everywhere.

7. The bathroom is disgusting. There's no toilet paper, no napkins in the bathroom. No one has been able to wipe any surfaces. The soap that we use is watered down. When the

officers bring it out for us to wash our hands, we are pretty much just washing our hands with water.

8. We do not have any supplies to keep things clean here – no bleach, no disinfectant, nothing. I help out with sweeping and mopping before lunch and I help clean the bathroom, so I know the cleaning supplies. When you clean bathrooms, you are supposed to use bleach. But we don't have that – just watered-down soap and hot water. What good is that for stopping germs?

9. Officers said that they'll bring better chemicals to clean the bathrooms and the bunks, but I haven't seen anything. Last week, they said they'd give us chemicals to clean the building, but nothing has changed.

10. None of the officers wear masks, gloves, or anything. There are a few officers that cough and we are worried that they have coronavirus. A few weeks ago, there were two officers who seemed sick and they got sent home, but only for a few days before they came back to work.

11. I worry because I have asthma. My asthma will be triggered very quickly.

12. Everyone here is talking about the coronavirus all the time. All of us are scared. Every time we see a new person, we worry about whether they have it. ICE keeps bringing people in from the streets. They just brought two new people in today. I don't think the new people they brought in got checked for symptoms or were tested.

13. I feel like I'm being punished. I know the officers can make things better for us, and they say they will do it. But when will they start doing it? The officers will roll their eyes at us when we ask for things.

14. We live here, we have to live here. Officers and others can go home at the end of the day, so they don't have to worry about the virus being around. We do.

15. I feel trapped. I feel like a dog caged in, like I'm in a kennel. If you could see this place from the inside, it would open your eyes to how serious the problem is. It's like I'm being played; they play like us like we're animals. We're not animals, we're human beings.

16. This declaration was read to me in English, and I swear it is true. I have authorized Megan Yan, a law student intern working on *Savino v. Hodgson*, to sign for me.

Date: March 27, 2020

/s/ Carlos Menjivar-Rojas
Carlos Menjivar-Rojas

CERTIFICATE OF SERVICE

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, et al., Petitioners-Plaintiffs, v. THOMAS HODGSON, et al., Respondents-Defendants.	Case No. 1:20-cv-10617-WGY

Declaration of Cesar Francisco Vargas Vasquez

I, Cesar Francisco Vargas Vasquez, hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge:

1. My name is Cesar Francisco Vargas Vasquez. I am currently detained at Bristol County in Unit B.

2. I am very scared of being infected with coronavirus and getting sick.

3. I have asthma and only one of my lungs works. I am worried about receiving medical care while detained. I have had past trouble seeing the doctor – I need an operation on my right hand, which is not working properly.

4. I was given a new inhaler for my asthma three weeks ago, but it is expired. The date on the spray is December 2019.

5. Because I have asthma, I am very worried that if I get sick, I will die.

6. It is only a matter of time before the disease spreads everywhere here.

7. There are 47 people in Unit B as of today. I am being held in the same room as all of them.

8. The room is roughly 3,500 square feet of open space and we sleep on bunk beds that are barely 3 feet apart from each other. My bed is too close to the others.

9. I am not able to engage in "social distancing." For example, the dining room has plastic party tables which are set up inches from each other during meal times. All of us eat at the exact same time, so the dining room is always very crowded.

10. The bathroom stalls and showers are also very crowded. We do not have access to disinfectant or toilet paper.

11. The "soap" in the bathroom is not enough. It is mixed with water and will not be able to keep us safe from this disease. We need disinfectant to kill the germs.

12. The correctional officers said that they are stopping outside visits to keep us safe, but this cannot be true. We have not been moved and we are still kept in the same room for weeks with no separation or distance.

13. Meanwhile, ICE is bringing new individuals into the facility everyday, directly from the street.

14. Even though the jail is supposed to quarantine new individuals, they do not do so. They do not test them for the virus or check for symptoms.

15. Two nights ago, ICE brought a new individual—Ernesto—here. Yesterday, he began to throw up everywhere and was coughing very bad. We informed the correctional officer, who saw he was throwing up.

16. Officers came in with masks on and took him away, but I do not know where he went.

17. Even after this and other incidents, we have not received any protection. I have seen guards with flu-like symptoms like the coronavirus.

18. The correctional officers do not wear any protective gear. Yesterday, I saw the nurse giving medication without any gloves. We asked the nurse to put on gloves and she laughed at us.

19. Every time I see news about the coronavirus on the TV, I want to cry. I feel desperate and have not been sleeping. I am awake at 3 or 4AM in the morning and I try to sleep in the day to avoid watching the TV.

20. I began seeing a psychiatrist, but no pills will help me. The fear I feel is too strong.

21. I am very scared of getting sick and dying, especially because it is impossible to have proper hygiene in here. I want to be released so I can avoid infection.

22. Because ICE keeps bringing new people and because we are so close together, I believe everyone will get sick, including me.

23. Last week, one of the nurses said, “it’s a matter of time before you guys get it too. You will get it in less than a month.” On Sunday, one of the correctional officers said to us that we will all be sick soon.

24. All of the immigrants share my fear. Please get us out. We are being treated like dogs in here.

25. This declaration was read to me in English, and I swear it is true. I have authorized Megan Yan, a law student intern working on *Savino v. Hodgson*, to sign for me.

Date: March 27, 2020

/s/ Cesar Francisco Vargas Vasquez
Cesar Francisco Vargas Vasquez

CERTIFICATE OF SERVICE

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, *et al.*, Petitioners-Plaintiffs, v. THOMAS HODGSON, *et al.*, Respondents-Defendants.	Case No. 1:20-cv-10617-WGY

Declaration of Cristina Ortiz Ortiz

I, Cristina Ortiz Ortiz, hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge:

1. My name is Cristina Ortiz Ortiz. Francisco Ortiz Ortiz is my younger brother.

2. Francisco was apprehended by ICE officers in Stamford, CT on 25, 2020 from Stamford CT. He was taken to Bristol County House of Correction where he has been for about one month.

3. I had heard about Bristol County House of Correction from members of Unidad Latina en Accion (ULA) in New Haven because the conditions are so terrible. Several ULA members had been detained there and they said the conditions are deplorable.

4. When Francisco got to Bristol County, he told me that I need to deposit money in his account each day, because he does not have food. He is given only crackers, bread and coffee. After 5pm he is not given any food at all. Francisco is hungry a lot of the time. He and the others who are detained there do not have toilet paper or other supplies for personal cleaning. Francisco also suffers from a stomach hernia.

5. Since the beginning of the coronavirus pandemic, the only precautions that the facility has taken is to end visits by family members to individuals inside of the facility. However, the guards continue to enter the jail. That is not right, the guards can spread contagion inside of the jail. The family visits never had physical contact with detainees anyway. They always spoke through the phone or through glass.

6. Francisco suffers from respiratory problems. He has asthma. He also received surgery to insert a pacemaker into his body. He was held at the hospital for at least a week after that surgery. In recent weeks he has complained of a hernia. I worry that if he gets infected with coronavirus he will not come back alive.

7. The whole time that Francisco was inside Bristol, I felt powerless because I could not do anything for my brother. While I was eating three meals a day, he was going hungry. I felt powerless because he didn't even have soap to wash his hands. While I was sleeping in my bed, he was inside with dozens of other people in bunks. It was painful. It hurt me.

8. This declaration was read to me in English, and I swear it is true to the best of my knowledge. I have authorized Megan Yan, a law student intern working on *Savino v. Hodgson*, to sign for me.

Date: March 27, 2020

/s/ Cristina Ortiz Ortiz
Cristina Ortiz Ortiz

CERTIFICATE OF SERVICE

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, *et al.*, Petitioners-Plaintiffs, v. THOMAS HODGSON, *et al.*, Respondents-Defendants.	Case No. 1:20-cv-10617-WGY

Declaration of Yesenia Leyva

I, Yesenia Leyva, hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge:

1. My name is Yesenia Leyva. Francisco Ortiz Ortiz is my partner.

2. Francisco was apprehended by ICE officers in Stamford, CT on 25, 2020 from Stamford CT. He was taken to Bristol County House of Correction where he has been for about one month.

   I had heard about Bristol County House of Correction from members of Unidad Latina en Accion (ULA) in New Haven because the conditions are so terrible. Several ULA members had been detained there and they said the conditions are deplorable

3. Francisco told me three days ago that all of the prisoners are going to do a hunger strike to protest the conditions on the facility. None of the prisoners agree with unsafe conditions.

4. Francisco told me that two guards went to work sick last week. One of the guards was coughing a lot. The detention center sent both of the guards home.

5. When Francisco told me that the guards arrive sick at work. I got very worried. Yesterday we went to the protest outside of Bristol County and we saw posters that said, “This place will turn into a death camp.” I am very worried because if one person gets infected there is no way to protect everyone else. I am very worried.

6. This declaration was read to me in English, and I swear it is true to the best of my knowledge. I have authorized Aseem Mehta, a law student intern working on *Savino v. Hodgson*, to sign for me.

Date: March 27, 2020

/s/ Yesenia Leyva
Yesenia Leyva

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et al*.,	
Petitioners-Plaintiffs,	
v.	Case No. 1:20-cv-10617 WGY
Thomas Hodgson, Bristol County Sheriff in his Official Capacity, *et al.*,	
Respondents-Defendants.	

DECLARATION OF JULIO CESAR MEDEIROS NEVES

1. My name is Julio Cesar Medeiros Neves.
2. I am detained at Bristol County in Unit B.
3. I suffer from debilitating depression and anxiety.
4. I am being held in the same room as 49 other people.
5. My bed is too close to other people.
6. I am not able to engage in "social distancing."
7. The facility has not provided any guidance or information to help us protect ourselves from the coronavirus.
8. I am afraid of getting infected and sick.
9. I am hearing alarming stories about people getting sick and dying.
10. I am worried I am going to get sick and die too, especially because I can't follow proper hygiene and sanitation in here.
11. I want to be released so I can avoid infection.
12. I have seen guards with flu-like symptoms like the coronavirus.
13. Fear of infection is triggering my anxiety and panic.
14. I have seen at least one detainee arrested and placed in here since the coronavirus outbreak began. He got very sick. He was very sick all night, and they took him out.

15. Even after the incident with the sick person, we have not received any protection. No sanitizer, disinfectant or antiseptic.

16. My name has been included in letters about the coronavirus and the conditions in here, and I can confirm those details.

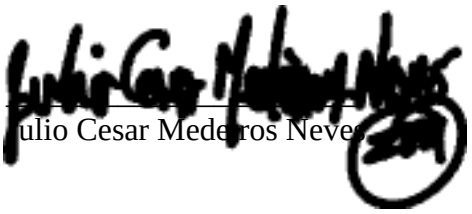
17. All immigration detainees share the same fear of infection.

18. I am very worried, and I am having trouble eating and sleeping.

19. Please get me out.

20. This declaration was read to me in Portuguese, and I swear it is true. I have authorized my attorney to sign for me.

Date: March 26, 2020



Julio Cesar Medeiros Neves

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et al*.,	
Petitioners-Plaintiffs,	
v.	Case No. 1:20-cv-10617 WGY
Thomas Hodgson, Bristol County Sheriff in his Official Capacity, *et al.*,	
Respondents-Defendants.	

DECLARATION OF MARIA ALEJANDRA CELIMEN SAVINO

1. My name is Maria Alejandra Celimen Savino.

2. I am detained at Bristol County.

3. I am in a unit called C. Carlos Carreiro Immigration Detention Center, Alley EB.

4. My unit has 8 cells of ICE detainees, 2 detainees are in each cell, and the total population varies often.

5. At this time, I am alone in my cell, which is 10 x 14 feet. I have been alone for the last two weeks, but this is unusual, there are usually 2 people per cell. At any time, someone can be brought to my cell.

6. The isolation cells are in front of this unit. That's where people are brought when they are disciplined, and that happens often.

7. Upstairs, there are regular inmates, who are not detained by ICE. We share common areas, including the bathroom and a common room, where we eat.

8. The detention conditions are terrible. For the last week, we have not even had toilet paper, they ran out and they have not restocked for an entire week. I have to wipe using sanitary pads, which I must soak first.

9. I eat in the common area. We eat right next to each other, ICE detainees with the regular inmate population.

10. The cleaning inside this unit is done by inmates, there are no janitors coming from outside. The standards of sanitation are very poor, and I am forced to touch things that are potentially contaminated by diseases, including tables, chairs, dishes, and cutlery.

11. I am not able to engage in "social distancing," the common areas do not provide for the space for that.

12. Just last week, a new inmate was added, she was not tested for Coronavirus, as far as I know. And there is a constant stream of new detainees. Also, there is people coming from outside regularly, including guards and other personnel. I don't know if they are infected or if they have been tested.

13. I am afraid of getting infected and sick. I have suffered asthma since I am a child and in 2015, I had my last severe episode, which led to my hospitalization. If I were to be infected with Coronovirus, I will be at high risk.

14. I hear alarming stories about people getting sick and dying outside in the community. A former inmate, who was deported to Guatemala, called another inmate a couple of days ago, and said that inside this detention center there are people who tested positive for Coronavirus.

15. I am worried I am going to get sick and die too, especially because I can't follow proper hygiene and sanitation in here, and because of my medical condition.

16. I want to be released so I can avoid infection.

17. We are not provided any protection from getting infected.

18. All detainees share the same fear and risk of infection.

19. I am having trouble eating and sleeping. I am very worried.

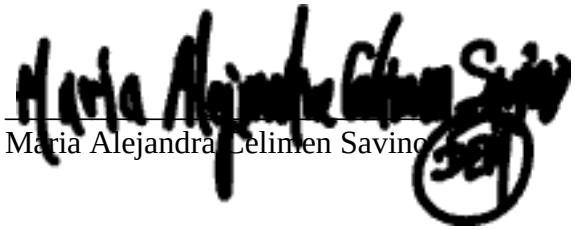
20. There's no mental or emotional health support for me in here.

21. I am not detained for a crime, I should not be here. This is a place for criminal punishment, and I am here for my immigration status, not for a crime. I have been here for more than one year.

22. Please, release me from detention.

23. I fully authorize Lawyers for Civil Rights to use this declaration, which I narrated via phone, to file legal actions on my behalf.

Date: March 26, 2020



María Alejandra Celimen Savino

CERTIFICATE OF SERVICE

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/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, *et al.*, Petitioners-Plaintiffs, v. THOMAS HODGSON, *et al.*, Respondents-Defendants.	Case No. 1:20-cv-10617 WGY

Declaration of Oren Sellstrom In Support of Application for Temporary Restraining Order

I, Oren Sellstrom, hereby declare under penalty of perjury, that the following is true and correct to the best of my knowledge:

1. My name is Oren Sellstrom. I am the Legal Director at Lawyers for Civil Rights. I am counsel to Plaintiffs in this case.

2. I make this declaration from my personal knowledge and, if called upon to do so, could and would competently testify to the matters set forth herein.

3. Attached hereto as **Exhibit A** is a true and correct copy of "What You Need to Know About Coronavirus Disease 2019, COVID-19," published by the Centers for Disease Control and Prevention (hereinafter, "CDC") on March 20, 2020.

4. Attached hereto as **Exhibit B** is a true and correct copy of "Cases in U.S." from the Coronavirus Disease 2019 (COVID-19) section of the CDC website, updated on March 26, 2020.

5. Attached hereto as **Exhibit C** is a true and correct copy of "Coronavirus disease 2019 (COVID-19) Situation Report—66" published by the World Health Organization (hereinafter, "WHO") on March 26, 2020.

6. Attached hereto as **Exhibit D** is a true and correct copy of "Preparedness, prevention, and control of COVID-19 in prisons and other places of detention" published by the WHO Regional Office for Europe on March 15, 2020.

7. Attached hereto as **Exhibit E** is a true and correct copy of "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" published by the CDC on March 26, 2020.

8. On March 27, 2020, at approximately 9:00 a.m., I emailed the Complaint in this matter to the following individuals: Attorney Robert Novack (robertnovack@bcso-ma.org); Assistant US Attorney Eve Piemonte (eve.piemonte@usdoj.gov); Assistant US Attorney Michael Sady (Michael.sady@usdoj.gov); and Assistant US Attorney Rayford Farquhar (Rayford.farquhar@usdoj.gov). Attorney Novack is known to the Plaintiffs' legal team as an attorney who has in the past represented Defendant Hodgson and the Bristol County Sheriff's Office. The AUSAs are known to the Plaintiffs' legal team as attorneys who have represented the federal Defendants in habeas and other actions raising issues of immigration detention at Bristol County immigration detention facilities.

9. I attached the Complaint to the email. I requested that if any of the Defendants would like to comply voluntarily with Plaintiffs' requested relief, or discuss the matter, that they should contact me by noon. I notified counsel that if we did not

hear back from them by then, Plaintiffs planned to move for a Temporary Restraining Order. I asked if they would accept service and asked if there were other counsel to whom Plaintiffs should be directing future correspondence about this matter.

10. At approximately 10:04 a.m. on March 27, 2020, Attorney Novack replied that the exhibits referenced in the complaint were not attached in the original email. At approximately 10:15 a.m., Plaintiffs' legal team furnished those documents to Attorney Novack and the other counsel who had received the Complaint. Plaintiffs did not hear back further from Attorney Novack or any of the other counsel.

11. At approximately 9 PM on the same day (March 27, 2020), I sent an email to the counsel listed in paragraph 8 that advised them that Plaintiffs were preparing to file the TRO and motion for class certification and related papers, and attaching all of the documents that we planned to file. I again advised that if they, or Defendants, desired to discuss the matter further, Plaintiffs' counsel would make themselves available.

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

Date: March 27, 2020

/s/ Oren Sellstrom
Oren Sellstrom

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren M. Sellstrom

Exhibit A

What you need to know about coronavirus disease 2019 (COVID-19)

What is coronavirus disease 2019 (COVID-19)?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can people in the U.S. get COVID-19?

Yes. COVID-19 is spreading from person to person in parts of the United States. Risk of infection with COVID-19 is higher for people who are close contacts of someone known to have COVID-19, for example healthcare workers, or household members. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19. Learn more about places with ongoing spread at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html#geographic.

Have there been cases of COVID-19 in the U.S.?

Yes. The first case of COVID-19 in the United States was reported on January 21, 2020. The current count of cases of COVID-19 in the United States is available on CDC's webpage at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but is now spreading from person to person. The virus is thought to spread mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or sneezes. It also may be possible that 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, but this is not thought to be the main way the virus spreads. Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of

- fever
- cough
- shortness of breath

What are severe complications from this virus?

Some patients have pneumonia in both lungs, multi-organ failure and in some cases death.

How can I help protect myself?

People can help protect themselves from respiratory illness with everyday preventive actions.

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

If you are sick, to keep from spreading respiratory illness to others, you should

- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled from an area with ongoing spread of COVID-19?

If you have traveled from an affected area, there may be restrictions on your movements for up to 2 weeks. If you develop symptoms during that period (fever, cough, trouble breathing), seek medical advice. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to take everyday preventive actions, like avoiding close contact with people who are sick and washing your hands often.

Is there a treatment?

There is no specific antiviral treatment for COVID-19. People with COVID-19 can seek medical care to help relieve symptoms.

CS 314937-A 03/20/2020

cdc.gov/COVID19

Exhibit B

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Cases in U.S.

Updated March 26, 2020

This page will be updated regularly at noon Mondays through Fridays. Numbers close out at 4 p.m. the d before reporting.

CDC is responding to an outbreak of respiratory illness caused by a novel (new) coronavirus. The outbreak first starte Wuhan, China, but cases have been identified in a growing number of other locations internationally, including the U States. In addition to CDC, many public health laboratories are now testing for the virus that causes COVID-19.

COVID-19: U.S. at a Glance*

- Total cases: 68,440
- Total deaths: 994
- Jurisdictions reporting cases: 54 (50 states, District of Columbia, Puerto Rico, Guam, and US Virgin Islands)

* Data include both confirmed and presumptive positive cases of COVID-19 reported to CDC or tested at CDC since January 21, 202 with the exception of testing results for persons repatriated to the United States from Wuhan, China and Japan. State and local public health departments are now testing and publicly reporting their cases. In the event of a discrepancy between CDC cases an cases reported by state and local public health officials, data reported by states should be considered the most up to date.

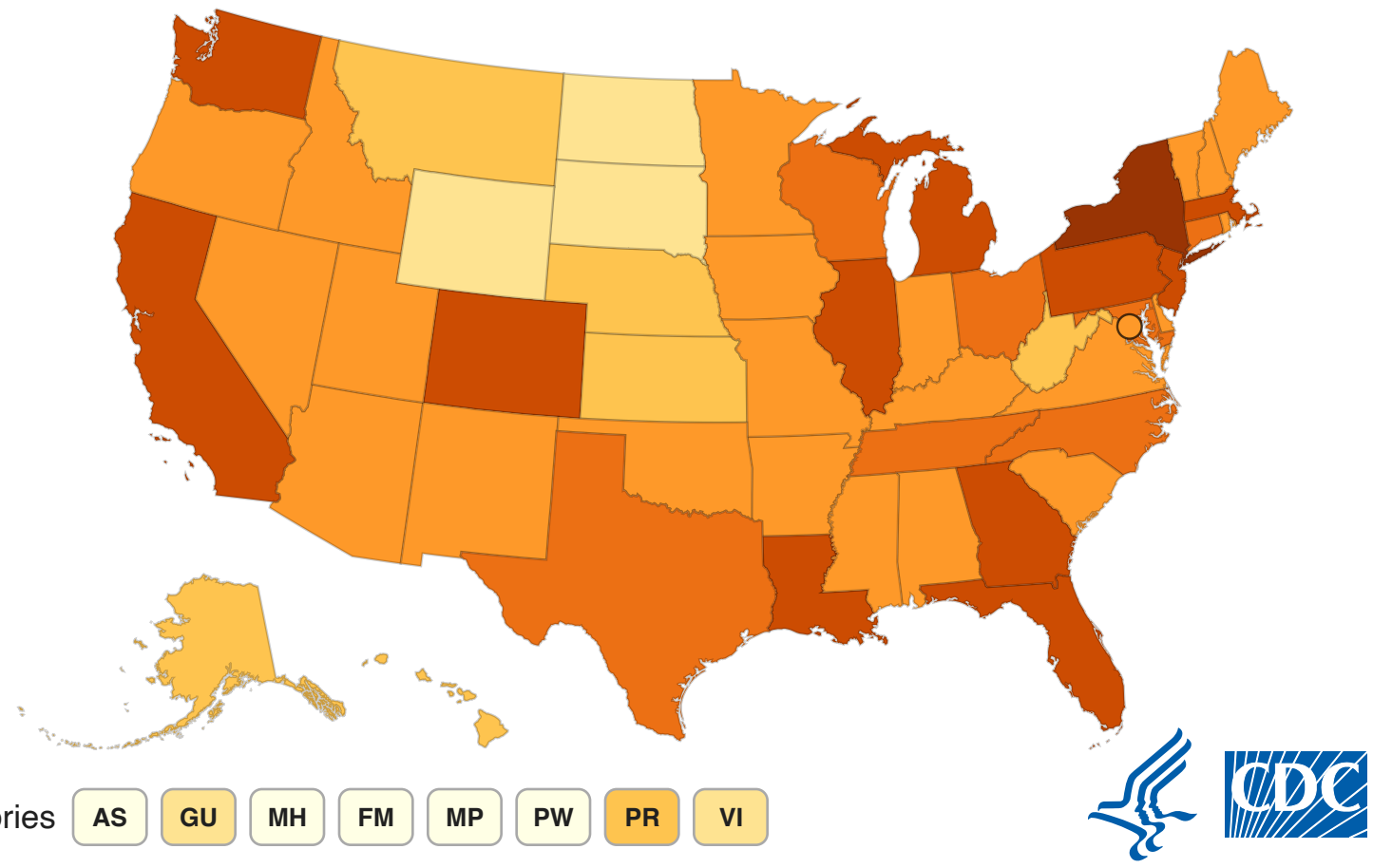
Cases of COVID-19 Reported in the US, by Source of Exposure*†

Travel-related	636
Close contact	1,074
Under investigation	66,730
Total cases	68,440

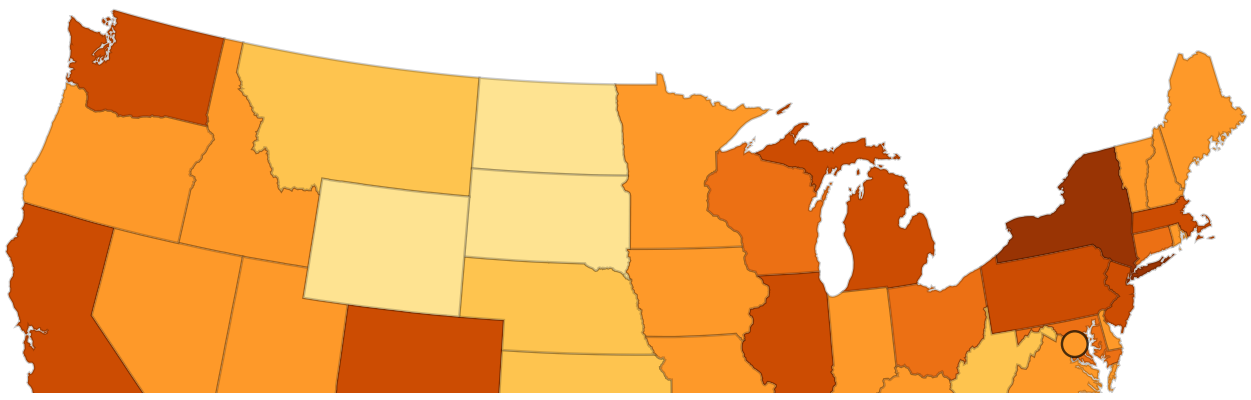
* Data include both confirmed and presumptive positive cases of COVID-19 reported to CDC or tested at CDC since January 21, 202 with the exception of testing results for persons repatriated to the United States from Wuhan, China and Japan. State and local public health departments are now testing and publicly reporting their cases. In the event of a discrepancy between CDC cases an cases reported by state and local public health officials, data reported by states should be considered the most up to date.

† CDC is no longer reporting the number of persons under investigation (PUIs) that have been tested, as well as PUIs that have tested negative. Now that states are testing and reporting their own results, CDC's numbers are not representative of all testing being done nationwide.

States Reporting Cases of COVID-19 to CDC*



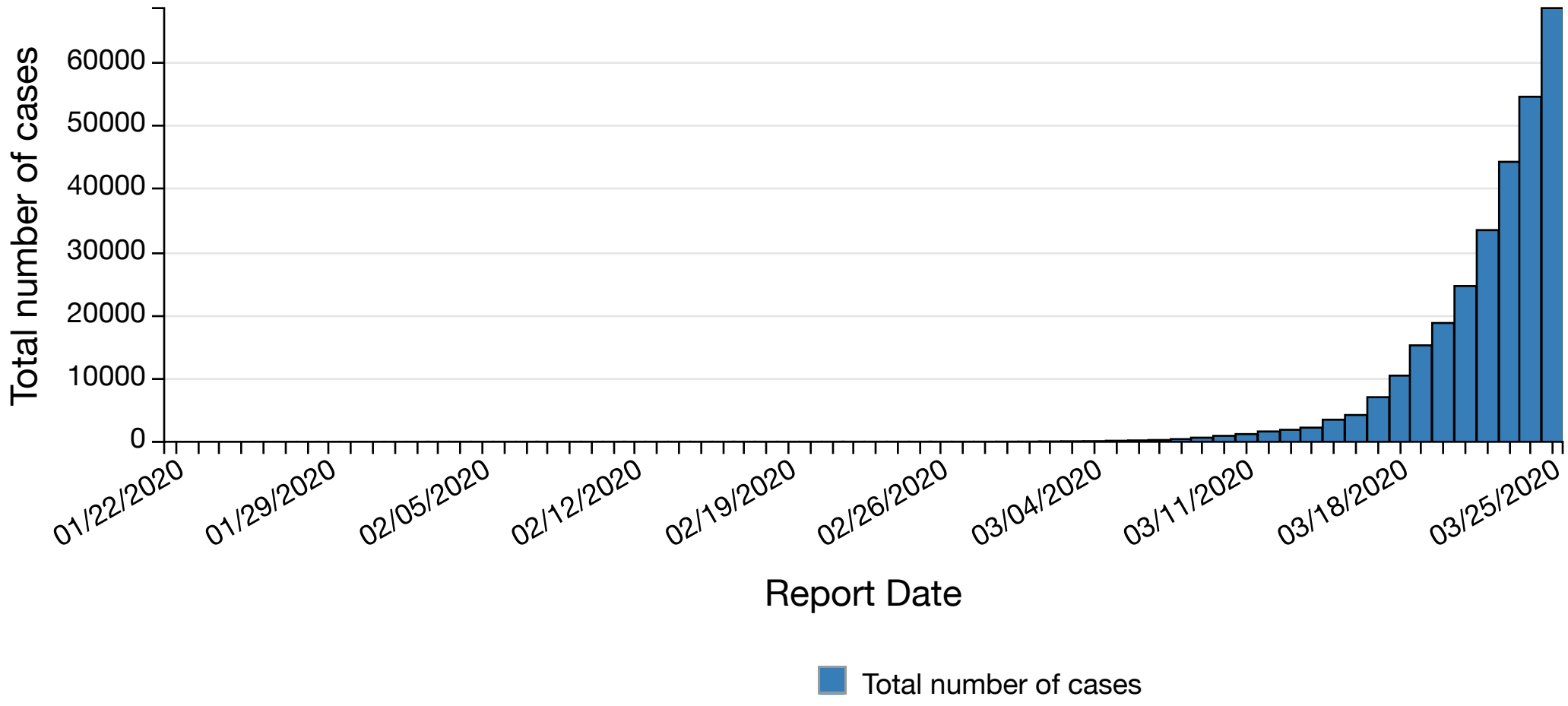
States



* Data include both confirmed and presumptive positive cases of COVID-19 reported to CDC or tested at CDC since January 21, 2020, with th exception of testing results for persons repatriated to the United States from Wuhan, China and Japan. State and local public health departments are now testing and publicly reporting their cases. In the event of a discrepancy between CDC cases and cases reported by sta and local public health officials, data reported by states should be considered the most up to date.

†Self-reported by health department characterizing the level of community transmission in their jurisdiction as: “Yes, widespread” (defined a widespread community transmission across several geographical areas); “Yes, defined area(s)” (defined as: distinct clusters of cases in a, or few, defined geographical area(s)); “Undetermined” (defined as: 1 or more cases but not classified as “Yes” to community transmission); or “N/A” (defined as: no cases).

Cumulative total number of COVID-19 cases in the United States by report date, January 12, 2020, to March 25, 2020, at 4pm ET (n=68,440)*



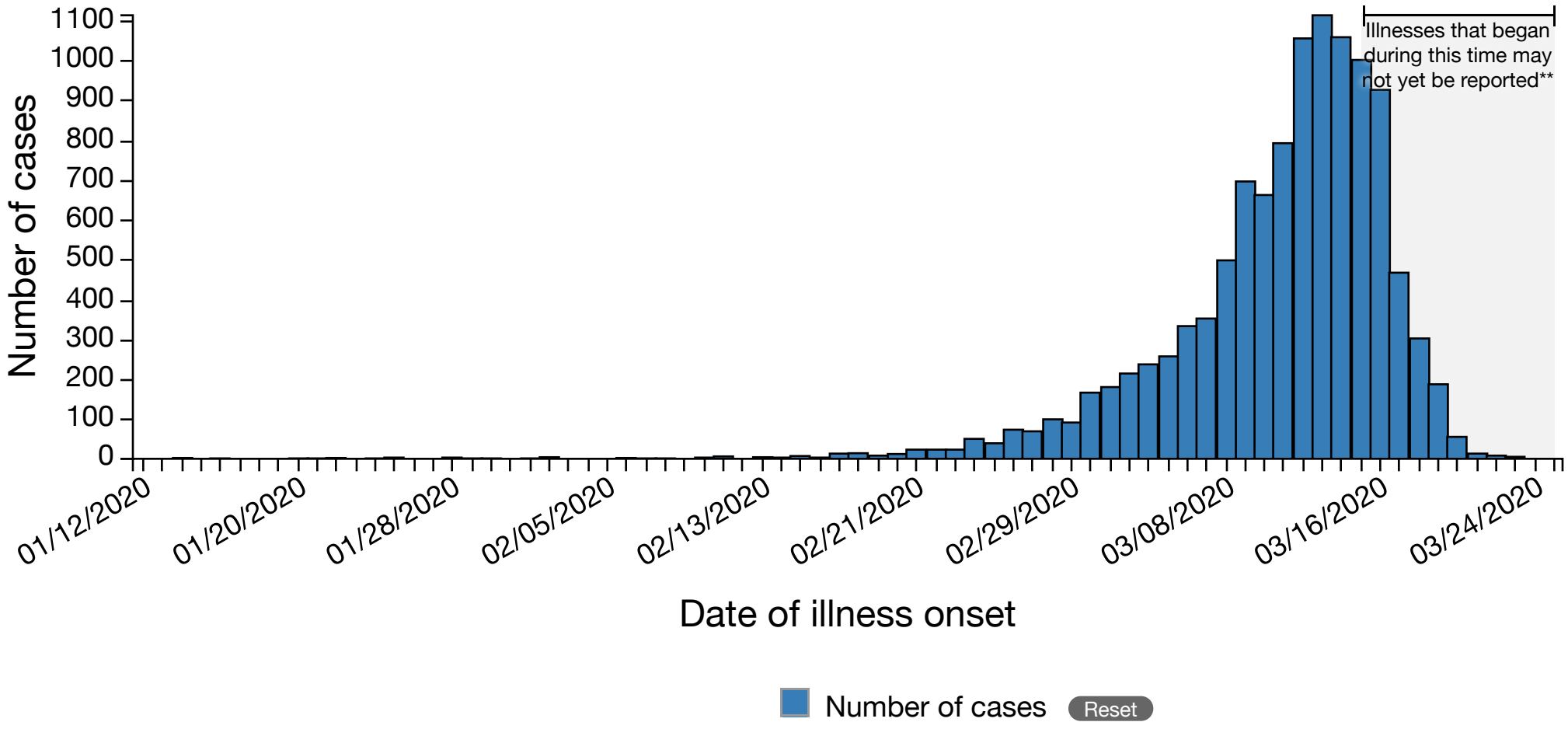
Total number of COVID-19 cases in the United States by date reported

	01/22/2020	01/23/2020	01/24/2020	01/25/2020	01/26/2020	01/27/2020	01/28/2020
Total number of cases	1	1	2	2	5	5	5

Scroll for additional

* Does not include cases among persons repatriated to the United States from Wuhan, China and Japan.

COVID-19 cases in the United States by date of illness onset, Januar
12, 2020, to March 25, 2020, at 4pm ET (n=11,165)*



COVID-19 cases in the United States by date of illness onset

	01/12/2020	01/13/2020	01/14/2020	01/15/2020	01/16/2020	01/17/2020	01/18/2020	01/1
Number of cases	0	0	2	0	1	0	0	

Scroll for additional

Region Name	Start Date	End Date
Illnesses that began during this time may not yet be reported**	03/15/2020	03/25

Illnesses that began during this time may not yet be

* Does not include cases among persons repatriated to the United States from Wuhan, China and Japan, or U.S.-identified cases where the da illness onset or specimen collection date has not yet been reported. Date is calculated as illness onset date if known. If not, an estimated illnes onset date was calculated using specimen collection date.

Note: On March 24, CDC updated the data included in this figure to include estimated illness onset date.

Related Pages

- Confirmed COVID-19 Cases Global Map
- About Coronavirus Disease 2019 (COVID-19)
- Information for Healthcare Professionals
- Guidance for Travelers

Page last reviewed: March 26

Exhibit C

Coronavirus disease 2019 (COVID-19)
Situation Report – 66

World Health Organization

Data as reported by national authorities by 10:00 CET 26 March 2020

HIGHLIGHTS

- Three new countries/territories/areas from the Region of the Americas [1], and African Region [2] have reported cases of COVID-19.
- The United Nations launched a US$2 billion COVID-19 Global Humanitarian Response Plan to support the world's most vulnerable countries. More information can be found here.
- The WHO Director-General mentioned many key issues and action steps to effectively combat COVID-19, as well as maintaining physical distance but not social distance. More information can be found here.
- WHO published the *COVID-19: Operational guidance for maintaining essential health services during an outbreak* and the *Handbook for public health capacity-building at ground crossings and cross-border collaboration* on 25 March 2020. All guidance documents can be found here.
- In line with current evidence, WHO maintains the recommendations of droplet and contact precautions for healthcare workers caring for COVID-19 patients. For those performing aerosol generating procedures, WHO recommends airborne and contact precautions. The use of medical masks, eye protection, gloves and gown are required for direct patient care; respirator masks are specifically required for aerosol generating procedures. Greater detail can be found in "Subject in Focus" below.

SITUATION IN NUMBERS
total (new) cases in last 24 hours

Globally
462 684 confirmed (49 219)
20 834 deaths (2401)

Western Pacific Region
99 058 confirmed (1292)
3540 deaths (22)

European Region
250 287 confirmed (29 771)
13 950 deaths (1964)

South-East Asia Region
2536 confirmed (192)
79 deaths (7)

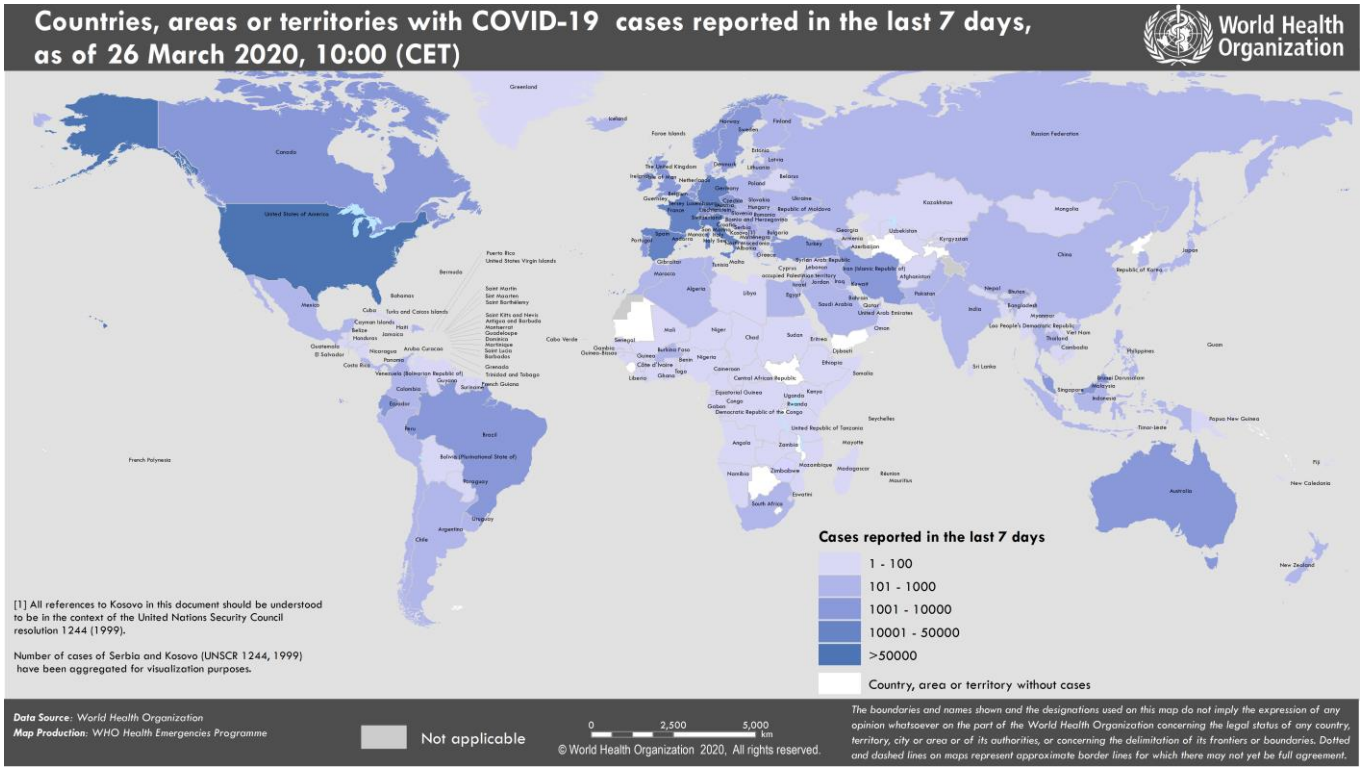
Eastern Mediterranean Region
32 442 confirmed (2811)
2162 deaths (154)

Region of the Americas
75 712 confirmed (14 878)
1065 deaths (252)

African Region
1937 confirmed (275)
31 deaths (2)

WHO RISK ASSESSMENT
Global Level Very High

Figure 1. Countries, territories or areas with reported confirmed cases of COVID-19, 26 March 2020



SUBJECT IN FOCUS: COVID-19 virus persistence: Implications for transmission and precaution recommendations

An experimental study, which evaluated virus persistence of the COVID-19 virus (SARS-CoV-2), has recently been published in the NEJM[1.] In this experimental study, aerosols were generated using a three-jet Collison nebulizer and fed into a Goldberg drum under controlled laboratory conditions. This is a high-powered machine that does not reflect normal human coughing or sneezing nor does it reflect aerosol generating procedures in clinical settings. Furthermore, the findings do not bring new evidence on airborne transmission as aerosolization with particles potentially containing the virus was already known as a possibility during procedures generating aerosols.

In all other contexts, available evidence indicates that COVID-19 virus is transmitted during close contact through respiratory droplets (such as coughing) and by fomites.[2-8] The virus can spread directly from person to person when a COVID-19 case coughs or exhales producing droplets that reach the nose, mouth or eyes of another person. Alternatively, as the droplets are too heavy to be airborne, they land on objects and surfaces surrounding the person. Other people become infected with COVID-19 by touching these contaminated objects or surfaces, then touching their eyes, nose or mouth. According to the currently available evidence, transmission through smaller droplet nuclei (airborne transmission) that propagate through air at distances longer than 1 meter is limited to aerosol generating procedures during clinical care of COVID-19 patients.

As such, WHO continues to recommend that everyone performs hand hygiene frequently, follows respiratory etiquette recommendations and regularly clean and disinfect surfaces. WHO also continues to recommend the importance of maintaining physical distances and avoiding people with fever or respiratory symptoms. These preventive measures will limit viral transmission.

Since the start of the COVID-19 outbreak, and in alignment with available evidence, WHO maintains the recommendation, in the context of droplet and contact precautions for the use of medical masks for regular care of COVID-19 patients and respirators (N95, FFP2 or FFP3) for circumstances and settings where aerosol generating procedures are performed.[9]

References

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8. Ong SW, Tan YK, Chia PY, Lee TH, Ng OT, Wong MS, et al. Air, surface environmental, and personal protective equipment contamination by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) from a symptomatic patient. *JAMA.* 2020 Mar 4 [Epub ahead of print].
9. WHO Infection Prevention and Control Guidance for COVID-19 available at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control

SURVEILLANCE

Table 1. Countries, territories or areas with reported laboratory-confirmed COVID-19 cases and deaths. Data as of 26 March 2020[*]

Reporting Country/ Territory/Area[†]	Total confirmed [‡] cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[§]	Days since last reported case
Western Pacific Region						
China	81961	113	3293	6	Local transmission	0
Republic of Korea	9241	104	131	5	Local transmission	0
Australia	2799	547	11	3	Local transmission	0
Malaysia	1796	172	19	3	Local transmission	0
Japan	1291	98	45	2	Local transmission	0
Philippines	636	84	38	3	Local transmission	0
Singapore	631	73	2	0	Local transmission	0
New Zealand	262	73	0	0	Local transmission	0
Viet Nam	141	7	0	0	Local transmission	0
Brunei Darussalam	109	5	0	0	Local transmission	0
Cambodia	96	5	0	0	Local transmission	0
Mongolia	10	0	0	0	Imported cases only	4
Fiji	5	1	0	0	Local transmission	0
Lao People's Democratic Republic	3	1	0	0	Under investigation	0
Papua New Guinea	1	0	0	0	Imported cases only	5
Territories[**]						
Guam	37	5	1	0	Local transmission	0
French Polynesia	25	0	0	0	Local transmission	1
New Caledonia	14	4	0	0	Local transmission	0
European Region						
Italy	74386	5210	7505	685	Local transmission	0
Spain	47610	7937	3434	738	Local transmission	0
Germany	36508	4954	198	49	Local transmission	0
France	24920	2895	1331	231	Local transmission	0
Switzerland	9714	925	103	17	Local transmission	0
The United Kingdom	9533	1452	463	41	Local transmission	0
Netherlands	6412	852	356	80	Local transmission	0
Austria	5888	606	34	4	Local transmission	0
Belgium	4937	668	178	56	Local transmission	0
Portugal	2995	633	43	10	Local transmission	0
Norway	2916	350	12	2	Local transmission	0
Sweden	2510	238	42	6	Local transmission	0
Turkey	2433	561	59	15	Local transmission	0
Israel	2369	199	5	0	Local transmission	0
Denmark	1724	133	34	2	Local transmission	0
Czechia	1654	260	6	3	Local transmission	0
Ireland	1564	235	9	2	Local transmission	0
Luxembourg	1333	234	8	0	Local transmission	0
Poland	1051	150	14	4	Local transmission	0
Romania	906	144	13	2	Local transmission	0
Finland	880	88	3	2	Local transmission	0
Russian Federation	840	182	2	2	Local transmission	0
Greece	821	78	22	2	Local transmission	0
Iceland	737	89	2	0	Local transmission	0
Slovenia	528	48	4	1	Local transmission	0

Croatia	418	36	1	0	Local transmission	0
Estonia	404	35	1	1	Local transmission	0
Serbia	384	81	4	1	Local transmission	0
Armenia	290	25	0	0	Local transmission	0
Lithuania	274	65	4	2	Local transmission	0
Hungary	261	35	10	0	Local transmission	0
Bulgaria	242	22	3	0	Local transmission	0
Latvia	221	24	0	0	Local transmission	0
Slovakia	216	12	0	0	Local transmission	0
Andorra	213	25	3	2	Local transmission	0
San Marino	208	21	21	0	Local transmission	0
North Macedonia	177	29	2	0	Local transmission	0
Albania	174	28	5	0	Local transmission	0
Bosnia and Herzegovina	173	9	3	1	Local transmission	0
Ukraine	156	43	5	1	Local transmission	0
Republic of Moldova	149	24	1	0	Local transmission	0
Cyprus	132	8	3	0	Local transmission	0
Malta	129	9	0	0	Local transmission	0
Kazakhstan	97	18	0	0	Imported cases only	0
Azerbaijan	93	6	2	1	Local transmission	0
Belarus	86	5	0	0	Local transmission	0
Georgia	77	4	0	0	Local transmission	0
Uzbekistan	65	15	0	0	Local transmission	0
Montenegro	52	23	1	1	Imported cases only	0
Liechtenstein	51	4	0	0	Imported cases only	0
Kyrgyzstan	44	2	0	0	Local transmission	0
Monaco	23	0	0	0	Local transmission	3
Holy See	4	3	0	0	Under investigation	0
Territories**						
Faroe Islands	132	10	0	0	Local transmission	0
Kosovo[1]	71	8	1	0	Local transmission	0
Guernsey	30	7	0	0	Local transmission	0
Gibraltar	26	11	0	0	Local transmission	0
Isle of Man	23	0	0	0	Imported cases only	1
Jersey	18	2	0	0	Local transmission	0
Greenland	5	1	0	0	Under investigation	0
South-East Asia Region						
Thailand	934	0	4	0	Local transmission	1
Indonesia	790	104	58	3	Local transmission	0
India	649	87	13	4	Local transmission	0
Sri Lanka	102	0	0	0	Local transmission	1
Bangladesh	39	0	4	0	Local transmission	1
Maldives	13	0	0	0	Local transmission	10
Myanmar	3	0	0	0	Imported cases only	1
Nepal	3	1	0	0	Imported cases only	0
Bhutan	2	0	0	0	Imported cases only	6
Timor-Leste	1	0	0	0	Imported cases only	5
Eastern Mediterranean Region						
Iran (Islamic Republic of)	27017	2206	2077	143	Local transmission	0
Pakistan	1057	66	8	1	Local transmission	0
Saudi Arabia	900	133	2	1	Local transmission	0
Qatar	537	11	0	0	Local transmission	0

Egypt	456	54	21	1	Local transmission	0
Bahrain	419	27	4	1	Local transmission	0
Iraq	346	30	29	2	Local transmission	0
Lebanon	333	29	4	0	Local transmission	0
United Arab Emirates	333	85	2	0	Local transmission	0
Morocco	225	55	6	1	Local transmission	0
Kuwait	208	13	0	0	Local transmission	0
Tunisia	173	59	5	2	Local transmission	0
Jordan	172	19	0	0	Local transmission	0
Oman	99	0	0	0	Local transmission	1
Afghanistan	80	6	2	1	Local transmission	0
Djibouti	12	9	0	0	Local transmission	0
Syrian Arab Republic	5	4	0	0	Imported cases only	0
Sudan	3	0	1	0	Imported cases only	1
Somalia	2	1	0	0	Imported cases only	0
Libya	1	0	0	0	Imported cases only	1
Territories**						
occupied Palestinian territory	64	4	1	1	Local transmission	0
Region of the Americas						
United States of America	63570	11656	884	211	Local transmission	0
Canada	3409	1670	35	10	Local transmission	0
Brazil	2433	232	57	11	Local transmission	0
Ecuador	1211	162	29	2	Local transmission	0
Chile	1142	220	3	1	Local transmission	0
Panama	558	213	8	2	Local transmission	0
Peru	480	64	9	4	Local transmission	0
Mexico	478	108	5	1	Local transmission	0
Colombia	470	164	4	1	Local transmission	0
Dominican Republic	392	80	10	4	Local transmission	0
Argentina	387	86	6	2	Local transmission	0
Uruguay	217	55	0	0	Imported cases only	0
Costa Rica	201	24	2	0	Local transmission	0
Venezuela (Bolivarian Republic of)	91	14	0	0	Local transmission	0
Trinidad and Tobago	60	3	1	1	Local transmission	0
Cuba	57	9	1	0	Local transmission	0
Honduras	52	22	0	0	Local transmission	0
Paraguay	41	14	3	1	Local transmission	0
Bolivia (Plurinational State of)	39	11	0	0	Local transmission	0
Jamaica	26	5	1	0	Local transmission	0
Guatemala	24	3	1	0	Local transmission	0
Barbados	18	0	0	0	Local transmission	1
El Salvador	13	8	0	0	Imported cases only	0
Haiti	8	1	0	0	Imported cases only	0
Dominica	7	5	0	0	Local transmission	0
Suriname	7	1	0	0	Imported cases only	0
Bahamas	5	1	0	0	Local transmission	0
Guyana	5	0	1	0	Local transmission	7
Antigua and Barbuda	3	0	0	0	Imported cases only	1
Saint Lucia	3	0	0	0	Imported cases only	2
Belize	2	1	0	0	Local transmission	0

Nicaragua	2	0	0	0	Imported cases only	4
Saint Kitts and Nevis	2	2	0	0	Imported cases only	0
Grenada	1	0	0	0	Imported cases only	3
Saint Vincent and the Grenadines	1	0	0	0	Imported cases only	13
Territories**						
Guadeloupe	76	3	0	0	Imported cases only	0
Martinique	66	9	1	1	Imported cases only	0
Puerto Rico	51	12	2	0	Imported cases only	0
French Guiana	28	5	0	0	Local transmission	0
Aruba	19	7	0	0	Local transmission	0
United States Virgin Islands	17	0	0	0	Imported cases only	2
Saint Martin	11	3	0	0	Under investigation	0
Cayman Islands	8	3	1	0	Imported cases only	0
Bermuda	7	1	0	0	Local transmission	0
Curaçao	6	0	1	0	Imported cases only	1
Saint Barthélemy	3	0	0	0	Under investigation	10
Montserrat	2	1	0	0	Imported cases only	0
Sint Maarten	2	0	0	0	Imported cases only	2
Turks and Caicos Islands	1	0	0	0	Imported cases only	2
African Region						
South Africa	709	155	0	0	Local transmission	0
Algeria	264	0	17	0	Local transmission	1
Burkina Faso	146	32	3	0	Local transmission	0
Senegal	99	13	0	0	Local transmission	0
Côte d'Ivoire	80	8	0	0	Imported cases only	0
Cameroon	70	0	1	0	Local transmission	2
Ghana	68	15	2	0	Local transmission	0
Democratic Republic of the Congo	51	6	3	1	Local transmission	0
Mauritius	47	5	2	0	Imported cases only	0
Nigeria	46	4	1	1	Local transmission	0
Rwanda	41	1	0	0	Local transmission	0
Kenya	25	0	0	0	Local transmission	1
Togo	23	3	0	0	Imported cases only	0
Madagascar	19	0	0	0	Imported cases only	1
Uganda	14	5	0	0	Imported cases only	0
United Republic of Tanzania	13	1	0	0	Imported cases only	0
Ethiopia	12	0	0	0	Imported cases only	1
Seychelles	7	0	0	0	Imported cases only	4
Equatorial Guinea	6	0	0	0	Imported cases only	4
Gabon	6	0	1	0	Imported cases only	3
Benin	5	0	0	0	Imported cases only	2
Central African Republic	5	1	0	0	Imported cases only	0
Mozambique	5	2	0	0	Local transmission	0
Namibia	5	1	0	0	Imported cases only	0
Congo	4	0	0	0	Imported cases only	4
Eritrea	4	3	0	0	Imported cases only	0
Eswatini	4	0	0	0	Imported cases only	3
Guinea	4	0	0	0	Imported cases only	2

Cabo Verde	3	0	0	0	Imported cases only	4
Chad	3	0	0	0	Imported cases only	2
Liberia	3	0	0	0	Local transmission	4
Zambia	3	0	0	0	Imported cases only	3
Angola	2	0	0	0	Imported cases only	4
Gambia	2	0	0	0	Imported cases only	1
Guinea-Bissau	2	2	0	0	Imported cases only	0
Mali	2	2	0	0	Imported cases only	0
Mauritania	2	0	0	0	Imported cases only	7
Niger	2	0	0	0	Imported cases only	2
Zimbabwe	2	0	1	0	Imported cases only	4
Territories**						
Réunion	94	11	0	0	Local transmission	0
Mayotte	35	5	0	0	Local transmission	0
Subtotal for all regions	**461972**	**49219**	**20827**	**2401**		
International conveyance (Diamond Princess)	712	0	7	0	Local transmission	10
Grand total	**462684**	**49219**	**20834**	**2401**		

*Numbers include both domestic and repatriated cases

†The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

‡Case classifications are based on WHO case definitions for COVID-19.

§Transmission classification is based on WHO analysis of available official data and may be subject to reclassification as additional data become available. Countries/territories/areas experiencing multiple types of transmission are classified in the highest category for which there is evidence; they may be removed from a given category if interruption of transmission can be demonstrated. It should be noted that even within categories, different countries/territories/areas may have differing degrees of transmission as indicated by the differing numbers of cases and other factors. Not all locations within a given country/territory/area are equally affected.

Terms:

- **Community transmission** is evidenced by the inability to relate confirmed cases through chains of transmission for a large number of cases, or by increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories).
- **Local transmission** indicates locations where the source of infection is within the reporting location.
- **Imported cases only** indicates locations where all cases have been acquired outside the location of reporting.
- **Under investigation** indicates locations where type of transmission has not been determined for any cases.
- **Interrupted transmission** indicates locations where interruption of transmission has been demonstrated (details to be determined)

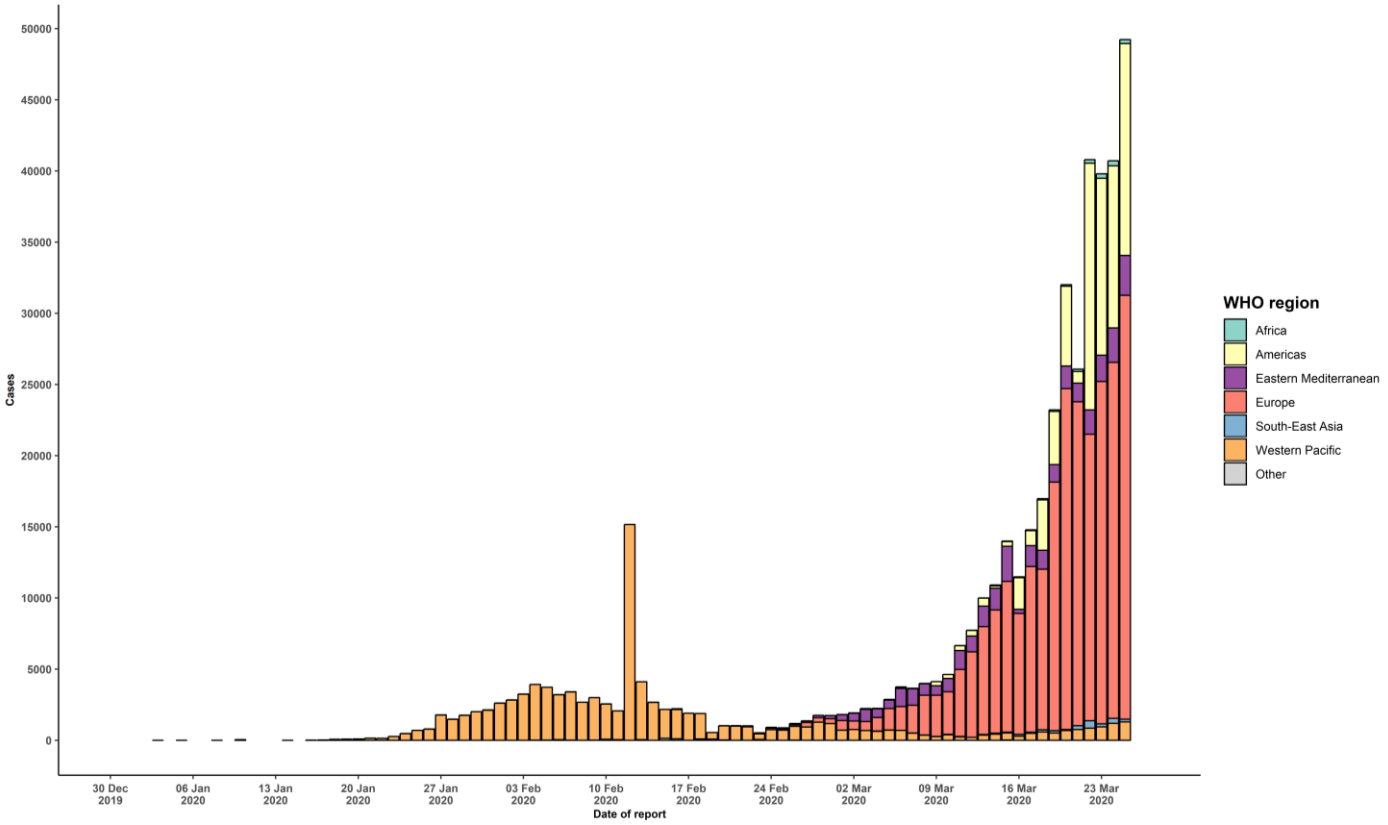
** "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Due to differences in reporting methods, retrospective data consolidation, and reporting delays, the number of new cases may not always reflect the exact difference between yesterday's and today's totals. WHO COVID-19 Situation Reports present official counts of confirmed COVID-19 cases, thus differences between WHO reports and other sources of COVID-19 data using different inclusion criteria and different data cutoff times are to be expected.

New countries/territories/areas are shown in red.

Figure 2. Epidemic curve of confirmed COVID-19, by date of report and WHO region through 26 March 2020



STRATEGIC OBJECTIVES

WHO's strategic objectives for this response are to:

- Interrupt human-to-human transmission including reducing secondary infections among close contacts and health care workers, preventing transmission amplification events, and preventing further international spread*;
- Identify, isolate and care for patients early, including providing optimized care for infected patients;
- Identify and reduce transmission from the animal source;
- Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines;
- Communicate critical risk and event information to all communities and counter misinformation;
- Minimize social and economic impact through multisectoral partnerships.

*This can be achieved through a combination of public health measures, such as rapid identification, diagnosis and management of the cases, identification and follow up of the contacts, infection prevention and control in health care settings, implementation of health measures for travelers, awareness-raising in the population and risk communication.

PREPAREDNESS AND RESPONSE

- To view all technical guidance documents regarding COVID-19, please go to this webpage.
- WHO has developed interim guidance for laboratory diagnosis, advice on the use of masks during home care and in health care settings in the context of the novel coronavirus (2019-nCoV) outbreak, clinical management, infection prevention and control in health care settings, home care for patients with suspected novel coronavirus, risk communication and community engagement and Global Surveillance for human infection with novel coronavirus (2019-nCoV).
- WHO is working closely with International Air Transport Association (IATA) and have jointly developed a guidance document to provide advice to cabin crew and airport workers, based on country queries. The guidance can be found on the IATA webpage.
- WHO has been in regular and direct contact with Member States where cases have been reported. WHO is also informing other countries about the situation and providing support as requested.
- WHO is working with its networks of researchers and other experts to coordinate global work on surveillance, epidemiology, mathematical modelling, diagnostics and virology, clinical care and treatment, infection prevention and control, and risk communication. WHO has issued interim guidance for countries, which are updated regularly.
- WHO has prepared a disease commodity package that includes an essential list of biomedical equipment, medicines and supplies necessary to care for patients with 2019-nCoV.
- WHO has provided recommendations to reduce risk of transmission from animals to humans.
- WHO has published an updated advice for international traffic in relation to the outbreak of the novel coronavirus 2019-nCoV.
- WHO has activated the R&D blueprint to accelerate diagnostics, vaccines, and therapeutics.
- OpenWHO is an interactive, web-based, knowledge-transfer platform offering online courses to improve the response to health emergencies. COVID-19 courses can be found here and courses in additional national languages here. Specifically, WHO has developed online courses on the following topics:
    - A general introduction to emerging respiratory viruses, including novel coronaviruses (available in Arabic, Chinese, English, French, Russian, Spanish, Hindi, Indian Sign Language, Persian, Portuguese, Serbian and Turkish);
    - Clinical care for Severe Acute Respiratory Infections (available in English, French, Russian, Indonesian and Vietnamese);
    - Health and safety briefing for respiratory diseases - ePROTECT (available in Chinese, English, French, Russian, Spanish, Indonesian and Portuguese);
    - Infection Prevention and Control for Novel Coronavirus (COVID-19) (available in Chinese, English, French, Russian, Spanish, Indonesian, Italian, Japanese, Portuguese and Serbian); and
    - COVID-19 Operational Planning Guidelines and COVID-19 Partners Platform to support country preparedness and response (available in English and coming soon in additional languages).
- WHO is providing guidance on early investigations, which are critical in an outbreak of a new virus. The data collected from the protocols can be used to refine recommendations for surveillance and case definitions, to characterize the key epidemiological transmission features of COVID-19, help understand spread, severity, spectrum of disease, impact on the community and to inform operational models for implementation of countermeasures such as case isolation, contact tracing and isolation. Several protocols are available here. One such protocol is for the investigation of early COVID-19 cases and contacts (the "First Few X (FFX) Cases and contact investigation protocol for 2019-novel coronavirus (2019-nCoV) infection"). The protocol is designed to gain an early understanding of the key clinical, epidemiological and virological characteristics of the first cases of COVID-19 infection detected in any individual country, to inform the development and updating of public health guidance to manage cases and reduce the potential spread and impact of infection.

RECOMMENDATIONS AND ADVICE FOR THE PUBLIC

If you are not in an area where COVID-19 is spreading or have not travelled from an area where COVID-19 is spreading or have not been in contact with an infected patient, your risk of infection is low. It is understandable that you may feel anxious about the outbreak. Get the facts from reliable sources to help you accurately determine your risks so that you can take reasonable precautions (see Frequently Asked Questions). Seek guidance from WHO, your healthcare provider, your national public health authority or your employer for accurate information on COVID-19 and whether COVID-19 is circulating where you live. It is important to be informed of the situation and take appropriate measures to protect yourself and your family (see Protection measures for everyone).

If you are in an area where there are cases of COVID-19 you need to take the risk of infection seriously. Follow the advice of WHO and guidance issued by national and local health authorities. For most people, COVID-19 infection will cause mild illness however, it can make some people very ill and, in some people, it can be fatal. Older people, and those with pre-existing medical conditions (such as cardiovascular disease, chronic respiratory disease or diabetes) are at risk for severe disease (See Protection measures for persons who are in or have recently visited (past 14 days) areas where COVID-19 is spreading).

CASE DEFINITIONS

WHO periodically updates the Global Surveillance for human infection with coronavirus disease (COVID-19) document which includes case definitions.

For easy reference, case definitions are included below.

Suspect case

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.
OR
B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset;
OR
C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

A. A suspect case for whom testing for the COVID-19 virus is inconclusive.
    a. Inconclusive being the result of the test reported by the laboratory.
OR
B. A suspect case for whom testing could not be performed for any reason.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

- Technical guidance for laboratory testing can be found here.

Definition of contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days

after the onset of symptoms of a probable or confirmed case:

1. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
2. Direct physical contact with a probable or confirmed case;
3. Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment[1]; OR
4. Other situations as indicated by local risk assessments.

Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days *after the date on which the sample was taken* which led to confirmation.

[1] World Health Organization. Infection prevention and control during health care when COVID-19 is suspected https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125

Exhibit D

World Health Organization
REGIONAL OFFICE FOR Europe

Preparedness, prevention and control of COVID-19 in prisons and other places of detention

Interim guidance

15 March 2020

Preparedness, prevention and control of COVID-19 in prisons and other places of detention

Interim guidance

15 March 2020

This document is based on the latest available evidence on the COVID-19 outbreak as of 15 March 2020. The World Health Organization (WHO) continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update.

Address requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (http://www.euro.who.int/pubrequest).

CONTENTS

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ABBREVIATIONS

ARDS	acute respiratory distress syndrome
COVID-19	coronavirus disease 2019
ECDC	European Centre for Disease Prevention and Control
HCID	high-consequence infectious disease
IPC	infection prevention and control
MERS	Middle East respiratory syndrome
nCoV	novel coronavirus
PHE	Public Health England
PPE	personal protective equipment
SARI	severe acute respiratory infection
SARS	severe acute respiratory syndrome
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1. INTRODUCTION

People deprived of their liberty, such as people in prisons and other places of detention,[1] are likely to be more vulnerable to the coronavirus disease (COVID-19) outbreak than the general population because of the confined conditions in which they live together for prolonged periods of time. Moreover, experience shows that prisons, jails and similar settings where people are gathered in close proximity may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons. Prison health is therefore widely considered as public health. The response to COVID-19 in prisons and other places of detention is particularly challenging, requiring a whole-of-government and whole-of-society approach, for the following reasons:[2,3]

1. Widespread transmission of an infectious pathogen affecting the community at large poses a threat of introduction of the infectious agent into prisons and other places of detention; the risk of rapidly increasing transmission of the disease within prisons or other places of detention is likely to have an amplifying effect on the epidemic, swiftly multiplying the number of people affected.
2. Efforts to control COVID-19 in the community are likely to fail if strong infection prevention and control (IPC) measures, adequate testing, treatment and care are not carried out in prisons and other places of detention as well.
3. In many countries, responsibility for health-care provision in prisons and other places of detention lies with the Ministry of Justice/Internal Affairs. Even if this responsibility is held by the Ministry of Health, coordination and collaboration between health and justice sectors are paramount if the health of people in prisons and other places of detention and the wider community is to be protected.
4. People in prisons and other places of detention are already deprived of their liberty and may react differently to further restrictive measures imposed upon them.

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[1] Places of detention, as defined for the purposes of these guidelines, include prisons, justice-related detention settings and immigration removal centres.

[2] 2019 Novel Coronavirus (2019-nCOV): Strategic Preparedness and Response Plan. Geneva: World Health Organization; 2020 (https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf?sfvrsn=7ff55ec0_4&download=true).

[3] Good governance for prison health in the 21st century: a policy brief on the organization of prison health. Copenhagen: WHO Regional Office for Europe/Vienna: United Nations Office on Drugs and Crime; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf).

2. RATIONALE

People deprived of their liberty, such as people in prisons, are likely to be more vulnerable to various diseases and conditions. The very fact of being deprived of liberty generally implies that people in prisons and other places of detention live in close proximity with one another, which is likely to result in a heightened risk of person-to-person and droplet transmission of pathogens like COVID-19. In addition to demographic characteristics, people in prisons typically have a greater underlying burden of disease and worse health conditions than the general population, and frequently face greater exposure to risks such as smoking, poor hygiene and weak immune defence due to stress, poor nutrition, or prevalence of coexisting diseases, such as bloodborne viruses, tuberculosis and drug use disorders.

The COVID-19 outbreak, which was first detected in Wuhan, China, in December 2019, has been evolving rapidly. On 30 January 2020, the WHO Director-General declared that the current outbreak constituted a public health emergency of international concern, and on 12 March 2020 the COVID-19 outbreak was declared a pandemic.[4]

In these circumstances, prevention of importation of the virus into prisons and other places of detention is an essential element in avoiding or minimizing the occurrence of infection and of serious outbreaks in these settings and beyond.

Depending on the COVID-19 situation of the specific country, the risk of introducing COVID-19 into prisons and other places of detention may vary. In areas with no local virus circulation, the risk of virus introduction into closed settings may be associated with prison staff or newly admitted individuals who have recently stayed in affected countries or areas or who have been in contact with people returning from affected countries or areas. However, as several countries in Europe are now experiencing widespread sustained community transmission, the risk of transmission has substantially increased.

In all countries, the fundamental approach to be followed is prevention of introduction of the infectious agent into prisons or other places of detention, limiting the spread within the prison, and reducing the possibility of spread from the prison to the outside community. This will be more challenging in countries with more intense transmission.

Prisons and other places of detention are enclosed environments where people (including staff) live in close proximity. Every country has a responsibility to increase their level of preparedness, alert and response to identify, manage and care for new cases of COVID-19. Countries should prepare to respond to different public health scenarios, recognizing that there is no one-size-fits-all approach to managing cases and outbreaks of COVID-19. Four transmission scenarios that could be experienced by countries at the subnational level have been defined for COVID-19, and countries should therefore adjust and tailor their approach to the local context.[5]

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[4] WHO Director-General's opening remarks at the mission briefing on COVID-19 (12 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-mission-briefing-on-covid-19---12-march-2020).

[5] Critical preparedness, readiness and response actions for COVID-19: interim guidance (16 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-covid-19).

3. PLANNING PRINCIPLES AND HUMAN RIGHTS CONSIDERATIONS

Contingency planning is essential in ensuring an adequate health response and maintaining secure, safe and humane detention settings. Generally, plans are available for local, short-lived emergency and resilience actions. However, the evolving nature of infectious outbreaks of epidemic or pandemic proportions, locally, nationally and globally, go beyond such plans, having a potential impact on security, the wider judicial system and, in extreme cases, civil order.

In addition, business continuity plans should be in place for ensuring the security and safety functions inherently associated with prisons and other places of detention.

It is of paramount importance to work in partnership across public health agencies, health-care services and places of detention, bringing together community services and prison/detention services.

The human rights framework provides guiding principles in determining the response to the outbreak of COVID-19. The rights of all affected people must be upheld, and all public health measures must be carried out without discrimination of any kind. People in prisons and other places of detention are not only likely to be more vulnerable to infection with COVID-19, they are also especially vulnerable to human rights violations. For this reason, WHO reiterates important principles that must be respected in the response to COVID-19 in prisons and other places of detention, which are firmly grounded in human rights law as well as the international standards and norms in crime prevention and criminal justice:[6]

- The provision of health care for people in prisons and other places of detention is a State responsibility.
- People in prisons and other places of detention should enjoy the same standards of health care that are available in the outside community, without discrimination on the grounds of their legal status.
- Adequate measures should be in place to ensure a gender-responsive approach in addressing the COVID-19 emergency in prisons and other places of detention.
- Prisons and other detention authorities need to ensure that the human rights of those in their custody are respected, that people are not cut off from the outside world, and – most importantly – that they have access to information and adequate healthcare provision.[7]

[6] Cf. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) (https://www.refworld.org/pdfid/4538838d0.pdf); United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations General Assembly Resolution A/RES/70/175, adopted 17 December 2015 (https://undocs.org/A/RES/70/175); High Commissioner updates the Human Rights Council on human rights concerns, and progress, across the world. Human Rights Council 43rd Session, Item 2, Geneva, 27 February 2020. United Nations Human Rights Office of the High Commissioner (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25621&LangID=E); Advice from the SPT [Subcommittee on Prevention of Torture] to the UK NPM [National Preventive Mechanism] regarding compulsory quarantine for Coronavirus (https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/02/2020.02.25-Annexed-Advice.pdf).

[7] Coronavirus: healthcare and human rights of people in prison. London: Penal Reform International; 2020 (https://www.penalreform.org/resource/coronavirus-healthcare-and-human-rights-of-people-in).

- Enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages. Priority should be given to non-custodial measures for alleged offenders and prisoners with low-risk profiles and caring responsibilities, with preference given to pregnant women and women with dependent children.
- Similarly, refined allocation procedures should be considered that would allow prisoners at highest risk to be separated from others in the most effective and least disruptive manner possible and that would permit limited single accommodation to remain available to the most vulnerable.
- Upon admission to prisons and other places of detention, all individuals should be screened for fever and lower respiratory tract symptoms; particular attention should be paid to persons with contagious diseases. If they have symptoms compatible with COVID-19, or if they have a prior COVID-19 diagnosis and are still symptomatic, they should be put into medical isolation until there can be further medical evaluation and testing.

- The psychological and behavioural reactions of prisoners or those detained in other settings are likely to differ from those of people who observe physical distancing in the community; consideration should therefore be given to the increased need for emotional and psychological support, for transparent awareness-raising and information-sharing on the disease, and for assurances that continued contact with family and relatives will be upheld.
- Adequate measures should be in place to prevent stigmatization or marginalization of individuals or groups who are considered to be potential carriers of viruses.
- Any decision to place people in prisons and other places of detention in conditions of medical isolation should always be based on medical necessity as a result of a clinical decision and subject to authorization by law or by the regulation of the competent administrative authority.
- People subjected to isolation for reasons of public health protection, in the context of prisons and other places of detention, should be informed of the reason for being placed in isolation, and given the possibility to have a third party notified.
- Adequate measures should be in place to protect persons in isolation from any form of ill treatment and to facilitate human contact as appropriate and possible in the given circumstances (e.g. by audiovisual means of communication).
- The COVID-19 outbreak must not be used as a justification for undermining adherence to all fundamental safeguards incorporated in the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) including, but not limited to, the requirement that restrictions must never amount to torture or other cruel, inhuman or degrading treatment or punishment; the prohibition of prolonged solitary confinement (i.e. in excess of 15 consecutive days); the requirement that clinical decisions may only be taken by health-care professionals and must not be ignored or overruled by non-medical prison staff; and that while the means of family contact may be restricted in exceptional circumstances for a limited time period, it must never be prohibited altogether.[8]
- The COVID-19 outbreak must not be used as a justification for objecting to external inspection of prisons and other places of detention by independent international or national bodies whose mandate is to prevent torture and other cruel, inhuman or degrading treatment or punishment; such bodies include national preventive mechanisms under the Optional Protocol to the Convention against Torture,[9] the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,[10] and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.[11]
- Even in the circumstances of the COVID-19 outbreak, bodies of inspection in the above sense should have access to all people deprived of their liberty in prisons and other places of detention, including to persons in isolation, in accordance with the provisions of the respective body's mandate.

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[8] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations General Assembly Resolution A/RES/70/175, adopted 17 December 2015 (https://undocs.org/A/RES/70/175).

[9] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. United Nations General Assembly Resolution A/RES/57/199, adopted 18 December 2002 (https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx).

[10] Optional Protocol to the Convention against Torture (OPCAT) Subcommittee on Prevention of Torture. The SPT in Brief (https://www.ohchr.org/EN/HRBodies/OPCAT/Pages/Brief.aspx).

[11] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment [website]. Strasbourg: Council of Europe (https://www.coe.int/en/web/cpt).

4. SCOPE AND OBJECTIVES

4.1 Scope

This document is based on the international standards and norms in crime prevention and criminal justice related to prison management and non-custodial measures as well as international guidance on prison health, including the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules),[8] the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules),[12] the Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules),[13] the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules),[14] and WHO guidance on *Prisons and health* (2014).[15] The document aims to assist countries in developing specific plans and/or consolidating further action for prisons and other places of detention in response to the international COVID-19 outbreak, with consideration of preparedness plans, prevention and control strategies, and contingency plans to interface with the wider health and emergency planning system.

4.2 Objectives

1. To guide design and implementation of adequate preparedness plans for prisons and other detention settings to deal with the COVID-19 outbreak situation in such a way as to:
   - → protect the health and well-being of people detained in prisons and other closed settings, those who work there (custodial, health-care and other staff), and people who visit prisons and other places of detention (legal visitors, family and friends of prisoners, etc.);
   - → support the continued safe operation of prisons and other detention settings;
   - → reduce the risk of outbreaks which could place a considerable demand on health-care services in prisons and in the community;
   - → reduce the likelihood that COVID-19 will spread within prisons and other places of detention and from such settings into the community;
   - → ensure the needs of prisons and other detention settings are considered in national and local health and emergency planning.

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[12] United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders. United Nations General Assembly Resolution A/RES/65/229, adopted 21 December 2010 (https://www.unodc.org/documents/justice-and-prison-reform/crimeprevention/UN_Rules_Treatment_Women_Prisoners_Bangkok_Rules.pdf).

[13] Standard Minimum Rules for the Administration of Juvenile Justice. United Nations General Assembly Resolution A/RES/40/33, adopted 29 November 1985 (https://www.ohchr.org/Documents/ProfessionalInterest/beijingrules.pdf).

[14] United Nations Standard Minimum Rules for Non-custodial Measures. United Nations General Assembly Resolution A/RES/45/110, adopted 14 December 1990 (https://www.ohchr.org/Documents/ProfessionalInterest/tokyorules.pdf).

[15] Prisons and health. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf).

2. To present effective preventive and response mechanisms for:
   - → preventing the introduction of COVID-19 into prisons and other places of detention;
   - → preventing the transmission of COVID-19 in prisons and other places of detention;
   - → preventing the spread of COVID-19 from prisons and other closed settings to the community.
3. To outline an appropriate approach to dovetailing the prison health system and the national and local health and emergency planning system for:
   - → preventive measures, including physical distancing and hand hygiene facilities;
   - → disease surveillance;
   - → identification and diagnosis, including contact tracing;
   - → treatment and/or referral of COVID-19 cases requiring specialized and intensive care;
   - → wider system impacts (including impact of other measures on workforce, e.g. need for home isolation, etc.).

5. TARGET AUDIENCE

This guidance is intended to assist health-care and custodial staff working in prisons and other places of detention to coordinate public health action in such settings; it provides information on:

- the novel COVID-19 virus;
- how to help prevent spread of COVID-19;[16]
- what to do if a person in prison/other place of detention or a staff member with suspected or confirmed COVID-19 infection is identified;
- what advice to give to people in prison or in another place of detention and their family members, or to staff members, travelling from affected areas within the last 14 days.

The information given here will also be useful for prison authorities, public health authorities and policy-makers, prison governors and managers, health-care professionals working in prison settings, detention centre employees, people in detention, and the social contacts of people in detention.

The following large, institutional, residential establishments are included within the definition of places of detention used in this guidance:

- prisons (public and privately managed)
- immigration detention settings
- the children and young people's detention estate.

[16] This applies to respiratory infections that are transmitted mainly via droplets. For aerosol-transmitted diseases such as tuberculosis, refer to: WHO guidelines on tuberculosis infection prevention and control. Geneva: World Health Organization; 2019 (https://www.who.int/tb/publications/2019/guidelines-tuberculosis-infection-prevention-2019/en).

6. GENERAL APPROACH

Controlling the spread of infection in prisons and other places of detention is essential to preventing outbreaks of COVID-19 in such settings, protecting the health and well-being of all those who live and work in them and those who visit them, and protecting the outside community. Establishing such control is dependent on the coordinated efforts of health-care and custodial staff, working with local and national public health agencies and with justice and interior ministries and their local counterparts, in applying the general approach summarized below.

1. Actions need to be taken to enable and support coordinated, collaborative efforts across organizations to achieve IPC, following national guidance. Such actions should be commensurate with the level of emergency at the time to avoid panic and to ensure implementation of the most appropriate response at the appropriate time.
2. Joint planning
   - → Custodial/detention staff should work together with health-care teams in prisons and other places of detention, following existing national protocols and country arrangements, to enable identification of suspected cases among employees and their subsequent management in accordance with national guidelines.
   - → Custodial/detention staff should work together with health-care teams in prisons and other places of detention to enable identification of suspected cases among prisoners/detainees, their subsequent isolation in single accommodation and a subsequent clinical assessment.
3. Risk assessment/risk management
   - → Screening at point of entry to prison should be available: health-care and public health teams should undertake a risk assessment of all people entering the prison, irrespective of whether or not there are suspected cases in the community; information should be collected on any history of cough and/or shortness of breath, patients' recent travel history and possible contact with confirmed cases in the last 14 days.
   - → Persons checked should include prisoners/detainees, visitors and prison staff.
   - → Clear messaging is important so that staff with recent travel history or coming from affected areas who develop COVID-19 symptoms can home-isolate and managers can provide a high level of vigilance and support of their staff. Advice to visitors should also be provided well in advance of their attending the prisons/other detention facilities so that those who have to travel are not disadvantaged. Those who are symptomatic should be excluded from visiting.
   - → For asymptomatic visitors with recent travel history or coming from affected areas, there should be protocols in place to permit entry (e.g. for legal advisers), but additional measures, such as non-contact visits, should be considered.
   - → Decisions to limit or restrict visits need to consider the particular impact on the mental well-being of prisoners and the increased levels of anxiety that separation from children and the outside world may cause.
   - → A detailed daily registry of people moving in and out of the prison should be maintained.

- → Prison/detention management should consider implementing measures to limit the mobility of people within the prison/detention system and/or to limit access of non-essential staff and visitors to prisons and other places of detention, depending on the level of risk in the specific country/area. The psychological impact of these measures needs to be considered and mitigated as much as possible, and basic emotional and practical support for affected people in prison should be available.[17]
- → Prison/detention management should increase the level of information on COVID-19 proactively shared with people in detention. Restrictions, including a limitation of visitors, need to be carefully explained in advance and alternative measures to provide contact with family/friends, e.g. phone or Skype calls, should be introduced.

4. Referral system and clinical management
   - → In the context of the current COVID-19 outbreak, the containment strategy includes the rapid identification of laboratory-confirmed cases, and their isolation and management either on site or in a medical facility. For contacts of laboratory-confirmed cases, WHO recommends that such persons be quarantined for 14 days from the last time they were exposed to a COVID-19 patient.[18]
   - → Health-care teams, using recommended personal protective equipment (PPE) including eye protection (face shield or goggles), gloves, mask and gown, should ensure that appropriate biological samples are taken, on advice from their public health agency, from any suspected cases and sent for analysis to local microbiology services as per local protocols, in a timely manner and in compliance with clinical and information governance procedures. PPE stocks should be maintained and kept secure to ensure their availability under the indicated circumstances.
   - → Prison authorities should be informed and made aware of the hospitals to which they can transfer those requiring admission (respiratory support and/or intensive care units). Appropriate actions need to be taken for any confirmed cases, including transfer to specialist facilities for respiratory isolation and treatment, as required; appropriate escorts should be used and advice on safe transfers followed. However, consideration should be given to protocols that can manage the patient on site with clear criteria for transfer to hospital, as unnecessary transport creates risk for both transport staff and the receiving hospital.
   - → Environmental and engineering controls intended to reduce the spread of pathogens and contamination of surfaces and inanimate objects should be in place; this should include provision of adequate space between people,[19] adequate air exchange, and routine disinfection of the environment (preferably at least once daily).
   - → Consideration should be given to measures such as distributing food in rooms/cells instead of a common canteen; or splitting out-of-cell time, which could be divided by wing/unit to avoid concentration of prisoners/staff even in open spaces. With these caveats, access of prisoners to the open air should be maintained and not fall below a minimum of one hour per day.

5. Prison/detention management and health-care staff should work alongside local public health agencies to implement the IPC recommendations described in this document; at all times, they must balance public health risk against any operational pressures on prisons and other places of detention and the wider secure and detained estate.

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[17] Psychological first aid: guide for field workers. Geneva: World Health Organization; 2011 (https://www.who.int/mental_health/publications/guide_field_workers/en).

[18] Considerations for quarantine of individuals in the context of coronavirus disease (COVID-19): interim guidance (29 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(covid-19)).

[19] A minimum space of 1 metre is recommended.

7. COVID-19 VIRUS: PATHOGEN CHARACTERISTICS, SIGNS AND SYMPTOMS, TRANSMISSION

7.1 Pathogen characteristics

Coronaviruses are a large family of viruses found in both animals and humans. Some infect people and are known to cause illnesses ranging from the common cold to more severe diseases, such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). A novel coronavirus is a new strain of coronavirus that has not previously been identified in humans. The latest novel coronavirus, now called COVID-19 virus, had not been detected before the outbreak reported in Wuhan, China, in December 2019. So far, the main clinical signs and symptoms reported in people during this outbreak include fever, coughing, difficulty in breathing, and chest radiographs showing bilateral lung infiltrates.

Although the current outbreak of COVID-19 is still evolving, infection may present with mild, moderate or severe illness and can be passed from human to human, primarily (as in other respiratory viruses) by droplet spread. While about 80% of cases manifest as a mild illness (i.e. non-pneumonia or mild pneumonia), approximately 20% progress to a more severe illness, with 6% requiring specialist medical care, including mechanical ventilation. Situation reports on the outbreak, updated daily, are available on the WHO website.[20]

Most estimates of the incubation period of COVID-19 range from 1 to 14 days, with a median of 5–6 days.[21] This means that if a person remains well 14 days after exposure (i.e. contact with an infected person), they may not have been infected. However, these estimates may be updated as more data become available.

7.2 Signs and symptoms of COVID-19

The most common symptoms of COVID-19 are fever, tiredness and dry cough. Some patients may have aches and pains, nasal congestion, runny nose, sore throat or diarrhoea. These symptoms are usually mild and begin gradually. Some people become infected but do not develop any symptoms and do not feel unwell. Most people (about 80%) recover from the disease without needing special treatment. Around one out of every five people who are infected with COVID-19 becomes seriously ill and develops difficulty breathing. Older people, and those with underlying medical problems such as high blood pressure, heart problems or diabetes, are more likely to develop serious illness. Based on the latest data, about 3–4% of reported cases globally have died, but mortality varies according to location, age and existence of underlying conditions.[22] People with fever, cough and difficulty breathing should seek medical attention.[23]

7.3 Transmission of COVID-19

Respiratory secretions, formed as droplets and produced when an infected person coughs, sneezes or talks, contain the virus and are the main means of transmission.

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[20] Coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports).

[21] Coronavirus disease 2019 (COVID-19): situation report 30. 19 February 2020. Geneva: World Health Organization; 2020 (https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200219-sitrep-30-covid-19.pdf?sfvrsn=3346b04f_2).

[22] WHO Director-General's opening remarks at the media briefing on COVID-19. 3 March 2020. Geneva: World Health Organization; 2020 (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020).

[23] Q&A on coronaviruses (COVID-19). 23 February 2020. Geneva: World Health Organization; 2020 (https://www.who.int/news-room/q-a-detail/q-a-coronaviruses).

There are two main routes by which people can spread COVID-19:

- infection can be spread to people who are nearby (within 1 metre) by breathing in droplets coughed out or exhaled by a person with the COVID-19 virus; or
- people may become infected by touching contaminated surfaces or objects (fomites) and then touching their eyes, nose or mouth (e.g. a person may touch a doorknob or shake hands and then touch their own face). This is why environmental disinfection is so important.

According to current evidence, transmission may start just before symptoms become visible. However, many people infected with COVID-19 experience only mild symptoms. This is particularly true at the early stages of the disease. It is therefore possible to catch COVID-19 from someone who has, for example, just a mild cough and does not feel ill. WHO is assessing ongoing research on the period of transmission of COVID-19 and will continue to share updated findings.

7.4 How long can the virus survive on surfaces?

How long any respiratory virus survives will depend on a number of factors, including:

- the type of surface the virus is on
- whether it is exposed to sunlight
- differences in temperature and humidity
- exposure to cleaning products.

Under most circumstances, the amount of infectious virus on any contaminated surface is likely to have decreased significantly within 48 hours.

Once such viruses are transferred to hands, they survive for very short lengths of time. Regular cleaning of hands and frequently touched hard surfaces with disinfectants will therefore help to reduce the risk of infection.

8. PREPAREDNESS, CONTINGENCY PLANNING AND LEVEL OF RISK

To manage a COVID-19 outbreak, there need to be effective planning and robust collaborative arrangements between the sectors (health and justice or interior, as applicable) that have responsibility for the health and well-being of people in prisons and other places of detention. Such collaboration will be critical in ensuring a sustainable health-care delivery system within prisons and places of detention.

Important steps in setting up such collaborative planning include the following:

- Appropriate contingency plans,[24] including checklists,[25] should be established to help prison and detention systems to self-assess and improve their preparedness for responding to COVID-19.
- Close collaboration/direct links with local and national public health authorities and other relevant agencies (e.g. local crisis units, civil protection) should be established; regular contact should be maintained throughout the planning period to share information, risk assessments and plans.
- A comprehensive risk assessment should be undertaken at the beginning of the planning phase and reviewed regularly; it should have input from (or be led by) the public health authority and include an up-to-date evaluation of the epidemiological situation. It is crucial to identify the different levels of risk and what impact they may have on the prison system and other places of detention (e.g. imported cases in the country; local but circumscribed circulation in the country; local circulation, including in the area where the prison institution is located; circulation within the prison system).
- Action plans in a given country/custodial institution should be developed to mitigate all risks identified in the assessment. Some actions will be the responsibility of the national public health authority to deliver; some will be the responsibility of the local health service provider; and prisons and other places of detention will be responsible for others. Each action plan should specify who is responsible for delivering a particular action, the timescale for delivery, and how and by whom delivery will be ensured. Action plans should include:[26]
  - → integration with national emergency planning and response plans for infectious diseases;
  - → command and control arrangements to facilitate rapid communication of information and efficient situation analyses and decision-making;
  - → disease surveillance and detection (for example, who will be screened for COVID-19 symptoms? Will there be an initial screening for symptoms for all on entry (staff/visitors)? How will the disease be diagnosed and confirmed? How will cases and contacts of confirmed cases be managed?);
  - → case management (for example, how will suspected cases of COVID-19 within the detained population be treated? Is there an appropriate place for rapid health assessment and isolation, in the event of detecting a potential COVID-19 case? Can units to house suspected cases or contacts be created? Is there a mechanism for safely transporting ill travellers to designated hospitals, including identification of adequate ambulance services? What response will be available in the event of

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[24] Multi-agency contingency plan for the management of outbreaks of communicable diseases or other health protection incidents in prisons and other places of detention in England. Second edition. London: Public Health England; 2017 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585671/multi_agency_prison_outbreak_plan.pdf).

[25] Correctional facilities pandemic influenza planning checklist. Atlanta (GA): Centers for Disease Control and Prevention; 2007 (https://www.cdc.gov/flu/pandemic-resources/pdf/correctionchecklist.pdf).

[26] Adapted from: Key planning recommendations for mass gatherings in the context of the current COVID-19 outbreak: interim guidance (14 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/key-planning-recommendations-for-mass-gatherings-in-the-context-of-the-current-covid-19-outbreak).

a health-care emergency involving people in prisons and other places of detention? Are there standard operating procedures in place for environmental cleaning and disinfection, including for linens and utensils?);

→ staffing contingency planning with a special focus on (a) staff availability and business continuity, including local minimum service (e.g. essential medications, diabetic checks, wound dressings, etc.); and (b) health-care needs and provision – discuss the possibility/feasibility of providing care within prison versus the need to transfer patients to community health-care services for specialized/intensive care, as well as the expected impact on custodial staff contingency planning.

An essential element to be carefully considered in any preparedness plan for respiratory infectious diseases such as COVID-19 is availability and supply of essential supplies, including PPE and products for hand hygiene and environmental sanitation and disinfection. It is therefore recommended that prison governors, in collaboration with health-care professionals in prisons and other places of detention, assess the need for PPE and other essential supplies in order to ensure continuity of provision and immediate availability. It should be noted that, in order to avoid inappropriate use and misuse of PPE,[27] staff and people in prison should be adequately trained (for further information on training, see section 9 below). In some countries, the proportion of the population in detention that meets the criteria for influenza vaccination has been used as a basic proxy measure of the potential demand on health-care services in the case of COVID-19 outbreak in detention settings.

Given the possibility that some common disinfectants, such as those containing alcohol, may be misused, soap and water, together with personal towels, should be considered as a first option for hand hygiene. These should be supplied in rooms/cells night and day. Chlorine-based gels may be used by prison guards and by people in prison or in other places of detention in common spaces and/or if soap and water are not available. In the case of environmental disinfection, however, it is necessary to ensure that chlorine-based products are kept locked up when not being used by service providers.

[27] Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19): interim guidance (27 February 2020). Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331215/WHO-2019-nCov-IPCPPE_use-2020.1-eng.pdf).

9. TRAINING

Training of staff is a key element of any preparedness plan for prisons and other places of detention. Training activities should be appropriately planned and targeted towards custodial and health-care staff operating in prison settings. Such activities should, at a minimum, cover the following areas:

- basic disease knowledge, including pathogen, transmission route, signs and clinical disease progression
- hand hygiene practice and respiratory etiquette
- appropriate use of, and requirements for, PPE
- environmental prevention measures, including cleaning and disinfection.

In response to the COVID-19 outbreak, WHO has developed several resources that may be useful in prisons and other places of detention.

- Online training courses on IPC and clinical management of severe acute respiratory infection (SARI) are available, free of charge, from OpenWHO, WHO's web-based knowledge platform. These basic courses give a general introduction to COVID-19 and emerging respiratory viruses; they are intended for public health professionals, incident managers and personnel working for the United Nations, international organizations and nongovernmental organizations.[28]
- A risk communication package for health-care facilities provides health-care workers and health-care facility management with the information, procedures and tools required to work safely and effectively. The package contains a series of simplified messages and reminders based on WHO's more in-depth technical guidance on IPC in health-care facilities in the context of COVID-19 and can be adapted to local context.[29]
- In addition, there is a range of technical guidance covering many topics, such as case management, operational support and logistics advice on use of masks.[30]

Finally, before embarking on any initiative, it is absolutely essential to engage the prison population in widespread information and awareness-raising activities, so that people in prison/detention and visitors are informed in advance and understand the procedures to be adopted, why they are necessary, and how they are to be carried out. It is especially important that any potential restrictive measures are explained and their temporary nature emphasized.

Regrettably, as a consequence of stigma or fear, some health-care workers responding to COVID-19 in places of detention may experience avoidance by their family or community. This can make an already challenging situation far more difficult. Health-care personnel should be advised to stay connected with loved ones and have access to mental health and psychosocial support.

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[28] Emerging respiratory viruses, including COVID-19: methods for detection, prevention, response and control [OpenWHO online course]. Geneva: World Health Organization; 2020 (https://openwho.org/courses/introduction-to-ncov).

[29] The COVID-19 risk communication package for healthcare facilities. Manila: WHO Regional Office for the Western Pacific; 2020 (https://iris.wpro.who.int/handle/10665.1/14482).

[30] Country and technical guidance: coronavirus disease (COVID-19) [resource portal]. Geneva: World Health Organization (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance).

10. RISK COMMUNICATION

In an event such as the COVID-19 outbreak, it is crucial that there is good coordination between the teams at national and subnational levels involved in risk communication. Close contacts must be established to ensure rapid clearance of timely and transparent communication messaging and materials in such crisis situations.

Key messages for people in prison and other places of detention, custodial staff, health-care providers and visitors must be coordinated and consistent. To address language barriers, translation or visual material may been needed. Information resources for custodial and health-care staff, visitors, vendors and detained persons, such as short information sheets, flyers, posters, internal videos and any other means of communication, should be developed and placed in prison common areas and in areas designated for legal visits and family visits.

Consideration should be given to how messages about risk can be delivered quickly; this should include:

(1) an overall assessment of the local risk (community risk and risk within the prison);
(2) advice on preventive measures, especially hand hygiene practices and respiratory etiquette;
(3) advice on what measures to adopt if symptoms develop;
(4) information about disease signs and symptoms, including warning signs of severe disease that require immediate medical attention;
(5) advice on self-monitoring for symptoms and signs for those travelling from or living in affected areas, including checking their temperature;
(6) advice about how to access local health care if necessary, including how to do so without creating a risk to health-care workers;
(7) information that wearing a face mask is recommended for people who have respiratory symptoms (e.g. a cough); it is not recommended for healthy people.[31]

WHO's advice for the public about COVID-19, including information about the myths that surround it, may also be consulted.[32,33]

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[31] Advice on the use of masks in the community, during home care and in healthcare settings in the context of the novel coronavirus (2019-nCoV) outbreak. 29 January 2020. Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak).

[32] Coronavirus disease (COVID-19) advice for the public [website/portal]. Geneva: World Health Organization; 2019 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public).

[33] Coronavirus disease (COVID-19) advice for the public: myth busters [website]. Geneva: World Health Organization; 2019 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters).

11. IMPORTANT DEFINITIONS: SUSPECT CASE, PROBABLE CASE, CONFIRMED CASE, CONTACT, CASE REPORTING

WHO guidance for global surveillance of COVID-19 disease should be consulted for updated definitions. The WHO case definitions given below are based on information available as of 27 February 2020 and are being revised as new information accumulates.[34] Countries may need to adapt these case definitions depending on their own epidemiological situation.

[34] Global surveillance for human infection with coronavirus disease (COVID-19): interim guidance (27 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov)).

11.1 Definition of a suspect case

A suspect case is:

(A) a patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g. cough, shortness of breath) AND no other aetiology that fully explains the clinical presentation AND a history of travel to or residence in a country/area or territory reporting local transmission of COVID-19 during the 14 days prior to onset of symptoms;[35] OR

(B) a patient with any acute respiratory illness AND who has been in contact with a probable or confirmed COVID-19 case (see 11.2 and 11.3 below) in the last 14 days prior to onset of symptoms; OR

(C) a patient with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease, e.g. cough, shortness of breath) AND who requires hospitalization AND who has no other aetiology that fully explains the clinical presentation.

If it is determined that there is a suspect case of COVID-19, the local prison outbreak management plan should be activated. The suspect case should be immediately instructed to wear a medical mask and follow respiratory etiquette and hand hygiene practices. IPC measures, such as medical isolation, should be applied.

In this regard, it is recommended that, within each prison and other place of detention, according to the indications of health-care staff on duty and relevant national/international guidelines, a space is identified where suspect cases or confirmed cases not requiring hospitalization can be placed in medical isolation.[34,36] The creation of housing units may also be considered, as not everyone who is a suspect case, a probable case or a contact requires hospitalization.

11.2 Definition of a probable case

A probable case is a suspect case for whom testing for COVID-19 is inconclusive (that is, if the result of the test reported by the laboratory is inconclusive).

11.3 Definition of a confirmed case

A confirmed case is a patient with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms. Laboratory confirmation needs to be made according to an appropriate method.[37]

11.4 Definition of a contact

A contact is a person who is involved in any of the following:

- providing direct care without proper PPE for a COVID-19 patient;
- staying in the same closed environment (e.g. a detention room) as a COVID-19 patient;
- travelling together in close proximity (within 1 metre) with a COVID-19 patient in any kind of conveyance within a 14-day period after the onset of symptoms in the case under consideration.

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[35] For update on latest situation refer to: Coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports).

[36] Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected: interim guidance (25 January 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125).

[37] Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases: interim guidance (2 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/laboratory-testing-for-2019-novel-coronavirus-in-suspected-human-cases-20200117).

18 Monitoring of contacts of suspect, probable and confirmed cases

- Contacts should be monitored for 14 days from the last unprotected contact.
- External contacts should self-limit travel and movements. In prison settings, monitoring should be done by prison health-care or custodial staff with regular visits to see if symptoms have developed (this is important as people in prison may have a disincentive to admit to developing symptoms as they could be put in isolation).
- Any contact who becomes ill and meets the case definition becomes a suspect case and should be tested.
- Any newly identified probable or confirmed cases should have their own contacts identified and monitored.

Contact tracing should begin immediately after a suspect case has been identified in a prison or detention facility, without waiting for the laboratory result, in order to avoid delays in implementing health measures when necessary. This should be conducted by prison health-care or custodial staff under the supervision of the competent national health authority and according to national preparedness plans. Every effort should be made to minimize exposure of the suspect case to other people and the environment and to separate contacts from others as soon as possible.[38] Contacts outside the prison (visitors, etc.) should be followed up by the health authorities.

11.5 Case reporting

COVID-19 has been added to the list of notifiable diseases that doctors have a duty to report to public health authorities. COVID-19 is a high-consequence infectious disease (HCID) with outbreak potential in prisons and other detention settings; possible cases in such settings should therefore be notified straightaway to responsible public health authorities, who will then report to national and international authorities.

[38] Operational considerations for managing COVID-19 cases/outbreak on board ships: interim guidance (24 February 2020). Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331164).

12. PREVENTION MEASURES

There is currently no vaccine to prevent COVID-19. All staff and people in prisons and other places of detention should have comprehensive awareness of COVID-19 prevention strategies, including adherence to hand hygiene measures, respiratory etiquette (covering coughs and sneezes), physical distancing (maintaining a distance of at least 1 metre from others), being alert to signs and symptoms of COVID-19, staying away from ill people, and (in the case of staff) staying home when ill. Staff should also comply with any screening measures put in place by local authorities.

In alignment with local health authorities, a workplace protocol should be developed to determine how to manage any personnel who meet the definition of a suspected or confirmed COVID-19 case or their contacts.

12.1 Personal protection measures

It is recommended that the following general precautions for infectious respiratory diseases are taken to help prevent people (staff, visitors, vendors, detainees, etc. in prisons) from catching and spreading COVID-19:

- hands should be washed often with soap and water and dried with single-use towels; alcohol hand sanitizer containing at least 60% alcohol is also an option if available (for further guidance on hand hygiene, see section 13.1 below);
- physical distancing should be observed;
- a disposable tissue should be used to cover mouth and nose when coughing or sneezing, then thrown in a bin with a lid;
- touching of eyes, nose or mouth should be avoided if hands are not clean.

If possible, wall-mounted liquid soap dispensers, paper towels and foot-operated pedal bins should be made available and accessible in key areas such as toilets, showers, gyms, canteens and other high-traffic communal areas to facilitate regular hand hygiene. Security staff should assess whether such fixtures pose a security and safety risk to people in prisons and places of detention prior to their installation.

12.2 Use of masks

It is important to create a general understanding of what measures should be taken by, and on behalf of, each person in prison when infection by COVID-19 is suspected. It is very important to train people in prison as soon as possible to understand general hygiene and ways of transmission and to make it clear that, if masks are to be used, this measure must be combined with hand hygiene and other IPC measures to prevent human-to-human transmission of COVID-19.

Patient use of a medical mask is one of the prevention measures that can be taken to limit spread of certain respiratory diseases, including COVID-19, in affected areas. However, use of a mask alone is insufficient to provide an adequate level of protection and other equally relevant measures should also be adopted.

WHO has developed guidance for home-care and health-care settings on IPC strategies for use when infection with COVID-19 is suspected.[36] WHO has also issued guidance on the use of masks in the community, during home care and in health-care settings in the context of the COVID-19 outbreak.[31]

Wearing medical masks when not indicated may incur unnecessary cost, cause procurement burden and create a false sense of security that can lead to neglecting other essential measures such as hand hygiene practices. Furthermore, using a mask incorrectly may hamper its effectiveness in reducing the risk of transmission.[27]

Management of masks

If medical masks are worn, appropriate use and disposal are essential to ensure that they are effective and to avoid any increase in risk of transmission associated with incorrect use and disposal. The following advice on correct use of medical masks is based on standard practice in health-care settings:[31]

- place mask carefully to cover mouth and nose and tie securely to minimize any gaps between face and mask;
- while in use, avoid touching the mask;
- remove the mask by using an appropriate technique (i.e. do not touch the front but remove by the headband from behind);
- after removal or whenever you inadvertently touch a used mask, clean hands by using an alcohol-based hand rub (if available) or soap and water;
- replace masks with a new clean, dry mask as soon as they become damp/humid;
- do not reuse single-use masks;
- discard single-use masks after each use and dispose of them immediately upon removal (consider a central place in the ward/cell block where used masks can be discarded).

Cloth (e.g. cotton or gauze) masks are not recommended under any circumstances.

12.3 Environmental measures

Environmental cleaning and disinfection procedures must be followed consistently and correctly. Cleaning with water and household detergents and with disinfectant products that are safe for use in prison settings should be used for general precautionary cleaning.

Cleaning personnel should be made aware of the facts of COVID-19 infection to ensure that they clean environmental surfaces regularly and thoroughly. They should be protected from COVID-19 infection and wear disposable gloves when cleaning or handling surfaces, clothing or linen soiled with body fluids, and should perform hand hygiene before and after removing gloves.

As the COVID-19 virus has the potential to survive in the environment for several days, premises and areas that may have been contaminated should be cleaned and disinfected before they are reused, with regular household detergent followed by disinfectant containing a diluted bleach solution (e.g. one part liquid bleach, at an original concentration of 5.25%, to 49 parts water for a final concentration of about 1000 ppm or 0.1%). For surfaces that do not tolerate bleach, 70% ethanol can be used. If bleach or ethanol cannot be used in the prison for security reasons, ensure that the disinfectant used for cleaning is able to inactivate enveloped viruses. Prison authorities may have to consult disinfectant manufacturers to ensure that their products are active against coronaviruses.

To ensure adequate disinfection, janitorial and housekeeping personnel should take care to first clean surfaces with a mix of soap and water, or a detergent. Then they should apply the disinfectant for the required contact time, as per the manufacturer's recommendations. The disinfectant may be rinsed off with clean water after the contact time has elapsed.

Clothes, bedclothes, bath and hand towels, etc. can be cleaned using regular laundry soap and water or machine-washed at 60–90 °C with common laundry detergent. Waste should be treated as infectious clinical waste and handled according to local regulation. Guidance on environmental cleaning in the context of the COVID-19 outbreak is available from the European Centre for Disease Prevention and Control (ECDC);[39] see also Annex 1 below.

12.4 Physical distancing measures

All staff should be alert to the enhanced risk of COVID-19 infection in people in prisons and other places of detention who have a history of potential exposure, having travelled to, transited through or lived in high-risk areas in the last 14 days.

Any detainee who has (a) travelled from or lived in an identified high-risk area,[40] or (b) had contact with a known case of COVID-19, should be placed in quarantine, in single accommodation, for 14 days from the date of travel or last possible day of contact.[18] If it is not possible to house the detainee in medical isolation, then detainees with similar risk factors and exposures may be housed together while they undergo quarantine. The patient should wear a medical face mask while being transferred to an isolation room. During isolation, the isolated person should be under medical observation at least twice a day, including taking body temperature and checking for symptoms of COVID-19 infection.

An assessment of any language or communication issues should be made and access to a language interpretation/translation service must be provided as soon as a possible case enters the facility so that an accurate history can be taken.

12.5 Consideration of access restriction and movement limitation

An assessment of each case and setting should be undertaken by prison staff in conjunction with the local public health agency. Advice on the management of staff or people in prison or places of detention will be based on this assessment.

A temporary suspension of on-site prison visits will need to be carefully considered in line with local risk assessments and in collaboration with public health colleagues, and should include measures to mitigate the negative impact such a measure is likely to have on the prison population. The specific and disproportionate impact on different types of prisoners, as well as on children living with their parent in prison, must be considered. Measures to restrict movement of people in and out of the detention setting, including restricting transfers within the prison/detention system and limiting access to non-essential staff and visitors, need to be

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[39] Interim guidance for environmental cleaning in non-healthcare facilities exposed to SARS-CoV-2. ECDC technical report. 18 February 2020. Stockholm: European Centre for Disease Prevention and Control; 2020 (https://www.ecdc.europa.eu/sites/default/files/documents/coronavirus-SARS-CoV-2-guidance-environmental-cleaning-non-healthcare-facilities.pdf).

[40] Situation updates are available at: Coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports).

considered carefully in line with appropriate risk assessments, as such restrictions will have a wider impact on the functioning of the detention system. Measures that may be considered include, as appropriate, restriction of family visits, reducing visitor numbers and/or duration and frequency of visits, and introduction of video conferencing (e.g. Skype) for family members and representatives of the judicial system, such as legal advisers.

In particular:

- screening may be considered at entrance with self-reporting questionnaire to exclude those with symptoms;
- visitors who feel unwell should stay at home and not attend the establishment;
- staff must stay at home and seek medical attention should they develop any relevant signs and symptoms.

A workplace protocol for how to manage such situations, including a suspected or confirmed COVID-19 case or their contacts, should be in place.

12.6 Staff returning to work following travel to affected areas or with a history of potential exposure

Custodial/detention staff working in places of detention should consult occupational health services in their respective organization if they have travelled or live in a high-risk community/area where COVID-19 is spreading; they should also keep up to date on the latest information on the COVID-19 outbreak, available on the WHO website[40] and through the national and local public health authority, to familiarize themselves with any possible restrictions/quarantine periods in place.

Prisons should review their continuity and contingency plans and update them to ensure that they can perform critical functions with reduced numbers of personnel, in a manner that does not have a negative impact on the security of the prison.

12.7 What to do if a member of staff becomes unwell and believes they have been exposed to COVID-19

If a member of staff becomes unwell in the prison and has travelled to an affected area or lives in an area where COVID-19 is spreading, they should be removed to a location which is at least 1 metre away from other people. If possible, a room or place where they can be isolated behind a closed door, such as a staff office, should be made available. If it is possible to open a window for ventilation, do so.

Prison health-care professionals (or the individual who is unwell) should call health services or emergency services (if they are seriously ill or their life is at risk) and explain their current clinical symptoms and their epidemiological and travel history (this may not be necessary if the prison is located in affected area). If the person affected is not able for any reason to call a doctor themselves, then another staff member should call on their behalf.

While the unwell individual waits for advice or an ambulance to arrive, they should remain at least 1 metre from other people, and if possible be isolated behind a closed door. They should avoid touching people, surfaces and objects, and they should be provided with a medical mask. If a medical mask is not available, they should be advised to cover their mouth and nose with a disposable tissue when they cough or sneeze, then put the tissue in a bag and throw it in a bin. If they do not have any tissues available, they should cough and sneeze into the crook of their elbow.

If the unwell individual needs to go to the bathroom while waiting for medical assistance, they should use a separate bathroom, if available. This will apply only to the period of time while they wait for transport to hospital. Given the possible risk of environmental contamination, it is important to ensure that the bathroom is properly cleaned and disinfected after the suspected case has used it; the area where they were sitting should also be cleaned and disinfected.

13. ASSESSING SUSPECTED CASES OF COVID-19 IN PEOPLE IN PRISON/DETENTION

Case identification should be performed in accordance with available national/supranational guidance for primary care and community settings.

Suspected cases among people in prison may be identified by notifications received from custodial/detention staff, other prisoners/detainees, self-referral, and screening at reception, or by other means. For case definitions, see section 11 above.

Depending on the local level of risk, additional procedures to assess new arrivals in prison may be needed. Measures to consider are:

- creating a dedicated screening area at the facility entrance
- establishing a procedure for immediate isolation of suspected cases.

13.1 Advice on use of PPE and other standard precautions for health-care staff and custodial staff with patient-facing roles

Health-care professionals in prisons and other detention settings are most likely to work directly with patients with a possible diagnosis of COVID-19, but custodial staff and transport services may also be engaged, especially at initial presentation. This means that all staff (custodial and health-care workers) should be educated about standard precautions such as personal hygiene, basic IPC measures and how to deal with a person suspected of having COVID-19 as safely as possible to prevent the infection from spreading.

IPC management includes wearing the appropriate level of PPE according to risk assessment, and ensuring safe waste management, proper linens, environmental cleaning, and sterilization of patient-care equipment.

PPE for custodial staff

For activities that involve close contact with a suspected or confirmed case of COVID-19, such as interviewing people at a distance of less than 1 metre, or arrest and restraint, it is advised that the minimum level of PPE that custodial/escort staff should wear is:

- disposable gloves
- medical mask
- if available, a disposable full gown and disposable eye protection (e.g. face shield or goggles).

PPE for health-care staff

It is advised that the minimum level of PPE for health-care staff required when dealing with a suspected or confirmed COVID-19 case is:

- medical mask
- full gown
- gloves
- eye protection (e.g. single-use goggles or face shield)
- clinical waste bags
- hand hygiene supplies
- general-purpose detergent and disinfectant solutions that are virucidal and have been approved for use by the prison authorities.

Health-care staff should use respirators only for aerosol-generating procedures; for further details on use of respirators, see section 14 below and WHO guidance on PPE use.[27]

For all staff, PPE must be changed after each interaction with a suspected or confirmed case.

Removal of PPE

PPE should be removed in an order that minimizes the potential for cross-contamination. Before leaving the room where the patient is held, gloves, gown/apron, eye protection and mask should be removed (in that order, where worn) and disposed of as clinical waste. After leaving the area, the face mask can be removed and disposed of as clinical waste in a suitable receptacle.

The correct procedure for removing PPE is as follows:

(1) peel off gloves and dispose of as clinical waste
(2) perform hand hygiene, by handwashing or using alcohol gel
(3) remove apron/gown by folding in on itself and place in clinical waste bin
(4) remove goggles/face shield only by the headband or sides and dispose of as clinical waste
(5) remove medical mask from behind and dispose of as clinical waste
(6) perform hand hygiene.

Further WHO guidance, with illustrations, on putting on and taking off PPE is available online.[41,42]

All used PPE must be disposed of as clinical waste.

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[41] How to put on and take off personal protective equipment (PPE) [information sheet]. Geneva: World Health Organization; 2008 (https://www.who.int/csr/resources/publications/PPE_EN_A1sl.pdf).

[42] Steps to put on personal protective equipment (PPE) [poster]. Geneva: World Health Organization (https://www.who.int/csr/disease/ebola/put_on_ppequipment.pdf).

Hand hygiene

Scrupulous hand hygiene is essential to reduce cross-contamination. It should be noted that:

- hand hygiene involves cleansing hands either with an alcohol-based hand rub or with soap and water;
- alcohol-based hand rubs are preferred if hands are not visibly soiled;
- if an alcohol-based hand rub is used, it should be at least 60% alcohol;
- always wash hands with soap and water when they are visibly soiled.

All staff should apply the "My five moments for hand hygiene" approach to cleaning their hands:

(1) before touching a patient
(2) before any clean or aseptic procedure is performed
(3) after exposure to body fluid
(4) after touching a patient
(5) after touching a patient's surroundings.

More information on how to wash hands properly, in the form of a poster that can be adapted to the prison facility, is available on the WHO website.[43]

13.2 Advice for policing, border force and immigration enforcement activities

For police, border force and immigration enforcement officers, there may be situations where an individual who needs to be arrested or is in custody is identified as potentially at risk of COVID-19.[44]

If assistance is needed for an individual who is symptomatic and identified as a possible COVID-19 case, the person should, wherever possible, be placed in a location away from others. If there is no physically separate room, people who are not involved in providing assistance should be asked to stay away from the individual. If barriers or screens are available, they may also be used.

Appropriate IPC measures should be implemented. In activities that involve close contact with a symptomatic person who is suspected of having COVID-19 (such as interviewing at a distance of less than 1 metre, or arrest and restraint), staff should wear:

- disposable gloves
- medical mask
- long-sleeved gown
- eye protection (e.g. face shield or goggles).

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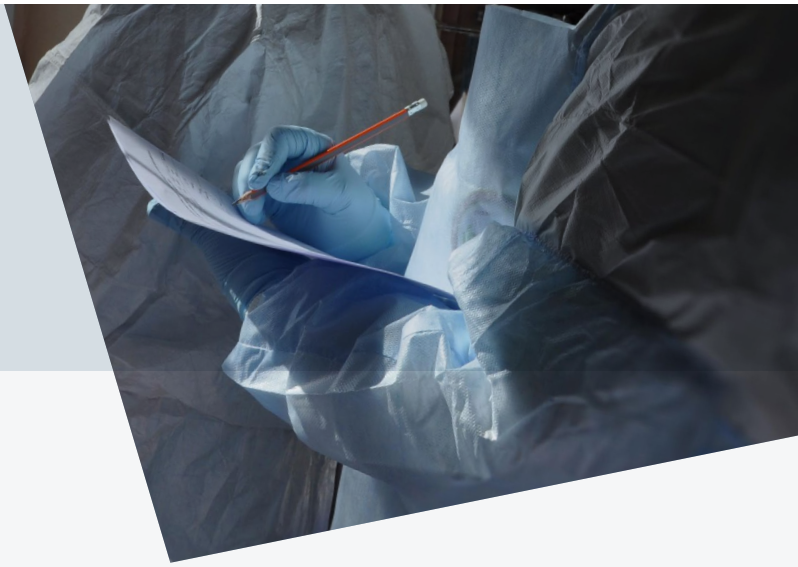
[43] How to handwash? [poster]. Geneva: World Health Organization; 2009 (https://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf).

[44] For further information, see: Guidance for first responders and others in close contact with symptomatic people with potential COVID-19. London: Public Health England; 2020 (https://www.gov.uk/government/publications/novel-coronavirus-2019-ncov-interim-guidance-for-first-responders/interim-guidance-for-first-responders-and-others-in-close-contact-with-symptomatic-people-with-potential-2019-ncov).



14. CASE MANAGEMENT

Case management should be performed in accordance with available national/supranational guidance for primary care and community settings.

14.1 Clinical management of severe acute respiratory infection (SARI) when COVID-19 is suspected

WHO has issued guidance intended for clinicians involved in the clinical management and care of adult, pregnant and paediatric patients with or at risk of SARI when infection with the COVID-19 virus is suspected.[45] It is not meant to replace clinical judgement or specialist consultation but rather to strengthen clinical management of these patients and to provide up-to-date guidance. Best practices for IPC, triage and optimized supportive care are included.

The WHO guidance is organized in the following sections:

1. Background
2. Screening and triage: early recognition of patients with SARI associated with COVID-19
3. Immediate implementation of appropriate IPC measures
4. Collection of specimens for laboratory diagnosis
5. Management of mild COVID-19: symptomatic treatment and monitoring
6. Management of severe COVID-19: oxygen therapy and monitoring
7. Management of severe COVID-19: treatment of coinfections
8. Management of critical COVID-19: acute respiratory distress syndrome (ARDS)
9. Management of critical illness and COVID-19: prevention of complications
10. Management of critical illness and COVID-19: septic shock
11. Adjunctive therapies for COVID-19: corticosteroids
12. Caring for pregnant women with COVID-19
13. Caring for infants and mothers with COVID-19: IPC and breastfeeding
14. Care for older persons with COVID-19
15. Clinical research and specific anti-COVID-19 treatments.

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[45] Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected: interim guidance (13 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected).

14.2 Additional precautions

Patients should be placed in adequately ventilated space. If more suspected cases are detected and if individual spaces are not available, patients suspected of being infected with COVID-19 should be grouped together. However, all patients' beds should be placed at least 1 metre apart whether or not they are suspected of having COVID-19 infection.

A team of health-care workers and custodial/detention staff should be designated to care exclusively for suspected or confirmed cases to reduce the risk of transmission.

14.3 How to undertake environmental cleaning following a suspected case in a place of detention

Once a suspected case of COVID-19 has been transferred out of the prison or other place of detention to a hospital facility, the room where the patient was placed and the room where the patient was residing should not be used until appropriately decontaminated; the doors should remain shut, with windows open and any air conditioning switched off, until the rooms have been cleaned with detergent and disinfectant that is virucidal and approved for use in the prison setting. Detailed information on cleaning and disinfection is provided on the WHO website [46] and in Annex 1.

Once the cleaning process has been completed, the room can be put back in use immediately. Medical devices and equipment, laundry, food service utensils and medical waste should be managed in accordance with the medical waste policy at the facility.

A disease commodity package for COVID-19 outlines the supplies needed for surveillance, laboratory analysis, clinical management and IPC.[47]

14.4 Discharge of people from prisons and other places of detention

If a person who has served their sentence is an active COVID-19 case at the time of their release, or is the contact of a COVID-19 case and still within their 14-day quarantine period, the prison health authorities should ensure that the person discharged has a place to go where they can maintain quarantine, that the local authority is notified that the person has been discharged, and thus that follow-up is transferred from the prison authorities to the local authorities.

If a discharged individual is transferred to a hospital or other medical facility after their prison term is over, but they are still under quarantine/medical care for their COVID-19 infection, the receiving facility should be notified of the person's COVID-19 status (confirmed or suspected) so that it is ready to provide proper isolation.

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[46] Home care for patients with suspected novel coronavirus (nCoV) infection presenting with mild symptoms and management of contacts: interim guidance (4 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts).

[47] Disease commodity package: novel coronavirus (COVID-19). Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/what-we-do/prevention-readiness/disease-commodity-packages/dcp-ncov.pdf).

15. INFORMATION RESOURCES

WHO general guidance on COVID-19

COVID-19 information portal: https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Daily situation updates on the COVID-19 outbreak
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

Mental health and social issues

Coping with stress during the COVID-19 outbreak
https://www.who.int/docs/default-source/coronaviruse/coping-with-stress.pdf?sfvrsn=9845bc3a_2

Helping children cope with stress during the COVID-19 outbreak

https://www.who.int/docs/default-source/coronaviruse/helping-children-cope-with-stress-print.pdf?sfvrsn=f3a063ff_2

Mental health considerations for different groups (including health workers) during the COVID-19 outbreak

https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_10

Addressing social stigma associated with COVID-19

https://www.epi-win.com/sites/epiwin/files/content/attachments/2020-02-24/COVID19%20Stigma%20Guide%2024022020_1.pdf

IASC briefing note on mental health and psychosocial support (MHPSS) aspects of COVID-19
https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/briefing-note-about

European Centre for Disease Prevention and Control

COVID-19 information portal: https://www.ecdc.europa.eu/en/novel-coronavirus-china

United Nations Office on Drugs and Crime

Assessing compliance with the Nelson Mandela Rules: a checklist for internal inspection mechanisms (2017)
https://www.unodc.org/documents/justice-and-prison-reform/17-04946_E_ebook_rev.pdf

Handbook on strategies to reduce overcrowding in prisons (2013)

https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf

Policy brief on HIV prevention, treatment and care in prisons and other closed settings (2013)
https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

Handbook on prisoners with special needs (2009)
https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf

Public Health England

Public Health England (PHE) – Public health in prisons and secure settings (collection of resources)
https://www.gov.uk/government/collections/public-health-in-prisons

COVID-19: prisons and other prescribed places of detention
https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance

Robert Koch Institute
Information portal (in German)
https://www.rki.de/DE/Home/homepage_node.html

National Commission on Correctional Health Care
What you need to know about COVID-19
https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections

Penal Reform International
Briefing note on COVID-19, health care, and the human rights of people in prison
https://www.penalreform.org/resource/coronavirus-healthcare-and-human-rights-of-people-in

ANNEX 1
ENVIRONMENTAL CLEANING FOLLOWING A SUSPECTED CASE OF COVID-19 IN A PLACE OF DETENTION*

Infection prevention and control (IPC) measures are essential to reduce the risk of transmission of infection in prisons and other places of detention. Environmental cleaning of health-care rooms, or cells, where a suspected case has been managed is an essential intervention to control infection as well as to enable facilities to be put back into use quickly. Once a possible case has been transferred from the prison or detention setting, the room where the patient was placed should not be used, the room door should remain shut, with windows opened and the air conditioning switched off (if relevant), until it has been cleaned with detergent and disinfectant. Once this process has been completed, the room can be put back in use immediately.

Preparation

The responsible person undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

- collect all cleaning equipment and clinical waste bags before entering the room
- dispose of any cloths and mop heads as single-use items
- perform hand hygiene, then put on a disposable plastic apron and gloves.

On entering the room

- keep the door closed with windows open to improve airflow and ventilation while using detergent and disinfection products
- bag all items that have been used for the care of the patient as clinical waste – for example, contents of the waste bin and any consumables that cannot be cleaned with detergent and disinfectant
- remove any fabric curtains or screens or bed linen and bag as infectious linen
- close any sharps containers, wiping the surfaces with either a combined detergent/disinfectant solution with a virucidal label claim, or a neutral-purpose detergent followed by disinfection with a virucidal product that has been approved for use in the facility.

Cleaning process

Use disposable cloths/paper roll/disposable mop heads to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the two options below:

- *either* use a combined detergent/disinfectant solution with a virucidal label claim
- *or* use a neutral-purpose detergent, followed by a virucidal disinfectant approved by the prison authority.

Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants. Any cloths and mop heads used must be disposed of as single-use items.

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* COVID-19: interim guidance for primary care (updated 25 February 2020). London: Public Health England; 2020 (https://www.gov.uk/government/publications/wn-cov-guidance-for-primary-care/wn-cov-interim-guidance-for-primary-care).

Cleaning and disinfection of reusable equipment

- clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers and glucometers, that are in the room prior to their removal
- clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings

If carpeted floors/items cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use, following or combined with detergent cleaning.

On leaving the room

- discard detergent/disinfectant solutions safely at disposal point
- all waste from suspected contaminated areas should be removed from the room and discarded as medical waste as per the facility guideline for medical waste
- clean, dry and store reusable parts of cleaning equipment, such as mop handles
- remove and discard personal protective equipment (PPE) as medical waste
- perform hand hygiene.

Cleaning of communal areas

If a suspected case spent time in a communal area, then these areas should be cleaned with detergent and disinfectant (as above) as soon as practicably possible, unless there has been a blood/body fluid spill, which should be dealt with immediately. Once cleaning and disinfection have been completed, the area can be put back in use.

Decontamination of vehicles following a transfer of a possible case

Any vehicle used to transport a possible case should be cleaned and disinfected (using the methods outlined above for environmental cleaning following a possible case) as soon as possible before it is brought back into service.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int

Exhibit E

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

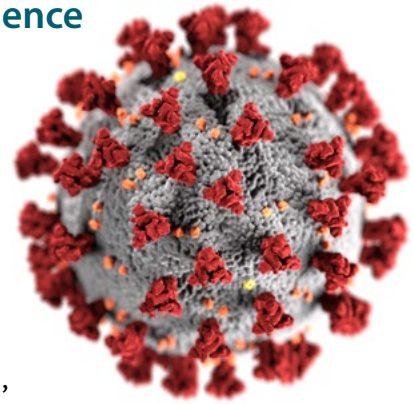
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

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

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

In this guidance

Who is the intended audience for this guidance?



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

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

Why is this guidance being issued?

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

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

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

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

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

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

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

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

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

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

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

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

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

Personnel Practices

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

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

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

Operations & Supplies

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

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

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

- See CDC guidance optimizing PPE supplies.

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

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

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

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

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

Prevention

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

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

Operations

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

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

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

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

Cleaning and Disinfecting Practices

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

Hygiene

- √ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- √ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis.** Sample signage and other communications materials **are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
  - o **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
  - o **Practice good** hand hygiene**:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
  - o **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
  - o **Avoid sharing eating utensils, dishes, and cups.**
  - o **Avoid non-essential physical contact.**
- √ **Provide incarcerated/detained persons and staff no-cost access to:**
  - o **Soap—**Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
  - o **Running water, and hand drying machines or disposable paper towels for hand washing**
  - o **Tissues** and no-touch trash receptacles for disposal
- √ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.
- √ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

- √ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).
  - o **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
    - Require the individual to wear a face mask.
    - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
    - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

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

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

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

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

Prevention Practices for Staff

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

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

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

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

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

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

Prevention Practices for Visitors

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

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

- 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:

- **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**
  - 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

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Maria Alejandra Celimen Savino, *et al*., *Petitioners-Plaintiffs*, v. Thomas Hodgson, Bristol County Sheriff in his Official Capacity, *et al.*, *Respondents-Defendants*.	Case No. 1:20-cv-10617-WGY **[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER**

Upon consider of Plaintiffs' Motion for Temporary Restraining Order, the parties' briefing, and oral argument, this Court finds that Plaintiffs have demonstrated a need for injunctive relief in this case. *See Winter v. Natural Resources Defense Council Inc.*, 555 U.S. 7, 20 (2008).

Accordingly, it is hereby ORDERED that Defendants and all of their respective officers, agents, servants, employees, attorneys, and persons acting in concert of participation with them must *immediately*:

1. Release plaintiffs and all similarly situated detainees in Bristol County Immigration Detention Facilities on their own recognizance with appropriate precautionary public health measures, or, in the alternative, release plaintiffs and all similar situated detainees in Bristol County Immigration Detention Facilities into community-based alternatives to detention, such as conditional release, supervision or electronic monitoring, with appropriate precautionary public health measures;

2. [In the alternative,] implement public health guidance and protocols designed to prevent the transmission of COVID-19;
3. Cease placing new detainees in Bristol County Immigration Detention Facilities until all public health protocols designed to prevent the transmission of COVID-19 have been implemented; and
4. Effectuate the release of Plaintiffs and all similarly situated detainees at Bristol County Immigration Detention Facilities upon the posting of the appropriate bond, if bond was previously set by ICE or an Immigration Judge.

This Court has exercised its discretion to determine that no security shall be required and that this Order shall be effectively immediately.

IT IS SO ORDERED.

DATED this _____ day of _____, 2020.

_____

William G. Young
United States District Judge

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, et al.,

Petitioners-Plaintiffs,

v.

THOMAS HODGSON, et al.,

Respondents-Defendants.

Case No. 1:20-cv-10617-WGY

PETITIONERS-PLAINTIFFS' MOTION FOR CLASS CERTIFICATION OR REPRESENTATIVE HABEAS ACTION

Petitioners-Plaintiffs and the proposed class, by and through their undersigned counsel, hereby respectfully move this Court for an order certifying a class pursuant to Fed. R. Civ. P. 23, or in the alternative, to certify a representative habeas class of Petitioners-Plaintiffs pursuant to *United States ex rel. Sero v. Preiser*, 506 F.2d 1115 (2d Cir. 1974). Petitioners-Plaintiffs ask this Court to certify a class consisting of all civil immigration detainees who are now or will be held by Respondents-Defendants at the Bristol County House of Corrections and the C. Carlos Carreiro Immigration Detention Center in North Dartmouth, Massachusetts. The grounds for this motion are set forth in the Memorandum in Support of Petitioners-Plaintiffs' Motion for Class Certification and Exhibits attached thereto and incorporated therein.[1]

[1] Undersigned counsel did not confer under Local Rule 7.1(a)(2) because no counsel has appeared on behalf of Respondents-Defendants as of the time of filing. See Declaration of Oren Sellstrom in Support of Motion for Temporary Restraining Order.

Respectfully Submitted,

/s/ Oren Nimni
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* Motion for law student appearance forthcoming.

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, JULIO CESAR MEDEIROS NEVES, and all those similarly situated, Petitioners-Plaintiffs, v. THOMAS HODGSON, et al., Respondents-Defendants.	Case No. 1:20-cv-10617 WGY

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

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INTRODUCTION

This action is filed on behalf of a highly vulnerable putative class: numerous individuals in civil immigration detention currently housed at Bristol County Immigration Detention Facilities, all of whom are at grave risk of contracting COVID-19 because of the life-threatening, congregate conditions under which they are confined. Common questions of both fact and law pervade this matter, and Defendants[1] have acted and refused to act on grounds that are generally applicable to the class as a whole, making class certification appropriate.

The requirements of Federal Rules of Civil Procedure 23(a) and (b) are amply met by the proposed class. The class is sufficiently numerous: more than 57 individuals are currently in civil immigration detention at Bristol County Immigration Detention Facilities.[2] All members of the class are bound together by common questions of law and fact – most prominently, whether in the face of the lethal COVID-19 pandemic, the conditions of confinement at the Detention Facilities place the detainees' safety and health at grave risk in a manner that amounts to unconstitutional punishment. The named Plaintiffs are proper class representatives because their claims are typical of the absent class members and because they and their counsel will adequately and vigorously represent the class. Finally, Rule 23(b)(2) is satisfied here because the Defendants have "acted or refused to act on grounds that apply generally to the class" through creating and maintaining conditions that put the class at imminent risk of contracting COVID-19, the deadly virus that is currently sweeping the globe.

[1] Defendants are Thomas Hodgson, Bristol County Sheriff; Steven J. Souza, Superintendent Bristol County House of Corrections; Todd Lyons, Boston Field Office, Acting Director, Immigrations and Customs Enforcement (ICE); Chad F. Wolf, Acting Secretary, Department of Homeland Security; and Matthew T. Albence, Deputy Director and Senior Official Performing the Duties of the Director for ICE. All are sued in their official capacities.

[2] The Detention Facilities consist of the Bristol County House of Corrections (BCHOC) and the C. Carlos Carreiro Immigration Detention Center (Carreiro) (collectively "Bristol County Immigration Detention Facilities" or "Detention Facilities"). At least 57 immigration detainees are being held in just one unit (Unit B) of the BCHOC.

The Centers for Disease Control and Prevention (CDC) advises that COVID-19 is thought to spread primarily from person-to-person, between people who are in close contact with one another (within about 6 feet), and through respiratory droplets produced when someone speaks, coughs, or sneezes, including the touch of shared surfaces.[3] *See* Declaration of Gregg Gonsalves ("Gonsalves Decl."), ¶ 15.[4] The CDC has made clear that the only known effective measures to reduce the risk of contracting COVID-19 are social distancing and hygiene. *See* CDC, *Coronavirus Disease (COVID-19): How to Protect Yourself*, (Mar. 18, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html. ("The best way to prevent illness is to avoid being exposed to this virus."). The calls for individuals and organizations throughout the world to adopt these measures has been uniform, *see* Gonsalves Decl. ¶ 13, and has led to entire nations, states, and cities being locked down, in an extraordinary and unprecedented battle to stop the spread of this deadly virus.

Medical experts and former ICE officials alike have recognized the obvious risk that is presented in congregate environments such as Bristol County Immigration Health Facilities. "'It's a vulnerable situation,' John Sandweg, an acting head of ICE during the Obama administration, told CBS News. 'You have the exact situation everyone is cautioning against. You have a bunch of people contained in a very small environment.'…'[c]an you imagine if you get an outbreak in these detention facilities? It's going to spread like wildfire,' Sandweg added."[5] Dr. Gregg Gonsalves notes that detention facilities are "enclosed environments," similar to

[3] World Health Organization, Rolling updates on coronavirus disease (COVID-19) (Updated Mar. 20, 2020) https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen. 4 As of March 21, 2020 at 7:06 p.m. EST. See COVID-19 CORONAVIRUS PANDEMIC, WORLDOMETER (Mar. 21, 2020), https://www.worldometers.info/coronavirus/. 5 Id. 6 As of March 21, 2020 at 3:10p.m. EST.
[4] Except as otherwise noted, all Declarations refer to Declarations filed in support of Plaintiffs' Motion for Temporary Restraining Order, filed concurrently with this Class Certification Motion.
[5] Camilo Montoya-Galvez, *"Powder Kegs": Calls Grow for ICE to Release Immigrants to Avoid Coronavirus Outbreak*, CBS News (Mar. 19, 2020), https://www.cbsnews.com/news/coronavirus-ice-release-immigrants-detention-outbreak.

others like cruise ships that were early sites of large COVID-19 outbreaks, but have 'even greater risk of infectious spread than other enclosed environments because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care resources." Gonsalves Decl. ¶ 16. Furthermore, according to Dr. Allen Keller, "the risk of COVID-19 infection and spread in immigration detention facilities, including Bristol County, is extremely high." Declaration of Allen Keller, ¶ 10. The risk is exacerbated by immigration detention staff, contractors, and vendors who "are at great risk of unknowingly spreading COVID-19 infection that was acquired in the community, given the[ir] daily back and forth routines . . . and lack of available tests." *Id.* ¶ 14.

In the Bristol County Immigration Detention Facilities, however, it is business as usual. Members of the proposed class – who are being held civilly, not pursuant to any criminal conviction – have pled with Defendants, in increasing frantic ways, to protect them from this deadly virus, but those pleas have fallen on deaf ears. Defendants have continued to confine detainees in close proximity, without adequate soap, disinfectant, sanitizer, toilet paper, and other daily anti-viral necessities. Declaration of Ira Alkalay ("Alkalay Dec."), ¶ 8; *see also* Declaration of Julio Cesar Medeiros Neves ("Medeiros Neves Dec.") ¶ 15; Declaration of Maria Alejandra Celimen Savino ("Celimen Savino Dec.") ¶ 8.

Defendants' response to the threats this lethal pandemic poses to immigrants has been unconstitutional, abysmal and haphazard. Following public outcry, on March 17, 2020, ICE issued a statement that it would modify its enforcement efforts in apparent recognition of the need for alternatives to detention to protect public health. The next day, however, in response to a lawsuit for the release of vulnerable ICE detainees in Washington state, the agency again demonstrated its failure to appreciate the threats the COVID-19 pandemic presents, stating that

"Plaintiffs' assertion that detention *per se* poses an increased risk of health complications or death from COVID-19 is purely speculative."[6]

On March 19, 2020, two medical subject matter experts for the Department of Homeland Security's Office of Civil Rights and Civil Liberties blew the whistle to Congress, writing "regarding the need to implement immediate social distancing to reduce the likelihood of exposure to detainees, facility personnel, and the general public, ***it is essential to consider releasing all detainees who do not pose an immediate risk to public safety.***"[7] On multiple occasions since at least February 25, 2020, these experts had sounded the alarm within the agency on the imminent risks to the health of immigrant detainees and the public at large presented by COVID-19 unless swift mitigation measures, including decreasing the number of immigrant detainees, are taken.

Defendant Hodgson, the Sheriff of Bristol County, issued a statement on March 19, 2020 noting that although 80% of the individuals detained at BCHOC are immunocompromised, and thus particularly vulnerable to exposure to COVID-19, he refused to take *any* measures to release anyone from custody.

Several recent court rulings have explained the health risks—to inmates, guards, and the outside community at large—created by large prison populations. *See, e.g.*, *Jimenez v. Wolf*, No. 18-10225-MLW (D. Mass. Mar. 26, 2020) (ordering release of immigrant detainee in the midst of the COVID-19 pandemic and noting that "being in a jail enhances risk" and that in jail "social distancing is difficult or impossible"); *United States v. Stephens*, No. 15-cr-95-AJN, 2020 WL 1295155, at *2 (S.D.N.Y. Mar. 19, 2020) (ordering the release of inmate in Federal Bureau of

[6] Respondents—Defendants' Opposition at 8, Dawson v. Asher, ECF No. 28, Case No. 20-0409 (W.D. Wash. Mar. 18, 2020).
[7] Letter from Scott A. Allen, MD and Josiah Rich, MD, MPH to Congressional Committee Chairpersons, dated Mar. 19, 2020, available at https://assets.documentcloud.org/documents/6816336/032020-Letter-From-Drs-Allen-Rich-to-Congress-Re.pdf (emphasis in original).

Prisons custody due, in part, to risk posed by COVID-19 in the facility); *In the Matter of the Extradition of Alejandro Toledo Manrique*, Case No. 19-mj-71055, 2020 WL 1307109, at *1 (N. D. Cal. March 19, 2020) (ordering change to conditions of bail for an individual to postpone incarceration, in part in light of risk of vulnerability to the coronavirus) *United States v. Barkman*, No. 3:19-cr-0052-RCJ-WGC, 2020 U.S. Dist. LEXIS 45628 (D. Nev. Mar. 17, 2020). On March 22 the New Jersey Supreme Court issued a consent order for the presumptive release of approximately 1,000 persons by March 26.

II. PROPOSED CLASS DEFINITION

All civil immigration detainees who are now or will be held by Respondents-Defendants at the Bristol County House of Corrections (BCHOC) and the C. Carlos Carreiro Immigration Detention Center ("Carreiro") in North Dartmouth, Massachusetts.

III. PROPOSED CLASS REPRESENTATIVES

The proposed class representatives are Maria Alejandra Celimen Savino and Julio Cesar Medeiros Neves, both of whom are currently detained at Bristol County Immigration Detention Facilities. Savino Decl. ¶ 1-3; Neves Decl. ¶ 1-2.

Mr. Neves is currently detained at BCHOC in Unit B. Neves Dec. ¶ 2. He is being held in the same cell as forty-nine other people, whose beds are close to one another and as a result cannot engage in "social distancing." *Id.* ¶¶ 4-6. Bristol County House of Corrections has not given him any guidance or materials to help protect himself from COVID-19 such as hand sanitizer or disinfectant. *Id.* ¶¶ 7, 15. He has observed guards at BCHC with coronavirus-like symptoms, and saw one detainee who arrived to BCHC after COVID-19 pandemic was underway who was very sick and had to be taken out of the unit. *Id.* ¶¶ 12, 14. Mr. Neves Junio suffers from depression and anxiety, which has been exacerbated by his fear of being infected by COVID-19 in this life-threatening environment. *Id.* ¶¶ 2, 9, 12.

Maria Alejandra Celimen Savino is currently detained in Bristol County Immigration Detention Facilities, in a unit called C. Carlos Carreiro Immigration Detention Center, Alley EB. Savino Decl., ¶¶ 1-3. Her unit has eight cells of ICE detainees with 2 detainees typically in each cell. *Id.* ¶ 4. There are non-immigration inmates directly above her unit, with whom she shared common areas such as the bathroom and a common room where they eat, sitting side-by-side. *Id.* ¶¶ 7, 9. For this reason, she has not been able to engage in social distancing. *Id.* ¶ 11. She has not had toilet paper for one week, as the facility ran out of it and has not restocked. *Id.* ¶ 8. The unit is only cleaned by detainees, with no professional cleaning staff or supplies, and detainees are forced to clean surfaces and objects using only hot water. *Id.* ¶ 10. She has continued to see a constant stream of new detainees and people coming into the unit from the outside and is has no knowledge that any of them have been tested for COVID-19 before entering. *Id.* ¶ 12. She suffers from asthma since she was a child and her health will be very compromised if she is infected with COVID-19. *Id.* ¶ 13. She worries that she will get sick and die in detention. *Id.* ¶ 15. Moreover, she and her fellow detainees have not been given tools to follow proper hygiene and sanitation and have not been given any materials to help protect themselves during this epidemic. *Id.* ¶ 17.

ARGUMENT

Petitioners seek certification of the class described above under Federal Rule of Civil Procedure 23. "By its terms, [Rule 23] creates a categorical rule entitling a plaintiff whose suit meets the specified criteria to pursue his claim as a class action." *Shady Grove Orthopedic Assocs., P.A. v. Allstate Ins. Co.*, 559 U.S. 393, 398 (2010). Class certification is thus appropriate where the proposed class satisfies the four requirements of Rule 23(a) – numerosity, commonality, typicality, and adequacy of representation – and at least one of the categories of Rule 23(b). These criteria are met here, where the numerous civil immigration detainees who

form the proposed class are all being held by one institution and uniformly placed at risk of contracting the COVID-19 virus due to their conditions of confinement.

Civil rights actions such as the instant one are particularly amenable to class treatment. Rule 23 was enacted to "facilitate the bringing of class actions in the civil-rights area." 7A Wright & Miller, Federal Practice & Procedure §1775 (3d ed. 2018). The arguments in favor of class certification are especially strong in this context, where individual class members are unlikely to be able to pursue their claims individually. Even under typical circumstances, civil immigration detainees are hard-pressed to bring their own claims, since they are all detained, largely lack counsel, and many do not speak English. *See Reid v. Donelan*, 297 F.R.D. 185, 189 (D.Mass. 2014), *reversed on other grounds*, 819 F.3d 486 (1st Cir. 2016) (certifying class of immigration detainees because, among other things, "many do not speak English, a majority do not have counsel, and most are unlikely even to know that they are members of the proposed class"); *Gordon v. Johnson*, 300 F.R.D. 28, 29 (D.Mass. 2014). These difficulties are compounded even further in the current moment, when Massachusetts (like much of the rest of the world) is essentially on lock-down. Class certification is particularly appropriate here, and all the requisite elements of Rule 23 have been met.

I. The Proposed Class Meets the Requirements of Rule 23(a).

A. The proposed class is so numerous that joinder would be impractical.

The proposed class satisfies the requirement that the class be "so numerous that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). The First Circuit has recognized that this is only a "low threshold," *Garcia-Rubiera v. Calderon*, 570 F.3d 443, 460 (1st Cir. 2009). "[A] class size of forty or more will generally suffice in the First Circuit." *Reid*, 297 F.R.D. at 189.

Here, there are currently more than 57 civil immigration detainees who are housed at Bristol County Immigration Detention Facilities. Many of these detainees are unrepresented, *see*

Reid, 297 F.R.D. at 189, and lack the financial resources to bring individual claims. *Torrezani v. VIP Auto Detailing, Inc.*, 318 F.R.D. 548, 554 (D. Mass. 2017) (class certification is favored where the Court "can reasonably infer that substantially all of the class members have limited financial resources….").

Moreover, new detainees continue to be admitted to Bristol County Immigration Detention Facilities, rendering the current number of detainees "merely the floor for this numerosity inquiry…." *Reid*, 297 F.R.D. at 189. The fact that future detainees form a part of the proposed class makes joinder, already an infeasible option, that much more impracticable. *Reid*, 297 F.R.D. at 189.

B. The proposed class representatives present issues of fact and law in common with the class.

Rule 23(a)(2) requires that "questions of law or fact" be "common to the class." Fed. R. Civ. P. 23(a)(2). Commonality requires the identification of an issue that by its nature "is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Dukes v. Wal-Mart Stores, Inc*., 564 U.S. 338, 350 (2011). A single common issue is sufficient to establish commonality. *Id*. at 359 ("We quite agree that for purposes of Rule 23(a)(2) even a single common question will do….") (internal quotation marks, brackets, and citations omitted). For this reason, the First Circuit has recognized that, like numerosity, the commonality requirement is "a low bar…." *In re New Motor Vehicles Canadian Exp. Antitrust Litig.*, 522 F.3d 6, 19 (1st Cir. 2008).

This case satisfies the requirement of at least "a single common question" that is shared by all members of the proposed class. Among others: Whether the conditions of confinement at Bristol County Immigration Detention Facilities, under the current conditions and in light of the

COVID-19 pandemic, render class members' confinement a punishment that violates constitutional standards. All of the class members either have been, or will be, subjected to these common conditions, and a determination that Defendants' conduct is unconstitutional will therefore "resolve an issue that is central to the validity" of each and every class member's detention. *Dukes*, 564 U.S. at 350 (2011).

The fact that certain details relating to their conditions of confinement will vary between class members does not defeat commonality. *Reid*, 297 F.R.D. at 191 (class certification granted despite individual differences among class members, where common issues pervade). And in fact conditions experienced in the Bristol County Immigration Detention Facilities by the proposed class representatives are shared with other members of the proposed class. Since the COVID-19 epidemic began, Defendants have continued to confine detainees in close proximity, without adequate soap, toilet paper, and other daily necessities. Declaration of Ira Alkalay ("Alkalay Decl."), ¶ 8; see also Declaration of Julio Cesar Medeiros Neves ("Medeiros Neves Decl.") ¶ 15; Declaration of Maria Alejandra Celimen Savino ("Celimen Savino Decl.") ¶ 8.

Defendants eat off plastic trays which have passed through the hands of three or four individuals before they eat off of them. Alkalay Dec. ¶ 5. Defendants continue to deny access to testing and medical care for Plaintiffs and other detainees: it takes days or weeks for them to get an appointment, and even longer to receive medication. Declaration of Cesar Francisco Vargas Vasquez ("Vargas Vasquez Decl.") ¶¶ 11

Indeed, "social distancing" is impossible for all of the class members, just as it is for the proposed class representative. Gonsalves Dec. ¶ 17, Keller Decl. ¶ 8. Beds are in close proximity to each other and meals are eaten in close quarters. Keller Decl. ¶ 17; Alkalay Decl. ¶ 4. Basic hygiene protections are unavailable. Alkalay Decl. ¶ 8. While the rest of the country

scours grocery store shelves for Purell, class members lack even the basics of adequate soap and toilet paper. And Defendants are introducing daily new detainees into these conditions without any mandatory quarantine period. See, e.g., Alkalay Decl. ¶ 9.

As courts have repeatedly recognized, even under the more stringent standards applicable to class actions that seek damages under Rule 23(b)(3), class action treatment is appropriate despite the existence of individual differences. *Tyson Foods, Inc. v. Bouaphakeo*, --- U.S. ---, 136 S.Ct. 1036, 1045 (2016) ("When one or more of the central issues in the action are common to the class and can be said to predominate, the action may be considered proper under Rule 23(b)(3) even though other important matters will have to be tried separately, such as damages or some affirmative defenses peculiar to some individual class members.") (internal quotation marks and citations omitted). Where as here, the commonalities are readily apparent, Rule 23 is amply satisfied.

C. The class representatives' claims are typical of those of the class.

Where commonality looks to the relationship among class members generally, typicality under Rule 23(a)(3) focuses on the relationship between the proposed class representative and the rest of the class. *See George v. Nat'l Water Main Cleaning Co.*, 286 F.R.D. 168, 176 (D.Mass. 2012) (citing 1 William B. Rubenstein, *Newberg on Class Actions* § 3:26 (5th ed. 2012)). In practice, however, the analysis of typicality and commonality "tend to merge." *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 157 n.13 (1982). To satisfy Rule 23(a)(3), "a class representative must be part of the class and possess the same interest and suffer the same injury as the class members." *Id.* at 156.

Typicality is "'not highly demanding' because 'the claims only need to share the same essential characteristics, and need not be identical.'" *Payne v. Goodyear Tire & Rubber Co.*, 216 F.R.D. 21, 24-25 (D.Mass. 2003), *quoting* 5 *Moore's General Practice* § 23.24[4]. "For purposes

of demonstrating typicality, '[a] sufficient nexus is established if the claims or defenses of the class and the class representative arise from the same event or pattern or practice and are based on the same legal theory.'" *In re Relafen Antitrust Litig.*, 231 F.R.D. 52, 69 (D.Mass. 2005), *quoting In re Terazosin Hydrochloride Antitrust Litig.*, 220 F.R.D. 672, 686 (S.D. Fla. 2004).

Here, the interests of the proposed class representatives and the proposed class members are aligned. *Cf. Faherty v. CVS Pharmacy, Inc.*, 2011 U.S.Dist.LEXIS 23547, at *6 (D.Mass., March 9, 2011) (noting that the alignment need not be perfect). The proposed class representatives are members of the class, have suffered the same injury as the proposed class members, and have been injured by Defendants' actions and inactions that have led to conditions of confinement that threaten the health and safety of all class members.[5/] In such circumstances, the representative's claims are "obviously typical of the claims … of the class," and satisfy Rule 23(a)(3). *See Baggett v. Ashe*, 2013 U.S.Dist.LEXIS 73202, at *2 (D. Mass. May 23, 2013); *see also Armstrong v. Davis*, 275 F.3d 849, 869 (9th Cir. 2001) (typicality requirement is satisfied when "the cause of the injury is the same—here, the Board's discriminatory policy and practice").

There is, moreover, no risk that issues involving the named Plaintiffs' individual claims will impede their litigation on behalf of the class. Because the named Plaintiffs are challenging the same practice and seeking the same relief without regard to the outcome of their own efforts to obtain release from unconstitutional conditions of confinement, they "can fairly and adequately pursue the interests of the absent class members without being sidetracked by [their] own particular concerns." *In re Credit Suisse-AOL Sec. Litig.*, 253 F.R.D. 17, 23 (D.Mass. 2008).

D. The proposed class representatives and class counsel can adequately represent the class.

5/ *See* Declarations cited *supra*.

Finally, the named plaintiffs and their counsel will "fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). Two factors must be satisfied to fulfill this prerequisite: "(1) the absence of potential conflict between the named plaintiff and the class members and (2) that counsel chosen by the representative parties is qualified, experienced and able to vigorously conduct the proposed litigation." *Adair v. Sorenson*, 134 F.R.D. 13, 18 (D. Mass. 1991), *quoting Andrews v. Bechtel Power Corp.*, 780 F.2d 124, 130 (1st Cir. 1985) (internal quotations omitted).

Here, "the interests of the representative party will not conflict with the interests of any of the class members," *Andrews v. Bechtel Power Corp.*, 780 F.3d 124, 130 (1st Cir. 1985), because – as already explained – those interests are aligned. The named Plaintiffs have alleged the same injuries, arising from the same conduct, and they seek the same injunctive and declaratory relief, which will apply equally to the benefit of all class members.

In addition, "counsel chosen by the representative party is qualified, experienced and able to vigorously conduct the proposed litigation." *Id.* The named Plaintiffs are represented by Lawyers for Civil Rights and Yale Law School's Worker and Immigrant Rights Advocacy Clinic. Collectively, counsel have significant experience in the areas of immigration law, constitutional law, class action litigation, and habeas corpus actions. *See* Declaration of Oren Sellstrom In Support of Class Certification; Declaration of Michael Wishnie In Support of Class Certification. For the same reasons, counsel also satisfy the requirements of Rule 23(g) and should be appointed as class counsel.

II. The Proposed Class Meets the Requirements of Rule 23(b)

"In addition to meeting the four requirements of Rule 23(a)," the Plaintiffs "must show that the proposed class falls into one of the three defined categories of Rule 23(b)." *Reid*, 297 F.R.D. at 192. Here, the most applicable category is described in Rule 23(b)(2), which applies

when "the party opposing the class has acted or refused to act on grounds generally applicable to the class, so that final injunctive relief or corresponding declaratory relief is appropriate with respect to the class as a whole."

The "prime examples" of Rule 23(b)(2) cases, *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 614 (1997), are civil rights cases like this one, where the claim asserts that the Defendants have "engaged in unlawful behavior towards a defined group…." *Reid*, 297 F.R.D. at 193. The rule applies, moreover, where "a single injunction or declaratory judgment would provide relief to each member of the class" (as opposed, for example, to cases in which each class member would need an individual injunction or declaration, or in which each class member would be entitled to an individualized award of money damages). *Dukes*, 564 U.S. at 360-61.

The claims asserted in the Petition and Complaint satisfy these requirements. Defendants have engaged in unconstitutional behavior towards the entire class. Every member of the class is at imminent risk of being infected by COVID-19, due to their conditions of confinement. And, because every member of the class is entitled to relief from these unconstitutional conditions, an appropriate injunction or declaration will provide relief on a class-wide basis. "The key to the (b)(2) class is the indivisible nature of the injunctive or declaratory remedy warranted – the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them. *Dukes*, 564 U.S. at 360.

CONCLUSION

Plaintiffs respectfully ask the Court to:

(1) Certify a class consisting of all civil immigration detainees who are now or will be held by Respondents-Defendants at Bristol County Immigration Detention Facilities;

(2) Appoint named Plaintiffs Maria Alejandra Celiman Savino and Julio Cesar Medeiros Neves as class representatives; and

(3) Appoint the undersigned counsel as class counsel.

Dated: March 27, 2020

Respectfully submitted,

MARIA ALEJANDRA CELIMEN SAVINO,
JULIO CESAR MEDEIROS NEVES
AND ALL THOSE SIMILARLY SITUATED

By their attorneys,

/s/ Oren Sellstrom
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† Motion for admission *pro hace vice* forthcoming.

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, JULIO CESAR MEDEIROS NEVES, and all those similarly situated,

Petitioners-Plaintiffs,

v.

THOMAS HODGSON, et al.,

Respondents-Defendants.

Case No. 1:20-cv-10617 WGY

DECLARATION OF OREN M. SELLSTROM IN SUPPORT OF MOTION FOR CLASS CERTIFICATION

I, Oren M. Sellstrom, declare under penalty of perjury that the foregoing is true and correct:

1. I am the Litigation Director at Lawyers for Civil Rights (LCR), a position I have held since 2015. Prior to that, I worked for 18 years at the Lawyers' Committee for Civil Rights of the San Francisco Bay Area, the last five of which I served as Legal Director. I have been a civil rights attorney and litigator for 27 years.
2. LCR is a non-profit legal organization whose mission is to fight discrimination and advance equality for people of color and immigrants. We do this work primarily through impact litigation, as well as individual representation. In my position as Litigation Director, I direct the organization's litigation and supervise a team of seven Staff Attorneys.
3. I have served as class counsel in numerous class actions, including *Boston Chapter, NAACP v. Beecher and Castro v. Beecher*, Nos. 72-3060, 73-269-PBS and No. 70-1220-W, 74-2982-C (D. Mass.) (employment class actions on behalf of Black and Latino police officers and firefighters); *Williams v. City of Antioch*,4:08-cv-02301 SBA (N.D.

Cal.) (class action on behalf of Black Section 8 tenants targeted by municipality); and *Kincaid v. City of Fresno*, 06-cv-1445 OWW (E.D. Cal. 2008) (class action on behalf of homeless individuals whose property was taken and destroyed by municipality).

4. I have also litigated numerous impact cases involving complex immigration issues, including *Centro Presente et. al. v. Trump et. al.*, No. 1:18-cv-10340-DJC (D. Mass) (challenge to termination of Temporary Protected Status for Haiti, El Salvador, and Honduras); *African Communities Together et al. v. Trump et. al.*, No. 4:19-cv-10432-TSH (challenge to termination of Deferred Enforced Departure for Liberians); and *Ryan et al v. Immigration and Customs Enforcement et al.*, No. 1-19-cv-11003-IT (D. Mass) (challenge to immigration enforcement in and around Massachusetts courthouses). I have litigated numerous other civil rights cases as well. *See, e.g.*, *Huot v. Lowell*, No. 1:17-cv-10895-DLC (D. Mass) (voting rights).
5. In addition to myself, other attorneys at LCR who are representing the Plaintiffs and the putative class in this matter include Oren Nimni and Iván Espinoza-Madrigal. Attorney Nimni has been a practicing civil rights attorney for the last 8 years. Attorney Espinoza-Madrigal is the Executive Director of LCR and has been a practicing civil rights attorney for 15 years. Both have particular expertise in immigration impact litigation.
6. Attorney Nimni is lead counsel for LCR on a number of the immigration cases listed above (*e.g.*, *Centro Presente v. Trump*, *African Communities Together v. Trump*; and *Ryan v. ICE*). Attorney Espinoza-Madrigal has litigated numerous class actions and impact cases, both at LCR and in his prior roles as Legal Director of The Center for HIV Law and Policy (where he focused on the intersection of public health and the law), and as Staff Attorney at Lambda Legal and at the Mexican-American Legal Defense and

Education Fund (MALDEF). Representative cases include *Friendly House v. Whiting* (challenge to Arizona's anti-immigrant law, SB 1070), and *Northwest Austin Municipal Utility District No. 1 v. Holder*, 557 U.S. 193 (2009) (voting rights).

I, Oren Sellstrom, declare under penalty of perjury, under 28 U.S.C. 1746, and the laws of the United States of America, that the foregoing Declaration is true and correct.

Dated: March 27, 2020

/s/ Oren M. Sellstrom
Oren M. Sellstrom

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren M. Sellstrom

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO, et al., Petitioners-Plaintiffs, v. THOMAS HODGSON, et al., Respondents-Defendants.	Case No. 1:20-cv-10617-WGY

DECLARATION OF MICHAEL J. WISHNIE IN SUPPORT OF PETITIONER-PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

I, Michael J. Wishnie, declare under penalty of perjury that the following is true and correct:

1. I am William O. Douglas Clinical Professor of Law and Counselor to the Dean at Yale Law School, where I teach and supervise clinical courses in the Jerome N. Frank Legal Services Organization ("LSO").

2. LSO is a law firm that includes eight clinics, in which Yale Law students enroll for credit to represent individuals and organizations without charge, under the supervision of clinical faculty. I co-direct the Worker and Immigrant Rights Advocacy Clinic ("WIRAC") in LSO, in which students represent clients in administrative, state, and federal courts in a range of immigration, employment, and other civil rights litigation. I also direct the Veterans Legal Services Clinic in LSO, in which students similarly represent veterans in administrative, state, and federal courts, including in complex litigation.

3. Attorneys and WIRAC law student interns have done considerable work identifying or investigating potential claims in this action.

4. My LSO students and I have been appointed class counsel in four pending, certified class actions in federal court. *See Reid v. Donelan*, 297 F.R.D. 185 (D. Mass. 2014) (appointing LSO and myself as counsel for certified class of long term immigration detainees in Massachusetts); *Reid v. Donelan*, 2018 WL 5269992 (D. Mass. Oct. 23, 2018) (denying defendants' motion to decertify class and expanding class to include immigration detainees in New Hampshire); *Kennedy v. Esper*, 2018 WL 6727353 (D.Conn. Dec. 21, 2018) (same, in order certifying nation-wide class of post-September 11 Army veterans with PTSD or traumatic brain injury and less-than-fully-Honorable discharges); *Manker v. Spencer*, 329 F.R.D. 110 (D.Conn. 2018) (same, in order certifying nation-wide class of post-September 11 Navy and Marine Corps veterans with PTSD or traumatic brain injury and less-than-fully-Honorable discharges); *Skaar v. Wilkie*, 32 Vet. App. 156 (2019) (*en banc*) (same, in order certifying first veterans' appeals class in history of court, a class of Air Force veterans exposed to radiation during 1966 nuclear clean-up in Palomares, Spain).

5. I have experience supervising law students in complex federal litigation not involving certified classes. *See, e.g., NAACP v. Merrill*, 939 F.3d 470 (2d Cir. 2019) (affirming in part district court denial of motion to dismiss first state-wide challenge to prison gerrymandering); *NAACP v. Bureau of the Census*, 945 F.3d 183 (4th Cir. 2019) (affirming in part and reversing in part district court dismissal of challenge to 2020 census operations and remanding constitutional claim); *Monk v. Shulkin*, 855 F.3d 1312, 1322 (Fed. Cir. 2017) (overturning nearly thirty years of precedent to hold that U.S. Court of Appeals for Veterans Claims "has the authority to establish a class action mechanism or other method of aggregating

claims."); *Batalla Vidal v. Nielsen*, 279 F.Supp.3d 401, 438 (E.D.N.Y. 2018) (enjoining termination of DACA program, concluding court possesses authority to enter nation-wide preliminary injunction, and denying motion for class certification as moot), *certiorari before judgement granted sub nom McAleenan v. Trump*, 139 S. Ct. 2773 (2019); *Darweesh v. Trump*, 2017 WL 388504 (E.D.N.Y. Jan. 28, 2017) (entering TRO on behalf of all persons detained at U.S. airports pursuant to Executive Order implementing first travel ban against refugees and nationals of Muslim-majority nations, after finding likelihood of success on pending motion for certification of nation-wide class); *Doe v. Hagenbeck*, 98 F.Supp.3d 672 (S.D.N.Y. 2015), *rev'd in part*, 870 F.3d 36 (2d Cir. 2017), *notice of appeal pending* (civil rights action by woman raped while a cadet at U.S. Military Academy at West Point).

6. My students and I have already devoted significant resources to maintaining this litigation, as evidenced by the staffing of this case with experienced attorneys supervising the work of multiple law student interns, and will continue to do so.

I, Michael J. Wishnie, declare under penalty of perjury, under 28 U.S.C. § 1746, and the laws of the United States of America, that the foregoing Declaration is true and correct

Dated: March 27, 2020
New Haven, Connecticut

/s/ Michael J. Wishnie
Michael J. Wishnie (BBO #568654)

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2020, the above-captioned document was filed through the ECF system and will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants.

/s/ Oren M. Sellstrom