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**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO**

MARCIANO PLATA, et al.,
Plaintiffs,
v.
GAVIN NEWSOM., et al.,
Defendants.

Case No. C01-1351 JST

**DECLARATION OF JAMES AUSTIN,
PH.D., IN SUPPORT OF PLAINTIFFS'
REPLY**

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DECLARATION OF JAMES AUSTIN, PH.D.

I, James Austin, declare as follows:

1. I am the Senior Policy Analyst for the JFA Institute, a nationally-recognized criminal justice and corrections research organization. I have the personal knowledge of the matters set forth herein, and if called as a witness, I could and would competently testify. I make this declaration in support of Plaintiffs’ reply brief on their emergency motion, and to supplement the Declaration I submitted to the Three-Judge Panel on April 1, 2020. ECF 3250.

2. As noted in my previous declaration, I have implemented inmate classification and risk assessment systems for juvenile adult custody in more than thirty local and state correctional systems. I have implemented parole guidelines and related risk assessment systems in a number of states and local jurisdictions, including most recently in Maryland, Texas, Arkansas, Kentucky, Illinois, South Carolina, Charleston, S.C., and New Orleans, LA. I have assisted a number of states and local jail systems in identifying policies and procedures that have resulted in a safe reduction in their prison and jail systems.

3. In 2006, I was appointed to the Expert Panel on Adult Offender and Recidivism Reduction Programming for the California Department of Corrections and Rehabilitation (CDCR). I correctly argued that the CDCR prison population could be safely reduced from 170,000 incarcerated people in 2007, to 120,000, without increasing crime rates.

4. I was the primary author for the National Institute of Corrections (NIC) manuscript on Objective Prison and Jail Classification Systems, which provides details on the same types of classification systems employed by CDCR.

5. I submit this declaration in support of Plaintiffs’ Reply, and to respond to assertions by Defendants regarding whether segments of the current CDCR population can be safely reduced for the purpose of lowering the risk of infection from the COVID-19 virus for

1 incarcerated people and staff.

2 6. I reviewed a spreadsheet that Defendants provided to Plaintiffs' counsel on April
3 8, 2020. This spreadsheet listed all people incarcerated in CDCR custody (1) who have medical
4 classifications as High Risk 1, High Risk 2, or Pregnant, (2) those who are currently assigned to
5 the Mental Health Delivery System and or (3) who have been admitted to the Mental Health
6 Delivery System in the past year. For each person Plaintiffs' counsel requested the following
7 information:

- 8 • Name
- 9 • CDCR Number
- 10 • Location (Prison, Building, and whether in a Dorm or Cell)
- 11 • Gender
- 12 • Age
- 13 • Race and Ethnicity
- 14 • Classification Score
- 15 • California Static Risk Assessment (CSRA) score
- 16 • COMPAS score
- 17 • Disability Placement Program (DPP) Codes, if any
- 18 • Developmental Disability Program (DDP) Codes, if any
- 19 • Current Mental Health Designation
- 20 • Admitted/been in MHDS in past year
- 21 • Medical Risk Level (High Risk 1, High Risk 2, or Pregnant)
- 22 • Underlying Health Conditions that lead to High Risk 1 or High Risk 2 score
- 23 • Security Level
- 24 • Commitment offense category
- 25 • Offense group
- 26 • Sex registrant
- Date of commitment to CDCR
- Sentence Length
- Projected release date
- Most Early Parole Date (MEPD) for people with sentences of life with the possibility of parole
- Controlling county

22 7. It's important to understand that the CSRA (California Static Risk Assessment)
23 was developed by the University of California-Irvine, Center for Evidenced-Based Corrections to

1 allow the CDCR to obtain a risk assessment for all newly admitted prisoners.¹ As such, it uses
2 20 items, of which 18 items reflect the current offense and prior record. The other two factors
3 are gender and current age. The term “static” is relevant as the only variable that changes over
4 time is the inmate’s age. Thus this instrument does not take into account the prisoner’s
5 participation in risk reduction programs and good conduct – all of which serve to reduce
6 recidivism rates. For these reasons the estimates of the prisoners who are “low” and “moderate”
7 risk are conservative estimates.

8 8. The COMPAS risk assessment instrument is used to assess a person’s need for
9 support services upon release from CDCR custody. The spreadsheet includes the prisoners’
10 COMPAS factors. These include: Substance Abuse, Criminal Thinking, Social Isolation,
11 Criminal Personality, Anger, Educational Problems, Employment Problems, Criminal Peers,
12 Criminal Opportunity, Leisure and Recreation, Financial, and Residential Instability.

13 9. For those prisoners with a determinate sentence, COMPAS is administered
14 toward the end of prisoner’s prison term (180 – 210 days prior to release). It’s important to note
15 that such a needs assessment is most relevant to prisoners scoring at the high or moderate risk
16 levels to determine which criminogenic risk factors need to be addressed prior to release or after
17 release to parole supervision. Prisoners scoring low risk do not need to have such an assessment
18 made given the fact they are already low risk to recidivate.

19 10. This spreadsheet listed 50,572 people. At my direction, Corene Kendrick, an
20 attorney at the Prison Law Office, extracted certain subpopulations of prisoners to create
21 worksheets for me to analyze. I also conducted my own statistical analysis to verify Ms.
22 Kendrick’s analysis. I describe each subgroup of population, and my opinion regarding their risk

24 ¹ [https://ucicorrections.seweb.uci.edu/files/2013/12/Development-of-the-CSRA-
25 Recidivism-Risk-Prediction-in-the-CDCR.pdf](https://ucicorrections.seweb.uci.edu/files/2013/12/Development-of-the-CSRA-Recidivism-Risk-Prediction-in-the-CDCR.pdf)

1 to recidivate in the following paragraphs. In addition, CDCR publishes recidivism statistics
 2 periodically; the last published set of data is for persons released in Fiscal Year 2014-15.² The
 3 data follows these people for the three years after their release, in other words, through FY 2017-
 4 18. I will reference CDCR's data throughout my declaration.

5 Pregnant Prisoners

6 11. As noted by medical experts, pregnant women are considered a population
 7 vulnerable to COVID-19. *See* ECF 3219-4 ¶ 6; ECF 3266-1 ¶ 4. Of the 50,572 people in the
 8 CDCR data file, there were 33 pregnant women currently in custody. Eighteen (18) of them
 9 have release dates between now and December 11, 2020, and eleven of those 18 have Low or
 10 Moderate CSRA scores. In my opinion, these women could be safely released from prison now.
 11 CDCR's data show that the three year conviction rate of released women of all ages is 34%,
 12 which is 13 points lower than for released men.³

13 Prisoners With Determinate Sentences and Planned Release Dates Before October 31, 2020

14 12. Next, Ms. Kendrick extracted from the CDCR spreadsheet all persons with
 15 determinate sentences who had a projected Earliest Possible Release Date (EPRD) between April
 16 10, 2020, and October 31, 2020 or six months from April 8, 2020. I then requested Ms.
 17 Kendrick to only include prisoners who had a CSRA score of Low or Moderate risk. At my
 18 direction, she excluded all persons with release dates before October 31, 2020 who did not have
 19 a CSRA score listed, or scores of High Violence, High Drug, or High Property risk.⁴

21 ² *See* Recidivism Report for Offenders Released From the California Department of
 22 Corrections and Rehabilitation in Fiscal Year 2014-2015 (Recidivism Report), available at,
[https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/01/Recidivism-Report-for-
 Offenders-Released-in-Fiscal-Year-2014-15.pdf](https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/01/Recidivism-Report-for-Offenders-Released-in-Fiscal-Year-2014-15.pdf).

23 ³ Recidivism Report, viii.

24 ⁴ While I purposely limited my analysis of this group to people with low or moderate
 CSRA scores with release dates in the next six months, CDCR's own data show that for *all* of
 California's released prisoners, only 7% are subsequently convicted of a violent crime after
 release. Recidivism Report, Page 10.

1 13. Based on the above criteria there are **3,182 people scheduled for release in the**
 2 **next six months who CDCR has assessed as a low or moderate risk to recidivate, who have**
 3 **a Medical Level 1 or 2 Condition, are currently assigned to one of the CDCR Mental**
 4 **Health Program Services and/or had previously been assigned to such a program in the**
 5 **past year.**

6 14. Of this group, 1,802 (or 57%) have a CSRA score of Low Risk, and 1,379 (or
 7 43%) have a CSRA score of Moderate Risk. The gender breakdown is 437 women (14%) and
 8 2,745 men (86%).

9 15. Their age ranges are as follows. As detailed in Table 1, many of the people over
 10 age 50 with release dates in the next six months are currently housed in dormitories. The high
 11 proportion housed in dorms speaks to 1) their low security levels which reflects good prison
 12 conduct and 2) their risk of COVID19 infection due to an inability to maintain social distancing:

13 **Table 1. Age and Location of Determinate Sentenced Prisoners Within 6 Months of**
 14 **Release, With Current or Past Medical and Mental Health Care**

Current Age	# of Prisoners	# In Dorms	% in Dorms
80-89	13	10	77%
70-79	85	58	68%
65-69	110	84	76%
60-64	189	131	69%
50-59	643	420	65%
40-49	735	454	62%
30-39	962	511	53%
19-29	444	223	50%
Totals	3,181	1,891	59%

15 16. In terms of medical and mental health care, the vast majority of these people
 16 either are in Medical Care Level 1 or 2 (856 people), are currently receiving mental health care
 17 services (2,227 people) and/or were previously assigned to some form of mental health care in
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1 the past 12 months (2,782 people).

2 17. To date these people have served an average of 39 months to date not including
 3 an estimated 3-6 months in local jails prior to being transferred to the CDCR (the median time
 4 served to date in CDCR is 15 months). Their average sentence length is 70 months with a median
 5 sentence of 48 months. Thus the average projected reduction of 3 months (ranges from a few
 6 days to 6 months) which is a small percent of the time these people have been incarcerated in
 7 either the jail and/or state prison for their current offense(s).

8 18. It is a well-established fact that reducing the expected length of stay (or LOS) by
 9 this amount of time (an average of 3 months) will have no impact on the recidivism rates of these
 10 people or the state's already low crime rate which has continued to decline as state prison, jail,
 11 probation and parole populations have declined since 2007.⁵

12 **Table 2. Key Medical and Mental Health Flags of Determinate Sentenced Prisoners Within
 13 Six Months of Release, With Current or Past Medical and Mental Health Care**

Attribute	Prisoners
Total CDCR Population	120,135
Determinate Sentenced Prisoners, within 6 months of release, Not High Risk, Who Meet Medical and Mental Health Criteria	3,181
Medical 1	278
Medical 2	578
Total Currently in MH	2,227
Acute	22
CCCMS	1,844
EOP	332
EOP Mod	23
ICF	66
MHCB	10
In MH Past Year	2,782

22 ⁵ Rhodes, William, Gerald G. Gaes, Ryan Kling, and Christopher Cutler. August 2018.
 23 Relationship between Prison Length of Stay and Recidivism: A Study Using Regression
 24 Discontinuity and Instrumental Variables With Multiple Break Points, *Criminology and Public
 25 Policy*. 17(3):731-770. Bartos, Bradley J. and Charis Kubrin. August 2018. Can We Downsize
 26 Our Prisons and jails Without Compromising Public Safety?: Findings from California Prop 47.
Criminology and Public Policy. 17(3):693-716.

1 19. Further, because a high proportion of these people are rated as “low” risk to
2 recidivate there is no need to require any special services. It is also a well-accepted fact that
3 providing unneeded services and levels of supervision to low risk prisoners only serves to
4 *increase* rather than *decrease* recidivism rates.⁶ Thus for many of this group there is no need for
5 the CDCR or local probation departments to provide any specialized assistance other than
6 verification of a residence.

7 20. The COMPAS scores also show that a large number of this group (879 prisoners)
8 are classified as low risk to recidivate, and have “low residential instability.” This means that
9 they should not have any significant issues maintaining a stable residence once released. There
10 were 641 additional people who had “low residential instability” and are classified as moderate
11 risk to recidivate. Finally, there are another 468 people in this cohort of 3,182 people for whom
12 there is no COMPAS assessment. This is problematic, as my understanding is that the COMPAS
13 test is administered between 180 and 210 days prior to release. CDCR should immediately
14 perform the COMPAS analysis on the low/moderate risk to recidivate people for whom there is
15 no information regarding their residential stability. CDCR should prioritize for expedited release
16 the 1,520 low/moderate risk to recidivate people with low residential instability.

17 21. The number of these people who would be released under current CDCR practices
18 and policies are as follows:

- 19 • From April 11-30, 2020: **309**
- 20 • May 2020: **382**
- 21 • June 2020: **515**
- 22 • July 2020: **491**
- 23 • August 2020: **480**
- 24 • September 2020: **502**
- 25 • October 2020: **499**

24 ⁶ Andrews, D. A., James Bonta, *The Psychology of Criminal Conduct, Fifth Edition*
25 Elsevier (2010), p. 48.

22. CDCR's own data show that persons who are over 60 years old present dramatically lower risks of a new conviction within three years after release, compared to other age groups.⁷ This is consistent with the general consensus in the field of correctional risk assessment that people age out of criminal behavior. A person who engaged in criminal behavior in his twenties is very unlikely to return to such behavior after age 45.

23. The CDCR argues that many of these candidates have been convicted of crimes against people and on that basis alone should not be granted a modest early release date. It is acknowledged that most of these people have been convicted of violent crimes but it is also true that they have served substantially longer prison terms for such convictions (Table 3).

Table 3. Sentence Length, Time Served and Time Left to Serve of Determinate Sentenced Prisoners Within 6 months of Release, With Current or Past Medical and Mental Health Care

Primary Offense	Prisoner	Average Sentence (months)	Average Time Served (days)	Average Time Left
Person Crimes	2,009	81 mos.	1,484 days	101 days
Drug	207	54	655	113
Property	443	54	731	110
Other	517	45	527	111
Total	3,181	70	1,170	105

24. Further, California prisoners convicted of violent crimes who have longer lengths of stay have significantly lower rates of recidivism than other prisoners largely because they are older, which lowers their risk of recidivism.⁸

25. The CDCR's own publication on recidivism shows an inverse relationship

⁷ Recidivism report at viii, Persons over 60 have a three-year conviction rate of 20.5% compared to 59% for persons ages 20 to 24.

⁸ Recidivism Report, Table 20, p. 44.

1 between the severity of the sentencing offense and recidivism rates.⁹ Specifically, prisoners with
2 a conviction for violent crimes have reconviction rates that are about half the rates of the
3 prisoners convicted of non-violent crimes.¹⁰ For these reasons excluding prisoners convicted of
4 violent crimes would only serve to worsen public safety rather than enhance it.

5 26. Of the 3,182 people, I also sorted by their controlling county, which normally is
6 the county to which they will return upon release. As shown below, with the exception of six
7 counties the number of accelerated releases is 100 or less.

- 8 • Alameda – 56
- 9 • Amador – 6
- 10 • Butte – 34
- 11 • Calaveras – 4
- 12 • Colusa – 3
- 13 • Contra Costa – 42
- 14 • Del Norte – 6
- 15 • El Dorado – 19
- 16 • Fresno – 128
- 17 • Glenn – 2
- 18 • Humboldt – 8
- 19 • Imperial – 11
- 20 • Inyo – 1
- 21 • Kern – 109
- 22 • Kings – 31
- 23 • Lake – 17
- 24 • Lassen – 2
- 25 • Los Angeles – 974
- 26 • Madera -19
- Marin – 10
- Mendocino – 8
- Merced – 35
- Modoc – 2
- Mono – 1
- Monterey – 35
- Napa – 13
- Nevada – 6
- Orange – 117
- Placer – 23

⁹ Recidivism Report. Figure 12, p. 23

¹⁰ Recidivism Report. Figure 12, p. 23.

- 1 • Plumas – 5
- 2 • Riverside – 249
- 3 • Sacramento – 168
- 4 • San Benito – 7
- 5 • San Bernardino -217
- 6 • San Diego – 297
- 7 • San Francisco – 21
- 8 • San Joaquin – 48
- 9 • San Luis Obispo – 29
- 10 • San Mateo – 31
- 11 • Santa Barbara – 34
- 12 • Santa Clara – 65
- 13 • Santa Cruz – 13
- 14 • Shasta – 22
- 15 • Sierra – 1
- 16 • Siskiyou – 9
- 17 • Solano – 20
- 18 • Sonoma – 21
- 19 • Stanislaus – 47
- 20 • Sutter – 13
- 21 • Tehama – 24
- 22 • Tulare – 40
- 23 • Tuolumne – 8
- 24 • Unknown – 1
- 25 • Ventura – 44
- 26 • Yolo – 10
- 27 • Yuba – 15

27. As Thomas Hoffman noted in his supplemental declaration submitted to the Three Judge Panel, CDCR can and should shift the workloads of Division of Adult Parole Operations (DAPO) employees, discharge some of the existing parole population, in order to focus upon the newly released people. ECF 3252 at ¶¶ 16-19, 21-22. Many of the people in this group will be discharged to county supervision, not DAPO supervision.¹¹ Mr. Hoffman also described how county probation departments, which supervise many of the people released from CDCR to

¹¹ See Recidivism Report at 45 (“Post Release Community Supervision [PRCS] is a form of supervision provided to an offender who has been released from a CDCR institution to the jurisdiction of a county agent, pursuant to the Post Release Community Supervision Act of 2011. Prior to Public Safety Realignment, almost all offenders released from CDCR were placed on state parole supervision after their release. After Public Safety Realignment, most non-serious, non-violent, and non-sex registrant offenders are release[d] to PRCS.”)

1 county supervision, can shift their caseloads to accommodate an increase in newly-released
2 people. *Id.* at ¶ 20. I agree with Mr. Hoffman’s opinions about how DAPO and the counties can
3 accommodate these persons.

4 28. Further, it should be noted that the state probation and parole populations have
5 declined significantly with the passage of Props 47 and 57. Specifically the adult parole
6 population has declined from 95,000 in 2010 to about 51,000 as of April 2020. The county
7 felony probation population has also declined from 255,000 in 2010 to 167,000 in 2019.¹²

8 **Parole-Eligible Lifers**

9 29. Next, I asked Ms. Kendrick to extract from CDCR’s spreadsheet a list of all
10 people with sentences of life with the possibility of parole, with parole dates in the past, thus
11 indicating that they are parole-eligible. The recidivism rate for these “lifers,” is extremely low,
12 regardless of age. Of the 688 lifers released in 2014-15, only 16 of them (2.3%) were convicted
13 of a new crime in the subsequent three years, the majority of which were misdemeanors.¹³

14 30. There were 3,981 parole-eligible lifers in CDCR’s spreadsheet. I then excluded
15 people with CSRA scores of High Violent (8 people), High Property (9 people), High Drug (2
16 people), or a blank entry for the CSRA score (25 people), to come up with **3,936 parole-eligible**
17 **lifers that CDCR has concluded have a low or moderate risk of recidivism, and have**
18 **medical or mental conditions (current or past 12 months).**

19 31. As compared to the determinate sentenced population discussed earlier, this
20 population is considerably older, lower risk to recidivate, have much higher medical care and
21 mental health needs. Of these 3,936 people, 3,846 of them have Low Risk CSRA scores and 90
22 have Moderate Risk CSRA scores. There are 173 women (4.3%) and 3,736 men (95.7%) in the

23
24 ¹² [https://openjustice.doj.ca.gov/exploration/crime-statistics/adult-probation-caseload-](https://openjustice.doj.ca.gov/exploration/crime-statistics/adult-probation-caseload-actions)
[actions](https://openjustice.doj.ca.gov/exploration/crime-statistics/adult-probation-caseload-actions)

25 ¹³ Recidivism Report at viii, 19-20.

1 Low/Moderate subgroup.

2 32. The amount of time that this group has served to date is much longer than the
3 determinate sentenced population (an average of 10,407 days or 29 years). On average they have
4 served 5,032 days (13.7 years) passed their legal parole eligibility date.

5 33. The age range of this subgroup of parole-eligible lifers is from 23 to 92 years old,
6 and average age is 59 which is also much longer than the determinate sentenced population
7 (average age of 43 years).

8 34. A large percentage of these inmates are currently assigned to dorms which again
9 reflects 1) their low security levels which reflects good prison conduct and 2) their risk of
10 COVID19 infection due to an inability to maintain social distancing. (Table 4.)

11 **Table 4. Age and Location of Parole Eligible Prisoners
12 With Current or Past Medical and Mental Health Care**

Current Age	Prisoners	In Dorms	% in Dorms
80 plus	70	36	51%
70-79	550	307	56%
65-69	686	314	46%
60-64	653	247	38%
50-59	684	242	35%
40-49	644	185	29%
30-39	113	39	35%
Under 30	4	2	50%
Totals	3,404	1372	40%

19 35. As noted above, the older population is at a significant lower risk of recidivism.

20 36. Given their sentence of life with the possibility of parole, it is not surprising that
21 most of these people were convicted of Murder 1st Degree (1,276 prisoners) and Murder 2nd
22 (1,565 prisoners). But a sizeable number are instead sentenced for property, drug, and other
23 crimes (155 prisoners). Further, the courts also sentenced them so they could be considered for
24 parole and as noted above most if these people are many years past their parole eligibility date.

1 And as, noted above there is an inverse relationship between the severity of the commitment
 2 offense and the probability of recidivism.

3 37. In terms of their current and past medical and mental health status within the
 4 CDCR, the vast majority of this population has such a history. See Table 5:

5 **Table 5. Key Medical and Mental Health Flags of Parole Eligible Inmates**

Attribute	Prisoners
Total CDCR Population	120,135
Parole Eligible Prisoners, Not High Risk, Who Meet Medical and Mental Health Criteria	3,936
Medical 1	1,344
Medical 2	1,282
Total Currently in MH	2,130
Acute	18
CCCMS	1,469
EOP	492
EOP Mod	73
ICF	76
MHCB	2
In MH Past Year	2,341

14 38. Similar to the group of low/moderate risk people with release dates in the next six
 15 months, I analyzed the low/moderate risk parole-eligible people by county of commitment. As
 16 these persons have life sentences, they will have to be supervised by DAPO. But as I noted
 17 above, I agree with Mr. Hoffman’s assessment of how DAPO could shift resources and caseloads
 18 to accommodate additionally released people.

- 19 • Alameda – 172
- 20 • Amador – 2
- Butte – 21
- Calaveras – 1
- 21 • Colusa – 1
- Contra Costa – 69
- 22 • Del Norte – 2
- El Dorado – 19
- 23 • Fresno – 126
- Glenn – 7
- 24 • Humboldt – 20

- 1 • Imperial – 19
- Inyo – 3
- 2 • Kern – 94
- Kings – 19
- 3 • Lake – 7
- Lassen – 2
- 4 • Los Angeles – 1,403
- Madera – 12
- 5 • Marin – 19
- Mariposa – 5
- 6 • Mendocino – 12
- Merced – 17
- 7 • Mono – 1
- Monterey – 47
- 8 • Napa – 8
- Nevada – 8
- 9 • Orange – 187
- 10 • “Other County” – 6
- Placer – 22
- 11 • Plumas – 2
- Riverside – 165
- 12 • Sacramento – 170
- San Bernardino – 188
- 13 • San Diego – 304
- San Francisco – 107
- 14 • San Joaquin – 84
- San Luis Obispo – 24
- 15 • San Mateo – 58
- Santa Barbara – 34
- 16 • Santa Clara – 166
- Santa Cruz – 17
- 17 • Shasta – 28
- Siskiyou – 8
- 18 • Solano – 34
- Sonoma – 27
- 19 • Stanislaus – 46
- Sutter – 13
- 20 • Tehama – 10
- Trinity – 1
- 21 • Tulare – 38
- Tuolumne – 4
- 22 • Unknown – 1
- Ventura – 49
- 23 • Yolo – 16
- 24 • Yuba – 9

1 39. Like the determinate sentenced prisoners, a large percentage of this group (1,965
2 prisoners) are classified as low risk to recidivate and have “low residential instability”. This means
3 that they should not have any significant issues maintaining a stable residence once released.

4 40. In summary, there is a considerable number of people in the current CDCR prison
5 system who have served substantial periods of time in prison, with significant medical and mental
6 health conditions who could be safely and immediately released to the community. Many of these
7 prisoners pose a significantly lower risk to public safety than many prisoners now being released
8 under current CDCR practices and state law. Moderately reducing their projected lengths of stay
9 would not change their risk or recidivism or negatively impact California’s low crime rate. When
10 distributed across the various counties over a reasonable but short time frame, the numbers of
11 additional cases will not negatively impact the DAPO or County Probation Departments’
12 populations, which have declined significantly since the implementation of Props 47 and 57, or
13 their capacity to manage these accelerated releases. Rather, there would be a slight surge in the
14 total number of CDCR releases (currently about 35,000 per year), but thereafter the number of
15 total releases would return to the current rate.

16 41. The fears raised by the Defendants that releasing these people who have already
17 spent many months and years incarcerated is “unsafe” are similar to the ones raised prior to *Plata*
18 decision in 2011 and are similarly false.

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

20 Executed this 14th day of April, 2020 in Camden, South Carolina.

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/s/ James Austin, Ph.D.
JAMES AUSTIN, PH.D.

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Exhibit A

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.

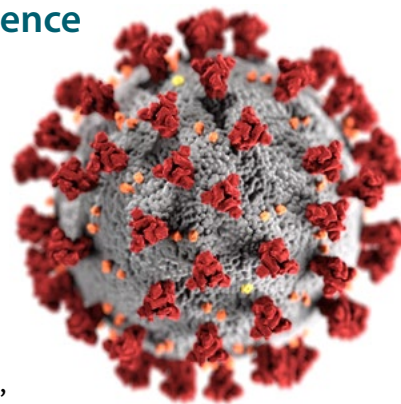
In this guidance

- Who is the intended audience for this guidance?
- Why is this guidance being issued?
- What topics does this guidance include?
- Definitions of Commonly Used Terms
- Facilities with Limited Onsite Healthcare Services
- COVID-19 Guidance for Correctional Facilities
- Operational Preparedness
- Prevention
- Management
- Infection Control
- Clinical Care of COVID-19 Cases
- Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons
- Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

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.



[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)

Why is this guidance being issued?

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

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

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

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

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

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
 - Where possible, put plans in place with other jurisdictions to prevent [confirmed and suspected COVID-19 cases and their close contacts](#) from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
 - Stay informed about updates to CDC guidance via the [CDC COVID-19 website](#) as more information becomes known.
- ✓ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**
- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See [Medical Isolation](#) and [Quarantine](#) sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
 - [Facilities without onsite healthcare capacity](#) should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
 - Make a list of possible [social distancing strategies](#) that could be implemented as needed at different stages of transmission intensity.
 - Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.
- ✓ **Coordinate with local law enforcement and court officials.**
- Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
 - Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.
- ✓ **Post [signage](#) throughout the facility communicating the following:**
- **For all:** symptoms of COVID-19 and hand hygiene instructions
 - **For incarcerated/detained persons:** report symptoms to staff
 - **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow [CDC-recommended steps for persons who are ill with COVID-19 symptoms](#) including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
 - Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

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

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

Operations & Supplies

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

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See [PPE section](#) and [Table 1](#) for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
 - Sterile viral transport media and sterile swabs [to collect nasopharyngeal specimens](#) if COVID-19 testing is indicated
- ✓ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**
 - See CDC guidance [optimizing PPE supplies](#).
 - ✓ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, [CDC recommends](#) cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.
 - ✓ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See [Hygiene](#) section below for additional detail regarding recommended frequency and protocol for hand washing.)
 - Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
 - ✓ **If not already in place, employers operating within the facility should establish a [respiratory protection program](#) as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**
 - ✓ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See [Table 1](#) for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

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

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

Operations

- ✓ **Stay in communication with partners about your facility's current situation.**
 - State, local, territorial, and/or tribal health departments
 - Other correctional facilities
- ✓ **Communicate with the public about any changes to facility operations, including visitation programs.**

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

Cleaning and Disinfecting Practices

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

Hygiene

- ✓ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- ✓ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis. [Sample signage and other communications materials](#) are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
 - **Practice good [cough etiquette](#):** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
 - **Practice good [hand hygiene](#):** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
 - **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
 - **Avoid sharing eating utensils, dishes, and cups.**
 - **Avoid non-essential physical contact.**
- ✓ **Provide incarcerated/detained persons and staff no-cost access to:**
 - **Soap**—Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
 - **Running water, and hand drying machines or disposable paper towels for hand washing**
 - **Tissues** and no-touch trash receptacles for disposal
- ✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.
- ✓ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

- ✓ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See [Screening section](#) below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see [PPE section](#) below).
 - **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
 - Require the individual to wear a face mask.
 - Ensure that staff who have direct contact with the symptomatic individual wear [recommended PPE](#).
 - Place the individual under [medical isolation](#) (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See [Infection Control](#) and [Clinical Care](#) sections below.)
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

- **If an individual is a [close contact](#) of a known COVID-19 case (but has no COVID-19 symptoms):**
 - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See [Quarantine](#) section below.)
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.
- √ **Implement [social distancing](#) strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:
 - **Common areas:**
 - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
 - **Recreation:**
 - Choose recreation spaces where individuals can spread out
 - Stagger time in recreation spaces
 - Restrict recreation space usage to a single housing unit per space (where feasible)
 - **Meals:**
 - Stagger meals
 - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
 - Provide meals inside housing units or cells
 - **Group activities:**
 - Limit the size of group activities
 - Increase space between individuals during group activities
 - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
 - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
 - **Housing:**
 - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are [cleaned](#) thoroughly if assigned to a new occupant.)
 - Arrange bunks so that individuals sleep head to foot to increase the distance between them
 - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
 - **Medical:**
 - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
 - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

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

Prevention Practices for Staff

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

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

Prevention Practices for Visitors

- ✓ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- ✓ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See [Screening](#) section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
 - Staff performing temperature checks should wear [recommended PPE](#).
 - Exclude visitors and volunteers who do not clear the screening process or who decline screening.
- ✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**
- ✓ **Provide visitors and volunteers with information to prepare them for screening.**
 - Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
 - If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
 - Display [signage](#) outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- ✓ **Promote non-contact visits:**
 - Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
 - Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
 - Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.
- ✓ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**
 - If moving to virtual visitation, clean electronic surfaces regularly. (See [Cleaning](#) guidance below for instructions on cleaning electronic surfaces.)
 - Inform potential visitors of changes to, or suspension of, visitation programs.
 - Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
 - If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

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

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

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

Management

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

Operations

- ✓ **Implement alternate work arrangements deemed feasible in the [Operational Preparedness](#) 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**

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

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

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

✓ **Electronics cleaning and disinfection**

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

Additional information on cleaning and disinfection of communal facilities such can be found on [CDC's website](#).

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

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

✓ **[Laundry from a COVID-19 cases](#) can be washed with other individuals' laundry.**

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

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.
- ✓ **Consult [cleaning recommendations above](#) to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

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

- ✓ **Incarcerated/detained persons who are close contacts of a [confirmed or suspected COVID-19 case](#) (whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**
 - If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.
- ✓ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is [considered a close contact](#) if they:**
 - Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
 - Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

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

- ✓ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**
 - Provide medical evaluation and care inside or near the quarantine space when possible.
 - Serve meals inside the quarantine space.
 - Exclude the quarantined individual from all group activities.
 - Assign the quarantined individual a dedicated bathroom when possible.
- ✓ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually. [Cohorting](#) multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.**
 - If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under [medical isolation](#) 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.**
 - If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See [Medical Isolation](#) section above.)
 - See [Screening](#) section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- ✓ **If an individual who is part of a quarantined cohort becomes symptomatic:**
 - **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
 - **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
 - **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- ✓ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- ✓ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- ✓ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- ✓ **Laundry from quarantined individuals can be washed with other individuals' laundry.**
 - Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
 - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
 - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
 - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

- ✓ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on [evaluation](#) and [testing](#). See [Infection Control](#) and [Clinical Care](#) sections below as well.
- ✓ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
 - If the COVID-19 test is positive, continue medical isolation. (See [Medical Isolation](#) section above.)
 - If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

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

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

Management Strategies for Staff

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

Infection Control

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

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

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).
- ✓ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see [PPE](#) section).
- ✓ **Refer to [PPE](#) section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

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

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

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

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's [respiratory protection program](#).
 - For PPE training materials and posters, please visit the [CDC website on Protecting Healthcare Personnel](#).
- ✓ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**
- ✓ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (see [Table 1](#)). Monitor linked CDC guidelines in [Table 1](#) for updates to recommended PPE.**
- ✓ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**
- ✓ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility will vary based on the type of contact they have with COVID-19 cases and their contacts (see [Table 1](#)). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.****
- **N95 respirator**
- See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.
- **Face mask**
 - **Eye protection**—goggles or disposable face shield that fully covers the front and sides of the face
 - **A single pair of disposable patient examination gloves**
- Gloves should be changed if they become torn or heavily contaminated.
- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
 - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
 - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.
- ✓ **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**
- [Guidance in the event of a shortage of N95 respirators](#)
 - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
 - [Guidance in the event of a shortage of face masks](#)
 - [Guidance in the event of a shortage of eye protection](#)
 - [Guidance in the event of a shortage of gowns/coveralls](#)

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