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UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

YONNEDIL CARROR TORRES; VINCENT REED; FELIX SAMUEL GARCIA; ANDRE BROWN; and SHAWN L. FEARS, individually and on behalf of all others similarly situated,

Plaintiff-Petitioners,

v.

LOUIS MILUSNIC, in his capacity as Warden of Lompoc; and MICHAEL CARVAJAL, in his capacity as Director of the Bureau of Prisons,

Defendant-Respondents.

No. CV 2:20-4450-CBM-PVCx

RESPONDENTS' STATEMENT AND RESPONSES TO REPORT OF DR. HOMER VENTERS

Honorable Consuelo B. Marshall
United States District Judge

STATEMENT AND RESPONSES TO THE REPORT OF DR. VENTERS

The Respondents hereby respond to the report of Dr. Homer Venters, which was filed in this action on September 25, 2020 [Dkt. no. 101-1]. The Respondents expect to submit additional evidence and expert testimony as this case proceeds,[1] but to communicate their position to the Petitioners now, consistent with the Court's minute order [Dkt. no. 112], submit the following responses to Dr. Venters' report.

A. The Expert Report of Dr. Jeffrey Beard Regarding FCC Lompoc

Respondents submit the expert report of Dr. Jeffrey Beard (the "Beard Report"), which is attached as Exhibit 1 hereto. Dr. Beard is an eminent expert regarding the operation and governance of correctional facilities. Among his many qualifications, in 2012, Dr. Beard was appointed Secretary of Corrections for the California Department of Corrections and Rehabilitation, where he served for three years in that capacity.

Dr. Beard conducted his own detailed inspection of the FCC Lompoc facilities, following Dr. Venters' visit, and he reviewed the Venters Report. The Beard Report sets forth Dr. Beard's opinions in detail, and discusses his numerous significant criticisms regarding the assertions, claims, methodology, and conclusions that Dr. Venters set forth in his report. The methodological problems and evidentiary deficiencies of Dr. Venters' opinions are specifically addressed by pages 34-44 of the Beard Report, and Dr. Beard's conclusions are set forth at pages 44-51 of the Beard Report. To briefly summarize some of the conclusions and criticisms that Dr. Beard discusses therein:

- Dr. Beard concludes that FCC Lompoc has acted reasonably and diligently in dealing with the COVID-19 pandemic based on the CDC guidance and BOP guidance applicable at the time, including the comprehensive BOP COVID-19 Pandemic Response Plan.
- In his report, Dr. Venters consistently bases his critical conclusions on unverified statements that were made to him by unidentified inmates, despite the harsh

[1] For example, Respondents anticipate producing epidemiologist expert testimony.

judicial criticism that he recently received in an Eastern District of New York COVID-19 case (discussed below) for following that unreliable methodology.

- Dr. Venters consistently departs from current CDC guidelines. He does not identify any non-compliance with those CDC guidelines on the part of the Respondents, but instead proposes idiosyncratic and novel approaches that are not supported by scientific evidence and governing standards of care.
- Dr. Venters does not identify specific documents that he relied upon for his conclusions, but when independent analysis of the relevant documents was conducted (for example, of screening records), Dr. Venters' conclusions were inconsistent with those records.
- Dr. Venters makes broad assertions in reliance upon statements made to him by unidentified inmates about the timeliness of their medical care, but he did not assess and validate whether those statements were accurate and reliable. Dr. Beard's review of the medical records shows that inmate requests are being timely processed in accordance with sick call triage procedure.
- Many of Dr. Venters' recommendations are already being done by BOP.
- Dr. Venters' other recommendations are either not consistent with CDC guidance, and/or are not supported by reliable evidence.

B. Additional Rebuttals of the Findings and Proposals Asserted by the Venters Report

Augmenting the Beard Report, the Respondents make additional responses herein to the assertions and conclusions in the Venters Report.

- Dr. Venters' recommendations for the extent and frequency of screening for COVID-19 symptoms for inmates at the facility are not consistent with the CDC Guidelines for Correctional Facilities, and they are also not consistent with the BOP COVID-19 Pandemic Response Plan. Screening at FCC Lompoc is already being conducted in accordance with CDC Guidelines for Correctional Facilities and the detailed BOP COVID-19 Pandemic Response Plan, both of which are

available online, and which the Petitioners have copies of. Screenings conducted by medical staff are included in the medical record.

- Dr. Venters' recommendations for "health encounters" for persons who have a recorded positive COVID-19 test are not consistent with CDC guidance on the discontinuation of medical isolation, as well as the NIH COVID-19 Treatment Guidelines. FCC Lompoc already provides for the assessment of inmates released from isolation, including having a clinical provider assess and evaluate them prior to release. However, treating physicians are able to determine and exercise their own medical judgment as practitioners as to whether any specific inmate should receive further monitoring.
- Dr. Venters vaguely recommends the increased use of quality assurance tools to assess timeliness of sick call requests, but he does not identify what those specific tools are, nor how they would be practical to implement at FCC Lompoc using its electronic systems. As discussed in the Dr. Beard report, the evidence demonstrates that sick call requests are being triaged and processed in a timely manner, contrary to Dr. Venters' speculation in reliance on comments by unidentified inmates. Further, records show that all annual chronic care appointments are up to date and timely scheduled. The quality assurance tools already in place to ensure the timely provision of care include annual operational reviews, program reviews, and peer reviews and are further evaluated by third party accreditors including the American Correctional Association and Accreditation Association for Ambulatory Health Care (AAAHC).
- Dr. Venters suggests hiring additional medical staff without taking into account the availability of medical staff and the limitations of the federal hiring process. FCC Lompoc has a comprehensive contract for the provision of medical specialists, and temporary contract medical providers are also on-site.
- Dr. Venters makes recommendations regarding social distancing. For example, he recommends the use of indoor programming space for recreation at the Camps.

FCC Lompoc uses *outside* recreation opportunities instead, which is consistent with the BOP's COVID-19 Pandemic Response Plan. He recommends that staff receive training on social distancing, but this is already being done. He recommends social distancing in medication, food, and other areas, but this is already being done at FCC Lompoc. See Exhibit 2 hereto (photographs). He vaguely recommends "enhanced cleaning/disinfecting" training, but he fails to acknowledge or be aware that the staff and assisting inmates have already been trained on how to clean and disinfect areas that might have been contaminated with COVID-19. He advocates monitoring of PPE use, but this is already being done, in compliance with the BOP's COVID-19 Pandemic Response Plan, and corrective action is taken in the rare instances of non-compliance.

- Dr. Venters recommends that paper towels and soap be made available to inmates. This is already being done. Consistent with CDC Guidelines for Correctional Facilities, paper towels and hand drying machines are available in shared inmate restrooms and are replenished on a standard schedule. Inmates at the Camp and FCI were distributed hygiene kits and paper towels every Thursday beginning April 3, 2020. No cost soap is available to all inmates and is issued weekly to all inmates throughout all the facilities. Finally, all inmates have two bath towels and two hand towels for their personal and exclusive use.
- Dr. Venters recommends that basic services and freedoms should be provided to inmates in quarantine and isolation. Such inmates are already provided regular medical visits from staff, however, along with access to cost-free phone calls, reading materials, and educational materials. By contrast, their use of the recreation yard is restricted during quarantine/isolation to help mitigate the potential spread of COVID-19, which is the appropriate procedure.
- Dr. Venters recommends the investigation of retaliation and threats against detained people who report medical or health-related concerns. FCC Lompoc has established processes for that. The process for investigating allegations of staff

misconduct, including retaliation and threats, is outlined in Program Statements 1210.24, *Office of Internal Affairs* and 3420.11, *Standards of Employee Conduct*. If inmates at FCC Lompoc make allegations against staff, these allegations are referred consistent with BOP Program Statement 1210.24, *Office of Internal Affairs* (5/10/2003). Inmates can also electronically message the Associate Wardens and Department Heads through TRULinks, file a Request for Administrative Remedy, or write directly to the Office of Internal Affairs or Office of Inspector General.

- Dr. Venters recommends expediting reviews of home confinement for high-risk patients. The Respondents have explained the process for considering HC under the CARES Act, and also limitations on expedition, such as contexts where the United States Probation Office must approve relocation requests. In addition, under Associate Warden Engleman, there will now be weekly meetings with the CMC and Unit Managers to address and track all HC release packet processing.
- Dr. Venters recommends that BOP Lompoc coordinate with the BOP and Public Health Service (PHS) headquarters to review all COVID-19 related deaths throughout BOP facilities. The PHS is not involved in the provision of medical care to inmates, however. Rather PHS officers work for the BOP, if detailed. The BOP already requires mortality reviews to be performed for every inmate death pursuant via a multilevel system of reporting and reviewing. See P.S. 6013.01, *Health Services Quality Improvement* (1/15/2005). All BOP mortalities are also reviewed by an external reviewer, and both review processes examine the care provided to the inmate and focus upon the events leading up to the death to assess quality of care, risk management, and whether BOP guidance and policies were followed. Areas of concern or where lapses in following guidance/ policy are identified result in recommendations for corrective action and/ or a Root Cause Analysis which then requires written responses. What Dr. Venters appears to propose beyond this is essentially to form a broad new cross-agency scientific

research program. This is not practical, nor consistent with the respective agency constraints, particularly in the midst of the current COVID-19 pandemic.

C. Dr. Venters' Prior Testimony as a Retained Expert Witness for Inmates in COVID-19 Cases, and the Criticisms of Dr. Venters' Testimony in that Context by EDNY District Judge Rachel Kovner

Dr. Venters has previously served as a party-retained expert—and was opposed in that capacity by Dr. Jeffrey Beard and epidemiologist expert Asma Tekbali—in two recent cases that inmate petitioners filed against the federal government regarding COVID-19 in federal correctional facilities: Chunn et al. v. Edge, 1:20-cv-01590-RPK-RLM (EDNY) and Martinez-Brooks et al. v. Easter, 3:20-cv-00569 (MPS) (D. Conn.).

In the Chunn case, District Judge Rachel P. Kovner issued a 62 page opinion on June 9, 2020 denying preliminary injunctive relief to the petitioners. See Exhibit 3 hereto (the "Chunn PI Order"). Because the deficiencies found in Dr. Venters' testimony in the Chunn case are substantially replicated by Dr. Venters' report here, Respondents will discuss some illustrative example from the Chunn PI Order.

In the Chunn PI Order, Judge Kovner assessed the competing expert testimony of Dr. Venters, Dr. Beard, and Asma Tekbali regarding the petitioners' claims of alleged deliberate indifference regarding COVID-19 risk at the Metropolitan Detention Center (MDC) in Brooklyn. Judge Kovner repeatedly determined that Dr. Venters' testimony and opinions were not reliable. For example, Dr. Venters' conclusion that inmate screening procedures were not in effect at the MDC was based on hearsay inmate statements, which Dr. Venters failed to validate, and which the respondent refuted with documentary evidence.

> Accordingly, petitioners' claim that "[i]ndividuals entering the MDC are not always screened for symptoms of COVID-19," Pet'rs' Proposed Findings of Fact ¶ 33, which is based on those two inmates' out-of-court statements to Dr. Venters, does not appear to be supported by the evidence.

Chunn PI Order at pp. 17-18. Dr. Venters' report in this case exhibits the same type of

uncritical acceptance of inmate statements. Those problems are aggravated, however, by the fact that Dr. Venters' report in this case often does not even identify the inmates he cites. See Beard Report, pp. 35-36 (noting that "Dr. Venters also frequently relies on statements from unknown inmates and in unknown quantities. In the *Chunn* case, he at least identified the inmates whose statements he relied on.").

In the Chunn case, Dr. Venters also made some unjustifiable and peculiar proposals for how the MDC should change its operations, such as criticizing the MDC for failing to give inmates N-95 masks, even though the use of N-95 masks in this context was inconsistent with the governing CDC guidance, and was inappropriate except in specialized healthcare contexts. See PI Order at pp. 27-28.

Dr. Venters also faulted the MDC for not giving gloves to all inmates, regardless of whether they were doing work that requires them. Judge Kovner found this peculiar proposal to be inconsistent with CDC Correctional Guidelines, which normally recommend hand hygiene, not continuous glove wearing. Id. at p. 28.

Dr. Venters also occasionally made broad conclusions that were not supported by evidence. "Neither the inmate declarants nor Dr. Venters offered a basis to conclude that staff members have been failing to wear masks or gloves when required under CDC protocols." Id. at p. 29.

Dr. Venters made some suggestions in Chunn that the District Judge found might be effective means of meeting infection control goals, but "his testimony did not establish that the tracking method he recommends is standard practice among other institutions. On this record, the tracking system that Dr. Venters recommends appears to be one means by which the MDC could meet its broader goal of implementing effective quarantine and isolation procedures, but it is not apparent that the MDC is violating any applicable standard of care because it has not adopted such a system. Id., p. 45.

Ultimately, Judge Kovner explained that "Petitioners finally contend that MDC officials are being deliberately indifferent because they have failed to adopt several steps recommended by petitioners' expert, Dr. Venters, but not called for by the CDC's

guidance. Petitioners fall far short of establishing deliberate indifference on those grounds." Id. at 60.

Respondents raise these points from the Chunn PI Order to illustrate the problem with uncritically assuming that Dr. Venters' varied opinions in an adversarial litigation are reliable and consistent with the relevant standard of care.[2] A rational assessment of the Venters Report demonstrates that his opinions therein suffer from serious deficiencies paralleling those found by the district court in the Chunn PI Order.

D. The Final Finding by the Department of Health and Human Services That Dr. Venters Repeatedly Submitted Intentionally Falsified Scientific Data in his Scientific Research and Papers

On December 18, 2008, the Department of Health and Human Services (DHS) issued its findings regarding the final action taken by the Office of Research Integrity and the Assistant Secretary for Health regarding Homer D. Venters, Jr., M.D., then at the University of Illinois at Urbana-Champaign.[3] See Exhibit 4 hereto (printout from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4259696/.).

Although the scientific misconduct by Dr. Venters took place from 1999-2001, while he was still at the University of Illinois, it was of such severity and duration that it must be considered when assessing the credibility and weight of his opinions—particularly as a putatively neutral expert who was appointed by the district court in this case pursuant to Rule 706, over the Respondents' objections.

Per the final findings of the U.S. Public Health Service (PHS), in 1999 Dr. Venters intentionally and knowingly submitted falsified scientific data in his PHS fellowship

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[2] Because of his history as a retained party expert committed to the Petitioners' positions in his prior district court testimony against the federal government, the Respondents objected to Dr. Venters' appointment in this case. [Dkt. no. 65]. Although he was subsequently appointed over those objections, the Respondents continue to object that Dr. Venters is not neutral. As evidenced by the deficiencies identified herein and in the Beard Report, he falls below the standard required for a neutral expert.

[3] For Dr. Venters' CV more broadly, see Dkt. no. 62-1 (CV, identifying Dr. Venters as having received his M.D. degree from the University of Illinois, Urbana in 2003).

application. Id. Dr. Venters then further submitted false scientific data in an article published in 1999 by the National Academy of Sciences, U.S.A. Id. In 2000, Dr. Venters submitted a thesis proposal to his dissertation committee that contained five falsified figures. Id. In 2001, Dr. Venters included these same falsified figures in his dissertation, and he added multiple additional falsified figures. Id. Dr. Venters ultimately entered into a voluntary settlement agreement as a result of these findings by the PHS of scientific misconduct, which extended for a period of three years. Id.

Although it relates to older conduct, this record of scientific dishonesty, which was neither temporary nor isolated, aggravates the Respondents' concerns with the methodological deficiencies of Dr. Venters' report in this adversarial proceeding. Respondents maintain that Dr. Venters is not a neutral expert. His opinions should be viewed as opinions that have been advanced by the Petitioners' own partisan expert, consistent with his role as a retained party expert for the petitioners in the Chunn and Martinez-Brooks cases earlier this year, and with his assertion by the Petitioners in this case [Dkt. no. 62].

Dated: October 30, 2020

Respectfully submitted,

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EXHIBIT 1

REPORT OF EXPERT JEFFERY BEARD

I have been retained by the United States Attorney's office for the Central District of California as an expert witness in the case of *Torres et al., v. Milusnic et al*, Case No. CV 20-4450-CBM-PVC(x). I have reviewed the Plaintiff's complaint and the actions taken by the Federal Bureau of Prisons (BOP) in general and FCC Lompoc specifically in response to the novel COVID-19 virus. I have toured the FCC Lompoc facilities in order to assess the overall operation of the facility and to determine the responses taken by that facility to deal with COVID-19. I have also reviewed Dr. Homer Venters' report regarding FCC Lompoc. Appendix A contains a list of documents and other resources that I have reviewed as a part of my assessment.

I. Qualifications in Prison Management and Prison Practices

I began my career in corrections in 1972. I worked for the Pennsylvania Department of Corrections (DOC) for 38 years. For the first 22 years, I worked in three different correctional facilities in Pennsylvania. I started as a psychological services associate, followed by serving as a supervisor, and then as a deputy superintendent in my first institution.

I was subsequently promoted to superintendent and activated a new institution before taking over one of Pennsylvania's largest institutions in the aftermath of two serious prison riots. I served as a superintendent for a total of about 8 years.

I then moved to Pennsylvania DOC headquarters, where I first worked as a regional deputy and then as executive deputy. For the last 10 years of my career in Pennsylvania, I was the Secretary of Corrections. I was appointed by Governor Ridge and then reappointed by Governor Rendall.

Following my retirement from the Pennsylvania DOC, I became an independent consultant for the National Institute of Corrections, various companies, and for the California Department of Corrections and Rehabilitation (CDCR), working on a number of outstanding lawsuits and some operational issues.

In 2012, I was appointed Secretary of Corrections for CDCR by Governor Brown and worked in that position for 3 years. CDCR is the second largest State prison system in the Country.

Since 2016, I have served as an independent consultant and expert witness for various companies and state and county systems, including the New York City Department of Corrections, Los Angeles County Corrections, New York State Department of Corrections and Community Supervision, and the Virginia Department of Corrections. I recently served as an expert witness for the United States Attorney's Office for the Eastern District of New York, the United States Attorney's Office for Connecticut, and the Texas Department of Criminal Justice in litigation regarding prison responses to COVID-19. The present case is one of two that I am currently working on with the United States Attorney's office for the Central District of California

I have a bachelor's degree in psychology, a master's degree in counseling, and a Ph.D. in counseling all from Penn State University. Since 1977, I have been a licensed psychologist in Pennsylvania, but the license is currently in inactive status.

The only testimony that I have given in the last four years was video testimony in the case of *Chunn v. Edge* on May 13, 2020, a video deposition in *Martinez v. Easter* on June 8, 2020, and a video deposition on July 9, 2020 and video court testimony on July 30, 2020 in *Valentine v. Collier*.

II. Summary of Opinions

- The BOP began planning for COVID-19 in January 2020 when news of a new virus first emerged. They moved quickly once a pandemic was declared and they continually updated their direction to the field as more was known about COVID-19 and as World Health Organization (WHO) and Centers for Disease Control (CDC) guidance evolved.
- The BOP rapidly provided medical personnel to FCC Lompoc when cases of COVID-19 emerged at that facility. They also activated an impressive,

sophisticated Hospital Care Unit within about three weeks of initial planning for the unit at FCC Lompoc.

- Early information on how COVID-19 spreads, the impact of pre-symptomatic and asymptomatic cases on the spread of the virus, and the lack of availability of testing served to hinder FCC Lompoc's attempts to contain and mitigate the virus in the early stages.
- FCC Lompoc followed BOP directions for dealing with the virus by making required changes as the BOP moved through their various phases.
- The number of COVID-19 cases at FCC Lompoc is not unique, as many correctional facilities around the country with dormitory and/or open bar front cells have had a difficult time containing the virus once it enters a facility.
- FCC Lompoc's relationship with the Los Angeles County Department of Public Health (LACDPH), which was developed through FCI Terminal Island, aided FCC Lompoc in developing a plan and obtaining testing to do multiple rounds of mass testing that contributed to ending the COVID-19 outbreak at the facility.
- The turnover in Wardens at FCC Lompoc had little to do with the COVID-19 outbreak at that facility
- FCC Lompoc is currently managed by a knowledgeable, effective Warden and management team, and the facility is clean and well maintained. At the time of my visit, the management team was complying with both BOP direction and CDC guidance relative to managing COVID-19 in a correctional facility.
- Dr. Homer Venters relies heavily on unidentified inmates in reaching his conclusions and makes recommendations that not infrequently are not grounded in CDC guidance. He also does not offer standards upon which the recommendations are based.
- FCC Lompoc has released 25% of its inmate population from the time of Attorney General Barr's memo on March 26, 2020 to September 4, 2020, which is more

than many other similarly situated facilities around the country.

III. The Bureau of Prison response to COVID-19

The BOP had a pandemic influenza plan in place since at least October of 2012.[1] The plan had six distinct phases to be implemented in response to any pandemic. A review of the plan reflects that it is comprehensive and would allow the BOP to respond in a rapid and thoughtful manner to an influenza pandemic. Many of the strategies employed in responding to COVID-19, such as social distancing, use of PPE, isolation, quarantine, and frequent hand washing, are part of the pandemic influenza plan. The pandemic influenza plan gave the BOP a starting point and essentially a head start as they developed their specific plans to respond to the COVID-19 pandemic.

The BOP implemented phase 1 of the plan in January of 2020 when there was initial reporting regarding the presence of an outbreak of a new virus in China. Phase 1 consisted of getting information from various sources, such as the CDC and the WHO, and doing some initial planning. Despite the fact that WHO was slow to raise concern about COVID-19, the BOP took some initial steps to get ready to respond to any outbreak.[2] In January, the BOP identified potential risks of exposure in BOP facilities and informed recipients about risks, exposure and preventive measures. They also directed that all new inmate arrivals be screened for COVID-19 and PPE be used for close contact with suspected or diagnosed individuals with COVID-19. In February, the BOP sent out a screening questionnaire for staff, directed conducting N95 fit testing, disseminated information about proper PPE use and established a baseline for PPE supplies. They also recommended communications with local public health authorities, identifying quarantine areas and alerting visitors that people with illnesses would not be

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[1] Bop.Gov

[2] ABC NEWS, "Timeline: WHO's response to the coronavirus pandemic and the ensuing controversy", 8/17/20,

The Wall Street Journal, "The World Health Organization Draws Flak for Coronavirus Response", 02/12/20.

able to visit. This positioned the BOP to move aggressively when a pandemic was declared.

On March 13, 2020 – two days after WHO declared a pandemic – the BOP initiated phase 2 of its pandemic plan at all facilities. This phase included suspending all social and legal visits, stopping volunteers and non-essential contractors from entering facilities, and cancelling tours. BOP also began screening all new inmates. Those that were asymptomatic with defined risk factors were quarantined and those who were symptomatic were isolated.

Phase 2 of the BOP's pandemic plan included screening staff with a questionnaire and temperature check in areas with sustained community transmission. Facilities were also to take steps to increase social distancing and reduce inmate contact by, among other things, limiting congregate gathering.

On March 18, 2020, the BOP implemented phase 3 of the plan. This required that all cleaning, sanitation and medical supplies be inventoried.

On March 26, 2020, the BOP implemented phase 4 of the plan, which required all new inmates to be screened and have a temperature check. All symptomatic inmates were isolated, and all other arriving inmates at a BOP facility were quarantined for 14 days. The plan now also required all staff to be screened with a temperature and symptom check. It also required all inmates leaving a facility to be screened.

On March 28, 2020, the BOP implemented phase 5 of the COVID-19 plan. All inmates were confined to their cells/quarters for most of the day and facilities were to start providing most services on the housing unit such as education, medical, dining, laundry, psychology, etc. Inmates were released in small groups for phone calls, showers, exercise and emails. They were directed to maintain physical distancing. The BOP required contract tracing for any symptomatic cases, quarantining close contacts and isolating any inmate with symptoms similar to COVID-19. They emphasized good hygiene and cleaning practices, and required institutions to limit staff movement to areas

that they were assigned. It also announced that UNICOR had started making face masks.

On April 13, 2020, the BOP enacted phase 6 which essentially extended phase 5 to May 18, 2020. On April 24, 2020, the BOP extended COVID-19 testing to asymptomatic inmates following the acquisition of rapid testing equipment at selected facilities.

On May 18, 2020, the BOP implemented phase 7 of its COVID-19 action plan that extended phase 6 to June 30, 2020. This phase continued the restrictions on external movement of inmates and maintained the suspension of internal inmate movement. It also permitted where possible inmate access to the electronic law library. Wardens were encouraged to identify and then notify staff of possible testing sites in the community.[3]

On June 30, 2020, the BOP issued phase 8 of the COVID-19 plan, which extended phase 7 to July 31, 2020. It maintained the restrictions in place in phase 7. It also detailed how court trips should be handled and added enhancements to how intakes were to be dealt with. Specifically, in addition to temperature/symptom checks phase 8 required COVID-19 testing upon reception and at the end of the 14-day quarantine. Since inter-institutional movement was beginning to increase, phase 8 provided specifics on handling such cases including the full test-in/out, and 14-day pre-release quarantine of transferring inmates prior to transfer. [4]

On August 5, 2020, the BOP announced phase 9 of the COVID-19 plan. Phase 9 allowed for the resumption of recreation and programing while maintaining social distancing and it established unannounced compliance reviews to ensure compliance with COVID-19 guidance. Wardens were to also have UNICOR operations running at 80% capacity by 9/1/20 and at 100% by 10/1/20. It also had further guidance on court

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[3] BOP0001017-BOP0001020

[4] BOP0001087-BOP0001093

trips, intake and movement.[5]

On August 31, 2020, the BOP issued a comprehensive Pandemic Response Plan for COVID-19. The plan consists of eleven modules covering all aspects of responding to COVID-19. The modules were developed based upon what is known about COVID-19 at this time and the intent is to continually update each module based on guidance from key stakeholders such as the CDC and WHO as new information and understanding about the virus becomes available. The modules include:

- Infection prevention and control measures
- Personal protective equipment
- Screening and testing
- Inmate isolation and quarantine
- Surveillance
- Inmate movement
- Non-COVID routing medical and dental services
- Inmate programming and services
- Inmate visitation
- Volunteer and contract staff management
- BOP employee management[6]

I was impressed with the BOP's overall response to the COVID-19 outbreak. The presence of a detailed pandemic influenza plan allowed them to gather information from authorities such as the CDC and WHO and to quickly develop their plan to deal with COVID-19. The BOP could then provide direction to all their facilities. They began doing so in phases as the information about COVID-19 evolved. The phases at first moved rapidly as the seriousness of the problem became more apparent, and then were

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[5] Bureau of Prison memo to all Chief Executive Officers, "Coronavirus (COVID-19) Phase Nine Action Plan", 8/5/20

[6] BOP, "COVID-19 Pandemic Response Plan", Overview, Module 1-11, 8/31/20.

generally issued on a monthly basis where some mitigation strategies were continued, and new strategies were added as more became known and as guidance from the CDC and WHO changed.

Correctional facilities have a large number of emergency plans in place at both the local facility level and at headquarters. These plans allow systems/facilities to deal with a whole host of possible adverse events such as riots, disturbances, loss of utilities, severe weather events, infectious diseases, and as in this case a pandemic. Some States and some facilities do a better job at having such planning in place so that they can more quickly respond to the specific threat.

Having extensive experience in both developing and periodically reviewing plans at both the facility and headquarters level I found that the BOP had a comprehensive plan in place. This allowed them to rapidly build their specific response to COVID-19 and then to quickly implement it as soon as it was clear that we were facing a pandemic. From my review of some other States' actions and numerous news articles, it is my opinion that the BOP was much better prepared than some institutions and has been more consistent and aggressive in the BOP's response to COVID-19. This could not have occurred without the presence of their detailed pandemic influenza plan. The actions that they took to mitigate the spread of COVID-19 in order to protect inmates, staff and the public are clear evidence that they were prepared and took this situation seriously.

Dealing with an infectious outbreak in a correctional setting is not easy due to the large number of people in a relatively small area. The record is clear that the BOP took many substantive actions prior to March 9, 2020 that positioned them to act quickly when WHO declared a pandemic. It is also clear that they took many substantive actions before the CDC issued their guidance on dealing with COVID-19 in corrections and detention facilities on March 23, 2020, and that they followed CDC guidance once it was

issued.[7] They have also continued to develop and refine the direction they provide to the field, and they have issued a comprehensive plan specific to COVID-19 that will be modified as new information becomes available.

IV. Other States' responses to COVID-19

There are a number of basic things that correctional facilities can do to help mitigate the effects of COVID-19. First, correctional facilities can reduce the number of people who enter the secure perimeter. Typically, systems would look at social and legal visits, volunteers, non-essential contractors, and other visitors in order to reduce the chance that the virus will get into the facility. Many State and County facilities have initiated limits in this area, but some did not go as far as the BOP. This was a part of the BOP pandemic plan, and it was put in place early in its response to the outbreak.

Second, correctional facilities should look at inmate intake into their facilities. Ideally, a facility would like to do what California and Texas have done and simply close down intake for a period of time.[8] If that is not possible, then the facility would need a process to deal with those who do enter into that system. Pennsylvania, for instance, had taken a facility that they were closing and turned that into a reception center where they could isolate and quarantine new inmates.[9] Here, the BOP stopped all but essential interfacility transfers and then, initially, began a process to screen inmates to determine which were symptomatic (who the BOP isolated) and which were asymptomatic but had certain risk factors (who the BOP then quarantined). Within two weeks, the BOP then moved to requiring all asymptomatic inmates received at the facility to be placed in quarantine. This is consistent with what some States have done.

Third, for those staff and essential contractors who must come in, the correctional

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[7] CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, 3/23/20

[8] www.cdcr.ca.gov., www.tdcj.texas.gov.

[9] www.cor.pa.gov.

facility needs a plan to deal with them. Many correctional systems have put in place screening tools to catch those that have symptoms of the virus including measuring their temperature before they are admitted. They are also looking for those who may have been exposed to COVID-19. This was one of the early actions taken by the BOP. Staff and essential contractors must pass the screening and temperature check in order to be admitted.

Fourth, correctional systems are taking a number of steps to protect staff and inmates in the facility. This usually begins with education about the virus, how to best prevent catching it and what to do if one thinks they may have it. Typically notices are also placed around the facility. In addition, systems make sure there is an adequate supply of soap and cleaning/sanitation supplies and generally soap is provided free to inmates upon request. Most systems are also increasing the cleaning of showers and common areas. Medical visits to housing areas are more frequent in order to catch symptomatic inmates as soon as possible and to reduce movement in the facility. Some systems still feed in the dining halls and while in smaller groups allow more movement within the facility as a generalized lockdown is not in place. The BOP has determined that movement within their facilities should be more restricted and are doing more including meals on the housing units. Many systems are also providing both staff and inmates with face masks, which is mandatory in the BOP. In reviewing the BOP action plan, these things have been put in place throughout the BOP.

Fifth, many correctional systems have procedures in place to deal with symptomatic inmates and those that have been exposed to them. Again, this is an integral part of the BOP plan where the BOP immediately isolates any symptomatic inmates and then quarantines anyone who had been exposed to those inmates to reduce the spread of the virus. They directed facilities early on to designate space for both quarantining and isolation.

V. Reduction of Inmate Population to Enhance Social Distancing

Another strategy to deal with COVID-19 has been to reduce the inmate population in correctional facilities in order to enhance social distancing and in the case of the BOP to also try to protect inmates at higher risk of an adverse reaction to COVID-19. County jails have had a much easier time doing so and are often cited when noting significant population reductions. For a number of reasons, significant and rapid reduction of inmate populations are much more difficult to obtain and processing takes longer in state and federal correctional facilities.

Some County jails have achieved inmate population reductions in the 25% to 50% range for a number of reasons. First, the County judges generally have more latitude to modify a sentence and they are readily available to the County prisons. Second, inmates who are serving time in County jails are generally the less serious offenders who are serving shorter sentences or are pretrial detainees that may be eligible for bail. So, it is easier for them to release large numbers of inmates without a significant impact on public safety. The County personnel would also be more aware of the presence or absence of community support for the offender which is critical to the release decision.

The State systems are, in some cases, looking at releasing less serious offenders, particularly those that are nearing release and parole violators. While some have released up to several thousand offenders, this generally represents a small percentage of the total inmate population. The California Department of Corrections and Rehabilitation, for instance, with an inmate population of 117,328 on March 25, 2020, expedited the release on parole of about 3,500 inmates.[10] New York Department of Corrections and Community Supervision, with an inmate population of about 42,000 inmates, has released about 1,100 technical parole violators.[11] The Pennsylvania Department of

[10] www.cdcr.ca.gov

[11] doccs.ny.gov

Corrections, with an inmate population of 45,000 inmates, is expediting parole and giving temporary reprieves to some inmates and has reduced their population by about 1,150 inmates over a month.[12] State systems are thus working to reduce their inmate populations in some cases, but these reductions generally fall within the 2% to 3% range – far below what many County systems have been able to do. There are also some State systems that do not appear to be pursuing expedited releases.[13] But even the ones that are trying to do so have not released high percentages. Virginia recently passed legislation allowing the Department of Corrections the authority to release some inmates while the Governor's state of emergency is in place. Restrictions on this authority will likely limit the number actually released and as of May 8, 2020 only 230 had been released.[14] Pennsylvania sought legislation that would allow inmates nearing the end of their sentences to be released. But the legislature did not approve the legislation, so the Governor issued an executive order allowing him to issue temporary reprieves. The expected pool of potential releases was 1500 inmates. In over three months since this was put in place only 160 have been approved because of public safety concerns, and opposition from District Attorneys and Victim groups. In fact, while there was an overall 8% inmate population drop in the State and Federal prison system, most of that reduction was attributed to prisons having stopped accepting new prisoners from county jails, court closures, and parole officers returning fewer inmates for low-level violations.[15]

State inmates, as opposed to County inmates, generally have longer sentences and

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[12] cor.pa.gov

[13] Ballotpedia, "Prison inmate release responses in response to the coronavirus (COVID-19) pandemic, 2020." Reported that as of 7/1/20 Alaska, Arizona, Delaware, Florida, Georgia, Idaho, Minnesota, Montana, Nebraska, New Hampshire, South Dakota, Tennessee, Texas, Wyoming have made no announcement relative to releases.

[14] Ballotpedia, "Prison inmate release responses in response to the coronavirus (COVID-19) pandemic, 2020." 7/1/20.

[15] The Marshall Project, "Prison Populations Drop by 1000,000 During Pandemic", 7/16/20.

more serious crimes. It is also more difficult and time consuming to ensure that appropriate release plans exist for them. These release plans should include appropriate housing and the ability to care for the inmate – who in the best of times would have a difficult time getting a job. Today, an inmate getting a job would be next to impossible. Additionally, the ability to obtain medical care when released is an important consideration for some inmates. Community spread of COVID-19 must also be considered at the release location.

In general, State prisons do not specifically focus on the older inmates because many of those inmates have been in prison for a number of years and are typically serving time for serious crimes such as murder and sex offenses. Few would be eligible for release from a public safety perspective. It also takes more time and resources to investigate proposed home plans, and some States simply do not have the legal authority to release inmates early. Even when they can, the numbers are generally small. There is also opposition from a number of areas, such as prosecutors, victim groups, Sheriffs and Police Chiefs, to the early release of inmates, which further limits the actual numbers that are released from State prisons.

The BOP's inmate population is more like the State systems than the County jails. Thus, it would face some of the same difficulty to first identify suitable inmates from a public safety perspective and to make sure that they had release plans that would not put the inmate or the public at risk.

The BOP is looking at reducing its prison population by moving more inmates to home confinement. In addition, Attorney General Barr has advised to prioritize home confinement placements to those inmates that have certain COVID-19 risk factors. But although Attorney General Barr talks about prioritizing release for some inmates and even focuses on specific facilities, his March 26, 2020 memo cautions that home confinement must be ensured not to increase an inmate's risk of contracting COVID-19 and that the public must be protected. In his April 3, 2020 memo, the Attorney General

concludes by emphasizing the need to protect the public especially at this time when our police forces are "massively over-burdened."

As of September 28, 2020, the BOP has placed an additional 7,695 inmates in home confinement, consistent with the Attorney General's direction. The BOP has about 126,661 inmates in custody, and those released to home confinement represent about 6% of this total.[16] Thus, the BOP has done better in terms of total percentage released than a number of States that made attempts at reducing their inmate population during the COVID-19 outbreak.

Just as some State systems are doing, the BOP has taken a number of steps to mitigate the impact of COVID-19. They are releasing inmates, transferring others to Residential Reentry Centers, and placing inmates in home confinement The, main difference, is that the BOP is focusing more on those at greater risk, rather than just generally trying to reduce its inmate population, as some State systems are doing. They have also reopened closed housing units and converted other space into temporary housing units in order to help with the mitigation.

The BOP has also been careful to require a 14-day quarantine period for any inmate who is to be released to home confinement. The process requires that the inmate be tested for COVID-19 before being placed in quarantine, and then to be tested again at the end of the 14-day quarantine period. When test result turnaround time is taken into account it could take up to 21-days to complete the process.[17]This slows down the release process, but it provides protection for the communities who receive the inmates. At least one other State that I am aware of did not do so and released an inmate who was positive for the COVID-19 virus to an area that had a low rate of COVID-19 infections. This decision created community unrest.

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[16] www.bop.gov

[17] BOP, "COVID-19 Pandemic Response Plan", Module 6, 8/31/20.

This process caused considerable slowdown in processing inmates for Lompoc from early April 2020 right after their first positive staff and inmate cases until later May 2020 when the amount of positive cases began to subside. During a good part of this time period, many inmates remained in quarantine as new positive cases emerged within housing units. The decision to move to mass testing in early May helped identify all positive cases and move the facility towards resolution of the outbreak. FCC Lompoc also indicated that processing inmates for home confinement/RRC placement was slowed at times due to staffing shortages in the RRC's and a COVID-19 outbreak in a couple of the RRC's.

VI. FCC Lompoc's Response to COVID-19

FCC Lompoc took a number of substantive steps to deal with COVID-19, and as the number of positive cases increased, they took further steps to try to contain the spread of the virus within the facility. They did so by following the guidance they received from the BOP, as the BOP implemented each of their specific phases, and in some cases going beyond the specific requirements of a specific phase.

On March 10, 2020, FCC Lompoc provided guidance to staff relative to screening and leave procedures related to COVID-19.[18] On March 12, 2020 they posted some signage for inmates on how to stop the spread of COVID-19.[19] Then on March 13, 2020, when the BOP initiated phase 2 of their COVID-19 response plan—just two days after WHO declared a pandemic—FCC Lompoc took a number of specific steps. First, as directed by the BOP, FCC Lompoc suspended all visits, while increasing inmate monthly telephone allotment from 300 free minutes to 500 minutes. Second, FCC Lompoc began screening staff and inmates for COVID-19. Third, FCC Lompoc limited inmate movement within the facility. They also provided notice to the inmate population

[18] Engleman Declaration, 15:2

[19] Engleman Declaration, 15:4

regarding protective measures to take to prevent COVID-19.[20] FCC Lompoc also provided notice to the inmate population regarding visitor suspension and other measures that would be taken to help contain COVID-19.[21]

On March 16, 2020, FCC Lompoc established a staff screening site to check all staff prior to entering the facility at their training center.[22] On March 20 and 22, 2020, FCC Lompoc provided guidance to medical providers regarding screening inmates and clinical information on medical quarantine and isolation.[23] This was prior to the CDC guidance on corrections and detention facilities that was issued on March 23, 2020.

As of March 25, 2020, FCC Lompoc had not modified procedures regarding commissary, showers, recreation, phone, and computer use. But they did provide education to the inmates on how to stop the spread, initiate cohorts by housing unit, and keep inmates generally in their housing units.[24] On March 25, 2020, FCC Lompoc also put up CDC posters regarding stopping the spread of the virus and established a Quarantine unit.[25] Then on March 26, 2020, FCC Lompoc provided preventative measures for Quarantine and Isolation units and the required Personal Protective Equipment (PPE) as a part of the BOP's Phase 4.[26] All of these actions and others were taken by FCC Lompoc to carry out the BOP's directions prior to any inmate testing positive for COVID-19, which occurred for the first time at FCC Lompoc on March 30, 2020.

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[20] Engleman Declaration, 15:6

[21] Engleman Declaration, 15:24

[22] Engleman Declaration, 16:19

[23] Cross Declaration, 8:23, 8:25

[24] Engleman Declaration, 15:28

[25] Engleman Declaration, 17:8

[26] Engleman Declaration, 17:11

On March 30, 2020, sick call copay was suspended for any COVID-19 like symptoms so that inmates would not fail to go on sick call because of the copay.[27] Then on March 31, 2020, as a part of implementing the BOP's Phase 5, FCC Lompoc went on an initial 14-day period when most inmates were confined to their cells most of the day to decrease the spread of the virus. Small groups were let out for several hours a day for commissary, laundry, showers, telephones, and computer use.[28] FCC Lompoc also used hdqc2 and Avistat-d as their primary cleaning agents, both of which were approved by the EPA for use with COVID-19.[29] On April 3, 2020, the CDC recommended use of face masks, a recommendation that the BOP began to implement the next day. FCC Lompoc did so by initially providing surgical masks to all inmates and staff, and when available providing all inmates with three cloth masks.[30] Also as noted earlier, the BOP had directed UNICOR, their correctional industries, to begin making cloth masks on March 28, 2020, prior to the CDC guidance on face masks.

In early April 2020, additional signage was posted for both staff and inmates concerning the importance of cleanliness, social distancing, personal hygiene, and coughing practices.[31] FCC Lompoc also started to do regular symptom and temperature checks on every inmate.[32] On April 7, 2020, a reminder was sent out regarding daily sanitation, social distancing, PPE, and cleaning frequently touched surfaces.[33] Weekly hygiene supplies, including soap, was provided to inmates. Housing units received

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[27] Cross Declaration, 9:4

[28] Engleman Declaration, 17:23, 18:12

[29] Engleman Declaration, 18:19

[30] Engleman Declaration, 19:5, Cross Declaration 9:15

[31] Cross Declaration, 9:18

[32] Cross Declaration, 9:26

[33] Engleman Declaration, 19:12

cleaning supplies weekly, which inmates had daily access to. Computer keyboards and phones were either disinfected between uses or in some cases saran wrap was used and replaced after each use.[34] On April 13, 2020, the BOP put Phase 6 in place, which essentially continued all the movement restrictions and also updated the criteria for Quarantining and isolating inmates.[35] On April 16, 2020, FCC Lompoc cancelled all staff leave.[36]

In a further effort to mitigate the spread of the virus, FCC Lompoc went beyond general BOP direction and implemented enhanced mitigation efforts.[37] This essentially resulted in confining inmates at USP to their cells with no showers, telephone, or computer access; those at the Camps had no computer or phone access; and those at FCI could only leave their quarters for restroom use or to talk with staff. They also had no computer or phone access. Hygiene and cleaning supplies continued to be made available. This remained in place from about April 17, 2020 until May 1, 2020 when FCC Lompoc began relaxing the enhanced procedures.[38]

On April 18, 2020, the BOP entered Phase 7 of their action plan. All inmates remained in their cells/quarters for most of the day. They were fed on the housing unit and only left their cells/quarters in small groups on a rotating basis for shower, phone, and computer use.[39]

On April 20, 2020, FCC Lompoc began negotiating a contract for an onsite mobile hospital (HCU) with staffing and equipment. On May 4, 2020, the construction finished,

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[34] Engleman Declaration, 19:16, 19:25, 20:4

[35] Engleman Declaration, 21:4

[36] Engleman Declaration, 21:17

[37] Engleman Declaration, 22:26

[38] Engleman Declaration, 23:19, Cross Declaration, 13:26-14:21

[39] Engleman Declaration, 26:21

and on May 12, 2020, the HCU was activated. [40] The HCU allowed FCC Lompoc to handle all but intensive-care medical services (such as those requiring a ventilator) and to lessen the impact on the three local hospitals.[41] They also erected a BLU-MED: Negative Pressure Isolation System at FCI Lompoc to handle inmates with mild symptoms who needed isolation.[42]

FCC Lompoc, along with FCI Terminal Island, reached out to the Public Health Departments in Los Angeles and Santa Barbara. The LACDPH suggested that all inmates at FCC Lompoc be tested. The BOP decided to do mass testing at FCC Lompoc based on this information. Unlike at FCI Terminal Island where LACDPH provided the tests, Santa Barbara Public Health had no recommendations and offered no tests. So, FCC Lompoc obtained its own contract with West Pac Labs and followed the procedure worked out in consultation with LACDPH at Terminal Island at Lompoc.[43] On May 5, 2020, FCC Lompoc announced that all inmates at FCI Lompoc would be tested for COVID-19.[44]

On May 8, 2020, FCC Lompoc moved 182 inmates who had tested negative from the FCI to the USP, both for protection and to aid with social distancing at the FCI.[45]

There is no question that the BOP and FCC Lompoc took the COVID-19 outbreak at FCC Lompoc seriously. The BOP began preparing in January of 2020 for COVID-19, and it moved quickly through various Phases in an attempt to mitigate the impact of COVID-19 at BOP facilities around the country. They also provided direction, guidance and both medical and correctional staff to facilities that experienced problems with

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[40] Engleman Declaration, 23:10, 23:3, 25.21.

[41] Cross Declaration, 17:1-9

[42] Cross Declaration, 17:10-15

[43] Cross Declaration, 10:6-25

[44] Engleman Declaration, 24.25

[45] Engleman Declaration, 25.3

COVID-19. FCC Lompoc was one of those facilities. They authorized the construction and staffing of an HCU and acquired a BLU-MED tent facility to assist FCC Lompoc with the outbreak. They worked closely with Public Health authorities and when the local Santa Barbara Public Health authority was unable to provide assistance to FCC Lompoc, they followed the model recommended by LACDPH officials and then directly contracted for testing at FCC Lompoc.

FCC Lompoc followed the direction from the BOP, and also consistently moved to comply with CDC guidance. This guidance evolved over time as more became known about COVID-19 and FCC Lompoc changed their procedures to match these changes from the CDC. FCC Lompoc also took some additional steps to help mitigate the outbreak, such as separating the negative inmates from those that tested positive and going on an enhanced 14-day lockdown to slow the spread of the virus.

VII. Tour of Lompoc

I conducted an in-person inspection of FCC Lompoc on September 8, 2020. I arrived at FCC Lompoc at 8:30 a.m. and reported to the training center. The training center is used to screen all staff, essential contractors, and any other visitor to any facility in the FCC Lompoc complex each day prior to entry into any facility. I was greeted by a staff member wearing a mask, gown, gloves, and a face shield. This individual asked me if I had any COVID-19 symptoms by verbally listing a number of potential symptoms. My temperature was taken, and I was asked to complete a form that again listed symptoms. Once I completed this process, I was sent to another staff member in full PPE who issued me a colored band for my wrist. This is the same process that is used each day for anyone entering any facility. A different colored wrist band is issued every day. This process ensures that everyone is screened and that the screening is consistent over time. It also speeds up the process of getting staff and others into the facilities where security screening is conducted.

The Emergency Preparedness Coordinator then fitted me for a stab resistant vest, which all staff are required to wear by law. I then met Warden Bradley, and some of her staff who accompanied me on the tour.

We started the tour at FCI-Lompoc, the low security facility. This facility has a capacity of 1522, but the current population is 1001 inmates. We started in the gym, which was used as backup housing during the outbreak. It is currently vacant, and the beds have been removed. We then went to the education building and the Assistant education supervisor showed me around the area. He indicated that they were beginning to reopen educational programming and were focusing on GED and ESL programs at that time. They were only operating at 50% capacity to allow for social distancing. He also indicated that they cleaned things between classes. We saw the law library area, which had new membrane type keyboards for ease of cleaning. The typewriters had something like saran wrap over the keyboards that was changed between uses. I also saw numerous bottles of hdqc2, a cleaning/disinfectant approved for use against COVID-19. The bathroom in this area was clean and had liquid soap. Signage regarding COVID-19 symptoms and hand washing was present in both English and Spanish.

We then went to B dorm, which is composed of several dormitory units with double bunks. We walked thru E and D units. I noticed bottles of hdqc2 hanging on almost every bunk bed that the inmates can use to clean their cubicles. Apparently, inmates had been given personal bottles of cleaning solution to clean their living area or use to clean in the restroom even before COVID-19. The bathrooms and showers were in good shape and clean. Liquid soap was available in all areas with sinks. Signage concerning COVID-19 was present in all units. The inmate cubicles were clean and organized. The inmates responded to greetings and generally were pleasant. No one expressed any concerns to me. Most of the inmates were wearing masks, and the few who weren't had gotten up from their bunks and promptly put one on when reminded. At the time of my tour, the inmates were cohorted by unit, a process started in early March.

As things have started to reopen, inmates are allowed access to recreation, food service and pill line but by unit. There is a written schedule to ensure that all units have access and don't mix with other units. While this slows things down and limits the time for each unit, it is a start of returning to normality while still being aware of the need to be controlled to mitigate the chance of another outbreak. I had a brief conversation with a unit Counselor who has been at FCI Lompoc since 2008. He indicated that things were going much better today, and that things were handled as well as could be expected. I also saw the telephone and computer area. These too are used by cohort and are cleaned after each cohort. There was COVID-19 related signage present, and several spray bottles with hdcq2 for use by the inmates who were using the telephone and/or computer. They also had replaced all the computer keyboards with an easier to clean membrane type keyboard.

We then went through food service, where I noted every other seat was marked off, indicating not to sit there for social distancing. It was also indicated that the area and tables were cleaned between cohorts or units. The area appeared clean and in good repair, as did the kitchen. Signage concerning COVID-19 was present.

We then went to A dorm. The first floor of this building contains the medical department. The Health Care Administrator took me through the area. He showed me the pill line area, which had social distancing markings on the floor. He also indicated that medical staff pick up sick call slips from the locked boxes on each housing unit each day, and they are triaged and scanned into the computer system. If an inmate has an emergency medical situation, they tell the Corrections Officer or other staff and they will be seen immediately. I saw exam rooms, which appeared well equipped, the lab, emergency service, and x-ray area. I also saw the new dental clinic, which was bright and very clean. The Dentist indicated that the new equipment made their job a lot easier. The HCA also indicated that he believed that medical care was being delivered as needed and chronic care cases were being seen. Their biggest problem had been a

shortage of staff, but the BOP had addressed this by sending in additional staff during the COVID-19 outbreak. The inmate bathroom was clean and had liquid soap, and signage was present there and throughout the medical area. We also toured H and G units in A dorm. These were the same as the units toured on B dorm.

We then went to J unit, which is another dormitory area. The inmates in this area have all tested negative for COVID-19. At FCI Lompoc, once mass testing began, inmates who tested positive were isolated in place. Those that tested negative were removed from the unit and quarantined in J unit where they remain today. While this made sense to best isolate the positives and protect the negatives, now that there are no positives at FCI Lompoc, the negatives need to be reintegrated into the general population to best protect them in the future. This same situation occurred at FCI Terminal Island, and they have reintegrated the negatives at that facility. Staff have begun discussing this with the inmates in J unit, but the inmates have some concerns which the staff are working to alleviate before they begin the process.

J unit was clean and well maintained as was the rest of the facility. The inmates seem to be in good spirits, and no one expressed any concerns to me. The bathroom and shower area were also clean and in good shape. Liquid soap was available in all the restrooms. Nearly every bunk had a bottle of spray cleaner/disinfectant. The Associate Warden indicated that they always have cleaner/disinfectant and that they never run out throughout the facility. We then went to the Lieutenant's office where I was shown the supplies that were available to be dispensed to the units on a regular basis or upon request should some unit run out of supplies. There was a lot of bottles of bleach, concentrated hdcq2, and soap. There were also numerous boxes of PPE. I asked an Officer in this area what she did if they ran out of something, and she indicated that they generally didn't because they would send request to the warehouse for more if they started to run low. But if they did, she would call the warehouse and the item would be promptly delivered.

I then had an opportunity to talk with five inmates.[46] All of them had been at FCI Lompoc before and during the outbreak, and had tested positive but now have recovered. A few of the inmates I spoke with indicated that they did not know about the virus early on and therefore weren't prepared to deal with it. A few of the inmates I spoke with said they learned about the virus from the news and there wasn't a lot of information provided by the institution, though one inmate did state that a lieutenant did go around the facility and that he provided good information about what was happening. The inmates I spoke with indicated that they had multiple masks and could get replacements. Several indicated that cleaning supplies and hygiene kits were available. Two inmates said that they were still experiencing some mild symptoms, the other three originally had only mild or no symptoms. One who indicated that he has a condition that may cause him to have a more serious reaction to COVID-19 and is concerned about reinfection, despite only having mild symptoms the first time. No one complained about the medical response or care they received. One inmate indicated the difficulty of social distancing in the facility, particularly in the dormitory settings.

I then talked with a paramedic who has been at the facility for almost three years. He indicated that they responded to the outbreak the best they could given the limited knowledge that was available about COVID-19 early on. He said it was stressful and taxing particularly given the shortage of medical staff in the beginning. However, things got better as more staff came onboard. He also indicated that sick call response was good throughout the outbreak. They would get the paper sick call slips each day and triage them. Those with COVID-19 symptoms or other more serious problems would be seen on a priority basis. The BOP policy requires anyone who submits a slip to be seen in 14 days, but he indicated that most were seen in 2-3 days.

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I also talked with a lieutenant who had been at FCI-Lompoc throughout the outbreak. He indicated that early on when the virus began being active in the community, visitation at FCC Lompoc discontinued. Lompoc staff also began educating the inmates about COVID-19. They told the inmates to let someone know if they were sick. FCC Lompoc also acquired more chemicals for cleaning /disinfecting and went to a more powerful cleaner, hdcq2, which is approved for use against COVID-19. The first signs about COVID-19 symptoms and hand washing went up on February 24, 2020, and they started to cohort by group at the same time. They also had the inmates begin sleeping head-to-toe to allow for better social distancing. He is not sure what else could have been done early on given the state of knowledge about COVID-19.

I then went to the North Camp, which consists of one dormitory and had a population of 97 inmates at the time of my visit. Two Unit staff members conducted the tour. We walked through the dorm. It was clean and organized, and the inmates who were present appeared to be in good spirits. Recreational equipment like pool tables, weights and treadmills were still shut down, just as they are in the general community, as a precaution against COVID-19. The bathrooms and showers were clean and in good shape, and it was indicated that they are cleaned regularly. There were liquid soap dispensers in the sink area. There were also a number of bottles of hdcq2 in the area where the phones and computers for access to TRULINCS are located. They also had the new membrane type keyboards. Most bunk beds in the dorm also had bottles of hdcq2 hanging on them. The inmates use this to clean their living area, and they can take them to the bathroom and shower area to personally clean before use. There were also signs regarding COVID-19 symptoms in both Spanish and English in the dorm area and signs about the proper way to wash hands in the sink area. Food is prepared in the kitchen, the equipment looked to be quite new, and picked up by the inmates to be eaten in the dorm at their cubicles. It was also indicated that in addition to hdcq2, they use bleach and HALT for cleaning and disinfecting at the Camp.

I was then approached by inmate [redacted] who told me that on March 29, 2020, he was the first North Camp inmate to test positive. He said he had chills and a temperature and was moved to the SHU in USP Lompoc, and then he was moved to H unit. He said that he believed that H unit was not clean and had no shower. There were also no phone or computer access. He believed that all departments were understaffed, and staff were rotating. He believed some inmates were afraid to tell if they were sick. He believed that Lompoc should have shut things down earlier and tested earlier. But he now wants more outside time and believes they are being too restricted.

We then went to the South Camp, which consists of two dorms and a number of other buildings. The one dorm has a population of 90 and a capacity of 168, and the other a population of 95 and capacity of 188. The dorms were very similar to the North Camp as they were clean and organized. Spray bottles were present hanging on most bunks, and they were also available at each computer station and for the telephones. They also had the new keyboards. All bathrooms and showers were clean, and it was indicated that they were cleaned twice a day. They had a pill line at the medical area with social distancing markings. One difference is that the kitchen and food service area in the South Camp is closed for refurbishment, part of the ongoing maintenance done at the complex. It was indicated by the Warden that the refurbishment will start as soon as some roof repairs are completed. This ongoing maintenance is one reason that FCC Lompoc generally appears to be in good repair. The North Camp kitchen currently prepares the food for the South Camp, and once it is delivered, inmates pick it up and eat at their bunks, just as the North Camp does. Since they have two dorms, they are cohorted and areas like the telephones and computers are sanitized between use by each dorm. No inmates expressed any concerns or raised any issues with me.

I left the FCC Lompoc complex at 12:30 p.m.

On September 9, 2020, at 8:45 a.m., I arrived back at FCC Lompoc. I reported to the training center, was screened as I had been the prior day, and was given a wrist band.

I met with the Warden, the Associate Warden (AW), U.S. Public Health Officer Lt. Commander [redacted], and other staff who accompanied me on the tour. We began the tour at the Hospital Care Unit (HCU), which had been constructed in a vacant warehouse in April and May 2020. The BOP had decided to quickly construct the HCU to deal with the surge of COVID-19 patients who needed higher level care so as to not overwhelm outside hospitals. The HCU is an 18-bed unit that has state of the art medical equipment. The unit is extremely clean, self-contained, and very well equipped. Since they only have one COVID-19 positive case who has few symptoms, the HCU was closed at the time of my visit and the equipment was covered with plastic. There is also a large screened-in area directly outside the HCU that is filled with medical supplies needed to run the HCU if it is opened in the future. The BOP is apparently looking at expanding the unit to 40-beds (there is plenty of space within the warehouse to do so) and operate it on an ongoing basis to provide additional medical care for the Western region. The HCU is impressive and after expending a considerable amount of money to get the HCU up and running, it makes sense to use this for general medical care in the future.

We then went to J unit, which has a capacity of 242 but currently houses 117 inmates. It is a two- tier celled housing unit. I met the Unit Manager, and he and the AW showed me around the housing unit. It was indicated that they not only cohort by housing unit, they are cohorted by side of the unit, with one side being opened for six hours and then the other. During that time, inmates can shower, use the phone/computers, recreate, and use the law library. Those requiring GED can also participate at this time. Inmates can also go to the auditorium and watch a movie once a week. Each inmate is also provided a hygiene kit with soap, and two rolls of toilet paper a week. Inmates also get 500 minutes of free telephone time a month, which is an increase from the 300 minutes permitted prior to the suspension of visitation. I noted spray bottles of cleaner/disinfectant in the cells I looked into. I also checked the showers that are available on the upper and lower tier. They were clean and in good repair.

Inmates seemed pleasant and no one expressed any concerns to me. Signage about COVID-19 was present.

From there we went to the auditorium. I noted that many seats had been marked off so they wouldn't be used to provide for social distancing.

We then went to the Security Housing Unit (SHU). Part of the SHU is being used for Quarantine cases for pre-release inmates that need protection, close contact and self-surrender cases. The rest of the unit is for disciplinary cases. They are separated by range and all the cells have solid doors and each cell has a shower. The SHU Lieutenant indicated that cells are cleaned with bleach between uses and that PPE, including bleach, is well-stocked. He also indicated that he assigns staff to quarantine or disciplinary and doesn't mix them. Staff who must open the food slots to feed the quarantine ranges were wearing the proper PPE for quarantine units, gowns, mask, face shield and gloves. I visited range 5, which was a quarantine range, and range 6, which was a disciplinary range. The unit was clean and had no smell. Inmates who are quarantined are not getting exercise, because CDC recommends keeping them in their quarantine space unless absolutely necessary, but their time in the unit is limited.

Next we went to receiving and discharge. Receptions are limited but do occur, and there were several incoming inmates in temporary holding cells when I arrived. A receiving Officer indicated that when they received an inmate, they made sure he was wearing a mask before he was brought into the reception area. They also had a temperature and symptom check, and a rapid test for COVID-19. They were then placed directly into what they called a "dirty" cell by cohort, because no strip search or security screen had yet taken place. If they are clear on all the checks and test, they are then put through security screening and moved to a "clean" cell. The reception process is completed, and within a few hours, they are moved to Quarantine for 14 days before being tested again and then being placed in general population. Since the release test is sent out to a lab, they generally spend two or three more days in Quarantine before the

results are available.

We then walked thru the barber shop that is in operation. The Instructor indicated that the barber training program was a 1500- hour program that inmates complete to obtain a license. We then went to the education area, and the supervisor provided information as to how things were going. He said that they had restarted programs, and at this time, they were focusing on GED, ESL, and some vocational training programs. They are operating at about 50% capacity to allow for social distancing and are bringing inmates for programs and law library by cohort. Signage concerning COVID-19 was present throughout the area. The computers had the new membrane type keyboards and typewriters had something like saran wrap covering the keyboards that was replaced between uses.

We then went to M unit, which is used for prerelease quarantine. While not required here, staff were wearing full PPE. It was explained that they had different types of quarantine units and they were concerned that if they had different requirements for different units, staff may become confused, so they standardize what is required in all quarantine units. This certainly makes sense and reduces the likelihood that mistakes will be made.

We then went to I unit which had the only inmate who was positive for COVID-19 at the time of my visit. He had been in prerelease quarantine but was positive upon being tested and moved to isolation in H unit. Lt Commander Figlenski and I donned full PPE and went down the range to his cell. He only spoke Spanish but the officer who was assigned there and who was in full PPE, spoke Spanish and was able to translate. He did not indicate that he was having any problems and noted no symptoms. He was looking forward to leaving and said that he had 8 more days. This case is an excellent example as to why it is important to quarantine and test inmates before they are released back into the community.

We then went to the medical department. The Health Care Administrator took me thru the area. He noted that they were short of medical staff when the outbreak hit but that the BOP began sending medical teams to supplement staff. They got nine medical personnel early on and a total of 19 medical staff rotated through during the outbreak. This was important because in addition to the extra medical care needed, and increased sick call slips, the medical staff also had to do daily temperature and symptom checks for quarantine and isolation units. The supplemental staff allowed them to deal with the increased medical demand such as sick call requests and other ongoing medical needs.

Before COVID-19, the process to get on sick call was for an inmate to report directly to medical at breakfast time. Since they were eating in their cells and are still being moved in cohorts at this time, the prior process was not practical. So, BOP staff have placed locked sick call boxes on each housing unit. Inmates place their sick call request there and a medical staff member picks them up on a daily basis. Emergency requests are handled as they always have been by reporting it directly to a Correctional Officer or other staff member who will notify medical. I ask him if he were aware of any issues in seeing chronic care cases during the outbreak. He indicated that the medical provider schedules the next visit, and he was not aware of any problem with these cases being seen.

I then met the medical director. He indicated that when they needed staffing help, it was provided by the BOP. The medical director personally monitored the chronic care cases closely, and he never felt that they fell behind in providing care. He also said they conducted peak flow testing when indicated, and while some of the processes may have changed, proper care was given throughout the outbreak. They also had weekly calls with Santa Barbara County Health Department and the CEOs of the three local hospitals. This allowed them to stay on top of things and to manage the use of the hospitals.

I then talked with four staff members, all of whom had been present for the outbreak of COVID-19. One who worked for the Special Investigative Services

indicated that when it started he was a part of the union, and that they worked closely with management. He said the complex went heavy on getting PPE and that staff was educated about the virus through daily emails and during shift call the Lieutenant would provide updates or any new information. The inmates also received daily updates through TRULINCS.

A Correctional Officer stated that there was a lot of education, especially with the inmates. There was plenty of PPE available. The Officer believed that BOP did a good job dealing with the outbreak at FCC Lompoc.

Another Correctional Officer also noted the regular emails and said that they received regular information during shift call with the Lieutenant. He further indicated that there was never a problem with masks or PPE, signs were posted, and things were sanitized regularly. He believes that the inmates knew that the steps taken were to help them and that staff were trying to keep them safe.

I also spoke with an Infectious Disease Nurse who said that the BOP did a good job of responding to the COVID-19 at FCC Lompoc. They identified, tested and isolated as required. She also indicated that they used a form that provided guidance to do the temperature and symptom checks and at one time they were doing everyone. They also did their pill line twice a day and checked on diabetics and other chronic cases as required. At one time, they were going to the units but now have returned to the practice of running pill line at medical. She indicated that talking points were passed out regularly, town halls were conducted, and weekly updates continue to this day.

As a next step in my tour, we returned to the Warden's conference room and covered a few other issues. The first inmate was positive on March 27, 2020. The medical staff had been treating him for a gall bladder problem and had no indication he was COVID-19 positive. When he was sent to the hospital for his gall bladder problem, he was tested for COVID-19 and was positive. He has since recovered.

There was concern in the Plaintiffs' filing about H unit. Plaintiffs claim that it had been closed due to mold. Both the AW who had been at the facility for some time and the Public Health Lieutenant Commander indicated that this was not true. H, I and M units had been closed at the time of the COVID-19 outbreak. They were not closed due to any structural or environmental issues. They were closed because the inmate population was low enough to allow the closure and to reduce staff required to operate the facility. All three units were reopened to allow the facility space for quarantining and isolating inmates. They remain open at this time. M unit is used for prerelease quarantine, I unit is used for intake quarantine, and H unit is still being used for isolation for the only COVID-19 positive at the facility. There is no mold in H unit and during my visit it was clean and in good order.

FCC Lompoc went on a very restrictive lockdown for about two weeks in April 2020 in an effort to mitigate the spread of the virus. Some inmates in USP Lompoc didn't get out of their cells, and everything was delivered to them (food, Medication, etc.). Therefore, some didn't get showers for a number of days, but they had soap and a sink/toilet in their cells. The rest of the complex, which is mostly dormitory, had to have access to the central restrooms and still were able to shower. But inmates in the entire complex were restricted from telephone/TRULINC access. All inmates still had access to incoming and outgoing mail. At USP Lompoc, staff, including mental health staff, checked on the inmates on a regular basis.

All staff have been issued small bottles of alcohol-based hand sanitizer. All inmates at USP Lompoc receive a weekly hygiene kit for use in their cells. Inmates in the dormitories at FCI Lompoc and the Camps have access to hot water and liquid soap in their bathrooms.

VIII. Inspector General's Remote Inspection of FCC Lompoc

In July 2020, the Inspector General issued a report on FCC Lompoc's response to the COVID-19 pandemic. The report had a number of findings.

First, there was a preexisting shortage of medical staff at Lompoc that presented some initial challenges in mitigating the spread of COVID-19. Medical staff now had to screen staff and inmates for Covid-19 symptoms as well as providing ongoing routine medical care. Staff shortages also existed in correctional staff, which prevented them from full implementation of staff movement restrictions for up to 15 days.

Second, the report indicated that the initial screening process was not fully effective because the report identified two staff members whose symptoms were not detected in the screening process and were allowed to continue working. The report also indicates that an inmate with COVID-19 symptoms was allowed to stay at the facility, not isolated, for about four days.

Third, the report noted the lack of a permanent leadership team coupled with the physical characteristics of the facility contributed to deficiencies in Lompoc's response to COVID-19. The Warden at FCC Lompoc retired on January 19, 2020, prior to the COVID-19 pandemic, and three experienced BOP upper level staff rotated thru the position until the position was filled on June 7, 2020.

Fourth, the report indicated that, in a survey, staff indicated that they felt there was a shortage of PPE, hygiene items, and space for quarantining inmates. Finally, the report indicates that the BOP in general and FCC Lompoc specifically were slow to utilize home confinement in order to protect the vulnerable and improve social distancing.

The report also indicates that in response to the medical and correctional staff shortages, the BOP began deploying staff from other institutions to assist with inmate security, clinical care, administrative oversite, and the HCU.[47] The BOP indicated in a

[47] DOJ Office of the Inspector General, Pandemic Response Report, "Remote Inspection of Federal Correctional Complex Lompoc", July 2020.

response to the report that they had deployed 40 additional medical staff and 131 correctional staff at various points during the outbreak.[48]

While the report indicated that some of the initial screening may not have been effective, it also indicates that the one staff member did not report his symptoms and the other had symptoms that were not included in the FCC Lompoc survey at that time. The inmate in question was thought to have gall bladder issues and his symptoms were not seen as being COVID-19 related. In fact, he was hospitalized for at least a day before the hospital decided to test him for COVID-19.

The report also indicated that while the survey indicated that some staff felt there was a shortage of PPE and hygiene items, FCC Lompoc officials stated that they had an adequate supply. They indicated that in accordance with CDC guidelines, Lompoc was testing symptomatic inmates, and they arranged for mass testing in late April 2020 before this was recommended by the CDC. They also complied with the mask policy by issuing masks as directed by the BOP, after CDC made this recommendation. The report further indicated that Lompoc took a number of steps to enhance social distancing by using the chapel, visiting room, tents, a drug abuse facility, the gym and a closed UNICOR factory. FCC Lompoc created space for isolation and quarantine in three housing units that had been closed, and activated the HCU. Not only did this help with social distancing, it also allowed them to isolate and quarantine inmates.[49]

IX. Dr. Venters' Report

I have reviewed Dr. Venters' report on FCC Lompoc and find that much as he did in *Chunn vs. Edge* (Case 1:20-cv-01590-RPK-RLM), he makes recommendations that go beyond CDC guidance and he offers no standards supporting his recommendations. In *Chunn*, Judge Kovner noted this criticism in a number of places in her Memorandum

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[48] Santa Maria Times, "Officials defend methods used in Lompoc prison's response to COVID-19", by Dave Minsky, July 28, 2020.

[49] DOJ Office of the Inspector General, Pandemic Response Report, "Remote Inspection of Federal Correctional Complex Lompoc", July 2020.

Order in that case. Dr. Venters also frequently relies on statements from unknown inmates and in unknown quantities. In the *Chunn* case, he at least identified the inmates whose statements he relied on. In one example noted by Judge Kovner, two inmates claimed that they had not been screened upon reception, but the facility was able to produce documentation proving that they were in fact both screened. In this case, however, there is no way to validate the inmate statements that Dr. Venters relies on, because he does not identify their source. There are also some areas that Dr. Venters presents as concerns where the facts and documentation do not substantiate his concern.

Dr. Venters mentions a number of deficiencies in his report. The first revolves around screening of inmates who are not known to have had COVID-19 and who are housed in J unit at FCI Lompoc. He believes that each of these individuals should have daily screenings for COVID-19. However, the most recent CDC guidelines do not have this recommendation.[50] In addition, since FCC Lompoc wants to reintegrate those that have tested negative back into the general population, Dr. Venters' concern will become moot once reintegration occurs.

Second, Dr. Venters expresses concern about inmates on work details from the Camps not being screened. He indicated that despite assurances from leadership at the facility and a PHS officer that inmates were screened daily, he did not have a written record that daily screening occurs. He also indicates that some inmates told him that they aren't screened, and some individual officers were unaware of the process. Dr. Venters, however, does not identify who the inmates are nor how many indicated the lack of screening. Dr. Venters also does not identify who the officers are nor does he indicate who is supposed to conduct the screening.

Third, Dr. Venters believes that many medical records indicate inconsistent medical screening of some inmates who became ill from COVID-19, because some of

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[50] CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, 7/22/20.

those who died from COVID-19 had less than daily documented screening while in quarantine or isolation. He also indicates that 140 pages of screening records reflect a reliance on temperature checks only.

Since Dr. Venters fails to identify any of the documents that he relied upon, responding to this concern is somewhat difficult. However, I did review the records for the four inmates who died. In two cases, they were not known COVID-19 cases until they were tested at the hospital so there was no time spent in isolation.[51] Another inmate was screened, as clearly shown in the records for the 14 days that he was in isolation. He died four days after being released from isolation in accordance with CDC guidelines. That screening included checks for temperature, and symptoms as reported in the record.[52] The fourth inmate who died was also checked upon from the date he was symptomatic and tested positive on a rapid COVID-19 test until he was transferred to the hospital, except for the day prior to his transfer to the hospital. He had tested positive on May 2, 2020 and was checked on May 3 and 4. On May 4, he was taken to medical and had an x-ray that indicated lung issues. The record doesn't indicate where he was or what happened on May 5, but his name was removed from the pre-printed sheet that medical personnel used to conduct screening on the housing unit, so he was no longer in cell E01-005U. This would seem to indicate that he was held in some other location prior to his transfer to the hospital on May 6, 2020. The record also indicates that temperature, pulse and O2 level were monitored and recorded during this time period.[53]

Additionally, while Dr. Venters does correctly indicate that the 140 pages of records using the pre-printed list by housing unit and cell only lists a temperature check being conducted, the records of the two inmates who died and were being appropriately monitored reflect that more than just a temperature check was occurring. It appears that

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[51] BOP0007714-0008055, BOP0007426-0007713

[52] BOP0008056-0008123

[53] BOP0008124-0008320

the 140 pages of pre-printed records he reviewed was used to ensure that everyone was seen, and the actual individual information was recorded elsewhere and later entered into the individual inmate's record.

Dr. Venters' next area of concern related to sick call access. Dr. Venters believes that timeliness exceeded "stated expectations" based on the unidentified inmates he spoke with. This may be true in that most people want immediate access to medical care, though we often have to wait for days depending on our symptoms. The BOP system isn't much different in that the sick call slip is triaged by medical and those with more serious problems are seen generally within 24 hours and the others are placed on sick call in accordance with availability. BOP policy is that any sick call slip must be responded to within 14 days. This is consistent with what staff told me and they further indicated that most are seen within three or four days. Since we again don't know who is expressing concern to Dr. Venters, it is not possible to check the case to see if they were responded to and how soon. We also don't know if multiple slips on the same subject were submitted nor if the individual was seen but simply wasn't happy with the treatment received. But the FCC Lompoc does have a viable sick call triage procedure where they lay out, a criterion, as to who should be prioritized.[54]

I reviewed in excess of 110 requests for medical care that were a part of the material provided to Dr. Venters and over 50% were responded to within 24 hours, often on the same day the request was made. Those with more serious concerns were the ones who had some action taken within the 24-hour time period. Beyond that, about 25% were seen or had some action taken within 2 to 5 days. The rest fell within the 6 to 14-day time period. Overall, these records indicate that the medical staff at FCC Lompoc are following BOP guidelines relative to sick call.[55]

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[54] FCC Lompoc Inmate Sick Call During COVID-19

[55] BOP0003921-0004118

Dr. Venters also believes that almost all the unidentified inmates he talked with who were on the chronic care list reported care being received beyond the 3-6-month period referenced by BOP staff. He again provides no names so that any of these claims can be investigated. Dr. Venters then makes a series of assumptions based upon chronic care encounters in August of 2020, the reported number of high-risk people, the number he then estimates to need chronic care services, and the percentage split between the potential time period that the people would need to be seen. From this, Dr. Venters then opines that approximately 200 more inmates would have needed to be seen in August to ensure that people were being seen in a timely fashion. This assessment runs counter to what the Medical Director at FCC Lompoc independently told both Dr. Venters and me during our tours at the Lompoc facilities.

I also had an opportunity to review a report listing chronic care encounters that was provided to Dr. Venters. The report contained the last physician chronic care clinic date and started in late 2019 through September of 2020. Some months have a higher number of encounters than others, but they all reflect ongoing chronic care services being provided. In fact May 2020, when COVID-19 positive cases were significantly present in the facility, seems to be the month when physicians had the highest number of encounters.[56] Thus it seems that just as with sick call, Dr. Venters relies mostly on unverified inmate reports to reach his opinions.

Dr. Venters notes that there is a lack of assessment for ongoing Covid-19 symptoms among those that have survived the infection. He goes on to state that they lack any system to look for these problems after a person leaves medical isolation. I have looked through the CDC guidelines for corrections and detention facilities and their advisory relative to discontinuation of isolation for persons with COVID-19 not in healthcare settings. I see no CDC recommendation for a follow- up several days or

[56] BOP0007315-0007420

weeks after release from medical isolation.[57] I would contend that the BOP and as such FCC Lompoc does have a system in place to deal with these kinds of issues and that is their sick call policy.[58] Just as I would contact my medical provider if I had lingering symptoms of concern or needed follow up care, the inmate population has such a system in place to report such problems.

Dr. Venters believes that there is a lack of infection control in the housing units at FCC Lompoc for several reasons. First, he states that there was a lack of paper towels to dry ones' hands. But except for one housing unit that apparently had a broken hand dryer, he offers no specifics and seems to largely rely upon what unknown inmates told him during his tour, rather than what he observed first hand. Inmates also have access to hand towels and bath towels within the housing unit near the bathroom facilities.

Second, Dr. Venters notes that while BOP/PHS staff stated common surfaces are cleaned and disinfected at least twice a day, his review of the Truintel system did not confirm these statements. It should be noted that Dr. Venters reached this conclusion based on a 48-hour time period at the North and South Camps, which house less than 300 of about 2200 inmates for the complex. Additionally, my review of the documentation that Dr. Venters relies does not substantiate his findings in this regard. The South Camp records provided to Dr. Venters indicate that the unit was sanitized twice on August 22, 2020, and that on August 23, 2020, records indicate that it was sanitized three times.[59] At the North Camp, records provided to Dr. Venters reflect sanitizing occurred twice a day on both August 22 and 23, 2020.[60]

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[57] CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, 7/22/20,

[58] FCC Lompoc Inmate Sick Call During COVID-19

[59] BOP0007287

[60] BOP0007288

Dr. Venters also notes the punitive nature to quarantine in the SHU unit and indicates that inmates don't have access to phone privileges and out of cell time in accordance to CDC guidelines. While CDC does indicate that those placed in isolation should to the extent possible not be treated punitively, they also expressly state that one should "keep a quarantined individual's movement outside the quarantine space to an absolute minimum".[61] So while I would agree that the situation should be normalized to the extent possible, out of cell time, beyond what is absolutely necessary is not a good idea nor in compliance with CDC recommendations.

Dr. Venters then goes on to make a series of recommendations. His first recommendation is to screen all inmates at FCC Lompoc on a daily basis for elevated temperature/symptoms. He prioritizes who should be screened by those on work crews, those that are COVID-19 negative, and those that are over 90 days post COVID-19 infection. However, according to BOP staff, the work crews are being screened. Dr. Venters indicated that inmates, some staff and a lack of documentation make him question that this is occurring. Since it is FCC Lompoc policy to screen these individuals, they should make sure that it is occurring. As to the other screenings noted, I see nothing in CDC guidance that indicates that this should occur. The presumed COVID-19 negative inmates are to be reintegrated back into the general population, which will lessen their risk of getting COVID-19, and in the case of those 90 days post infection, their immunity or lack thereof, is still an open question. Therefore, it would seem reasonable to look to CDC guidance relative to who, if anyone beyond those in quarantine or isolation, should be screened on a daily basis.

Dr. Venters also states that FCC Lompoc has vacant medical positions and therefore needs additional staff to meet sick call/chronic care obligations and should fill these positions within 30 days. As indicated earlier, the Medical director and HCA both

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[61] CDC, "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities", 7/22/20.

indicated that they were effectively dealing with both sick call and chronic care issues. The records would also indicate that this was occurring. So, while it is indeed important to try to fill any vacant positions that have been allocated to FCC Lompoc, this does not appear to be necessary to maintain appropriate medical care at the facility. The BOP has also shown that they are monitoring the situation, as when the number of COVID-19 cases began increasing and putting more stress on the medical services, the BOP provided supplementary medical staff to FCC Lompoc and even constructed and staffed a hospital care unit (HCU) in short order. Dr. Venters also wants a staffing plan and threshold for use of the HCU if future active COVID-19 cases arise. It would seem that both the BOP and FCC Lompoc are capable of making this determination since they did it when they constructed the unit in the first place. A unit that is still in place with ample supplies and which could be activated in short order.

Dr. Venters also recommends, as noted earlier, that any inmate with a recorded positive for COVID-19 have a health encounter within 7-10 days of release from medical isolation to look for lingering symptoms. As stated, this is not noted in CDC guidance relative to Corrections and Detention facilities nor in CDC guidance relative to discontinuation of isolation for persons with COVID-19 not in healthcare settings.[62]

Dr. Venters also wants changes to basic quality assurance tools relative to sick call and chronic care to ensure they are seen in a timely manner. Except for the statements of unidentified inmates and Dr. Venters' assumptions based on one month of encounters, there is nothing to indicate that there is a problem in these areas. Dr. Venters had good things to say about the quarterly quality meetings, which does look at these issues, but not in the way he would like them to do. Dr. Venters offers no specific standard or guidance that he believes requires some change. As he did in a number of areas, it is not even clear that Dr. Venters is aware of the breath of BOP and FCC Lompoc reviews in

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[62] CDC, "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities", 7/22/20, CDC, "Discontinuation of isolation for persons with COVID-19 not in healthcare setting", 7/20/20.

this area.

Dr. Venters then makes a series of recommendations relative to cleaning/disinfection, mask wearing, social distancing and training/education. Again, other than unidentified inmate statements and records on cleaning/disinfection, which were not accurately presented, he fails to show that efforts aren't being made in all of these areas by staff at FCC Lompoc. While we all know that COVID-19 presents an extremely unusual situation and it takes time to adapt to some of these changes, for the most part, things are occurring as they should at FCC Lompoc and some of the responsibility for compliance with social distancing and mask wearing rests with the inmates themselves. With social distancing, not only did staff start talking about this early on, they did a number of things to try to help. For instance, BOP staff at Lompoc started cohorting housing units, and they continue to do so throughout the facility. They have placed marking on the floor at pill lines to indicate the desired separation and they remind inmates about masks when needed. Dr. Venters also thinks that a monitoring tool should be put in place to ensure compliance with these issues. The BOP notified the field in their phase 9 memo that unannounced reviews would occur at facilities to check on compliance with CDC guidance relative to response to COVID-19. This review would not only check on the items that Dr. Venters notes, but on the broader CDC guidance in general.

Dr. Venters wants paper towels and soap to be available to all inmates where they wash their hands. However, liquid soap was available in all the restrooms that I observed during my tour. Other than some inmate statements Dr. Venters presents no general information that this is not occurring. In addition, inmates who are housed in cells with a sink are provided a free hygiene kit each week that includes soap. All inmates have a hand and bath towel available to them. To the extent that paper towel dispensers may occasionally be empty or hand dryers broken in a restroom, FCC Lompoc staff should try to minimize this from happening and correct the issue when made aware of it.

Dr. Venters' recommendation relative to basic services to inmates in quarantine and isolation is certainly not unreasonable and is in accordance with CDC guidance. This would include phone calls, reading material, and some property. However, his recommendation for recreation and out of cell time goes beyond and in fact is not in accordance with CDC guidance that states that movement outside the cell should be minimized.

He then recommends that FCC Lompoc and the BOP should investigate occurrences of retaliation and threats against inmates who report medical related concerns. While I think that we all can agree that such actions, if they occur, should be taken seriously and be fully investigated, Dr. Venters gives no specifics beyond unidentified inmate statements that this occurred. It is unclear to me how this should be investigated without more concrete information or some source point to begin this investigation.

Dr. Venters also believes that FCC Lompoc and the BOP should expedite applications of high-risk inmates for home confinement. At the time of my visit to FCC Lompoc, it was indicated that the FCC complex had processed 254 inmates to an RRC, 87 to home confinement, 68 to compassionate/immediate release and 143 to street releases. Therefore, from March 26, 2020 through September 4, 2020, FCC Lompoc has released a total of 552 inmates or about 25% of their current inmate population. This exceeds what many other state and federal facilities around the country have released and puts FCC Lompoc in the range of what some county jails, who have an easier time achieving releases have accomplished.

Dr. Venters' last recommendation centers around having the PHS and the BOP reviewing all COVID-19 related deaths throughout all BOP facilities nationwide. This recommendation seems to be tied to the fact that he believes there were gaps in daily screenings for some of the four inmates who died of a COVID-19 related death. As I noted previously, there was no gap in two cases because they did not test positive and

thus were not in isolation until they were received at the hospital. A third case was appropriately screened every-day until released from isolation. The fourth inmate was also screened for all but the day before he was hospitalized, when it appears, he was moved after having an x-ray that indicated some significant lung damage. The other reason for this expansive review is because of potential missed chronic care reviews but no specific information is given in this regard. Finally, Dr. Venters indicates that whether the inmate should have been released from prison and because the four mortality reviews fail to identify findings and make recommendations for improvements in care are additional reasons for such a review.

It would seem to me that with only four cases involved, the general absence of gaps in screenings, the absence of known chronic care issues, the large number of inmates released from FCC Lompoc, and because the four mortality reviews found no problems, that making a such a BOP wide recommendation significantly over-reaches the facts and is not grounded on the information and documentation that Dr. Venters relied on for his report.

X. Conclusions

The first COVID-19 cases at FCC Lompoc were identified in early April 2020. At that time, there was an acting Warden because their previous Warden had retired in January 2020. The Warden is a key position in any correctional facility, where a stable and effective warden can make a significant difference in how a facility operates. The fact that FCC Lompoc had four individuals operating in this position over a short period of time during a growing COVID-19 outbreak at the facility is certainly not ideal. However, there are a several things that mitigated the turnover in this critical position. First, the individuals who were temporarily assigned all had significant time and experience with the BOP. Second, the structure and direction provided by the BOP helped to make up for the lack of stability in that position, and there is ample evidence that FCC Lompoc followed the direction from the BOP as the various phases were

announced. Finally, there was stability at the associate warden level, as during my tour of both FCI and USP Lompoc the associate warden for each facility who accompanied me on my tour had been present during the COVID-19 outbreak at that facility.

While FCC Lompoc did have an initial shortage of staff when the first COVID-19 cases were identified at that facility, the BOP moved rapidly and provided temporary duty medical staff to assist with ongoing medical needs at the facility. During the time when the highest number of COVID-19 cases were present at the facility, a total of 19 temporary duty medical staff rotated though FCC Lompoc. In addition, on April 20, 2020, the BOP began working on establishing an 18-bed hospital care unit at FCC Lompoc. This unit was constructed, staffed with contract medical staff, and activated on May 12, 2020. So, in a little over three weeks a sophisticated hospital care unit was put in place to aid in responding to the increased number of COVID-19 cases at that facility.

It is unlikely that even without these initial problems that FCC Lompoc would have faired much better when COVID-19 cases began emerging at that facility. The design of the facility, particularly the FCI and Camps, which are primarily dormitory based, creates an environment where control of a highly contagious disease is difficult. The limited knowledge about COVID-19 at the time only further hampered efforts to get it under control.

I think it is important to note that the outbreak of COVID-19 at FCC Lompoc is not unique. There are a number of facilities around the country that had a similar problem. Most of these facilities were largely dormitory type housing, or a mixture of dormitory housing and cells with open bars in the front. In such settings, once the virus takes hold among inmates without immunity it may spread rapidly.

The Marion and Pickaway facilities in Ohio are an example. The Marion Correctional facility is a combo facility with open bay dorms and cells. It was reported to have an 80% positive rate among their inmate population, one of the highest in the country. The Pickaway correctional facility, which is an open bay dorm facility, had a

positive rate of 67%.[63] In Michigan the Muskegon Correctional facility had a positive rate of 75%. The Lakeland Correctional facility, a dormitory facility, had a 56% positive rate.[64] In Oklahoma, the Eddie Warrior Correctional Center which is open dorms had an 80% positive rate.[65]

An example of how fast COVID-19 can spread through a facility is San Quentin a California Department of Corrections and Rehabilitation (CDCR) facility. In May 2020, 121 inmates were transferred from the California Institution for Men (CIM). At that time, San Quentin had no inmates who were positive for COVID-19. The inmates who were transferred were those at higher risk of an adverse response to COVID-19, which was active at CIM at the time. While they were tested prior to transfer, apparently some of the testing had been done a week or more prior to the transfer. After arriving at San Quentin, which consists of cells with open bars and dormitories, over 20 tested positive for COVID-19. In less than a month, over 1200 inmates at San Quentin tested positive for COVID-19. While the outbreak has largely ended at this time, some 2152 inmates out of a population 3751or 57% tested positive.[66]

Another example rests with two other CDCR facilities: the California State Prison, Sacramento (CSPS) and Folsom State Prison. These two prisons are located right next to each other in the same community. Staff in both prisons are therefore equally exposed to the virus in the surrounding area. CSPS is a newer facility with cells that have solid doors with windows. Folsom is an older facility and the vast majority of the cells have open bar fronts. As of October 3, 2020, CSPS has had 16 confirmed cases of COVID-19 within the inmate population. Folsom on the other hand has had 1,306 cases, a clear

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[63] www.drc.ohio.gov.

[64] www.michigan.gov/corrections.

[65] www.doc.ok.gov.

[66] www.cdcr.ca.gov.

reflection on just how easily this virus can spread in facilities with open bar fronts or dormitory settings.[67]

This is not unexpected given what was known about COVID-19 in February, March, and April 2020, along with the rapidly evolving understanding and guidance for dealing with this virus. Early on there was a greater emphasis on surfaces as a major source of transmission, whereas we now focus more on the airborne transmission of COVID-19. The CDC didn't recommend the use of masks until April 3, 2020.[68] This was shortly after the first COVID-19 cases were emerging at FCC Lompoc, which means that the virus was already spreading within the facility. Testing was also an issue, as it wasn't readily available until April and May 2020. The CDC initially was only recommending testing for symptomatic cases, and as late as May 15, 2020, was still not recommending broader testing because of lack of availability of testing.[69] The CDC didn't provide broader guidance until July 7, 2020. Finally, while there has been talk about pre-symptomatic and asymptomatic cases, it wasn't until guidance from the CDC on July 7, 2020 that testing for these cases was recommended.[70] In fact, the CDC published a document on August 21, 2020 based on a study of 16 prisons and jails where they reported that asymptomatic and pre-symptomatic persons represent 40-45% of those infected. So, to truly get a handle on the extent of any outbreak testing is critical.[71]

The Plaintiffs filed their action on May 16, 2020 indicating that they believed that

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[67] www.cdcr.ca.gov.

[68] CDC, "Factors Associated with Cloth Face Covering Use Among Adults during COVID-19 Pandemic", 7/17/20.

[69] US Centers for Disease Control and Prevention (CDC) "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities", March 23, 2020, CDC, "COVID-19 in Correctional and Detention Facilities", 5/15/20

[70] Interim Considerations for Sars-CoV-2 Testing in Correctional and Detention Facilities, 7/7/20.

[71] CDC, "Mass Testing for SARS-CoV-2 in 16 Prisons and Jails- Six Jurisdictions, United States, April-May 2020", 8/21/20.

the BOP and FCC Lompoc had not responded appropriately to COVID-19 and further that FCC Lompoc had not released inmates in accordance with Attorney General Barr's memo.

Despite Plaintiffs' claims, the BOP started preparing for COVID-19 in January of 2020 and took a number of steps prior to early March of 2020 as detailed in this report. The BOP also took specific action and provided direction prior to CDC guidance being issued on March 23, 2020 and they continually updated their direction based upon WHO and CDC guidance and as we learned more about COVID-19. They specifically provided direct assistance to FCC Lompoc in April by sending additional medical personnel, and they activated a sophisticated Hospital Care Unit on May 12, 2020 at FCC Lompoc four days before the filing of the lawsuit by the Plaintiffs.

FCC Lompoc also acted reasonably in dealing with the COVID-19 pandemic. They began by providing guidance to staff on March 10, 2020 and posted initial signage for inmates on March 12, 2020. On March 13, 2020, they moved to follow BOP direction when the BOP put phase 2 of their COVID-19 plan in place and they continued to follow BOP direction as additional Phases were put in place. The BOP had nine specific phases through the end of August 2020, and on August 31, 2020, they issued a comprehensive pandemic response plan for COVID-19. FCC Lompoc also adopted an enhanced cleaning/disinfectant, approved for use with COVID-19 and put an enhanced cleaning schedule in place. They provided masks to staff and inmates as soon as CDC guidance and BOP direction indicated that they should become mandatory. They also ensured adequate PPE and cleaning material was available. They designated specific locations for isolation and quarantine space, monitored inmates placed in these areas, and provided PPE for staff who worked in these locations. As the need for more quarantine and isolation space increased, FCC Lompoc began using locations such as the visiting room, gymnasium and warehouse for temporary expanded housing. They also reactivated three housing units that had been closed to reduce staffing needs. This served

to both provide adequate space to separate various groups of inmates and to increase social distancing by reducing the number of inmates in the housing units. Then on May 12, 2020, they activated an 18-bed Hospital Care Unit.

FCC Lompoc also maintained regular contact with the Santa Barbara Public Health Authority (SBPHA). When FCI Terminal Island learned from the LACDPH and informed FCC Lompoc that there could be a high number of asymptomatic cases and that the LACDPH recommended testing to help resolve the COVID-19 outbreak at that facility, FCC Lompoc checked with the SBPHA. The SBPHA had no recommendation for testing and indicated that they could not provide tests to FCC Lompoc. FCC Lompoc then directly contacted West Pac Labs who was providing tests to the LACDPH for testing at FCI Terminal Island and contracted with them for testing. On May 5, 2020, FCC Lompoc indicated that they would be testing all inmates. This testing allowed them to identify inmates who either had not reported symptoms or were asymptomatic, and to properly isolate them, following the procedure that was worked out for FCI Terminal Island by the LACDPH by doing several rounds of testing that contributed to ending the outbreak at FCC Lompoc. This was evident during my tour as only one individual was in isolation at that time.

Therefore, FCC Lompoc not only followed BOP direction and CDC guidance in dealing with COVID-19, they reached out to their local public health authority and when their guidance and assistance was not adequate, they consulted with both FCI Terminal Island and the LACDPH for direction and guidance in ending the COVID-19 outbreak at their facility.

Dr. Venters reached a number of conclusions and made a number of recommendations in his report for the Court. However, many of his findings are based upon what he was told by unidentified inmates, which is not reliable. He also draws some conclusions based upon assumptions he made based on limited information while not accounting for other information that was provided to him that does not support his

conclusions. In at least one case, Dr. Venters makes a finding that is not consistent with the records that he used to make the finding. He also makes a BOP wide recommendation based upon very limited and in some cases inaccurate information. He also recommends more high-risk inmates be processed for home confinement, but does not provide any context relative to what has occurred to date. As I have noted in this report, for many reasons State and Federal facilities have much more difficulty and processing can take more time, to release inmates than County facilities. Despite this fact, FCC Lompoc has released 552 inmates from the time of Attorney General Barr's first memo on March 26, 2020 through September 4, 2020 through a variety of means including home confinement. This represents 25% of the inmate population during the time of my visit, significantly more than other similarly situated facilities.

The BOP and FCC Lompoc took the COVID-19 pandemic seriously and took many steps to deal with it. The BOP began in January of 2020 preparing for COVID-19, and two days after WHO announced a pandemic, they began providing specific information and direction to all of their facilities. They also updated their direction on a regular basis based upon CDC and WHO guidance. On August 31, 2020, the BOP issued a comprehensive response plan for dealing with COVID-19 moving forward, a plan which they intend to modify and update as new information about COVID-19 emerges. The BOP also rapidly provided medical staffing assistance to FCC Lompoc and an 18-bed Hospital Care Unit to help manage the need for additional medical care as the number of COVID-19 Cases increased at FCC Lompoc.

FCC Lompoc also moved quickly in dealing with COVID-19, as they began issuing instruction and information to both staff and inmates prior to the BOP implementing phase 2 of the BOP action plan. They then followed both the BOP direction and CDC guidance as things changed or were updated. They also took some actions on their own such as creating expanded space for temporary housing to better provide for quarantine and isolation needs, and a more restrictive lockdown to try to

mitigate the spread of the virus. In addition, they worked with local health authorities, and when their local authority had no recommendations and were unable to provide testing assistance, they worked with another BOP facility and their local authority, the LACDPH for guidance as to how to proceed. They also directly contracted with a lab for testing, which enabled BOP staff to end the COVID-19 outbreak at FCC Lompoc.

Finally, in accordance with the Attorney General's memo, the BOP has been actively processing inmates for release through RRCs, compassionate release, home confinement, and direct release to the street. As of September 4, 2020, some 552 inmates have been released since the first memo from the Attorney General on March 26, 2020. This represents about 25% of their current population.

The actions taken by the BOP and FCC Lompoc were significant and done based upon what was known about COVID-19 at specific points in time. We have to remember that no one has faced such a pandemic in the last 100 years, and as such, what we know about COVID-19 is continually evolving. As more was known and as testing became more available, the BOP and FCC Lompoc were able to more effectively deal with COVID-19.

10/22/20

JEFFERY BEARD. PH.D.

Appendix A (Lompoc)

- **Filings in *Torres v. Milusnic*, No.20-4450**
  - 10 TRO Ex Parte Application
  - 16 Corrected Complaint
  - 18 Petitioners Ex Parte Application for TRO and OSC
  - 18-1 Rim Declaration
  - 18-2 Threatt Declaration ISO Petitioners Ex Parte Application
  - 25 Respondents Opposition to Ex Parte Application
  - 25-1 Engleman Declaration
  - 25-2 Cross Declaration
  - 25-3 Arnold Declaration ISO Respondents Opposition
  - 32 Petitioners Reply ISO Ex Parte TRO application
  - 32-1 Roco Declaration
  - 39 Petitioners supplemental Filing
  - 45 Preliminary Injunction Order
  - 50 Lawrence Cross Supplement
  - 51 Todd Javernick Declaration
  - 54 Colvin Declaration
  - 54-1 Colvin Declaration Exhibit A
  - 54-2 Colvin Declaration Exhibit B
  - 56 Todd Javernick Supplemental Declaration
  - 57 Gabriel Gutierrez Declaration
  - 101-1 COVID-19 Inspection of BOP by Dr. Homer Venters
- **Websites**
  - bop.gov
  - www.cdcr.ca.gov
  - www.tdcj.texas.gov

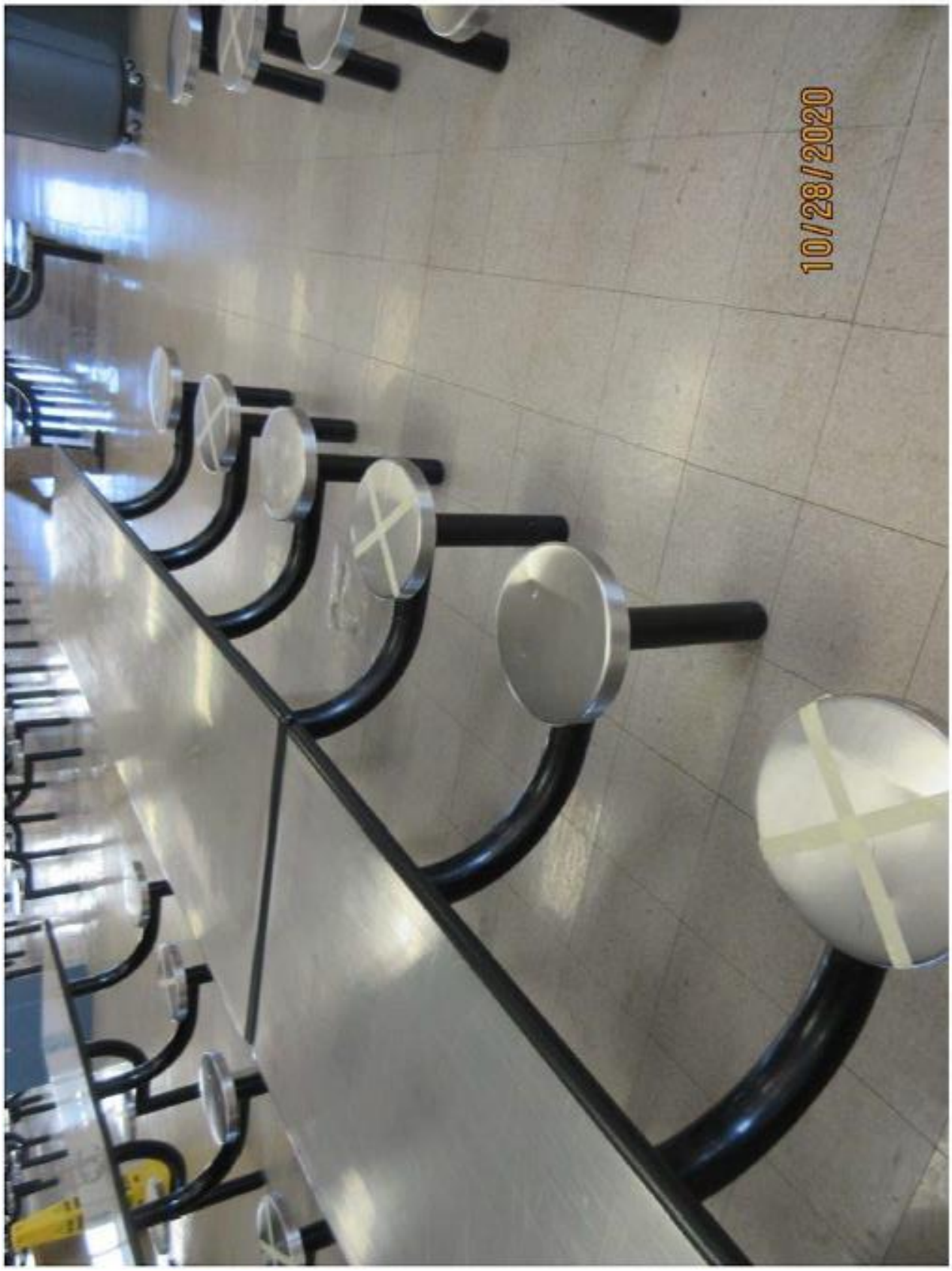
- www.cor.pa.gov
- www.doccs.ny.gov
- www.drc.ohio.gov
- www.michigan.gov/corrections
- www.doc.ok.gov
- www.spartanchemicals.com

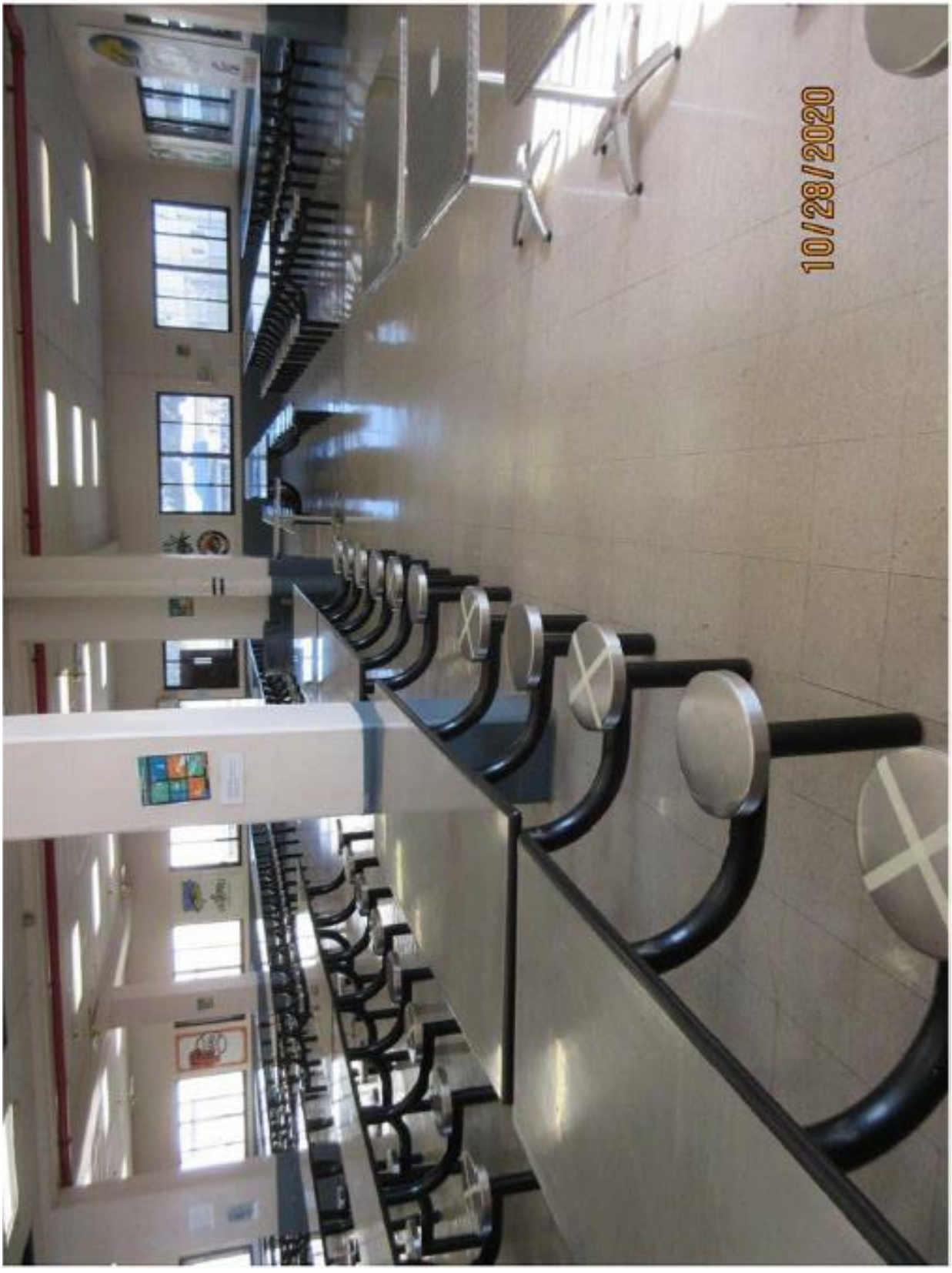
- **BOP documents and productions**
  - BOP0000001-0000936
  - BOP0000001-0000500
  - BOP0000501-0001000
  - BOP0001001-0001500
  - BOP0001501-0003000
  - BOP0003001-0003673
  - BOP0003674-0003757
  - BOP0003758-0003780
  - BOP0003781-0003920
  - BOP0003921-0004118
  - BOP0004119-0004804
  - BOP0004805-0005102
  - BOP0005103-0005746
  - BOP0005747-0006602
  - BOP0006603-0006837
  - BOP0006838-0007115
  - BOP0007116-0007193
  - BOP0007194-0007215
  - BOP0007216-0007240
  - BOP0007241-0007253

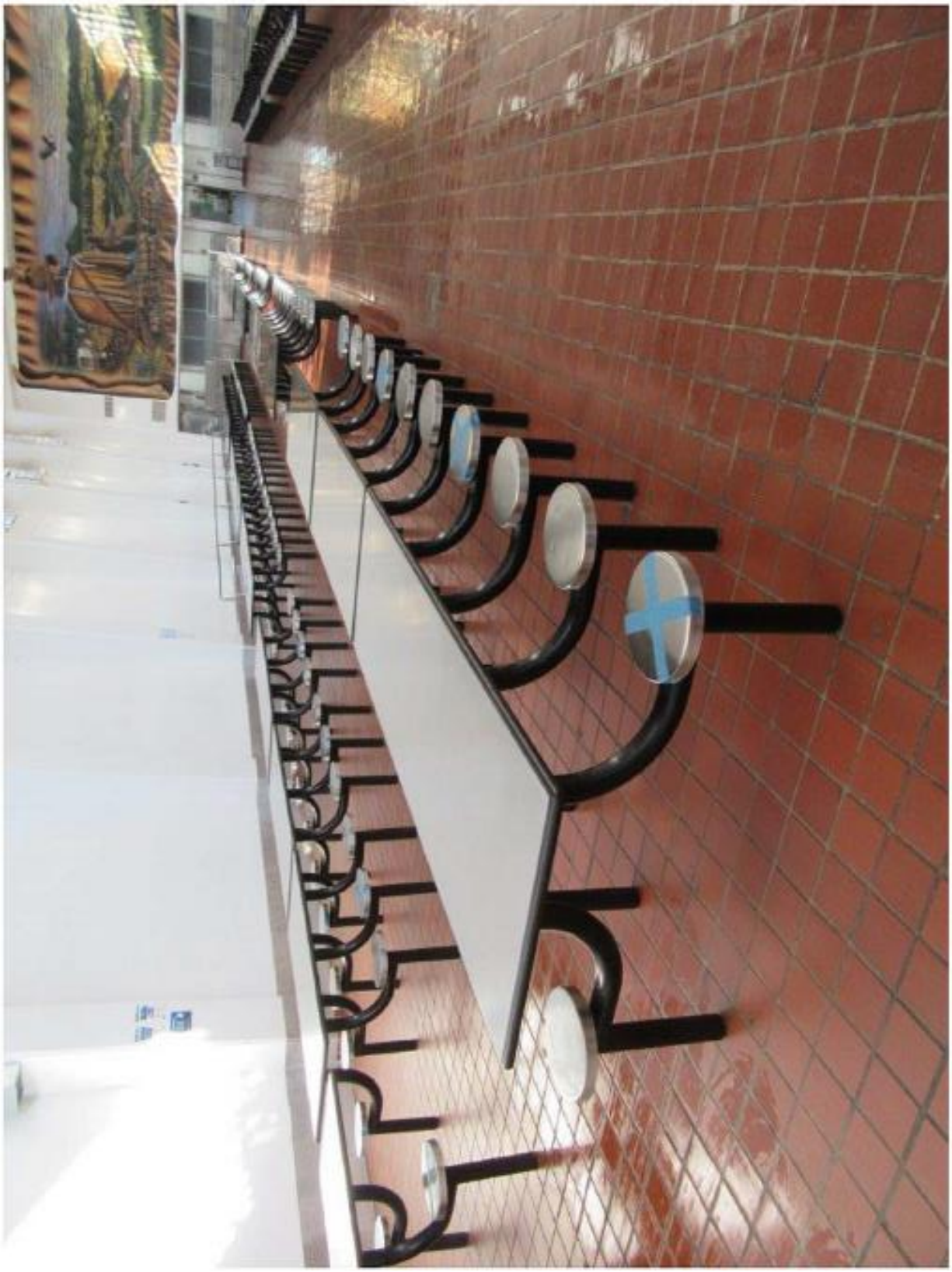
- BOP0007254-0007257
- BOP0007258-0007282
- BOP0007283-0007284
- BOP0007285-0007286
- BOP0007287
- BOP0007288
- BOP0007289-0007314
- BOP0007315-0007420
- BOP0007421
- BOP0007422-0007423
- BOP0007424-0007425
- BOP0007426-0007713
- BOP0007714-0008055
- BOP0008056-0008123
- BOP0008124-0008320
- June 9, 2020 Stipulated Protective Order
- August 28, 2020 Stipulated Protective Order
- Bureau of Prison memo to all Chief Executive Officers, "Coronavirus (COVID-19) Phase Nine Action Plan", 8/5/20
- BOP, "COVID-19 Pandemic Response Plan", Overview, Modules 1-11, 8/31/20 (available at https://www.bop.gov/foia/index.jsp#tabs-1)
- COVID-19 Sick Call Procedures LOX
- BOP, Phase 7 action plan memo
- BOP, Phase 8 action plan memo
- Photos of Lompoc on September 1-2, 2020

- **CDC Documents**
  - CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, 3/23/20.
  - CDC, "Interim considerations for Sars-CoV-2 testing in corrections and detention facilities", 7/7/20.
  - CDC, "Mass testing for SARS-CoV-2 in 16 prisons and jails-six jurisdictions, United States, April-May 2020", 8/21/20.
  - CDC, "COVID-19 in corrections and detention facilities", 5/15/20.
  - CDC, "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Corrections and Detention Facilities", 7/22/20.
  - CDC, "Discontinuation of isolation for persons with COVID-19 not in healthcare settings", 7/20/20.
  - CDC, "Factors associated with cloth face covering use among adults during pandemic", 7/17/20.
- **Other materials**
  - Ballotpedia, "Prison inmate release responses in response to the coronavirus (COVID-19) pandemic, 2020", 7/1/20.
  - The Marshall Project, "Prison Populations Drop by 1000,000 During Pandemic", 7/16/20
  - DOJ Office of the Inspector General, Pandemic Response Report, "Remote Inspection of Federal Correctional Complex Lompoc", July 2020.
  - Santa Maria Times, "Officials defend methods used in Lompoc prison's response to COVID-19", by Dave Minsky, July 28, 2020.
  - ABC NEWS, "Timeline: WHO's response to the coronavirus pandemic and the ensuing controversy", 8/17/20,
  - The Wall Street Journal, "The World Health Organization Draws Flak for Coronavirus Response", 02/12/20.

EXHIBIT 2

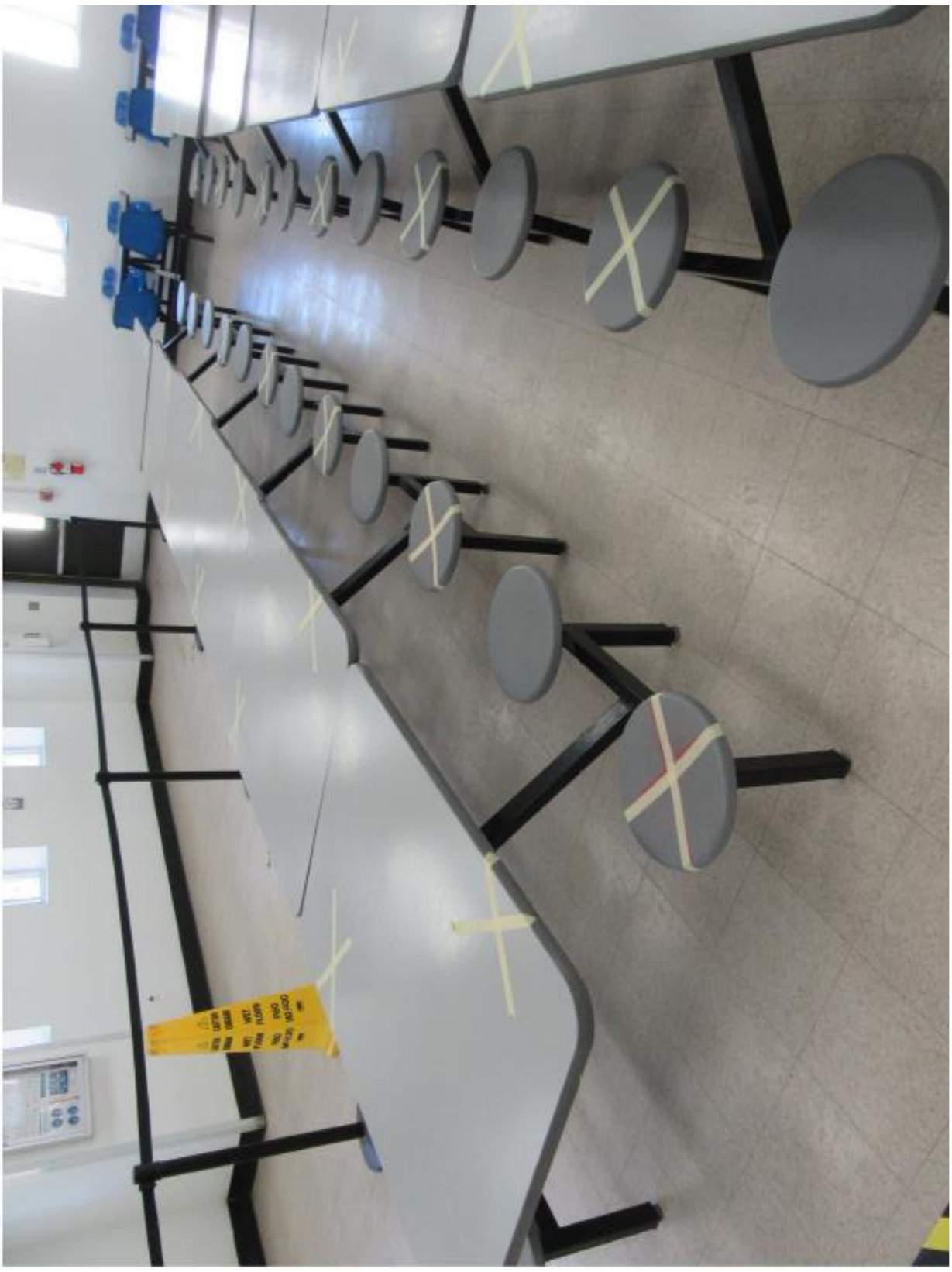

10/28/2020


10/28/2020




Cover Couch


10/28/2020




MAINTAIN 6 FEET
THANK YOU


MEDICAL
DENTAL
NOTICE
PLEASE WEAR A MASK


NOTICE
PLEASE
WEAR
A MASK
MEDICAL
DENTAL
KNOCK BEFORE ENTERING
Health Services Staff
Knock
Before
Entering
MAINTAIN 6 FEET
THANK YOU
Wash your hands
often with soap
and water for at
least 20 seconds.
CDC

EXHIBIT 3

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------X

HASSAN CHUNN; NEHEMIAH McBRIDE; AYMAN RABADI by his Next Friend Migdaliz Quinones; JUSTIN RODRIGUEZ, by his Next Friend Jacklyn Romanoff; ELODIA LOPEZ; and JAMES HAIR,

individually and on behalf of all others similarly situated,

Petitioners,

-against-

WARDEN DEREK EDGE,

Respondent.

MEMORANDUM AND ORDER
20-cv-1590 (RPK) (RLM)

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RACHEL P. KOVNER, United States District Judge:

Six federal prisoners who were detained at the Metropolitan Detention Center ("MDC") in Brooklyn when this suit was filed brought this lawsuit to challenge the facility's response to the COVID-19 pandemic on constitutional grounds. They contend that MDC officials' response to the pandemic has been so deficient as to violate the Eighth Amendment. They seek a preliminary injunction that would release all MDC inmates whose age or medical condition places them at heightened risk from the virus and would manage almost every aspect of the facility's COVID-19 response.

To obtain such an injunction, petitioners must establish a clear or substantial likelihood that the conditions at the MDC during the COVID-19 pandemic constitute cruel and unusual punishment. The bar is high: Petitioners must show that officials' response to the pandemic reflects "the deliberate infliction of punishment." *Francis v. Fiacco*, 942 F.3d 126, 150 (2d. Cir. 2019) (quoting *Blyden v. Mancusi*, 186 F.3d 252, 262 (2d Cir. 1999)). The standard is satisfied

when officials exhibit "'deliberate indifference' to a substantial risk of serious harm." *Farmer v. Brennan*, 511 U.S. 825, 828 (1994) (citation omitted). But it is not satisfied by negligent "lack of due care for prisoner interests or safety." *Fiacco*, 942 F.3d at 150 (quoting *Blyden*, 186 F.3d at 262).

Based on the record from a two-day evidentiary hearing, I conclude that petitioners have not shown a clear likelihood that MDC officials have acted with deliberate indifference to substantial risks in responding to COVID-19. Rather than being indifferent to the virus, MDC officials have recognized COVID-19 as a serious threat and responded aggressively. They have, for example, implemented heightened sanitation protocols, distributed masks to inmates and staff, required use of masks when social distancing is not possible, initiated COVID-19 screenings upon entry to the MDC, created quarantine and isolation units, and substantially restricted movement within the facility. With those measures in place, just one MDC inmate has been hospitalized in connection with COVID-19, and none have died from the disease, even though the surrounding community has been at the epicenter of the pandemic.

Evidence submitted at the hearing does expose several deficiencies in the MDC's implementation of Centers for Disease Control and Prevention ("CDC") guidelines that both parties have treated as authoritative. Those shortcomings merit a swift response from MDC officials—the institutional actors charged in the first instance with ensuring that their facilities are managed in accordance with appropriate standards of care. *See, e.g.*, *Turner v. Safley*, 482 U.S. 78, 84-85 (1987); *Bell v. Wolfish*, 441 U.S. 520, 547-48 (1979). But the facility's aggressive response to a public health emergency with no preexisting playbook belies the suggestion that these apparent deficiencies are the product of deliberate indifference on the part of prison officials.

PROCEDURAL HISTORY

I. Petitioners' Lawsuit

A. The Petitions

Four inmates serving sentences at the MDC filed the initial petition in this case asserting violations of the Eighth Amendment on March 27, 2020. After two of the named petitioners were granted compassionate release from custody by their sentencing judges under 18 U.S.C. § 3582(c)(1)(A), *see* Order Directing the Compassionate Release of Def. Hassan Chunn, *United States v. Chunn*, No. 16-cr-388 (E.D.N.Y. Apr. 8, 2020) (Dkt. #32); Order as to Nehemiah Casey McBride, *United States v. McBride*, No. 15-cr-876 (S.D.N.Y. Apr. 7, 2020) (Dkt. #73), petitioners filed an amended petition on April 23, 2020, raising the same Eighth Amendment claim but adding as named petitioners two additional inmates serving federal sentences at the MDC, including Elodia Lopez, *see* Am. Pet. (Dkt. #60). Since the amended petition was filed, the remaining petitioners other than Ms. Lopez have also been released or transferred from the MDC. *See* Ex. 76 (Declaration of Justin Rodriguez) ("Rodriguez Decl.") ¶ 2 (Dkt. #91-3); Status Report re: Release of Petitioner Ayman Rabadi (May 21, 2020) (Dkt. #104); Status Report re: Transfer of Petitioner James Hair (May 26, 2020) (Dkt. #106). Ms. Lopez remains housed at the MDC.

In the petition, which is styled as a representative habeas action or class action petition under 28 U.S.C. § 2241, Ms. Lopez and the other petitioners have sought to represent all individuals detained at the facility during the pandemic. Am. Pet. ¶ 110. They contend that MDC officials have been deliberately indifferent to the risks of COVID-19. *Id.* ¶¶ 98-103, 122-132. Petitioners argue that, as a consequence, MDC officials have violated the Eighth Amendment rights of sentenced inmates, such as the named petitioners. *Ibid.* Petitioners further argue that conduct which qualifies as deliberate indifference under the Eighth Amendment also violates the Fifth Amendment rights of pretrial detainees at the MDC, because conduct that violates the Eighth

Amendment rights of sentenced inmates also violates the Fifth Amendment rights of pretrial detainees. *See* Mem. Supp. of Pet'rs' Mot. for Prelim. Inj. ("Pet'rs Br.") 22 n.6 (Dkt. #73). They have not raised arguments under the Fifth Amendment that are distinct from their deliberate-indifference claims under the Eighth Amendment.

To remedy the asserted violations, petitioners seek extensive judicial oversight of the MDC's response to COVID-19, and they ask that I order respondent to release from custody all medically vulnerable inmates housed at the MDC, *see id.* at 26-27; Mot. for Prelim. Inj. 2-4 (Dkt. #71), who represent about a quarter of the facility's population, *see* Ex. 26 ("Vasquez Tr.") 205:4-10.

B. Application for a Temporary Restraining Order

On March 30, 2020—three days after the initial habeas petition was filed—the four original petitioners sought a temporary restraining order ("TRO") directing their immediate release. *See* Mot. for TRO 1-2 (Dkt. #12). They also requested the immediate appointment of a special master who would make recommendations for the release of other medically vulnerable MDC inmates and make further "recommendations for ameliorative action." *Id.* at 2-3. On April 8, 2020, I denied the request for a TRO. I then set a schedule for expedited discovery and for a hearing on petitioners' anticipated request for a preliminary injunction. *See* Order (Apr. 8, 2020).

II. Petitioners' Preliminary Injunction Motion

Petitioners filed their motion for a preliminary injunction on April 30, 2020. Petitioners seek a preliminary injunction based on Eighth Amendment violations that directs the "immediate release" of the nearly 400 inmates at the MDC whom respondent "has identified as medically

vulnerable due to underlying health conditions or age."[1] Mot. for Prelim. Inj. 2; *see* Am. Pet. ¶ 3. Petitioners also ask the Court to enter a detailed injunction controlling almost every aspect of the MDC's response to COVID-19. Mot. for Prelim. Inj. 2-4. The proposed injunction would require:

- Screening all detainees currently housed at the MDC for signs and symptoms of COVID-19;
- Screening all new detainees who arrive at the MDC, including those who return from the hospital or are transferred from other correctional facilities;
- Adopting a "standardized COVID-19 surveillance tool," including temperature checks, to be administered twice daily to (i) all incarcerated persons with elevated COVID-19 risks, (ii) all inmates in quarantine, and (iii) all inmates in isolation;
- Standardizing clinical evaluations of all inmates who are suspected or confirmed to have COVID-19 and administering those evaluations at least daily in a clinical setting;
- Implementing same-day review of every sick-call request to trigger same-day or next-morning assessment for COVID-19, along with tracking of such requests through a "facility wide symptom tracking dashboard" for use by healthcare staff;
- Identifying, grouping, and testing all inmates who are at elevated risk for COVID-19;
- Ordering the quarantine of all medically vulnerable detainees into units with routine checks for COVID-19 signs and symptoms, including temperature checks;
- Ordering all quarantine units to follow CDC guidelines, in areas such as use of appropriate personal protective equipment ("PPE"), cleaning of common surfaces, and surveillance;
- Testing inmates who exhibit more than one sign or symptom of COVID-19;
- Testing staff who are at risk of serious illness or death from COVID-19 or who exhibit more than one sign or symptom of COVID-19;
- Ordering all staff to wear PPE (including masks) when interacting with any person or when touching surfaces in cells or common areas;
- Ordering that disinfectants be supplied to inmates free of charge;
- Repairing broken emergency call-buttons in cells and requiring frequent medical rounds in units with broken call-buttons until such repairs are completed;

[1] When this case was filed, respondent had identified 537 inmates as medically vulnerable. *See* Pet. ¶ 3 (Dkt. #1). By April 27, 2020, the list had shrunk to approximately 380 inmates because some inmates had been released and because the CDC had revised its list of COVID-19 risk factors. *See* Ex. 26 (Vasquez Tr.) 205:4-20.

- Training all staff and orderlies on reporting inmate health issues to medical staff;
- Instituting rotations of Spanish-speaking health staff;
- Providing free personal hygiene supplies to all inmates, along with daily access to showers and clean laundry;
- Mandating social distancing amongst inmates to the maximum extent possible at the MDC's current population level;
- Training staff and inmates on the proper use of masks, gloves, and other PPE, and providing masks and gloves to inmates at no cost to them, to be replaced by the facility as appropriate; and
- Providing weekly COVID-19 information sessions for inmates and correctional staff.

Ibid. Petitioners further request that the preliminary injunction appoint a Special Master or other Court-appointed expert to "oversee implementation of the Court's ameliorative injunctive relief," make recommendations regarding the release of medically vulnerable inmates, and make "additional recommendations for ameliorative action at the MDC." *Id.* at 4. In order to enable the Court to enter the broad injunctive decree that petitioners seek, petitioners also seek an order "[c]onditionally certifying the class" of all inmates at the MDC. *Id.* at 2. Alternatively, they seek an order "awarding class-wide relief under the Court's general equity powers." *Ibid.*

III. Preliminary Injunction Hearing

I held an evidentiary hearing on petitioners' motion for a preliminary injunction on May 12 and 13, 2020. Petitioners offered testimony from one witness: Dr. Homer Venters, a physician and epidemiologist who specializes in the provision of health services for incarcerated people, and who conducted an inspection of the MDC on behalf of petitioners on April 23, 2020. *See* Ex. 25 (Facility Evaluation: Metropolitan Detention Center COVID-19 Response) ("Venters Report") ¶¶ 7, 13 (Dkt. #72-1).[2] Dr. Venters produced a written report that catalogues his observations,

[2] Citations to exhibits use those documents' internal pagination, rather than Bates stamps or other pagination assigned by the parties. Bates stamps are used for documents that lack internal pagination.

memorializes his conversations with 17 detainees, and offers recommendations. Dr. Venters also produced a supplemental report that addresses the expert reports submitted on behalf of respondents. *See* Ex. 82 (Suppl. Report of Dr. Homer Venters) ("Suppl. Venters Report") (Dkt. #91-6). Dr. Venters was sharply critical of the MDC's response to the pandemic. He described what he saw as "[m]ultiple systemic failures in the COVID-19 response in the MDC," including failure to properly screen inmates for signs and symptoms of COVID-19, to respond promptly to inmate requests for medical attention, and to implement adequate infection control practices. Venters Report ¶¶ 2-4, 23. Dr. Venters also concluded that "current practices in the MDC do not adequately identify and protect detainees who are particularly vulnerable to the effects of COVID-19 due to their high-risk underlying medical conditions." *Id.* ¶ 5.

Respondent offered testimony from three witnesses. Nicole C. English, Assistant Director of the Health Services Division at the Bureau of Prisons ("BOP"), testified concerning a surprise inspection she conducted of the MDC on May 2, 2020, after BOP officials learned of the conclusions in Dr. Venters' report. *See* Ex. OOO (Assessment of Metropolitan Detention Center, Brooklyn, New York, COVID-19 Response) ("English Report") 1. Ms. English and three other BOP officials arrived at the MDC unannounced on that date and, after meeting briefly with respondent, split up to evaluate the facility's response to COVID-19. *Ibid.* Following her inspection, Ms. English issued her own report describing the observations of the inspection team. The report addressed entry-point screenings, sick-call procedures, use of quarantine and isolation units, infection control practices, and education of inmates and staff, among other topics. *Id.* at 1-11. Ms. English offered a handful of recommendations for improvements, but she concluded that the MDC "was not . . . failing in its response to the COVID-19 virus pandemic." *Id.* at 11-12.

Next, respondent offered testimony from Asma Tekbali, an infection preventionist in the Epidemiology Department of Lenox Hill Hospital in New York, who defended the MDC's infection control practices and criticized some of Dr. Venters' recommendations. *See* Ex. AA (Expert Report of Asma Tekbali, M.P.H.) ("Tekbali Report") (Dkt. #93-1). At Lenox Hill Hospital, Ms. Tekbali has played a role in developing hospital-wide policies on COVID-19 isolation and testing protocols, and containment measures. *Id.* at 1. In addition to testifying at the hearing, Ms. Tekbali prepared a report on the MDC's COVID-19 infection control practices, which was entered into evidence. *See generally* Tekbali Report.

Finally, respondent offered testimony from Dr. Jeffrey Beard, a prison management consultant who served as Secretary of Corrections for two States. *See* Ex. RR (Report of Jeffrey A. Beard, Ph.D.) ("Beard Report") 1 (Dkt. #83-2). Dr. Beard inspected the MDC on April 28, 2020, visiting the same areas as Dr. Venters: the screening area, the health services area, the quarantine and isolation units, and the Special Housing Unit ("SHU"). *Id.* at 5-7; *see* Prelim. Inj. Hr'g Tr. ("Hr'g Tr.") 343:16-19; Venters Report ¶ 13. After observing screening, sanitation, isolation, and quarantine protocols and speaking with staff members and inmates regarding these measures, Dr. Beard concluded that the MDC "is effectively implementing practices that protect[] inmates and staff alike from the coronavirus." Beard Report 10; *see id.* at 1-11. His report vigorously disputed the factual conclusions that Dr. Venters had drawn from his inspection days earlier. *See id.* at 7-9. Dr. Beard also contested some of Dr. Venters' recommendations for addressing the dangers of COVID-19. *See id.* at 7-10.

The parties offered thousands of pages of documents as exhibits. Petitioners' documentary evidence included declarations from 36 MDC inmates attesting to shortcomings in the prison's COVID-19 response. *See* Exs. 27-33, 35-39, 41-50, 52-57, 59 (Dkt. #72); Ex. 51 (Dkt. #76); Ex.

63 (Dkt. #71-1); Ex. 64 (Dkt. #71-2); Ex. 65 (Dkt. #71-3); Ex. 66 (Dkt. #71-4); Ex. 76 (Dkt. #91-3); Ex. 81 (Dkt. #91-5); Ex. 83 (Dkt. #91-9). Petitioners also offered approximately 1,200 inmate sick-call requests, including 210 sick-call requests that petitioners identified as reporting symptoms that could relate to COVID-19. *See* Exs. 9, 24, 78, 88.

Respondent's documentary evidence included declarations from Stacey Vasquez, the Health Services Administrator for the MDC, and from Milinda King, an Associate MDC Warden. *See* Ex. LLL (Decl. of Health Services Administrator Stacey Vasquez) ("Vasquez Decl.") (Dkt. #80); Ex. TT (Decl. of Associate Warden Milinda King) ("King Decl.") (Dkt. #18-1); Ex. XX (Suppl. Decl. of Associate Warden Milinda King) ("Suppl. King Decl.") (Dkt. #21); Ex. ZZ (Decl. of Associate Warden Milinda King) ("Second King Decl.") (Dkt. #81). Ms. Vasquez offered a point-by-point response to Dr. Venters' report, arguing that the MDC has already implemented most of Dr. Venters' proposals and that those it has not implemented are impracticable. *See* Vasquez Decl. ¶ 6. Ms. King described various steps that MDC officials have taken to address the COVID-19 pandemic. *See* King Decl.; Suppl. King Decl.; Second King Decl. Both Ms. Vasquez and Ms. King were deposed by petitioners, and petitioners submitted their depositions into evidence. *See* Vasquez Tr.; Ex. 40 ("King Tr.") (Dkt. #72). Respondent also introduced a declaration from Lieutenant Commander D. Jordan, the MDC's Quality Improvement/Infection Prevention Control Officer that describes some of the infection prevention measures the MDC has adopted. *See* Ex. YY (Decl. Of Lieutenant Commander D. Jordan, RN/BSN) ("Jordan Decl.") (Dkt. #47-1).

At the start of the hearing, I denied respondent's request to exclude on hearsay grounds the 36 inmate declarations submitted by petitioners. *See* Hr'g Tr. 40:5-11. "[H]earsay evidence may be considered by a district court in determining whether to grant a preliminary injunction," *Mullins*

v. City of New York, 626 F.3d 47, 52 (2d Cir. 2010), since "the decision of whether to award preliminary injunctive relief is often based on 'procedures that are less formal and evidence that is less complete than in a trial on the merits,'" *id.* at 51 (quoting *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 395 (1981)). Nevertheless, when a party relies on hearsay statements that are not subject to any cross-examination in seeking a preliminary injunction, the fact that those statements would normally be inadmissible hearsay goes to the weight that such evidence deserves. *Id.* at 52; *see Zeneca Inc. v. Eli Lilly and Co.*, No. 99 Civ. 1452, 1999 WL 509471, at *4 (S.D.N.Y. July 19, 1999) ("[T]he affidavits are necessarily of less weight than the live testimony of witnesses who were available and subject to cross-examination at the hearing."); 11A C. Wright, A. Miller & M. Kane, *Federal Practice and Procedure* § 2949 (3d ed.); *see* Fed. R. Evid. 802. Accordingly, I have given these declarations somewhat less weight than the accounts of witnesses who offered live testimony regarding personal observations.

At the hearing, I also addressed petitioners' claim that respondent spoliated evidence by destroying hard-copy sick-call requests. *See* Pet'rs' Mots. in Lim. (Dkt. #86). I informed the parties then that I was considering drawing an adverse inference regarding the content of the destroyed records. Hr'g Tr. 450:9-25. I now find it is appropriate to draw an adverse inference that the destroyed records would have contained additional reports of COVID-19 symptoms for the period from April 1, when the MDC began relying heavily on paper sick-call requests, to April 23, the day before respondent began preserving paper sick-call requests. *See* Hr'g Tr. 451:10-16; 452:10-453:7. Petitioners have satisfied the three-prong test for spoliation sanctions. *See Klipsch Grp., Inc. v. ePRO E-Commerce Ltd.*, 880 F.3d 620, 628 (2d Cir. 2018). First, respondent had an obligation to preserve the paper sick-call records at the time they were destroyed because he was on notice that sick-call requests were central to this litigation. *See In re Terrorist Bombings of*

U.S. Embassies in E. Afr., 552 F.3d 93, 148 (2d Cir. 2008). Second, contrary to respondent's suggestion, *see* Resp't's Opp'n to Pet'rs' Mots. in Lim. 3-6 (Dkt. #89); Decl. of Cdr. Scott A. Griffith, MSN, RN-BC ("Griffith Decl.") (Dkt. #97-1), it does not appear that the information in the paper records was uniformly preserved in the MDC's electronic medical activities report. That report contains multiple vague or blank entries that leave questions as to what symptoms were reported. *See, e.g.*, Attachment to Griffith Decl. ("Activities Report") 2, 30, 32. Second, respondent destroyed the records with a culpable state of mind. *See Klipsch Grp., Inc.*, 880 F.3d at 628. That requirement is satisfied when documents were destroyed knowingly, even when, as here, the documents appear to have been destroyed without an intent to breach a duty of preservation. *See Residential Funding Corp. v. DeGeorge Fin. Corp.*, 306 F.3d 99, 108 (2d Cir. 2002). Finally, the destroyed sick-call records were "relevant" to petitioners' claims, "such that a reasonable trier of fact could find that [they] would support" those claims. *See Klipsch Grp., Inc.*, 880 F.3d at 628 (quoting *Chin v. Port Auth. of N.Y. & N.J.*, 685 F.3d 135, 162 (2d Cir. 2012)).

In addition to putting forward evidence of the conditions at the MDC, both parties offered into evidence CDC documents that provide guidance on COVID-19 both generally and in the correctional context. *See, e.g.*, Exs. 6, 20, G, H, J; Exs. BB, CC, EE, GG, HH, II, LL, MM, NN, OO, PP (Dkt. #93-1); Ex. VV (Dkt. #18-2); Ex. JJJ (Dkt. #82-1), Ex. MMM (Dkt. #80-1). The CDC protocols include a 26-page document setting out the CDC's recommendations for the management of COVID-19 in correctional facilities. *See* Ex. 20 ("CDC Correctional Guidelines").

The parties frequently invoke these and other CDC guidance as authoritative. *See, e.g.*, Pet'rs' Br. 3, 23; Pet'rs' Proposed Findings of Fact ¶ 16 (Dkt. #101); Mem. Opp'n to Pet'rs' Mot. for Prelim. Inj. ("Resp't Opp'n Br.") 9-12 (Dkt. #79); Resp't's Proposed Findings of Fact ¶¶ 188-199 (Dkt. #99). And the experts retained by the parties have also treated CDC guidance as

authoritative. *See, e.g.*, Venters Report ¶¶ 1, 6, 18, 20-21, 41, 46, 47, 52, 62, 64; Beard Report 6, 9-10; Tekbali Report 1-7. After reviewing the CDC guidelines and considering the testimony of the experts regarding those guidelines, I have given the CDC's guidance substantial weight in assessing petitioners' challenge to the conditions of confinement at the MDC.

Finally, the parties filed letters after the hearing concerning whether the petitioners who were recently released or transferred from the MDC can continue to pursue their claims on behalf of the putative class. Respondent suggests that all claims other than Ms. Lopez's are moot. *See* Status Report re: Transfer of Petitioner James Hair (May 26, 2020). Petitioners do not expressly disagree, but they argue that the petitioners who were released or transferred after the filing of the preliminary injunction motion can "continue to seek relief on behalf of the class even after [their] individual claims have been mooted." Pet'rs' Letter (May 27, 2020) 1 (Dkt. #107);. I need not resolve that question to decide petitioners' motion. The claims of Ms. Lopez are indisputably not moot because Ms. Lopez is still detained at the MDC. And petitioners have made the same basic arguments with respect to all of the named petitioners. While Ms. Lopez is female and the other named petitioners are male, the only gender-related difference in the MDC's approach to COVID-19 appears to be that men have somewhat greater capacity to engage in social distancing, because women are generally housed in dormitory-style accommodations while men are typically housed in two-person cells. Under these circumstances, my determination that Ms. Lopez has not demonstrated a clear likelihood of success on the merits of her Eighth Amendment claim would apply equally to the remaining petitioners if their claims remain live for purposes of seeking injunctive relief on behalf of the asserted class.

Based on the witness testimony and documentary evidence at the hearing, I make the following findings of fact and draw the following conclusions of law.

FINDINGS OF FACT

I. The COVID-19 Outbreak

COVID-19 is an acute respiratory illness caused by a novel coronavirus that first appeared in the United States in January 2020. *See Clinical Care Guidance*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html (last visited June 7, 2020); *Evidence for Limited Early Spread of COVID-19 Within the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/mmwr/volumes/69/wr/mm6922e1.htm?s_cid=mm6922e1_w (last visited June 7, 2020). There have now been over 1.9 million cases of COVID-19 in the United States. *See Cases in the U.S.*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last visited June 7, 2020). The State of New York, with 379,322 cases, accounts for about 20% of the nationwide total. *See ibid.* New York City has been at the epicenter of the outbreak in the United States, with about 208,517 COVID-19 cases. *See ibid*. Symptoms of COVID-19 include fever, chills, cough, shortness of breath or difficulty breathing, muscle pain, headache, sore throat, and loss of the sense of taste and/or smell. *See* Ex. MMM ("CDC List of Symptoms of Coronavirus"). Symptoms typically appear between two and 14 days after exposure to the virus. *Ibid.* The CDC has stated that the disease poses a heightened risk for those who are age 65 or older, those who are immunocompromised, and those who suffer from certain underlying health conditions such as chronic lung disease, moderate to severe asthma, serious heart conditions, severe obesity, diabetes, chronic kidney disease, and liver disease. *See People Who Are at Higher Risk*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html (last visited June 8, 2020).

II. The MDC and Its COVID-19 Action Plan

The MDC is a federal detention facility in Brooklyn that housed about 1,630 inmates as of May 2, 2020. English Report 2. As an institution administered by the BOP, the MDC has been following the BOP's COVID-19 Action Plan. *See* Jordan Decl. ¶¶ 4-6. Phase One of that plan, which was implemented in January, involved developing strategies and soliciting guidance for managing the virus response in BOP facilities. *Id.* ¶ 7. Phase Two, which began on March 13, 2020, suspended virtually all legal and social visitation and started new entry screenings for staff and prisoners. *Id.* ¶¶ 8-10. In addition, prison officials put into place "modified operations," such as staggered meal and recreation times, to maximize social distancing. *Id.* ¶ 11. Phase Three, which took effect on March 18, 2020, required inventories of cleaning, sanitation, and medical supplies, among other steps. *Id.* ¶ 13. Phase Four, which began on March 26, 2020, strengthened quarantine and isolation procedures. *Id.* ¶ 14. BOP facilities also began to assess all inmates arriving at its facilities with a screening tool and temperature check. *Ibid.* Phase Five, which took effect on April 1, 2020, mandated facility-wide lockdowns in every BOP institution for a 14-day period. *Id.* ¶ 15. During lockdown, inmates are to be secured in their cells where possible, with limited exceptions for essential activities. *Ibid.* Later phases have extended those lockdowns, which are currently scheduled to remain in effect through at least June 30, 2020. *See id.* ¶ 16; *COVID-19 Action Plan: Phase Seven*, FED. BUREAU OF PRISONS, https://www.bop.gov/resources/news/20200520_covid-19_phase_seven.jsp (last visited June 7, 2020).

III. The Prevalence of COVID-19 at the MDC

While the parties dispute the prevalence of COVID-19 at the MDC, the evidence at the hearing indicates that the facility has been more successful than many other prisons in preventing an outbreak. In the absence of broad testing, the best available indicator of the extent to which the

virus has spread within the MDC are deaths and Intensive Care Unit hospitalizations. As Ms. Tekbali explained, those objective measures "are correlated with the rates or with the level of infection," and are "indicators . . . on how the pandemic is progressing." Hr'g Tr. 239:5-11. That data suggests that MDC officials have thus far succeeded in preventing a significant outbreak. In the months since the pandemic began, there have been no COVID-linked deaths at the MDC, and only a single MDC inmate has been hospitalized in connection with COVID-19. Vasquez Decl. ¶ 8; Hr'g Tr. 238:20-25. That inmate was discharged back to the MDC the next day. *See* King Decl ¶¶ 27-28. This data is especially striking because the MDC has identified about a quarter of its population as at elevated risk from COVID-19 due to age or preexisting conditions, and because the MDC is in New York City, which has been at the epicenter of America's COVID-19 outbreak over the past several months. There have been about17,150 confirmed deaths from COVID-19 in the surrounding community of about 8,340,000 people. *See* Hr'g Tr. 238:22-239:2; *COVID-19: Data*, N.Y.C. DEP'T OF HEALTH, https://www1.nyc.gov/site/doh/covid/covid-19-data.page (last visited June 7, 2020); *Population*, N.Y.C. DEP'T OF CITY PLANNING, https://www1.nyc.gov/site/planning/planning-level/nyc-population/nyc-population.page (last visited June 7, 2020). The MDC's extremely low COVID-19 hospitalization and death rates suggest that it is faring reasonably well compared to its surrounding community.

Petitioners contend that "a significant amount of COVID-19 activity and infection among detained people" may be "currently undetected" at the facility. Hr'g Tr. 99:15-20 (testimony of Dr. Venters). They note that after the number of confirmed COVID-19 cases among inmates plateaued, reports of staff infections continued to rise from five cases on April 2 to 36 cases on May 5. *See* Suppl. Venters Report ¶ 8. Petitioners argue that if the MDC had more robust testing in place, the number of confirmed COVID-19 cases among the inmate population would have

likely followed the same upward trajectory, because the "primary way in which the virus comes into and moves around [a] facility is through the movement of staff." Hr'g Tr. 116:20-117:5 (testimony of Dr. Venters). Petitioners are correct that the fact that just nine inmates have tested positive thus far sheds little light because the MDC has only tested 68 inmates out of its population of approximately 1,630. *See* Letter from MCC Warden Licon-Vitale and MDC Warden Edge to Chief Judge Mauskopf (June 4, 2020) ("Edge Letter") 2 (https://www.nyed.uscourts.gov/pub/bop/MDC_MCC_20200604_044508.pdf). But the number of confirmed cases among staff also sheds limited light on the infection rate among inmates, because divergent rates could be the product not only of limited testing of inmates but also of effective infection-control measures. In any event, reported staff infections are no longer rising quickly. *Compare* Suppl. Venters Report ¶ 8 (36 cases on May 5), *with* Edge Letter 2 (40 cases on June 4). And while the MDC more than doubled the number of inmates tested between the end of May and early June, the number of positives increased only from six to nine. *Compare* Letter from MCC Warden Licon-Vitale and MDC Warden Edge to Chief Judge Mauskopf (May 28, 2020) (*available at* https://www.nyed.uscourts.gov/pub/bop/MDC_MCC_20200529_093332.pdf) (25 tests and six positives as of May 28) *with* Edge Letter 2 (68 tests and nine positives as of June 4). Thus, the available data gives reason for cautious optimism about the effectiveness of the facility's COVID-19 response thus far.

IV. Conditions at the MDC

The parties offered divergent accounts at the preliminary injunction hearing concerning what steps the MDC has actually implemented in response to the COVID-19 pandemic and whether those steps are adequate. The evidence establishes that, on the whole, the MDC has responded aggressively to COVID-19, implementing an array of measures that largely track CDC guidance. The record leaves open the possibility, however, that there were early lapses in

implementation of these policies. And it suggests that in several areas, most notably relating to sick-call responses and use of isolation, the MDC has yet to fully implement the CDC's recommendations.

A. Inmate Screening at Entry

The best available evidence indicates that, contrary to petitioners' arguments, the MDC has implemented rigorous intake-screening procedures for inmates that comply with CDC guidance. Upon arrival at the MDC, inmates are now directed to a special area designated for receiving and discharge. King Decl. ¶ 6. All inmates entering or re-entering the facility are then screened with a "national inmate screening tool," Vasquez Decl. ¶ 6(a)-(b), which requires a temperature check as well as an inquiry into COVID-19 risk factors, including symptoms linked to COVID-19, *see* Ex. ZZZZ (Coronavirus Disease 2019 (COVID-19) Inmate Screening Tool Examples) ("Inmate Screening Examples"); Vasquez Tr. 26:5-8, 104:18-106:3. Asymptomatic inmates are then quarantined in an "intake" unit for 14 days to ensure that they do not develop symptoms before being admitted into the general population. King Decl. ¶ 6; *see* Jordan Decl. ¶ 14; Vasquez Tr. 24:17-25:13, 26:3-15, 108:22-109:22. Inmates who present COVID-19 symptoms on arrival, and possibly some inmates with exposure risk, are placed in medical isolation. Jordan Decl. ¶ 29; Vasquez Tr. 105:22-106:22. Those inmates are not released from isolation until they test negative for COVID-19 or are cleared by medical staff for release. Jordan Decl. ¶ 14. When they inspected the facility, both Dr. Beard and Ms. English confirmed that these inmate screening procedures were in effect. *See* Beard Report 7-8, 10; English Report 3.

Dr. Venters drew a contrary conclusion after speaking with two identified inmates who "reported that they had not been screened at all when they arrived in [the] MDC." Venters Report ¶ 18. In response, however, respondent submitted intake forms documenting that those two

inmates had their temperatures taken and were asked about their symptoms and other risk factors. *See* Inmate Screening Examples 1-2. Petitioners argue that for one of these inmates, the checkboxes under the sections labeled "Assess the Risk of Exposure" and "Assess Symptoms" were "left blank," indicating that he was not in fact screened. *See* Pet'rs' Proposed Findings of Fact ¶ 33; Inmate Screening Examples 2. However, a closer look at the form reveals that the official who filled it out simply drew a line through the "No" boxes, rather than checking them off individually. Accordingly, petitioners' claim that "[i]ndividuals entering the MDC are not always screened for symptoms of COVID-19," Pet'rs' Proposed Findings of Fact ¶ 33, which is based on those two inmates' out-of-court statements to Dr. Venters, does not appear to be supported by the evidence.

The MDC's inmate screening procedures conform to CDC guidelines, which provide that "pre-intake screening and temperature checks for all new entrants" should occur "in the sallyport, before beginning the intake process." CDC Correctional Guidelines 10. The guidelines further provide that any asymptomatic inmate entering the facility who is a "close contact of a known COVID-19 case" should be placed under quarantine for 14 days. *Id.* at 11. The MDC's policy of quarantining asymptomatic inmates upon arrival—whether a close contact of a known COVID-19 case or not—is thus more protective of the inmate population than the policy recommended by the CDC. Finally, the CDC's guidelines provide that an inmate presenting COVID-19 symptoms on arrival should be placed in medical isolation, CDC Correctional Guidelines 10, which is the approach taken by the MDC.

B. Staff Screening at Entry

The MDC is also conducting COVID-19 screenings of staff members upon entry, as the CDC recommends, but it appears to have deviated from CDC guidance in two parts of that process.

Staff are screened at the point of entry with a screening tool that requires a temperature check and asks employees if they are suffering from a "New On-Set Cough," "New Onset Trouble Speaking because of Needing to take a Breath," or a "Stuffy/Runny Nose." Ex. 22 (Coronavirus Disease (COVID-19) Staff Screening Tool) ("Staff Screening Tool"); *see* Vasquez Tr. 130:15-131:15. Any staff member with a fever is denied entry to the MDC and placed on leave for three days. *See* Staff Screening Tool; Vasquez Tr. 138:20-139:12. If a staff member has a normal temperature but exhibits other COVID-19 symptoms, he or she is subjected to a clinical evaluation and may be admitted to the facility on a discretionary basis. *See* Staff Screening Tool; Vasquez Tr. 139:13-24. When Dr. Beard and Ms. English toured the MDC, each observed that these screening procedures for staff members were being followed, and petitioners have not offered evidence to the contrary. *See* Beard Report 5, 10; English Report 2.

As petitioners observe, however, several aspects of the MDC's screening process do not appear consistent with CDC guidance. First, staff members are not being asked at entry whether they have had contact with a confirmed COVID-19 case in the past 14 days. *See* Vasquez Tr. 136:15-21; Staff Screening Tool; *cf.* CDC Correctional Guidelines 26. Second, the MDC does not appear to categorically bar staff from entering if they exhibit possible symptoms of COVID-19. *See* Vasquez Tr. 139:13-24 (describing fever as the only symptom that categorically prevents entry); Staff Screening Tool (noting that symptomatic staff may be directed to "Leave" or "Work"); *but see* Vasquez Tr. 137:21-138:2 (stating that staff who begin to experience COVID-19 symptoms on the job are instructed to "[r]eport it immediately to their supervisor and go home"). That contravenes CDC guidance which explains that staff members with COVID-19 symptoms should be sent home immediately. *See* CDC Correctional Guidelines 12.

C. Facility-Wide Preventative Measures

1. Social Distancing

MDC officials have implemented measures to promote social distancing that comport with CDC guidance. Female inmates are housed in a dormitory-style unit after a quarantine period when they first enter the facility. Vasquez Tr. 100:24-101:7; Ex. III (Decl. of Associate Warden Caryn Flowers) ("Flowers Decl.") ¶ 15 (Dkt. #82). They are required to wear masks if they are unable to social distance. King Tr. 96:24-97:2, 99:21-100:3, 101:7-11; Flowers Decl. ¶¶ 17, 22-23; *see* Vasquez Tr. 102:2-16. Because of space constraints, bunks in the unit may be less than six feet apart. King Tr. 96:16-97:18; Flowers Decl. ¶ 23. Nevertheless, MDC officials attempt to alternate bed assignments so that when one inmate sleeps on the top bunk, the neighboring inmate sleeps on the bottom bunk. King Tr. 96:16-25. Given the number of female inmates and the size of the unit, inmates in the women's unit are generally able to engage in social distancing. *See* Vasquez Tr. 102:2-16.

Most male inmates are housed in two-person cells, except in the isolation and intake units, where inmates are generally housed alone. *See id.* at 25:5-13; 33:17-23; 38:4-11; 68:11-17. Male inmates are now secured in their cells for at least 23 hours each day to reduce contacts that could spread the virus, Jordan Decl. ¶ 15; Flowers Decl. ¶ 7; King Tr. 88:6-18, although a small number leave their cells more regularly to work, King Tr. 88:19-23. Male inmates are generally allowed out of their cells in staggered intervals, so that no more than 10 inmates are outside their cells at once. *Id.* at 88:24-89:7.

The MDC's actions in this area are consistent with the CDC's recommendation that correctional facilities implement "strategies to increase the physical space between incarcerated/detained persons," such as staggering meal and recreational times, limiting group activities, and reassigning bunks to provide more space between inmates. CDC Correctional

Guidelines 11. The MDC's lockdown of male inmates is arguably more protective than any of the social distancing measures suggested in CDC guidance. While women are housed in a dormitory-style unit, rather than in two-person cells, CDC guidance recognizes that social distancing "strategies will need to be tailored to the individual space in the facility." *Ibid.* And the MDC's approach of alternating bed assignments in the women's unit, where possible, is a strategy that the CDC has expressly recommended for dormitory-style housing units. *Ibid.*

2. Sanitation

The MDC has instituted heightened sanitation protocols that conform to CDC guidance. While inmate declarations raise the possibility that there have been occasional failures to fully live up to the MDC's policies in this area, particularly in the earliest stages of the pandemic, the evidence does not support finding widespread or ongoing deficiencies.

a. Soap

The evidence indicates that soap is now widely available to inmates housed at the MDC. Staff provide soap through several mechanisms. First, soap is provided to new inmates upon arrival. King Decl. ¶ 11; Jordan Decl. ¶ 51. Second, soap is available for purchase at the commissary. King Decl. ¶ 11. Inmates with insufficient funds to purchase soap can obtain it at no cost. Jordan Decl. ¶ 51; King Tr. 25:12-19. Third, soap is delivered on a biweekly basis to staff teams that work in the housing units, and inmates may request additional soap from those team members. King Decl. ¶ 11; King Tr. 24:12-26:16. Accordingly, MDC officials maintain that "[a]ll inmates have access to sinks and soap at all times." King Decl. ¶ 11.

The individuals who inspected the MDC generally confirmed that inmates have access to soap. Ms. English interviewed a number of inmates chosen at random about their access to soap and other hygiene products, and reported that "[e]very inmate stated that they have access to proper supplies." English Report 4. Ms. English noted that in each area she toured, "inmates have access

to adequate personal hygiene supplies for hand washing," and that while "[i]nmates are provided with soap upon request," most choose to buy soap from the commissary "based off personal preference." *Id.* at 6-7. Dr. Beard reached similar conclusions. He "looked in a number of cells and each cell had at least one bar of soap, and some had more than one." Beard Report 6. Dr. Beard also noticed "a pile of hand soap in a storage area on the housing unit." *Id.* at 7. Dr. Venters did not contradict these observations. *See generally* Venters Report. Many of the inmate declarations in this case also state that inmates are receiving soap on a weekly or near-weekly basis. *See, e.g.*, Ex. 32 ("Dixon Decl.") ¶ 6; Ex. 35 ("Finch Decl.") ¶ 6; Ex. 39 ("Sojos-Valladares Decl.") ¶ 10; Ex. 41 ("Altino Decl.") ¶ 6.

Other inmate declarations, dated between April 20 and May 4, assert that inmates receive soap infrequently and cannot always obtain soap upon request. *See, e.g.*, Ex. 27 ("Powell Decl.") ¶ 6; Ex. 47 ("Miller Decl.") ¶ 7; Ex. 49 (Haney Decl.) ¶ 6; Ex. 51 ("Sanchez Decl.") ¶ 20. Because almost all of the declarations appear to describe conditions before the facility inspections, it is possible that these declarations are indicative of distribution problems at the outset of the pandemic. But given the in-court testimony attesting to the availability of soap during the facility inspections, I do not conclude these out-of-court statements reflect a widespread or ongoing problem with access to soap.

The MDC's policies comport with CDC guidance, which recommends that correctional facilities "provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing." CDC Correctional Guidelines 8. While petitioners fault the MDC for failing to make hand sanitizer available to inmates in addition to soap, *see* Am. Pet. ¶ 75(e), the CDC recommends the use of hand sanitizer only "[i]f soap and water are not readily available," *see* Ex. LL ("CDC Guidance on How to Protect Yourself and Others") at Tekbali 82. And even

then, hand sanitizer is only an acceptable alternative to soap if it contains "at least 60% alcohol." *Ibid.* Like many correctional facilities, the MDC does not permit inmates to possess alcohol-based hand sanitizer. *See* Jordan Decl. ¶ 53; King Tr. 35:22-36:5. In deference to this policy, the CDC's correctional guidelines provide that alcohol-based hand sanitizer should only be made available "where permissible based on security restrictions." CDC Correctional Guidelines 7. The MDC's policy of making soap and sinks available to inmates, but not alcohol-based sanitizer, does not run contrary to CDC guidance.

b. Cleaning Supplies

The best available evidence indicates that inmates are regularly supplied with a potent disinfectant to sanitize their living spaces, although it is possible that access was constrained at the outset of the pandemic. The MDC was authorized in response to the pandemic to use and distribute hdqC2, a powerful disinfectant, throughout the institution. King Tr. 40:2-7. According to Associate Warden King, the MDC has provided inmates with spray bottles and permits inmates to leave their cells on Mondays, Wednesdays, and Fridays to fill their bottles with hdqC2 for spraying and wiping down their cells. *Id.* at 40:15-23.

The individuals who inspected the MDC in connection with this case confirmed that inmates are being provided hdqC2. When Dr. Beard toured the MDC, inmate workers showed him what they use to clean their cells. Beard Report 6. The workers presented to him bottles of hdqC2. *Ibid.* Dr. Beard testified that he asked these workers if inmates were having difficulty accessing hdqC2 and was told that there was "no problem with access." Hr'g Tr. 330:9-13. Dr. Beard also noted that in preparing his evaluation of the MDC, he had reviewed a "significant order" for hdqC2 and spray bottles that was placed by the BOP. Beard Report 6. By the time Ms. English arrived at the facility on May 2, the MDC had 250 gallons of hdqC2 on hand. *See* English Report 7. Ms. English also observed that in all areas she toured, inmates had access to "disinfectant

products effective against the virus that causes COVID-19 for daily cleanings." *Id.* at 6. And while Dr. Venters spoke to several detainees who claimed to have received "insufficient cleaning solution for their cell area," Venters Report ¶ 42, he also testified that he saw spray bottles and disinfectant wipes in some of the housing areas and that some inmates told him that they had received cleaning supplies for their cells, Hr'g Tr. 146:8-18.

In written declarations dated between April 20 and 28, some inmates state that they have been provided with cleaning material for their cells, albeit not always in sufficient quantity to satisfy demand. *See, e.g.*, Ex. 28 ("Bynum Decl.") ¶ 4; Ex. 29 (Olivera Decl.) ¶ 6; Ex. 31 ("Mabry Decl.") ¶ 10; Dixon Decl. ¶¶ 6-7. Other inmate declarations from this period assert that inmates have not been provided with cleaning supplies. *See, e.g.*, Altino Decl. ¶ 7; Ex. 43 ("Hall Decl.") ¶ 7; Ex. 45 ("Watson Decl.") ¶ 9; Sanchez Decl. ¶ 20. It is difficult to assess these out-of-court statements because the declarants have not been subjected to any questioning about their claims. Crediting the observations of the individuals who inspected the facility and testified at the hearing, I conclude that the MDC now has an adequate supply of hdqC2 and is making that disinfectant available to inmates, but I do not rule out the possibility that there were occasions early in the pandemic on which individual inmates did not have access to those chemicals.

c. Cleaning of Common Areas and Shared Items

MDC officials have also provided cleaning supplies to inmates to wipe down shared items in common areas and have arranged for high-touch areas and surfaces to be cleaned periodically by orderlies. Associate Warden King and Health Services Administrator Vasquez have stated that spray bottles filled with hdqC2 and paper towels have been placed next to the phones and computers shared by inmates so that they can be cleaned between uses. *See* King Tr. 56:16-58:7; Vasquez Decl. ¶ 6(l). Inmates have been instructed to disinfect those items between each use. *Id.* at 56:18-57:9. Spray bottles with hdqC2 and Tilex have also been placed in the shower areas for

inmates to disinfect the showers between uses. *Id.* at 58:18-59:13. In addition, orderlies have been furnished with cleaning supplies and have been instructed to clean common areas "multiple times throughout the day." Jordan Decl. ¶ 52; *see* King Tr. 53:9-56:19.

When Dr. Beard and Ms. English inspected the MDC, they observed that disinfectant had been made available to both inmates and orderlies for cleaning common areas and shared items. During Dr. Beard's inspection, inmates showed Dr. Beard "the cleaning/disinfectant that had been diluted and put into spray bottles" that "is used on the telephones, computers and to clean common areas." Beard Report 6. Staff and inmate workers informed Dr. Beard that this disinfectant "was used by [orderlies] to disinfect showers, telephones[,] and computers after each use by an inmate," and that "spray bottles would be available if individual inmates wanted to clean any area themselves." *Id.* at 7-8. Ms. English's interviews with randomly selected inmates corroborated these observations, although Ms. English noted that in one area she did not see disinfectant spray near the phone handsets. English Report 5; Hr'g Tr. 192:10-19. Dr. Venters also testified that when he visited the MDC he saw disinfectant spray bottles and wipes in the housing units. Hr'g Tr. 146:14-18. In addition, several inmate declarations state that high-touch objects and common areas are being cleaned, both by inmates and orderlies, though a number of those inmates faulted the frequency with which cleaning is taking place. *See, e.g.*, Bynum Decl. ¶ 11; Sanchez Decl. ¶ 20; Ex. 55 ("Deutsch Decl.") ¶¶ 8-9; Powell Decl. ¶ 5; Dixon Decl. ¶ 10; Mabry Decl. ¶ 10.

Petitioners offer a contrary view, relying on declarations from other inmates dated between April 20 and 29 stating that almost no cleaning of shared items is occurring and that no supplies have been provided for this purpose. *See, e.g.*, Finch Decl. ¶ 10; Ex. 38 ("Pierson Decl.") ¶ 10; Watson Decl. ¶ 11; Ex. 53 (Batista Decl.) ¶ 9; Deutsch Decl. ¶ 9. They also rely on the reports of several inmates to Dr. Venters when he toured the facility that "they have not observed any

cleaning of the phones." Venters Report ¶ 42. I give these statements less weight than in-court testimony because the individuals who made them have not been subjected to questioning about their claims. Moreover, these accounts are contradicted by declarations of other inmates and by the observations that Dr. Beard and Ms. English made when they toured the facility. Indeed, Dr. Venters testified as well that when he visited the MDC he saw disinfectant spray bottles and wipes placed in the housing units. Hr'g Tr. 146:14-18. Taking together the staff declarations, live testimony, inspection reports, and inmate declarations, the MDC appears to be complying with its stated policy of providing supplies so that inmates can clean shared items and common areas, as well as assigning inmate workers to periodically clean those items. But the inmate declarations suggest that the roll-out of this sanitation policy may not have been seamless, and there may have been instances in which the requisite supplies were not available or in which shared items were not cleaned by inmate workers.

In addition to arguing that shared items are not being cleaned in accordance with the MDC's policies, petitioners have faulted the MDC for failing to ensure that such items are cleaned between each use. *See, e.g.*, Am. Pet. ¶ 54. But the enforced cleaning of shared items between each use, while perhaps an ideal practice, is not called for by the CDC's guidelines. Rather, those guidelines provide that frequently touched items and common areas should be cleaned "[s]everal times per day." CDC Correctional Guidelines 9. The MDC complies with that guidance. Moreover, the availability of cleaning supplies so that inmates can disinfect shared items themselves undercuts any argument that cleaning *by orderlies* between every use should be required.

3. Personal Protective Equipment (PPE)

The MDC's current PPE protocols for both inmates and staff are substantially in compliance with applicable CDC guidelines.

a. Inmate PPE

The best available evidence suggests that inmates are being provided with appropriate PPE in accordance with CDC guidelines. On or about April 5, the MDC provided all inmates with surgical masks. Jordan Decl. ¶ 56. Inmates were provided with new masks on April 12, *ibid.*, and the MDC's policy going forward has been to provide inmates with new masks on a weekly basis, *see* King Tr. 76:19-23. Inmates can request new masks from MDC staff if their masks become damaged. King Tr. 76:24-77:9. The MDC has instructed inmates that they must wear masks whenever they leave their cells if they cannot maintain appropriate social distance from others. *See* King Tr. 78:2-14, 79:10-17. It appears that this policy is being followed. *See* Beard Report 6 ("[A]ll inmates had and were using their masks as we moved through the facility. It is evident that this has become a part of their regular daily routine.").

A number of inmates acknowledge through written declarations that the MDC has been providing masks on a weekly basis, but some of those inmates complain that the masks have been non-washable. *See, e.g.*, Altino Decl. ¶ 8; Hall Decl. ¶ 8; Ex. 44 ("Carpenter Decl.") ¶ 8; Dixon Decl. ¶ 8. MDC officials addressed these concerns, responding to complaints about the "poor quality of some of the initial face coverings," English Report 5, by shifting to washable cloth masks, *see* Vasquez Decl. ¶ 6(r); Second King Decl. ¶ 20.

Petitioners' expert, Dr. Venters, has criticized the MDC for failing to give inmates N-95 masks, which are tight-fitted respirators specifically designed to filter out airborne particles. *See* Venters Report ¶ 45; *see also* Personal Protective Equipment: Questions and Answers, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html (last visited June 7, 2020). Respondent acknowledges that inmates have not been fitted with such masks. *See* King Tr. 78:15-79:9. But CDC correctional guidance advises that "face masks"—not N-95s—should be provided to inmates "as feasible based

on local supply." CDC Correctional Guidelines 25. The same guidelines recommend that even "[i]ncarcerated/detained persons who are confirmed or suspected COVID-19 cases, or [are] showing symptoms of COVID-19" should be provided with face masks, not N-95 respirators. *See ibid.* Respondent's expert Asma Tekbali, the witness with the greatest expertise on COVID-19 protocols, has explained that N-95 masks are "reserved for airborne viruses such as tuberculosis and measles" and generally are "indicated for [health care] providers only," rather than patients. Tekbali Report 3. Accordingly, the MDC's decision to provide inmates with ordinary face masks, rather than N-95 masks, is consistent with CDC guidance.

Dr. Venters also faults the MDC for failing to provide inmates with gloves unless they work as orderlies. *See* Venters Report ¶ 64(r). MDC officials have not disputed that the MDC provides gloves to inmates only when they work as orderlies or when they are involved in laundry or food services. *See* King Tr. 64:4-16. Here too, the MDC's policy comports with CDC guidelines, which generally recommend hand hygiene, rather than glove-wearing, to protect against COVID-19. *See* CDC Guidance on How to Protect Yourself and Others at Tekbali 82. The CDC accordingly recommends providing inmates with gloves only if (i) they handle laundry or food service items "from a COVID-19 case or case contact," or (ii) are assigned to clean an area where a COVID-positive person was present. CDC Correctional Guidelines 25. The MDC's policy aligns with this guidance.

b. Staff PPE

The MDC has instituted PPE policies for staff that conform to CDC guidelines. MDC staff members receive two surgical masks a week and are required to wear masks when they cannot engage in social distancing. King Tr. 69:21-23, 71:19-21. While gloves have been made available to staff, staff members generally are not required to wear gloves except when they perform tasks such as taking temperatures, working in the isolation unit, or dealing with an inmate who is

confirmed or suspected to have COVID-19. *See id.* at 81:18-83:16. Dr. Beard and Ms. English both noted that staff were wearing appropriate PPE when they toured the MDC. *See* Beard Report 6; English Report 5.

In suggesting that staff do not make appropriate use of PPE, petitioners rely on Dr. Venters' statement that he "observed several correctional staff not wearing gloves or masks," and that it "was not clear who was mandated to wear masks or gloves." Venters Report ¶ 43. Petitioners also rely on a number of written declarations from inmates stating that staff members do not always wear masks and gloves. *See, e.g.*, Bynum Decl. ¶ 12; Mabry Decl. ¶ 11; Dixon Decl. ¶ 16; Pierson Decl. ¶ 24. But those observations, without more, do not support the inference that MDC staff members are failing to wear PPE when it is called for. The CDC only recommends that staff members wear gloves when they are undertaking certain tasks, such as performing temperature checks or providing care to quarantined inmates. *See* CDC Correctional Guidelines 25; Tekbali Report 6. Similarly, the CDC recommends mask-wearing only when it is not possible to engage in social distancing. *See generally* CDC Correctional Guidelines 25; Tekbali Report 7. Neither the inmate declarants nor Dr. Venters offered a basis to conclude that staff members have been failing to wear masks or gloves when required under CDC protocols.

The MDC also has special PPE protocols for staff who work in the quarantine and isolation units, or who otherwise have direct contact with confirmed or suspected COVID-positive inmates. Consistent with the CDC's recommendation that staff interacting directly with confirmed or suspected COVID-19 cases wear N-95 masks, *see* CDC Correctional Guidelines 25, staff members who work in the quarantine or isolation units are given N-95 masks daily, *see* King Tr. 72:2-22. Each staff member is required to wear an N-95 mask, as well as a gown and either a face shield or goggles, when dealing with inmates who have tested positive for COVID-19. *Id.* at 69:13-19,

84:19-85:25. Dr. Beard and Ms. English both noted the availability and use of this specialized PPE when they toured the MDC. Beard Report 7; English Report 5. Ms. English did not see a cart for specialized PPE outside the quarantine unit, but she observed that "[t]he quarantine area was receiving masks and gloves [from] the Captain at the start of each shift on a cart which [was] pushed to the location." English Report 4. While noting that "there were no significant concerns raised about [the] availability of PPE for staff," she recommended that a "stationary cart" with PPE be placed in front of all units to "avoid even the appearance that PPE is not being made readily available" to staff who need it. *Id.* at 12.

Dr. Venters did not reach the same conclusion because when he toured the isolation unit, he observed that the cart stationed outside the unit "lacked any gowns or masks." Venters Report ¶ 45. From that observation, Dr. Venters drew the conclusion that MDC staff "appear to lack appropriate PPE" for dealing with presumed or confirmed COVID-19 cases. *Id.* ¶ 46. But that broad conclusion is unwarranted, particularly because later visits to the MDC, including an unannounced inspection, found that staff had access to sufficient PPE and noted that the PPE cart outside the isolation unit was stocked. Given that evidence, it appears likely that Dr. Venters simply came upon the isolation unit's PPE cart at a time when it needed restocking.

Petitioners also rely on a written declaration from Anthony Sanon, an official in a union that represents correctional officers, in which Mr. Sanon disputes whether the MDC has made appropriate PPE available to staff in the isolation and quarantine units. *See* Ex. 79 (Sanon Decl.) ¶¶ 28, 30. But Sanon's declaration deserves less weight than other accounts. He appears to be reporting second-hand information rather than his own observations, he has not been subjected to any kind of questioning, and his statements are contradicted by the sworn testimony of Dr. Beard

and Ms. English, each of whom were subjected to cross-examination. The best available evidence thus suggests that staff in the isolation and quarantine units have access to appropriate PPE.

4. Communication Regarding COVID-19

MDC officials communicate with inmates about COVID-19 through "weekly town halls" at which "written information" is handed out to inmates. Vasquez Decl. ¶ 6(s). While these "town halls" initially took the form of group meetings, prison officials now distribute information by going cell-to-cell. King Tr. 92:21-93:14. Staff members also make rounds to answer inmates' questions. Vasquez Decl. ¶ 6(s). The facility evaluations by Ms. English and Dr. Beard corroborated that prison officials are disseminating information about the virus in these ways. *See* English Report 9-11; Beard Report 3. Ms. English further noted that informational posters have been placed "throughout the institution" in both Spanish and English. English Report 9-11. Dr. Venters' report did not dispute that the MDC has adopted these educational measures. These communications protocols appear consistent with CDC guidance recommending that correctional institutions give inmates and staff "up-to-date information about COVID-19," to be conveyed "verbally on a regular basis" and via signs placed "throughout the facility." CDC Correctional Guidelines 10, 12.

D. Testing for COVID-19

The MDC has tested only a small number of inmates for COVID-19, due to limited access to testing, although BOP officials expect that the facility's testing capacity will be increased in the near future. As noted above, as of June 4, the MDC had tested just 68 inmates for the virus, with nine positive results. Edge Letter 2. The small number of tests conducted reflects MDC officials' difficulty obtaining test kits thus far. *See* Vasquez Tr. 116:8-23 (noting that the MDC has made weekly requests for new tests from the lab that services it, without success). That difficulty, in turn, reflects broader supply shortages. *See* Tekbali Report 3-4. Nevertheless, the

BOP has arranged for the MDC to receive new testing equipment in the near future. In an apparent reference to the BOP's acquisition of Abbott ID NOW testing machines for some BOP facilities, Ms. English testified that "machines" will be sent to the MDC "shortly" because it "is being recognized as a detention facility in a hot zone." Hr'g Tr. 226:15-17; *see* Press Release, Bureau of Prisons to Expand Rapid Testing Capabilities (May 7, 2020), https://www.bop.gov/resources/news/pdfs/20200507_press_release_expanding_rapid_testing.pdf. The MDC does not test staff because it is not "licensed" to do so, Vasquez Tr. 145:17-146:23, but staff members are encouraged to self-report if they test positive in the outside community, *id.* at 148:2-10.

Petitioners have faulted the MDC for failing to conduct "[b]roader testing" thus far. Pet'rs Br. 7. They argue that the MDC should be testing all inmates and staff who possess "more than one sign and/or symptom of COVID-19" or who possess "risk factors for serious illness or death from COVID-19." Mot. for Prelim. Inj. 3. But petitioners have failed to demonstrate that such an approach has been feasible to date, given the supply shortages discussed by Ms. Vasquez and Ms. Tekbali. Indeed, CDC guidelines implicitly acknowledge that tests are in short supply by providing guidance to clinicians about how to prioritize testing. *See Evaluation & Testing*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html (last visited June 8, 2020). While Ms. Tekbali did not dispute that greater testing of inmates with symptoms would be desirable when "possible," Hr'g Tr. 285:1-15, and the availability of test kits appears to be increasing, it does not appear that the MDC has thus far missed opportunities to engage in widespread testing.

E. Quarantine and Isolation Procedures

The MDC has established quarantine and isolation units whose basic design comports with CDC guidelines. The isolation unit houses inmates who have tested positive for COVID-19 or who are "presumed positive" based on their symptoms. Vasquez Tr. 56:13-23, 61:5-63:21, 118:4-24. It is the MDC's policy to test the first inmate in a unit who exhibits symptoms that MDC officials deem consistent with COVID-19. *Id.* at 119:13-16. The inmate is placed in isolation pending test results and kept in isolation if the test comes back positive. *Id.* at 61:22-62:6. If the test is positive, the inmate's entire housing unit is placed under quarantine for 14 days. *See* King Decl. ¶ 9; Jordan Decl. ¶¶ 37-38; Vasquez Tr. 84:25-85:2. Inmates in the quarantine unit who display symptoms that MDC medical staff deem indicative of COVID-19 are to be treated as "presumed positive" without a test and placed in isolation. *See* Vasquez Tr. 32:1-8, 56:15-23, 62:14-63:21. Between when the MDC first began isolating inmates in connection with COVID-19 and April 27, a total of 19 inmates were confirmed or presumed positive for COVID-19 and placed in the isolation unit for some period. *See* Ex. 80 (Resp't's Response to Interrogatory 1(c)) 3.

Inmates in the isolation unit are housed in single cells that each have a dedicated bathroom. Vasquez Tr. 68:11-17. They cannot leave their cells except for limited purposes, such as to make legal calls and to shower. *See* King Decl. ¶ 8 n.1. Inmates are not released from the isolation unit until (i) seven days after the onset of their symptoms, and (ii) 72 hours without a fever. Vasquez Tr. 81:19-82:4.

Male inmates in a quarantined unit remain housed in double cells, *id.* at 33:17-23, except that the cellmate of the individual who tested positive is housed alone in his original cell, *id.* at 34:5-23. If the cellmate is determined to be symptomatic, he is transferred to the isolation unit.

Ibid. Inmates in a quarantined unit may use the unit's common area but "will not be moved from the housing unit to other areas of the institution." King Decl. ¶ 8 n.1. The unit remains under quarantine until 14 days have passed since the last inmate was deemed symptomatic for COVID-19 and transferred to isolation. *See* Jordan Decl. ¶ 49.

Medical staff make twice-daily rounds in the quarantine and isolation units. Vasquez Tr. 38:17-40:10, 78:23-79:6; Vazquez Decl. ¶ 6(c); Beard Report 6; English Report 3. On each round, the medical staff conduct temperature and wellness checks. English Report 3. The MDC did not originally specify particular questions to be asked during the wellness checks. Vasquez Tr. 38:23-39:10. By the time Ms. English inspected the facility in May, however, medical staff were asking about "wellness and symptomatic criteria." English Report 3. If the questioning or temperature check suggests that an inmate may have COVID-19 symptoms, the inmate "will be removed from the cell and escorted to a health services exam room on the floor for further examination." *Ibid.*

Petitioners raise a number of objections to the MDC's procedures for quarantine and isolation units. First, petitioners cite 12 declarations from inmates to question whether the MDC has actually been conducting wellness checks or twice-daily temperature checks in those units. *See* Suppl. Venters Report ¶ 3(a); Pet'rs' Proposed Findings of Fact ¶ 18 (citing Bynum Decl.; Dixon Decl.; Ex. 36 (Nelson Decl.); Ex. 37 (Platt Decl.); Pierson Decl.; Sojos-Vallardes Decl.; Hall Decl.; Carpenter Decl.; Miller Decl.; Ex. 48 (Soria Decl.); Deutsch Decl.; Ex. 64 (Lopez Decl.)). But only two out of the 12 declarations appear to have been submitted by inmates who had actually spent time in quarantine or isolation units. *See* Sojos-Valladares Decl.; Miller Decl. And one of those two declarations complains only about the inmate's experiences before he entered quarantine. *See* Sojos-Valladares Decl. Respondent, by contrast, has marshalled first-hand deposition testimony from Ms. Vasquez about wellness and temperature checks that she and other

staff conduct, *see* Vasquez Tr. 38:17-40:10, 78:23-79:6, and testimony from Ms. English that her staff reported witnessing temperature and wellness checks in quarantine units, *see* Hr'g Tr. 213:12-16. Unlike the single relevant declaration cited by petitioners, the testimony cited by respondent was provided under oath, and subject to cross-examination. I credit this evidence that wellness and temperature check procedures are being implemented in quarantine and isolation units.

Second, petitioners assert that the current twice-daily medical rounds are insufficient. *See* Mot. for Prelim. Inj. 2. They contend that medical staff must (i) engage in more detailed questioning during wellness checks, (ii) perform "standardized clinical evaluation[s] at least daily" in the isolation unit, and (iii) evaluate inmates in the isolation unit "in a clinical setting and not cell-side." Mot. for Prelim. Inj. 2. Petitioners' preferred procedures go beyond anything the CDC has recommended. Their recommendations do not even appear to be consistent with the ordinary standard of care for COVID-19 patients, who are commonly advised to "isolate and manage" symptoms rather than to seek daily assessments from healthcare providers. Hr'g Tr. 242:5-23 (testimony of Ms. Tekbali). To the extent petitioners believe CDC guidelines require more detailed questioning during wellness checks, *see* Pet'rs' Proposed Findings of Fact ¶ 15 (citing CDC Correctional Guidelines 26), that view is mistaken. The list of screening questions petitioners highlight is for individuals entering a correctional facility, being transferred to a correctional facility, or being released from a correctional facility—not for daily rounds. CDC Correctional Guidelines 26; *see* Ex. 6 ("CDC Correctional Guidelines Slides") at BOP 96. In any event, the MDC has over time augmented its wellness checks to include inquiries about specific symptoms.

F. Access to Medical Staff Outside of the Isolation and Quarantine Units

In the general population units, MDC officials do not conduct regular wellness screenings or temperature checks, but instead principally rely on inmates to alert prison staff to medical problems. *See* Hr'g Tr. 523:25-524:23. Inmates have at least two opportunities per day to report medical problems to medical staff—when members of the health team go door-to-door at every cell for the sick call and when they go door-to-door at every cell to distribute medications in the process known as the pill line. *See* Vasquez Tr. 169:11-24, 182:15-183:20, 202:21-204:13; King Decl. ¶ 18. On these rounds, inmates can report symptoms and seek care by submitting sick-call requests—a system discussed in more detail below.

Petitioners fault the MDC's monitoring of the general population because health staff do not initiate wellness screenings or temperature checks. *See* Pet'rs Br. 8-9; Pet'rs' Proposed Findings of Fact ¶ 17. But the MDC's approach tracks the CDC's recommendations. The CDC's guidance on "Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms" advises correctional facilities to instruct "healthcare staff [to] perform regular rounds to answer questions about COVID-19" and to implement "daily temperature checks in just a subset of housing units"—those "where COVID-19 cases have been identified." CDC Correctional Guidelines 22. That is precisely what the MDC does, because MDC staff perform twice-daily temperature checks in quarantined units (i.e., those where COVID-19 cases have been identified). *See* Vasquez Tr. 38:17-40:10, 78:23-79:6; Vazquez Decl. ¶ 6(c); Beard Report 6; English Report 3.

G. The Sick-Call System

Petitioners raise more substantial concerns about the MDC's system for handling sick-call requests once they are made. Evidence at the preliminary injunction hearing suggests that the

MDC's sick-call process and the related isolation determinations are falling short when measured against CDC standards because of delays in response times and sparing use of isolation.

By way of background, the MDC's sick-call system permits inmates to report COVID-19 symptoms and seek medical attention verbally, electronically, or through a paper slip. *See* Ex. 80 (Resp't's Response to Interrogatory 1(f)) 4. Inmates usually submitted electronic requests before the pandemic, but the facility now relies heavily on paper requests because most inmates have only occasional computer access during the lockdown. *See* English Report 4; Hr'g Tr. 179:18-180:3; Eichenholtz Decl., Ex. A 28 (Dkt. #89-1). Inmates can obtain paper sick-call slips from medical staff when they make rounds each day. Vasquez Tr. 48:18-49:2; 186:19-187:7; *see* King Decl. ¶ 18. Medical staff then pick up the sick-call slips and triage requests as emergent or non-emergent "at the cell door," Hr'g Tr. 180:10-13; *see* Vasquez Tr. 54:10-19, 186:19-187:7, 194:13-21; English Report 3-4, although the cell-door triage system was not fully implemented at the beginning of the pandemic, Hr'g Tr. 180:4-15 (testimony from Ms. English noting that before her inspection, correctional staff sometimes collected the sick-call slips instead of leaving them for medical staff, which delayed triage by a few hours). Requests classified as "emergent" are to be addressed that same day, and non-emergent requests are to be entered into a scheduling system for follow-up at a later date. *See* Vasquez Tr. 54:10-19, 186:21-187:7, 188:13-23, 194:16-21. The MDC has added temporary medical staff to assist with the sick-call system during the pandemic. Vasquez Tr. 194:17-20; Hr'g Tr. 520:10-13.

The evidence at the preliminary injunction hearing indicates that the speed of the MDC's response to sick-call requests and its use of isolation in response to sick-call requests reporting COVID-19 symptoms both currently fall short of the standards in CDC guidelines. With respect to speed, CDC guidance specifies that inmates experiencing COVID-19 symptoms should be

evaluated expeditiously—"at the first sign of symptoms." CDC Correctional Guidelines Slides at BOP 108; *see* CDC Correctional Guidelines 23. Doing so enables inmates to receive treatment quickly, when treatment is warranted. *See* CDC Correctional Guidelines 23. And it ensures that inmates who are experiencing COVID-19 symptoms can "be immediately placed under medical isolation," "[a]s soon as" they develop COVID-19 symptoms. CDC Correctional Guidelines 15; *see* CDC Correctional Guidelines Slides at BOP 100-01 (recommending isolating "[s]ymptomatic people . . . [i]mmediately once symptoms appear").

Evidence at the hearing indicates that the MDC is not currently meeting that standard because medical staff may take days or sometimes even weeks to respond to some sick-call requests reporting possible COVID-19 symptoms. Petitioners' expert concluded based on his interviews of detainees that responses to sick-call requests typically took "between 3-7 days." Venters Report ¶ 23. And Ms. Vasquez acknowledged that MDC medical staff would likely treat at least one COVID-19 symptom—loss of sense of taste—as non-emergent. Vasquez Tr. 196:3-10. She stated that the average response time to a non-emergent request is two and a half weeks. *Id.* at 195:2-8.

Further, multiple inmates submitted declarations stating that they reported symptoms that could be consistent with COVID-19 but did not receive timely responses from medical staff. *See, e.g.*, Sojos-Valladares Decl. ¶ 5; Rodriguez Decl. ¶ 7; Ex. 81 ("Gonzalez Decl.") ¶ 3; Ex. 66 ("Chunn Decl.") ¶ 21; Ex. 33 ("Needham Decl.") ¶¶ 19-27; Powell Decl. ¶¶ 11-12; Miller Decl. ¶ 8, Ex. 54 ("Singer Decl.") ¶ 12; Ex. 65 ("Hair Decl.") ¶¶ 12-13; Ex. 46 ("Wilson Decl.") ¶ 10. Several inmates reported delays even when they described symptoms such as trouble breathing. *See, e.g.*, Rodriguez Decl. ¶ 7; Ex. 88 ("Pet'rs Sick-Call Exhibit") at BOP_SCR 478, BOP_SCR 679. That is of particular concern because the CDC has designated trouble breathing to be an

"emergency warning sign[ ]" for COVID-19. CDC List of Symptoms of Coronavirus. Indeed, Health Services Administrator Vasquez acknowledged that symptom to be emergent. Vasquez Tr. 195:9-16.

Moreover, some inmates' accounts of the medical encounters that occurred after they reported COVID-19 symptoms raise questions about whether MDC medical staff are uniformly performing appropriate screening for COVID-19 when they do respond to sick-call requests reporting possible symptoms. In particular, one inmate who reported experiencing symptoms consistent with COVID-19 stated that despite repeated requests for care, he went at least two weeks without receiving more than a temperature check from a nurse, who told him he could not "get tested or see a doctor" because he "did not have a fever and had not fainted." Bynum Decl. ¶ 8. Another inmate stated that he experienced shortness of breath and chest tightness and was told via electronic response that he should buy allergy medicine from the commissary. Deutsch Decl. ¶¶ 17-19. And a third inmate reported that a physician's assistant told her that there was no point to testing her when she had already experienced symptoms for several weeks and that it would create panic in her unit if she tested positive. Needham Decl. ¶¶ 19-27. To be sure, the general course of treatment for many COVID-19 cases is simply to monitor and manage symptoms—there are "virtually no clinical interventions for patients who present with mild symptoms." Tekbali Report 2; *see* Hr'g Tr. 241:22-242:23. And it is hard to fully assess these accounts because the record before me does not include medical records and because the declarants did not provide live testimony and were not subject to questioning. It is also not possible to gauge the extent to which these complaints reflect a widespread problem. But these accounts suggesting that several inmates reporting COVID-19 symptoms may have had only a cursory medical encounter, after which they were neither tested nor placed in isolation, reinforce concerns about whether the MDC is

appropriately responding to sick-call requests describing potential COVID-19 symptoms and then quickly isolating possible cases based on informed clinical judgment.

Sick-call requests themselves provide additional evidence of delayed responses. Petitioners entered into evidence anonymized versions of electronic sick-call requests submitted between March 13 and early May, as well as certain paper sick-call requests from that period. *See* Pet'rs Sick-Call Exhibit; *see also* Attachment to Third Suppl. Decl. of Health Services Administrator Stacey Vasquez ("Suppl. Paper Sick Calls") (*see* Dkt. #97-2) (additional paper sick-call requests from this time period submitted by respondent). Dr. Venters determined after reviewing a subset of sick-call requests supplied to him by petitioners' counsel that at least 37 inmates had submitted requests reporting COVID-19 symptoms in which the inmate "expressly identified their concerns as a repeat." Venters Report ¶ 25. Some of those requests may come from inmates who were seen by medical staff but then filed an additional slip to request further attention. *See, e.g.*, Pet'rs Sick-Call Exhibit at BOP_SCR 822. But the dozens of submissions that appear to be repeat requests corroborate the inmate declarations that reports of symptoms of COVID-19 did not receive timely responses. In sum, taking together Ms. Vasquez's deposition testimony, the declarations submitted by inmates, and the evidence from the sick-call requests themselves, the MDC appears to be falling short of the CDC's guidance that correctional facilities should evaluate inmates reporting COVID-19 symptoms quickly, so that potential COVID-19 cases can be isolated immediately and receive swift medical treatment if needed.

The sick-call data also suggests that the MDC is not using isolation as fully as recommended under the CDC guidelines, which call for inmates with COVID-19 symptoms to "be immediately placed under medical isolation." CDC Correctional Guidelines 15; *see* CDC Correctional Guidelines Slides at BOP 100-01. The sick-call requests reflect that between March

13 and early May, roughly 150 to 200 inmates submitted sick-call requests containing symptoms or combinations of symptoms that CDC guidance identifies as possible signs of COVID-19, and roughly 120 to 150 of these had been submitted by April 27. *See* Pet'rs Sick-Call Exhibit; Suppl. Paper Sick Calls.[3] Moreover, I have drawn the inference that an unknown additional number of paper sick-call requests from April 1 to April 23 also contained reports of COVID-19 symptoms. Yet as of April 27, the MDC had only transferred 19 inmates to medical isolation. *See* Ex. 80 (Resp't's Response to Interrogatory 1(c)) 3. The substantial number of sick-call requests reporting COVID-19 symptoms and the small number of inmates placed in isolation are hard to square with the CDC's guidance that "[i]f an individual has symptoms of COVID-19" such as "fever, cough, [or] shortness of breath," medical staff should "[p]lace the individual under medical isolation." CDC Correctional Guidelines 10; *see id.* at 15; CDC Correctional Guidelines Slides at BOP 100-01.

Respondent replies that it would not be reasonable to isolate every inmate who reports a symptom consistent with COVID-19. *See* Hr'g Tr. 522:19-523:15. After all, many symptoms of COVID-19 are also common symptoms of other ailments, such as sore throat, cough, and headaches. CDC List of Symptoms of Coronavirus. Respondent therefore contends that CDC guidelines are best understood to allow medical staff some discretion regarding whether isolation is warranted. Hr'g Tr. 528:21-529:3. And he notes that petitioners' expert appeared to agree that a single symptom consistent with COVID-19 would not necessarily warrant isolation. *See id.* at

[3] The exact number of requestsis difficult to calculate, in part because the CDC has updated its list of possible symptoms of COVID-19 over the course of the pandemic. *Compare* CDC List of Symptoms of Coronavirus, *with Symptoms of Coronavirus*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (last visited June 8, 2020); *see also* CDC Correctional Guidelines 10.

155:4-16 (testimony of Dr. Venters that he "would anticipate that most patients who go into an Isolation Unit for COVID-19 would have multiple signs or symptoms").

But the MDC's approach does not appear consistent with CDC guidelines even accepting, as I do, that the guidelines are properly understood to allow healthcare providers to exercise clinical discretion in deciding whether to isolate particular inmates. The sick-call data suggests that, for the period from March 13 to early May, the MDC was neither isolating nor testing more than 80 percent of inmates who report symptoms of COVID-19. In other words, in the main, the MDC appears not to be isolating individuals who report COVID-19 symptoms. That seems to be in tension with the CDC's guidance that those reporting symptoms should be isolated, even if the CDC guidelines are understood to allow discretion in individual cases. The conclusion that MDC staff are not fully utilizing isolation as called for under the CDC guidelines is compounded by several declarations that indicate that the MDC has failed to isolate at least some inmates who exhibited many symptoms of COVID-19 over an extended period. For instance, Victor Sojos-Valladares was not isolated until about a week after he started feeling sick and only after he refused three consecutive meals, seemingly because he did not immediately present with a fever. *See* Sojos-Valladares Decl. ¶ 5. Similarly, Justin Rodriguez reports "suffering in [his] cell for about two weeks" with multiple COVID-19 symptoms, without being transferred to isolation, because he did not have a temperature. Rodriguez Decl. ¶ 7. A blood test after Mr. Rodriguez was released several weeks later showed he had COVID-19 antibodies. *See id.* ¶¶ 15-17; Ex. 71. Respondent's unelaborated explanation that MDC medical staff are making "clinical decisions" about isolation, Resp't Opp'n Br. 13, does not sufficiently rebut the evidence that the MDC is underutilizing isolation relative to the CDC's expectations.

H. Sick-Call Record-Keeping and Tracking

Petitioners argue that MDC officials have been deficient in their handling of sick-call requests themselves, contending that officials have failed to preserve records of such requests and that officials have also been deficient because they have not used sick-call data to create an MDC-wide symptom dashboard.

With respect to preservation, petitioners fault MDC officials for failing to retain paper sick-call requests and then scan them into inmates' medical records before April 24, 2020. *See* Hr'g Tr. 14:8-17; Venters Report ¶¶ 28-31. Dr. Venters argued that if the paper requests are discarded, "the health service does not know how many requests were made, and how many responded to," and providers cannot determine "whether the assessment and care provided was appropriate to the patient's original concerns." Venters Report ¶ 29. Respondent does not appear to dispute that some record of the medical complaint raised in a paper request should be maintained for the quality-control purposes that Dr. Venters describes. Instead, respondent argues that the substance of each medical complaint should be recorded in staff comments in the BOP's electronic scheduling system, in patient medical records, or in both. *See* Resp't's Mem. Opp'n to Pet'rs' Mots. in Lim. 3; Hr'g Tr. 9:21-23, 11:9-12:3, 519:2-9. Respondent is also now retaining the paper sick-call documents. *See* Hr'g Tr. 451:10-16.

Contrary to respondent's arguments, it does not appear that the substance of the medical complaints in paper sick-call requests was uniformly preserved in the weeks between April 1, when the facility began relying heavily on paper sick-call requests, and April 24, when respondent began retaining paper sick-call requests. *Id.* at 451:10-16. When Dr. Venters reviewed one set of medical records that included a sick-call encounter note, Dr. Venters found that there was "no way of knowing" from the patient's medical record whether the record contained the substance of the

inmate's original request, and that therefore he could not determine "if the thing that the patient was worried about was addressed or even acknowledged." *Id.* at 140:13-141:23. And while respondent has now produced an activities report reflecting that staff sometimes recorded the nature of an inmate's complaint in the MDC's electronic scheduling system, *see* Activities Report, that report itself suggests that medical staff did not uniformly record inmate complaints. For instance, the comment on one inmate's scheduler entry simply reads "several medical issues"; the comment field on several other entries is left blank. *See, e.g.*, Activities Report 2, 32.[4] Thus, I credit petitioners' assertion that not all of the sick-call data has been preserved.

Petitioners also fault the MDC for failing to use data from its sick-call requests to create a "facility wide symptom tracking dashboard," Mot. for Prelim. Inj. 2-3, but they have not demonstrated that this particular method of record-keeping is required under CDC or other guidance. Petitioners argue, more specifically, that a "symptom tracking dashboard" would enable staff to "track the overall incidence of various symptoms by date and location" within the facility. Venters Report ¶ 37; *see* Hr'g Tr. 80:17-81:13, 479:7-481:12. Respondent does not dispute that the MDC lacks such a centralized tracking system; instead, the facility maintains information about clinical encounters with inmates in their individual medical files. Hr'g Tr. 539:13-17; *see* Ex. 80 (Resp't's Response to Interrogatory 1(f)) 4. A tracking system of the type petitioners recommend might well assist MDC staff in identifying clusters of symptoms consistent with COVID-19 within the facility. That data, in turn, could inform MDC staff in deciding which sick-call requests to prioritize, when to perform testing once the facility has greater capacity to conduct tests, and when

[4] Petitioners object to the inclusion in the preliminary injunction record of the activities report and a related declaration from BOP National Health Technology Administrator Scott A. Griffith because respondent did not file these documents until after the evidentiary hearing. Petitioners principally argue that the documents are "late" and therefore "prejudicial" to petitioners, and they raise several concerns about the reliability of the documents. *See generally* Pet'rs' Ltr. in Opp'n to Resp't's Request 1 (Dkt. #102); *see* Griffith Decl. I do not find that including these documents in the record is prejudicial to petitioners, given that I have relied on them for the limited purpose of establishing that the activities report does not appear to uniformly preserve inmate complaints.

isolation is warranted. Nevertheless, the CDC's detailed 26-page guidance on COVID-19 for correctional facilities does not call for officials to use this particular record-keeping or tracking method. Nor does guidance from any other expert body on medical care or correctional facilities that petitioners have identified. And while petitioners' expert, Dr. Venters, opined that such a dashboard was "essential" and described his own use of that approach in monitoring infectious disease outbreaks at Rikers Island, *see* Venters Report ¶¶ 37-39; Hr'g Tr. 64:22-65:13, his testimony did not establish that the tracking method he recommends is standard practice among other institutions. On this record, the tracking system that Dr. Venters recommends appears to be one means by which the MDC could meet its broader goal of implementing effective quarantine and isolation procedures, but it is not apparent that the MDC is violating any applicable standard of care because it has not adopted such a system.

I. Emergency Call Buttons and Translation Services

Petitioners raise several facility-wide concerns relating to inmates' ability to communicate medical concerns to staff, but petitioners have not demonstrated that the MDC's care is deficient in these areas.

First, petitioners allege that inmates' ability to communicate medical problems to medical staff is unacceptably impaired because while the MDC has emergency call buttons in inmates' cells, it is undisputed that some of the emergency call buttons do not work. *See* Pet'rs Br. 15; King Tr. 103:3-13. Respondent has explained that the MDC requested funding to repair these buttons earlier this year but that the funding was denied. King Tr. 103:5-13. And Ms. English testified that many BOP facilities do not have any "duress buttons." Hr'g Tr. 187:19-25. I cannot conclude the MDC is violating any standard of care because it has not yet performed repairs to buttons that many other federal facilities do not have at all, where the record indicates that inmates can report

medical concerns through other channels. As noted above, the MDC provides that opportunity through regular medical rounds. *See, e.g.*, Vasquez Tr. 169:11-24, 182:21-184:21, 202:21-204:14; King Decl. ¶ 18; *cf.* Mot. for Prelim. Inj. at 3 (arguing that until buttons are repaired, MDC staff should "conduct frequent medical rounds in those units where there are malfunctioning call buttons"). Correctional staff also perform rounds every 30 minutes, providing another avenue for reporting medical emergencies. Vasquez Tr. 75:5-9, 187:8-15, 200:23-201:4.

Second, petitioners suggest that the MDC provides inadequate access to Spanish-language interpretation. Mot. for Prelim. Inj. at 3. But Ms. English's inspection report indicates that the MDC has a Spanish-speaking medical staff member at the facility seven days a week. English Report 9; *see* Vasquez Decl. ¶ 6(o). Health Services Administrator Vasquez further explained that the facility uses an interpretation service called Language Line if there are no interpreters available to speak with a particular inmate. *See* Vasquez Tr. 174:19-175:8; Vasquez Decl. ¶ 6(o). While petitioners invoke Dr. Venters' statement that he spoke with "more than one" Spanish-speaking inmate who reported having difficulty communicating his concerns "based on a language barrier," Hr'g Tr. 108:9-14; *see* Venters Report ¶¶ 58-59, petitioners have not established that the accounts of Ms. English and Ms. Vasquez are incorrect, or that the translation services prison officials have described violate any standard of care.

J. Inmates at an Elevated Risk from COVID-19

The MDC is tracking inmates who would face greater health risks if they contracted COVID-19, but it has not sought to protect those inmates using procedures different from those applicable to the rest of the inmate population. At the beginning of the pandemic, the MDC's Health Services Department reviewed inmate medical records to determine which individuals at the MDC could be considered "high risk" under CDC guidelines due to age or a preexisting

medical condition. Jordan Decl. ¶¶ 33-34. The MDC then created a list of those inmates. Vasquez Tr. 204:15-205:3. The list originally contained 537 people. *Id*. at 205:4-6. As of April 27, 2020, the list had shrunk to approximately 380 inmates because some inmates were released and because the CDC delisted some medical conditions as risk factors. *Id.* at 205:4-20. MDC officials monitor the high-risk list on a dashboard. Hr'g Tr. 215:19-216:2; English Report 3. They also update the list periodically. King Decl. ¶ 25. Beyond maintaining and monitoring the high-risk list, the MDC does not take specific measures within the facility to protect high-risk inmates. Vasquez Tr. 207:16-209:12.

Petitioners fault MDC officials for failing to treat high-risk inmates differently from other inmates in three respects, but the MDC's approach comports with CDC guidance in those areas. Petitioners first contend that the MDC should house all high-risk inmates in single-person cells. Hr'g Tr. 119:20-120:12. But petitioners have not rebutted the testimony of Health Services Administrator Vasquez that staffing and space constraints prevent the facility from single-celling nearly 400 high-risk inmates—about a quarter of the facility's population. Vasquez Decl. ¶ 6(f). Nor have petitioners shown that isolation reflects the accepted standard of care for high-risk individuals during the COVID-19 pandemic. The CDC's detailed guidelines call for isolation of certain inmates—those with COVID-19 symptoms—but conspicuously do not recommend this measure for high-risk inmates. *See generally* CDC Correctional Guidelines.

Petitioners next argue that the MDC should create a cohort of high-risk inmates, who would be grouped together in the same housing unit or units. *See* Mot. for Prelim. Inj. 3. They contend that this strategy would make it easier for medical staff to provide more intensive medical supervision. *See* Hr'g Tr. 486:17-487:11; *see also* Suppl. Venters Report ¶ 14. But while the CDC recommends cohorting confirmed COVID-19 cases if isolation is not possible, the CDC has not

recommended cohorting high-risk inmates. *See* CDC Correctional Guidelines 16. Instead, the CDC merely recommends what the MDC is already doing—being "especially mindful of those who are at higher risk of severe illness from COVID-19," and "ideally" avoiding cohorting high-risk inmates with "other infected individuals." *Ibid.* Moreover, petitioners have not rebutted respondent's justifications for declining to cohort. Health Services Administrator Vasquez has testified that the MDC does not have enough open space to move the hundreds of high-risk inmates into dedicated units. Vasquez Decl. ¶ 6(f); Vasquez Tr. 209:3-18. And grouping high-risk inmates into a cohort based on their elevated risk from COVID-19 would present security complications, because the MDC has safety-related reasons to keep apart many inmates who might share similar COVID risk profiles, such as gang members. *See* Hr'g Tr. 346:10-347:23 (testimony of Dr. Beard); Beard Report 9-10. Finally, shuffling inmates into new cohorts in the midst of a pandemic could spread the virus. As Dr. Beard observed, "[i]f MDC-Brooklyn were to move everyone around so that it could cohort the high risk, there is a chance that you could spread the disease throughout the facility during these wide-spread transfers." Beard Report 10.

Petitioners next contend that the MDC's care for high-risk inmates is deficient because the MDC is not conducting twice-daily temperature checks of those inmates. *See* Mot. for Prelim. Inj. 2. But again, CDC guidelines do not suggest that this particular method of monitoring is necessary—despite the fact that they do recommend temperature checks in numerous other contexts, such as upon entry to the facility and for quarantined individuals. *See, e.g.*, CDC Correctional Guidelines 3, 21. As noted above, the CDC instead encourages correctional facilities to be mindful of high-risk inmates and to keep high-risk inmates separated from infected inmates. *Id.* at 16. Moreover, while MDC medical staff do not perform daily temperature checks in the general population units, they perform them twice daily in the quarantine and isolation units, and

they conduct twice-daily rounds in the general population units, giving inmates regular access to medical staff. English Report 3; Vasquez Tr. 38:17-40:10, 78:23-79:9; Vazquez Decl. ¶ 6(a), (c). Particularly given these alternative measures, petitioners have not demonstrated that the MDC's failure to monitor high-risk inmates in precisely the manner they seek violates any standard of care.

DISCUSSION

I. Preliminary Injunction Standard

A preliminary injunction is an "extraordinary and drastic remedy." *Mazurek v. Armstrong,* 520 U.S. 968, 972 (1997) (citation omitted). Such injunctions are "never awarded as of right." *Winter v. Natural Res. Def. Council*, 555 U.S. 7, 24 (2008). To obtain such an injunction, as a general matter, a litigant must establish (1) a likelihood of success on the merits, (2) a likelihood of irreparable harm in the absence of preliminary relief, (3) that the balance of equities tips in the party's favor, and (4) that an injunction is in the public interest. *Am. Civil Liberties Union v. Clapper*, 804 F.3d 617, 622 (2d Cir. 2015) (citing *Winter*, 555 U.S. at 20); *see Metro. Life Ins. Co. v. Bucsek*, 919 F.3d 184, 188 n.2 (2d Cir. 2019) (citing *Winter*, 555 U.S. at 20).

An even stronger showing on the merits is generally needed when a litigant seeks a "mandatory" injunction that will alter the status quo by commanding some positive act. *D.D. ex rel. V.D. v. New York City Bd. of Educ.*, 465 F.3d 503, 510 (2d Cir. 2006); *see North American Soccer League, LLC v. United States Soccer Fed'n, Inc.*, 883 F.3d 32, 36-37 (2d Cir. 2018). In such cases, the movant must demonstrate a "clear or substantial likelihood of success on merits." *North American Soccer League*, 883 F.3d at 37 (citations omitted)*; see New York Progress & Prot.*

PAC v. Wash, 733 F.3d 483, 486 (2d Cir. 2013).[5] Petitioners must make that heightened showing on the merits here, because they seek an injunction that would "alter[] the status quo by commanding" numerous "positive act[s]." *D.D. ex rel. V.D.*, 465 F.3d at 510. They seek an injunction that would require respondent to release all medically vulnerable persons from the MDC and to make major changes at the detention center. For instance, respondent would be ordered to reorganize housing units, change the handling of medical requests, and even modify inmates' shower schedules. Mot. for Prelim. Inj. 2-4. Petitioners must therefore show "a clear or substantial likelihood of success on the merits." *DD ex rel. V.D.,* 465 F.3d at 510. As explained below, I conclude that petitioners have not made the requisite showing on the merits, and therefore do not consider whether petitioners have met the additional requirements for a preliminary injunction.

II. Likelihood of Success on the Merits

Prison conditions can constitute "cruel and unusual punishment" if prison officials act (or fail to act) with "deliberate indifference to a substantial risk of serious harm to a prisoner." *Farmer*, 511 U.S. at 836. A constitutional violation under these principles has both objective and subjective components. First, a prisoner must be incarcerated under conditions that, objectively, pose "a substantial risk of serious harm." *Hayes v. N.Y.C. Dep't of Corr.*, 84 F.3d 614, 620 (2d Cir. 1996) (citing *Farmer*, 511 U.S. at 834). Second, because "only the unnecessary and wanton infliction of pain implicates the Eighth Amendment," a prison official must possess "a 'sufficiently culpable state of mind,'" which "[i]n prison-conditions cases . . . is one of 'deliberate indifference' to inmate health or safety." *Farmer*, 511 U.S. at 834 (quoting *Wilson v. Seiter*, 501 U.S. 294, 297

[5] Some Second Circuit decisions—albeit not especially recent ones—have stated that a movant may be able to obtain a mandatory injunction without needing to make the heightened showing of a clear likelihood of success on the merits "where extreme or very serious damage will result from a denial of preliminary relief." *Tom Doherty Assocs., Inc. v. Saban Entm't, Inc.*, 60 F.3d 27, 34 (2d Cir. 1995). Petitioners have not invoked that standard or argued that they satisfy it.

(1991)). On the record before me at the preliminary injunction stage, petitioners have not demonstrated a clear likelihood of success on their claim that the MDC's response to COVID-19 reflects deliberate indifference to a substantial risk of serious harm.

A. Objective Element

Petitioners have not shown a clear likelihood of success in demonstrating that they face "a substantial risk of serious harm" from conditions at the MDC, *Lewis v. Siwicki*, 944 F.3d 427, 430-31 (2d Cir. 2019) (quoting *Farmer*, 511 U.S. at 834), given the measures that prison officials have instituted to address COVID-19 and the best available evidence regarding those measures' results. There is no "bright line test" to determine if a risk of serious harm is "substantial" for Eighth Amendment purposes. *Id.* at 432. Rather, a court must "assess whether society considers the risk that the prisoner complains of to be so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk." *Helling v. McKinney*, 509 U.S. 25, 36 (1993) (emphasis in original); *see Darnell v. Pineiro*, 849 F.3d 17, 30 (2d Cir. 2017); *Phelps v. Kapnolas*, 308 F.3d 180, 185 (2d Cir. 2002). "In other words," the Supreme Court has written, "the prisoner must show that the risk of which he complains is not one that today's society chooses to tolerate." *Helling*, 509 U.S. at 36.

The Supreme Court has made clear that whether a particular danger poses a substantial risk of serious harm in a prison must be evaluated in light of the steps that the facility has already taken to mitigate the danger. *See id*, 509 U.S. at 35-36. For instance, when addressing a prisoner's Eighth Amendment challenge to environmental tobacco smoke exposure in *Helling*, the Court held that a lower court must consider the prison's new "formal smoking policy" and the recent changes to the prisoner's confinement circumstances in assessing whether conditions at the prison presented a substantial risk to the plaintiff's health. *Id.* at 36. The Court described it as "[p]lainly

relevant" to "the objective factor" that the plaintiff had been moved to a new prison and was "no longer the cellmate of a five-pack-a-day smoker." *Id.* at 35. The Court also stated that "[i]t is possible that the new [formal smoking] policy will be administered in a way that will minimize the risk to [the plaintiff] and make it impossible for him to prove that he will be exposed to unreasonable risk with respect to his future health or that he is now entitled to an injunction." *Id.* at 36. Thus, determining whether prison conditions pose a substantial risk of serious harm from COVID-19, or any other risk, must be determined "after accounting for the protective measures [the prison system] has taken." *Valentine v. Collier*, 956 F.3d 797, 801 (5th Cir. 2020).

Under these principles, there is no question that an inmate can face a substantial risk of serious harm in prison from COVID-19 if a prison does not take adequate measures to counter the spread of the virus. Courts have long recognized that conditions posing an elevated chance of exposure to an infectious disease can pose a substantial risk of serious harm. Thus, the Supreme Court has rejected the proposition that prison officials may "be deliberately indifferent to the exposure of inmates to a serious, communicable disease." *Helling*, 509 U.S. at 33. And the Second Circuit has explained that "correctional officials have an affirmative obligation to protect inmates from infectious disease." *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996); *see Phelps*, 308 F.3d at 185 (noting that the Eighth Amendment reaches conditions that present an "unreasonable risk of serious damage to [prisoners'] future health"). Consistent with that principle, a number of courts have found substantial risk in particular facilities from COVID-19. *See, e.g.*, *Martinez-Brooks v. Easter,* No. 3:20-cv-00569 (MPS), 2020 WL 2405350, at *31 (D. Conn. May 12, 2020); *Mays v. Dart*, __ F. Supp. 3d __, 2020 WL 1812381, at *8 (N.D. Ill. Apr. 9, 2020); *Banks v. Booth,* No. 20-849, 2020 WL 1914896, at *6-7 (D.D.C. Apr. 19, 2020); *Swain v. Junior*, __ F. Supp. 3d __,

2020 WL 2078580, at *16 (S.D. Fla. Apr. 29, 2020), *stayed on appeal by* 958 F.3d 1081 (11th Cir. 2020).

As noted above, however, the relevant inquiry is whether petitioners have shown a substantial risk of serious harm from COVID-19 at the MDC in light of the countermeasures that the facility has in place. The preliminary injunction record leaves substantial reason to doubt petitioners will ultimately succeed in making that showing. The MDC's response to COVID-19 has been aggressive and has included, among other steps, massively restricting movement within the facility, enhancing sanitation protocols, and creating quarantine and isolation units. And the data—though limited—suggests that these measures have been quite effective in containing COVID-19 thus far. Not a single MDC inmate has died from COVID-19. And just one inmate has been hospitalized for a COVID-19 related illness, even though the MDC's population has a relatively high rate of comorbidities and the surrounding community has been at the epicenter of the pandemic for months. A plaintiff can certainly raise a claim under the Eighth Amendment based on risks that have not manifested themselves in any adverse health outcome. *See Helling*, 509 U.S. at 33. But given that COVID-19 can lead to adverse health consequences quickly, and that the MDC has seen no deaths and just one hospitalization so far, it is hard to conclude that inmates are at an elevated risk of contracting COVID-19 inside the MDC relative to the risk they would face in the surrounding community. That raises serious questions about whether petitioners can satisfy the objective prong of the Eighth Amendment test. It is hard to say that prisoners are exposed to a risk that "is not one that today's society chooses to tolerate," or a risk "so grave that it violates contemporary standards of decency," *id.* at 36, if the risk inside the facility is no greater than—and perhaps less than—the risk outside of it.

A comparison to a number of cases in which district courts *have* found a substantial risk of serious harm for Eighth Amendment purposes illustrates the point. The courts in those cases have commonly relied on evidence of elevated COVID-19 risks compared to the outside community. In *Mays*, for example, the court relied on statistical evidence that the jail "currently has the highest rate of new coronavirus infections in the country," and it determined that the plaintiffs had "demonstrated that certain of the conditions created by the intentional actions of the Sheriff enable the spread of coronavirus and significantly heighten detainees' risk of contracting the virus." 2020 WL 1812381, at *8. In *Banks*, the court found that the plaintiffs were likely to prevail only after concluding that the defendants' argument "that Plaintiffs' risk of infection is the same as that of the outside community" was undercut by undisputed data showing that "the infection rate in [Department of Corrections] facilities was over seven times the infection rate of the District of Columbia at large." 2020 WL 1914896, at *6. In *Martinez-Brooks*, the court relied on the fact that it was "undisputed that there is an active and serious outbreak of COVID-19" at the facility in question, 2020 WL 2405350 at *20, which the Attorney General had identified "as one of three experiencing significant outbreaks" across the entire BOP system of more than 100 facilities, *id.* at *11. And in *Swain*, the district court similarly relied on evidence of high infection rates, concluding that the "[d]efendants' contention that the actions they have taken to date are sufficient is belied by the exponential rate of infection since this case commenced." 2020 WL 2078580, at *16. This case is quite different, at least at this stage of the litigation, because petitioners have not made a comparable showing that those within the facility face a higher risk of infection than those outside of it. Under those circumstances and on this preliminary injunction record, I conclude that petitioners have not demonstrated a clear likelihood of success in establishing that they face a risk so grave that it violates contemporary standards of decency, given the MDC's existing precautions.

B. Subjective Element

Petitioners have also not shown a clear likelihood that they will succeed in establishing the subjective component of an Eighth Amendment violation—that MDC officials have exhibited "'deliberate indifference' to inmate health or safety," *Farmer*, 511 U.S. at 834 (quoting *Wilson,* 501 U.S. at 302-03), in their response to COVID-19. Because the Eighth Amendment prohibits only cruel and unusual "punishments," a prisoner who seeks to establish an Eighth Amendment violation based on conditions of confinement must demonstrate that officials' conduct reflects "the deliberate infliction of punishment," and not just "an ordinary lack of due care for prisoner interests or safety." *Fiacco*, 942 F.3d at 150; *see Farmer*, 511 U.S. at 834-35. While officials need not engage in "acts or omissions for the very purpose of causing harm or with knowledge that harm will result," they must at least "know[] of and disregard[] an excessive risk to inmate health or safety." *Farmer*, 511 U.S. at 835, 837; *see, e.g.*, *Morgan v. Dzurenda*, 956 F.3d 84, 89 (2d Cir. 2020); *Cuoco v. Moritsugu*, 222 F.3d 99, 106-07 (2d Cir. 2000); *Hathaway v. Coughlin*, 99 F.3d 550, 553 (1996). In other words, they must act with a *mens rea* "consistent with recklessness in the criminal law." *Farmer*, 511 U.S. at 837. Under this standard, "the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw that inference." *Id.* at 835; *see, e.g.*, *Salahuddin v. Goord*, 467 F.3d 263, 280 (2d Cir. 2006). "[A]n official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot . . . be condemned as the infliction of punishment." *Farmer*, 511 U.S. at 838. "Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence." *Id.* at 842.

1. The MDC's Aggressive Actions to Combat COVID-19 Belie Claims of Deliberate Indifference

Under these principles, even if I determined that petitioners had made the required objective showing of substantial risk from COVID-19 under current conditions at the MDC, I would nevertheless conclude that petitioners had not demonstrated a clear likelihood that MDC officials have displayed "deliberate indifference" to the risks of COVID-19 at the facility. The evidence shows that MDC officials have been acting urgently to prevent COVID-19 from spreading and from causing harm. They have imposed dozens of measures, such as (i) enhancing intake screening procedures for all inmates and staff, (ii) providing soap and other cleaning products to inmates at no cost, (iii) increasing cleaning of common areas and shared items, (iv) isolating symptomatic inmates, (v) broadly distributing and using PPE to prevent transmission of the virus, and (vi) modifying operations throughout the facility to facilitate social distancing to the greatest extent possible and abate the risk of spread. Taken together, these and other measures indicate that prison officials are "trying, very hard, to protect inmates against the virus and to treat those who have contracted it," and belie any suggestion that prison officials "have turned the kind of blind eye and deaf ear to a known problem that would indicate" deliberate indifference. *Money v. Pritzker*, No. 20-cv-2093, 2020 WL 1820660, at *18 (N.D. Ill. Apr. 10, 2020); *see Swain v. Junior*, 958 F.3d 1081, 1090 (11th Cir. 2020) ("Accepting, as the district court did, that the defendants adopted extensive safety measures such as increasing screening, providing protective equipment, adopting social distancing when possible, quarantining symptomatic inmates, and enhancing cleaning procedures, the defendants' actions likely do not amount to deliberate indifference."). As Judge Engelmayer put it in discussing an inmate's COVID-19-based challenge to conditions of confinement at the MDC at the start of the pandemic, the "numerous and significant plans and protocols recently implemented by the BOP to protect prisoners" at the MDC

do not support "find[ing] that the BOP has been deliberately indifferent." *United States v. Credidio*, No. 19 Cr. 111 (PAE), 2020 WL 1644010, at *2 (S.D.N.Y. Apr. 2, 2020).

Petitioners argue for a contrary result because, in their view, the MDC's policies amount to "aspirational goals" that do not reflect "actual practices." Reply Mem. Supp. of Pet'rs' Mot. for Prelim. Inj. ("Pet'rs Reply Br.") 1 (Dkt. #90). But petitioners do not dispute that the MDC is implementing most of the policies that it has adopted to address the COVID-19 pandemic. And the evidence presented at the preliminary injunction hearing contradicts petitioners' arguments, *id.* at 7-8, that the MDC's policies regarding PPE, sanitation, hygiene, and inmate entry screenings are mere aspirations. The MDC conducts entry screenings for inmates in accordance with its policies. *See* pp. 17-18, *supra.* And inspections showed that at minimum, by late April, the facility's policies on PPE, sanitation, and hygiene were being implemented as well. *See* pp. 21-31, *supra.* While out-of-court declarations raise the possibility that some inmates did not receive adequate quantities of soap and cleaning supplies in the period shortly after the MDC's heightened protocols were instituted, the record does not suggest that any such instances reflected deliberate indifference, rather than negligent errors in implementing a new policy under emergency conditions. *See Swain*, 958 F.3d at 1089 ("[L]apses in enforcement" of social-distancing policies during COVID-19 "do little to establish that the defendants were deliberately indifferent," absent evidence that prison officials were "ignoring or approving the alleged lapses."); *cf. Trammell v. Keane*, 338 F.3d 155, 165 (2d Cir. 2003) (concluding that although "deprivation of toiletries, and especially toilet paper, can rise to the level of unconstitutional conditions of confinement," the plaintiff failed to establish deliberate indifference when "[i]t appear[ed] . . . that the defendants were negligent in replenishing [the plaintiff's] supply"); *Rangolan v. County of Nassau*, 217 F.3d 77, 79 (2d Cir. 2000) (finding no deliberate indifference when "the County took steps to protect"

a vulnerable inmate "but mistakenly failed to implement them"). The sweeping measures that MDC officials have adopted—which the record reflects are more than "aspirational goals," Pet'rs Reply Br. 1—counsel strongly against a finding that MDC officials are being deliberately indifferent to risks associated with COVID-19.

2. Petitioners Have Not Shown the MDC's Failure to Fully Implement Several CDC Recommendations Reflects a *Mens Rea* More Culpable Than Negligence

Petitioners next contend that even if MDC officials have implemented their policies concerning COVID-19, they have displayed deliberate indifference to the risks of the virus because they have not fully implemented several measures that the CDC recommends. As discussed above, petitioners have adduced evidence that MDC officials are falling short of the CDC's guidance in several respects: While CDC guidance calls for inmates experiencing possible COVID-19 symptoms to be evaluated "at the first sign of symptoms," CDC Correctional Guidelines Slides at BOP 108, so that potentially infected inmates can be placed in isolation "immediately once symptoms appear," *id.* at BOP 100-01, evidence at the hearing indicates that MDC officials may take days or sometimes even weeks to respond to requests for medical attention that describe such symptoms. *See* pp. 36-40, *supra*. And while CDC guidelines call for isolating individuals who have symptoms of COVID-19, *see* CDC Correctional Guidelines at 10, 15, MDC officials appear to have isolated only a fraction of inmates displaying such symptoms, *see* pp. 40-42, *supra*. In addition, while the MDC is conducting daily entry-point screenings of staff, including temperature checks, those entry screenings are somewhat less stringent than those recommended by the CDC. *See* pp. 18-19, *supra*.

Under standards of care that both parties have accepted, MDC officials' apparent failure to fully implement the CDC guidance in these areas constitutes a deficiency in the MDC's response to COVID-19. Respondent has not disputed that the CDC protocols should guide the MDC's

response to COVID-19. In fact, both of respondent's experts embraced the CDC standards. *See* Hr'g Tr. 395:2-19 (Dr. Beard); Tekbali Report 1-7. The MDC's deficiencies in this area accordingly warrant prison officials' attention.

To establish an Eighth Amendment violation, however, petitioners must show not only that prison officials have committed errors but also that prison officials made those errors with a mental state equivalent to criminal recklessness, "know[ing] of and disregard[ing] an excessive risk to inmate health or safety." *Farmer*, 511 U.S. at 837. Here, the surrounding circumstances suggest that it is far more likely that MDC officials have made negligent errors in implementing complex guidelines during a novel crisis than that they have knowingly disregarded an excessive risk of serious harm. The MDC's swift and extensive countermeasures are evidence that MDC officials are taking the threat of COVID-19 seriously, amid "shifting parameters and guidance regarding how to combat a previously little known virus," *Money*, 2020 WL 1820660 at *18, rather than consciously turning a blind eye to any known danger.

Moreover, the principal CDC guidance as to which the MDC appears to have fallen short to date—sick-call responses and use of isolation—requires complex implementation. The guidance pertaining to sick-call requests calls for quick responses to scores of medical complaints per month relaying symptoms such as cough, sore throat, and headache that could be consistent with COVID-19. That is a massive undertaking, even for a medical staff that the facility has been augmenting during the crisis. And while the CDC guidelines call for extensive use of isolation, both parties appear to agree that the decision to isolate individual inmates should turn to some extent on the application of clinical judgment by healthcare providers. Shortfalls in the immediate implementation of guidelines this complex and resource-intensive do not suggest knowing disregard of a substantial risk of harm, rather than negligent error.

Finally, any inference that MDC officials have been knowingly disregarding an excessive risk in their implementation of CDC guidance is undercut by the data about the effectiveness of the MDC's countermeasures thus far. As noted above, the MDC has had no COVID-connected fatalities and only one COVID-linked hospitalization. Petitioners offer little reason to conclude that prison officials have drawn the inference that inmates currently face a substantial risk of serious harm inside the MDC, in the face of data suggesting that the rate of deaths and hospitalizations may be lower inside the facility than outside of it. *See Farmer*, 511 U.S. at 837 (deliberate indifference requires that a prison official have drawn the inference that a substantial risk of serious harm exists).

3. Petitioners Have Not Established Deliberate Indifference Based on the Failure to Implement Additional Measures Not Called for Under CDC Guidelines

Petitioners finally contend that MDC officials are being deliberately indifferent because they have failed to adopt several steps recommended by petitioners' expert, Dr. Venters, but not called for by the CDC's guidance. Petitioners fall far short of establishing deliberate indifference on those grounds. With respect to at least one of the measures that petitioners seek—cohorting of high-risk inmates—respondent has set forth strong arguments that adopting petitioners' strategy during a pandemic might well spread the virus. With respect to another—testing of all inmates and staff who possess "more than one sign and/or symptom of COVID-19" or who possess "risk factors for serious illness or death from COVID-19," Mot. for Prelim. Inj. 3—petitioners have failed to demonstrate that such an approach was practicable in the initial months of the pandemic, given shortages in supply. *See Hernandez v. Keane*, 341 F.3d 137, 146 (2d Cir. 2003) (finding no deliberate indifference from delays in treatment when they were mostly "caused by factors outside defendants' control"); *Williams v. Vincent*, 508 F.2d 541, 544 (2d Cir. 1974) (indicating that

deliberate indifference will not be found if treatment requested was "impossible under the circumstances" or not "practicable").

Petitioners also take aim at the MDC's failure to take additional steps that go beyond CDC guidelines, such as (i) instituting daily temperature screenings of all inmates (not just those in quarantine and isolation), (ii) directing orderlies to clean shared items between every use (rather than having orderlies clean periodically and making supplies available for other inmates to perform additional cleanings), and (iii) evaluating inmates in the isolation unit on a daily basis in a clinical setting (rather than through cell-side wellness checks). As discussed above, the CDC has not called for those practices, and petitioners have not demonstrated that respondent's failure to adopt those specific approaches falls below any standard of care. I cannot conclude on this record that MDC officials' failure to adopt those measures exposes inmates to a substantial risk of serious harm or that any MDC officials have drawn the inference that their failure to take such measures creates any such risk. *Cf. Valentine*, 956 F.3d 802 (finding that plaintiffs were unlikely to establish deliberate indifference when the evidence showed that prison officials were taking measures "informed by guidance from the CDC and medical professionals").

CONCLUSION

Prison officials have a responsibility to protect inmates from substantial risks to their health and safety. *See, e.g.*, *Farmer*, 511 U.S. at 832, 834. That duty has special urgency during the COVID-19 pandemic. The record from the preliminary injunction hearing reflects that MDC officials recognize their duty to inmates and have taken extensive measures to combat the virus. The record also gives reason for cautious optimism about the effectiveness of those measures thus far—with no COVID-connected fatalities and just a single COVID-related hospitalization at the facility even though the surrounding New York City community has been hard hit. On this record, petitioners have not established a clear or substantial likelihood that prison officials have violated

the Eighth Amendment through deliberate indifference to substantial risks of serious harm at the MDC. They are therefore not entitled to the extraordinary relief they seek: a preliminary injunction at the outset of this case that would release hundreds of prisoners and subject many aspects of the facility's operations to judicial control.

Because petitioners have not shown a clear or substantial likelihood that they will prevail on their Eighth Amendment claim, I do not address whether petitioners have satisfied any of the other requirements for obtaining a preliminary injunction. Nor do I address the parties' arguments regarding the scope of relief available in such an injunction. These include petitioners' contention that classwide relief should be granted before formal class certification and respondent's argument that the Prison Litigation Reform Act of 1995, 42 U.S.C. §§ 1997e *et seq.*, would prohibit an individual judge from ordering the release of inmates as a remedy. Petitioners, of course, remain free to develop the record further and to renew their requests for injunctive relief if warranted based on additional facts.

The motion for a preliminary injunction is denied.

SO ORDERED.

/s/ Rachel Kovner
RACHEL P. KOVNER
United States District Judge

Dated: Brooklyn, New York
June 9, 2020

EXHIBIT 4

NIH GUIDE FOR GRANTS AND CONTRACTS

NIH Office of Extramural Research

NIH Guide Grants Contracts. 2008 Dec 19 : NOT-OD-09-032.

PMCID: PMC4259696
PMID: 19105243

Findings of scientific misconduct.

FINDINGS OF SCIENTIFIC MISCONDUCT

Notice Number: NOT-OD-09-032

Key Dates
Release Date: December 18, 2008

Issued by
Department of Health and Human Services

Notice is hereby given that the Office of Research Integrity (ORI) and the Assistant Secretary for Health have taken final action in the following case:

Homer D. Venters, Jr., M.D., University of Illinois at Urbana-Champaign: Based on the report of an investigation conducted by the University of Illinois at Urbana-Champaign (UIUC) and extensive additional image analysis conducted by the Office of Research Integrity (ORI), the U.S. Public Health Service (PHS) found that Dr. Homer D. Venters, former graduate student, Neuroscience Program, UIUC, engaged in scientific misconduct in research supported by National Institute of Mental Health (NIMH), National Institutes of Health (NIH), awards R01 MH051569 and F30 MH12558 and National Institute on Aging (NIA), NIH, award R01 AG06246.

Specifically, PHS found that the Respondent committed misconduct in science:

By intentionally and knowingly preparing and including duplicate image data in Figures 5 and 10 of PHS fellowship application F31 MH12558, “Neurodegeneration via TNF-alpha inhibition of IGF-1,” submitted in 1999, which was funded as F30 MH12558 from June 1, 2000, to May 31, 2003. Because the duplicate data were labeled as having been obtained from different experiments, the results for at least one of the two figures were intentionally falsified and constitute an act of scientific misconduct.

By intentionally and knowingly preparing and including duplicate image data in Figure 3 and/or 4 of a manuscript submitted and published as: Venters, H.D., et al. ``A New Mechanism of Neurodegeneration: A Proinflammatory Cytokine Inhibits Receptor Signaling by a Survival Peptide.' Proceedings of the National Academy of Sciences U.S.A. 96:9879-9884, 1999.

By preparing and providing to his dissertation committee in March 2000 a thesis proposal entitled ``An Alternate Mechanism of Neurodegeneration: Silencing of Insulin-like Growth Factor-I survival signals by Tumor Necrosis Factor-[alpha],' which contained five falsified figures: Figures 1.3, 1.4a, 2.1b, 2.3e, and 2.5b. In each figure, he reused data within the same figure or in another thesis proposal figure as representing differently treated samples or as data obtained with different immunoblotting antisera.

In March and April 2001, Respondent included several of the same falsified figures as in the thesis proposal and multiple additional falsified figures in his dissertation ``Silencing of Insulin-like Growth Factor I Neuronal Survival Signals by Tumor Necrosis Factor-[alpha].' In all, Figures 3.3, 3.4a, 3.4b, 4.1b, 4.3a, 4.5b, 5.1a, 5.2, 5.4a, 5.5a, 5.6a, 5.7a, and 5.8a were falsified. In each instance, he assembled figures

by reusing significant data, on some occasions after manipulating the orientation of the data, either within the same figure or in other figures related to his thesis and represented the data falsely as coming from different samples or different experiments.

Dr. Venters has entered into a Voluntary Settlement Agreement (Agreement) in which he has voluntarily agreed, for a period of three (3) years, beginning on November 19, 2008:

(1) That any institution that submits an application for PHS support for a research project on which the Respondent's participation is proposed or that uses the Respondent in any capacity on PHS-supported research, or that submits a report of PHS-funded research in which the Respondent is involved, must concurrently submit a plan for monitoring of the Respondent's research to the funding agency and ORI for approval; the monitoring plan must be designed to ensure the scientific integrity of the Respondent's research contribution; Respondent agreed that he will not participate in any PHS-supported research until such a monitoring plan is submitted to ORI and the funding agency;

(2) That Respondent will ensure that any institution employing him will submit to ORI, in conjunction with each application for PHS funds or report, manuscript, or abstract of PHS-funded research in which the Respondent is involved, a certification that the data provided by the Respondent are based on actual experiments or are otherwise legitimately derived, and that the data analyses, procedures, and methodology are accurately reported in the application or report; Respondent must ensure that the institution sends a copy of each certification to ORI; and

(3) To exclude himself from serving in any advisory capacity to PHS, including but not limited to service on any PHS advisory committee, board, and/or peer review committee, or as a consultant or contractor to PHS. Respondent also voluntarily agreed that within 30 days of the effective date of this Agreement:

(4) He will submit a letter to the journal editor, with copies to his coauthors, identifying his falsification of Figures 3 and/or 4 in the following article: Venters et al. ``A New Mechanism of Neurodegeneration: A Proinflammatory Cytokine Inhibits Receptor Signaling by a Survival Peptide.' Proceedings of the National Academy of Sciences 96:9879-9884, 1999.

FOR FURTHER INFORMATION CONTACT:

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