UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.*,

Plaintiffs-Petitioners

v.

QUINCY BOOTH, in their official capacity as Director of the District of Columbia Department of Corrections, *et al.*,

Defendants-Respondents.

No. 1:20-cv-00849 (CKK)

EMERGENCY MOTION TO CONVERT APRIL 6, 2020 STATUS CONFERENCE INTO MERITS HEARING ON PLAINTIFFS' APPLICATION FOR A TEMPORARY RESTRAINING ORDER

Since Plaintiffs' filed their Application for a Temporary Restraining Order on March 30, 2020 (Docket No. 5), there have been two new developments that heighten the urgency of Plaintiffs' Application.

First, the spread of the virus in the District of Columbia and in the Department of Corrections ("DOC") is continuing rapidly. When Plaintiffs filed their suit, there were five positive cases in the DOC. Yesterday, Defendants represented that there were eight positive cases. By this morning, there were twelve, including at least one new positive test in an entirely new segment of the facility. *See* Docket No. 20-2 ("Jordan Decl.), at ¶ 11. There may well be more by now. Plaintiffs — and the public health of the District of Columbia — can ill-afford to wait for the virus to continue its exponential growth through the DOC population. As Plaintiffs' expert Dr.

Meyer explains, the "horizon of risk for rapid and severe COVID-19 in these facilities is a matter of hours not days." Docket No. 5-2, Exhibit 1 ("Meyer Decl."), at ¶ 37.

Second, Defendants' policies, which have not been updated since the start of the crisis and which are at least ten years old, do not rebut most of Plaintiffs' evidence in support of the TRO. Indeed, additional evidence from DOC staff, discussed below and attached to this motion, suggests that Defendants are not following or implementing their own policies.

In light of the escalation of the crisis at the Jail and the alarming gaps both in Defendants' preparedness and between their policies and the realities at the D.C. Jail, Plaintiffs request that the Court convert the status conference scheduled for 9:30 a.m. on April 6, 2020, into a hearing on the merits of Plaintiffs' application for a TRO. The Court has discretion to convert the status hearing into a merits hearing. *See* LCvR 7(f). In order to ensure that the Court has sufficient time to review the pleadings for that hearing, Plaintiffs would consent to moving the deadline for their reply brief, currently set for 5:00 pm on *Sunday*, April 5, 2020 (*see* Minute Order, April 1, 2020) to 5:00 pm on *Saturday*, April 4, 2020. Defendants have advised that they do not consent to this motion.

I. COVID-19 is Spreading Rapidly in the DOC, in the Region, and in Correctional Facilities Generally.

When Plaintiffs' filed suit on March 30, 2020, the World Health Organization, the Centers for Disease Control and Prevention, the District of Columbia, and the DOC provided the following statistics regarding infection and death from COVID-19:

- Worldwide – 638,146 confirmed cases; 30,039 deaths
- United States – 122,653 confirmed cases; 2,112 deaths
- DMV Region – 2,934 confirmed cases; 53 deaths
- DOC – 5 confirmed resident cases.

See Compl. ¶¶ 1, 20-22. Just three days later, the picture is significantly worse:

- Worldwide – 900,306 cases (41 percent increase); 45,693 deaths (52 percent increase)[1]
- United States – 213,144 cases (73 percent increase); 4,513 deaths (114 percent increase)[2]
- DMV Region – 4,697 cases (60 percent increase); 88 deaths (66 percent increase)[3]
- DOC – 12 confirmed resident cases (71 percent increase).[4]

Given the speed at which the virus is infecting people worldwide — and particularly the speed at which the virus is infecting people in DOC custody — it is no exaggeration to say that obtaining relief even one day sooner could mean the difference between life and death for those in DOC custody and DOC staff as well.

The fact that there has been some progress toward compliance with the D.C. COVID-19 Response Emergency Amendment Act of 2020 does not undermine this conclusion. It wasn't until two days after this lawsuit was filed, and two weeks after the Act was passed, that Defendants released 23 people under that emergency legislation. *See* Docket No. 18 ("3/31/20 Tr."), at 6. More importantly, even if the entire category of prisoners eligible for release under the Act were released at this moment either through Defendants' exercise of discretion or through Superior Court review process currently underway, that group — approximately 94 individuals, including the 23 released on Wednesday — amounts to less than six percent of the population of the Jail as

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1 *See* WORLD HEALTH ORG., *Coronavirus disease (COVID-19) Pandemic* (last visited April 2, 2020, 5:30 PM), https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

2 *See* CTRS. DISEASE CONTROL & PREVENTION, *Cases in U.S.* (last visited April 2, 2020, 5:30 PM), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

3 *See* Joe Heim & Dana Hedgpeth, *Live Updates: Jobless Claims Skyrocket in the D.C. Area; Mayor Tells Hospitals City Needs 3,600 More Beds for Surge*, Wash. Post (April 2, 2020, 4:50 PM), https://www.washingtonpost.com/dc-md-va/2020/04/02/coronavirus-dc-maryland-virginia-live-updates/.

4 Docket No. 20-2 ("Jordan Decl."), at ¶ 11.

of March 27, 2020.[5] That would leave over 1,500 individuals, including many with conditions that put them at particular risk in the facility, subject to the conditions described in frightening detail in Plaintiffs' TRO motion papers.

It is truly urgent that DOC be required to implement meaningful change, including both improvements in conditions and releases guided by the appointment of a public health expert to assist the Court in determining how many and which class members to order released, consistent with public health and safety, so as to ensure that the number of prisoners remaining at the CDF and CTF can be housed consistently with CDC guidance on best practices to prevent the spread of COVID-19, including the requirement that prisoners be able to maintain six feet of space between them. As Plaintiffs' expert Dr. Meyer explains, the "horizon of risk for rapid and severe COVID-19 in these facilities is a matter of hours not days." Docket No. 5-2, Exhibit 1 ("Meyer Decl."), at ¶ 37. The escalating numbers of diagnosed cases alone warrant expediting the proceedings so that Plaintiffs may be heard on their relief as soon as possible and before it is too late.

II. Defendants' Policies Fail To Rebut Plaintiffs' Evidence and New Evidence Suggests They Are Not Even Being Implemented.

In response to the Court's request for "all relevant written procedures and practices concerning COVID-19," Defendants docketed the following:

- Unity Health Care's — DOC's medical contractor — "Coronavirus Protocol" for the Department of Corrections Health Center (Docket No. 19-3);
- A flowchart showing DOC's COVID-19 screening protocol (Docket No. 19-4);
- An e-mail from Shreya Khuntia, Epidemiologist at the District of Columbia Department of Health to "Beth" (Docket No. 19-5); and
- Unity Health Care's 2008 "Medical Plan for Pandemic Influenza," most recently revised on October 1, 2018 (Docket No. 19-6).

[5] Keith L. Alexander et al., *As Inmates in D.C., Maryland and Virginia Test Positive for the Coronavirus, Jail Officials Scramble to Reduce the Risk*, WASH. POST (April 1, 2020) (reporting that there are around 1,600 residents in DOC custody).

Defendants also provided, under seal, a document they referred to as "DOC's Pandemic Flu Plan (2009, currently being revised)." *See* Docket Nos. 19, at 2 n.1 & 22-2. Defendants also provided two policies related to good-time credits. See Docket Nos. 19-1 & 19-2.

A review of these documents, in combination with evidence suggesting they are not being implemented, raises grave concerns that also merit expediting the proceeding. Unity Health Care — the medical services contractor for DOC — has developed a "Coronavirus Protocol" covering the DOC Health Center. *See* Docket No. 19-3, at 4 (discussing cleaning and disinfection "in healthcare facilities"). However, according to Defendants' submission, the only written policy or procedure guiding efforts to mitigate the spread of COVID-19 in the rest of DOC operations (that is, housing units and the rest of the facilities not operated by Unity Health Care) is a 2009 "Pandemic Flu Plan," Docket No. 22-2, which is "currently being revised," Docket No. 19, at 2.[6] As an initial matter, it is shocking that, over three weeks after the Mayor declared a public health emergency, DOC has not yet updated its policies to require the social distancing and other precautionary measures that the CDC and others have insisted on.

Another problem revealed by Defendants' submissions is that DOC has tested only 22 residents, Jordan Decl. ¶ 11, even though 65 residents interacted with the Deputy Marshal who tested positive (and that, according to DOC staff, *six* of those 65 residents subsequently tested positive themselves, *see* Docket No. 23-11, at ¶ 48). Defendants' response does not indicate when those tests were conducted or the unit or facility of the residents that were tested.

Defendants' submissions look even worse when juxtaposed with declarations from DOC's own staff members showing that Defendants' policies were not widely disseminated and have not

[6] Neither Defendants' flowchart (Docket No. 19-4) nor Defendants' email to Beth (Docket No. 19-5) purport to offer staff guidance on how to mitigate the spread of COVID-19 in the DOC.

been implemented. First, it appears that DOC's "Pandemic Flu Plan" is not even the most recent version of DOC's own policy. Doreen Deterville, a staff member who has worked at the DOC since February 2017, and who currently works in CTF, "searched through DOC's policies to identify any plan regarding pandemics" earlier this week and found a plan that seems to be an updated version of the policy that Defendants' filed under seal. *See* Exh. A ("Deterville Decl."), ¶ 7 & Attach. A. [7] The main difference between the two versions — itself troubling — is that the more recent policy deletes an entire section that had been present in the 2009 policy regarding staff training in preparation for the pandemic. *Compare* Docket No. 22-2, *with* Deterville Decl., Attach. A.

And apparently, no such training has occurred. It does not seem as if DOC leadership was even *aware* of this policy until March 27, 2020, when Ms. Deterville emailed DOC's Director of Programs & Case Management, Camile Williams, to inform her of the policy. Deterville Decl. ¶ 8. Ms. Williams responded: "Good stuff! I just glanced over the entire thing. Thanks for sharing." *Id.* Deterville's "understanding of her message was that she had not seen this policy until [she] sent it to [her]." *Id.* Indeed, it is difficult to understand Ms. Williams's reaction in any other way; if that document was one with which Ms. Williams had been familiar prior to Ms. Deterville's email, one would have expected her to say that rather than responding that she had "glanced" at it and expressing her appreciation.

Further, DOC did not inform its staff about the policy. According to Ms. Deterville, she has "never seen," until now, the policies and procedures that Defendants claim to be implementing, and "DOC never sent an all-staff email with those plans, or anything similarly comprehensive,"

[7] It is puzzling why Defendants' own search of what was presumably the same set of policies did not turn up the updated policy.

even though "DOC's standard procedure is to disseminate the relevant policies to all staff affected by it." Deterville Decl. ¶¶ 5-6.

That may be the reason why the policies do not actually seem to be implemented. For instance, while the policies call for certain staff to don personal protective equipment, Defendant Booth informed staff that "using personal protective equipment (PPE) could increase [staff] risk of contracting the virus." *Id.* ¶ 10. Those policies also call for high-touch surfaces to be disinfected, but Ms. Deterville points out that the "biometric scanning device" that literally "all staff must place their hands on" is "not wiped between uses." *Id.* ¶ 16. To make matters worse, Ms. Deterville recounts that on March 27, no hand sanitizer was available for staff at the entrance of CTF; the next day, CTF had refilled the hand sanitizer bottle with a formula containing "1% benzalkonium chloride," *id.* ¶ 16, which the CDC does not recommend and actively cautions that it "has less reliable activity against coronavirus than either of the alcohol[]" based sanitizers.[8]

Lennette Nesbitt, a DOC case manager at the CTF since 2017, corroborates these concerns and notes systemic deviations from the stated policies and the actual practices in the facilities. DOC relies on residents to clean the facilities themselves, but residents receive no training and almost always lack protective equipment when they clean. *See* Exhibit B ("Nesbitt Decl."), at ¶¶ 7-9. Social distancing is not occurring. *Id.* ¶ 15. The Jail does not have enough cleaning solution. *Id.* ¶ 11. Key common touch-points remain unsanitized: Ms. Nesbitt reports that "[d]uring the week of March 23, multiple inmate came to my office to make legal calls. After they left, I did not have any cleaning solution capable of killing covid-19 that I could use to wipe down surfaces. As

[8] *See* CTRS. DISEASE CONTROL & PREVENTION, *Frequently Asked Questions about Hand Hygiene for Healthcare Personnel Responding to COVID-2019,* https://www.cdc.gov/coronavirus/2019-ncov/infection-control/hcp-hand-hygiene-faq.html (last accessed April 2, 2020).

a result, any virus particles any inmate left on my phone remained there, where each successive inmate's face could come into contact with it." *Id.* ¶ 13. As a result of all the risks she faces in light of DOC's lack of precautionary measures, Ms. Nesbitt reports that "[t]he nature of our facility, the lack of protective gear, my inability to obtain adequate cleaning supplies all left me afraid to come to work—so much so that I would have to sit in my car for thirty minutes every day so I could calm myself down before entering the building. *Id.* ¶ 3.

The experiences of DOC staff and Plaintiffs documented in the TRO papers and the attached declarations are buttressed and expanded on by the proposed *amicus* brief of the Fraternal Order of Police for the District of Columbia Department of Corrections Labor Committee (FOP/DOC) — the union representing DOC staff — which attaches a joint declaration of five DOC Correctional Officers who serve as union officials. *See* Docket Nos. 23-2 & 23-11 (proposed *amicus* brief and Exhibit I). The brief and declaration thoroughly rebut Defendants' claims about the safety of their facilities and the nature of their practices. The five Correctional Officers document in detail, based on personal experience, that, for instance, they lack protective equipment, screening protocols are not observed, sanitizing and food-preparation protocols have not been communicated or executed, cleaning instructions to residents are not communicated to all residents, and cleaning supplies are not available for residents. Docket No. 23-11, at 12-16. Based upon their personal experiences working inside of DOC facilities for years, DOC staff state: "Very few changes to the daily operations have been implemented in preparation for and in response to COVID-19." *Id.* at 11.

Just as important as what Defendants' submissions say is what they do not say. Plaintiffs make the following specific and detailed allegations about current conditions in the jail that Defendants' policies and declarations make no mention of:

- Plaintiffs and proposed class members are not being required to practice social distancing, and in fact are being actively encouraged to do so by attending programs in large groups. One Plaintiff describes sitting in "group" sessions of up to 30 residents for hours a day, passing pens and papers between them. *See* Docket No. 6-2, Exhibit 5 at ¶¶ 3, 7. Another Plaintiff describes residents of his housing unit sharing a large cooler of juice, using their hands to dip cups into the cooler to get juice. *See* Docket No. 6-2, Exhibit 6 at ¶ 6.

- Plaintiffs and proposed class members are not being required to practice social distancing, and in fact are being actively encouraged to do so by attending programs in large groups.

- Defendants are still using Windex as an all-purpose cleaning solution, *see* Docket No. 5-2, Exhibit 3 at ¶ 6(a); Exhibit 16 at ¶ 4(f), despite the fact that Windex "could actually be harmful" in preventing the spread of COVID-19, according to Dr. Mever, *see* Meyer Decl. ¶ 28(a)(ii).

- Medical facilities are horribly under-equipped to provide care during an outbreak, as Dr. Meyer puts it: "The 2019 D.C. Auditor report suggests there is a single medical isolation space in CTF with negative pressure capacity . . . . To say this is unacceptable is an understatement."

- Plaintiffs and proposed class members wait days after requesting to see medical staff, as one Plaintiff recounts: "[I]t takes days before you get a visit with anyone from the medical unit." Docket No. 5-2, Exhibit 7, at ¶ 4.

- In Defendants' own words, the "current HVAC system has significant design problems that inhibit proper airflow," Meyer Decl., ¶ 28(c), a condition that is echoed repeatedly by Plaintiff Banks, who is housed next to a quarantine unit and describes the ventilation between his unit and the quarantine unit as "very poor," and that the units are "not sealed off," Docket No. 5-2, Exhibit 6, at ¶ 3.

In sum, there is a yawning gap between what DOC claims its policies are and what actually happens inside DOC facilities. Whether because of this gap, or because the policies themselves are ineffective, the results are clear: COVID-19 is rapidly spreading in Defendants' facilities.

Plaintiffs therefore request that the Court exercise its discretion to convert the hearing for Monday, April 6, 2020, into a merits hearing for argument on Plaintiffs' Application for Temporary Restraining Order and, if the Court feels it necessary to adjust the briefing schedule as a result, to advance the deadline of Plaintiffs' reply brief by 24 hours.

DATED: April 3, 2020
Washington, D.C.

Respectfully submitted,

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EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.*, Plaintiffs-Petitioners, v. QUINCY BOOTH, in his official capacity as Director of the District of Columbia Department of Corrections, *et al.*, Defendants-Respondents.	No. 1:20-cv-00849

DECLARATION OF DOREEN DETERVILLE

1. My name is Doreen Deterville. I am competent to make this declaration and I make these statements based on personal knowledge.
2. I have worked for the D.C. Department of Corrections (DOC) since February 2017 and currently serve as the chairperson for the Youth Rehabilitation Act Committee. In that role, I lead a team comprised of a case manager, licensed clinical psychologist and vocational experts who make sentencing recommendations to courts in cases involving youth defendants.
3. My office is located in an off-unit suite of the C-bldg of the Correctional Treatment Facility, in a space that sits between two housing units.
4. Based on my interactions with leadership and my observations of the safety precautions taken so far, I do not believe that the housing units are safe places to work, let alone live.
5. Plaintiff's counsel in this action sent me copies of Dkt. No. 19-3 (the Unity coronavirus protocol), 19-4 (the flow chart related to that protocol), and 19-6 (the Unity medical plan), which the government filed in this action on April 1, 2020. DOC never emailed me those

plans and I had never seen them before.

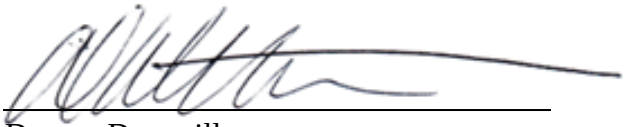
6. In the event of a new policy or emergency, DOC's standard procedure is to disseminate the relevant policies to all staff affected by it. Staff, in turn, are required to read those policies. The fact that DOC never sent an all-staff email with those plans, or anything similarly comprehensive, makes me seriously doubt that it has implemented them.
7. Earlier this week, I independently searched through DOC's policies to identify any plan regarding pandemics. I found a plan, which is attached to this declaration as Attachment A, that was distinct from the documents I received from plaintiff's counsel.
8. On Monday March 27, 2020, before I had any contact with plaintiff's counsel, I emailed the plan in Attachment A to my supervisor, Dr. Syncia Sabain, the chief of treatment and community services at DOC. She forwarded it to her supervisor, Director of Programs & Case Management Camile Williams. Ms. Williams responded by saying "Good stuff! I just glanced over the entire thing. Thanks for sharing." My understanding of her message was that she had not seen this policy until I sent it to her.
9. DOC officials have made statements and taken actions that contradict the plans filed in with the Court on April 1, 2020.
10. For example, on March 23, 2020, I attended a meeting where DOC Director Quincy Booth answered questions from staff about the Department's response to the Covid-19 crisis. In that meeting, Director Booth told staff that, although it might seem "counterintuitive," using personal protective equipment (PPE) could increase our risk of contracting the virus. He asserted that we needed specialized training to wear that gear, and without that training, we could contaminate ourselves by putting it on. Director Booth did not offer to provide training on how to wear the gear.

11. The next day, March 24, DOC made an announcement through its loudspeaker system instructing staff to meet with Dr. Sabain if they wished to learn more about PPE. The meeting was not mandatory, but I went to her office.
12. Dr. Sabain provided me with a single mask, a pair of gloves, and a bottle of cleaning solution. There are instructions on the mask's packaging demonstrating how to wear it; Dr. Sabain did not offer any additional information. Additionally, she told me that it was unnecessary to wear masks and gloves.
13. Although I was able to obtain a few PPE items, there have been Department-wide shortages of PPE and cleaning supplies. During the March 23 meeting with Director Booth, multiple staff members complained that they lacked access to cleaning supplies. Director Booth did not make any commitment to increase access.
14. Two or three days later, on March 25 or March 26, I entered the CTF with a colleague who works as a case manager, a position that requires regular contact with inmates. She asked a correctional officer for a mask and was told that none was available.
15. I have not seen any correctional officers wearing gowns and I see a minimum of 30 correctional officers every day.
16. On Monday, March 27, when I entered the CTF, there was no hand sanitizer at the entrance. That was concerning because, in order to enter the facility, all staff must place their hands on a biometric scanning device. We cannot use gloves to perform this activity and the biometric reader is not wiped between uses.
17. On Tuesday, March 28, the hand sanitizer bottle at the entrance was refilled. However, the active ingredient in the hand sanitizer was 1% benzalkonium chloride and, in reviewing the label, I did not see any reference to alcohol.

18. On its website, the CDC has stated that it "does not have a recommended alternative to hand rub products with greater than 60% ethanol or 70% isopropanol." CDC, Frequently Asked Questions about Hand Hygiene for Healthcare Personnel Responding to Covid-2019, https://www.cdc.gov/coronavirus/2019-ncov/infection-control/hcp-hand-hygiene-faq.html (last accessed Apr. 2, 2020). Although the website notes that the FDA has deemed "[b]enzalkonium chloride . . . eligible . . . for use in the formulation of healthcare personnel hand rubs," the CDC has explained that the "available evidence indicates that benzalkonium chloride has less reliable activity against coronavirus than either of the alcohols." *Id.*
19. I also have serious concerns about DOC's efforts to prevent the spread of virus. For example, prisoners who test positive for coronavirus are housed in unit SMU-B. SMU-B sits adjacent to the C-bldg elevators at the first level of the facility. The most expedient way to access that unit is through an elevator that runs through my building and that I use regularly. I have not seen any additional efforts to clean that elevator since March 1, 2020 and the floors remain dirty.

I, Doreen Deterville, certify under penalty of perjury under the laws of the United States, including 28 U.S.C. § 1746, that the following statement is true and correct pursuant to the best of my knowledge and belief.

Dated: April 2, 2020



Doreen Deterville
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Attachment A

DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS

Pandemic Plan

Number: 5031.1
Annex 14
Date: September 7, 2010

1. **OBJECTIVES**. Reasonable efforts will be made to protect staff, visitors, inmates and the general population. A plan is available for continuing operations of the facility in the event of staff work stoppage.

2. **DEFINITIONS**

   a. Influenza (flu). Refers to illnesses caused by a number of different influenza viruses. Flu can cause a range of symptoms and effects, from mild to lethal.

   b. Influenza-Like-Illness (ILI). Many upper respiratory diseases that cause people to be ill, including the common cold and influenza.

   c. Seasonal/Common Flu. A temporary illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available.

   d. Pandemic Flu. A global outbreak of disease that occurs when a new influenza virus emerges for which people have little or no immunity, and for which there is no vaccine. This can cause serious illness, and spreads easily from person to person worldwide.

   e. Avian Flu (H5N1). Is influenza; a virus subtype that occurs mainly in birds, is highly contagious among birds, and can be deadly to them. H5N1 virus does not usually infect people, but a number of confirmed cases of human infection have occurred since 1997. Most of these cases have resulted from people having direct contact or close contact with H5N1-infected poultry or H5N1-contaminated surfaces.

   f. Swine Flu (H1N1). Novel H1N1 (referred to as “swine flu”) is a new influenza virus causing illness in people. This virus was first detected in people in the United States in April 2009. This virus is spreading from person-to-person worldwide, probably in much the same way that regular seasonal influenza viruses spread. On June 11, 2009, the World Health

Organization (WHO) signaled that a pandemic of novel H1N1 flu was underway.

g. Flu Symptoms. Range from: fever, cough sore throat and muscle aches, to diarrhea, eye infections, pneumonia and severe respiratory disease; and other severe and life-threatening complications.

h. Isolation. Separation or restricted movement of ill persons with a contagious disease.

i. Quarantine. Separation or restricted movement of well person(s) presumed to have been exposed to a contagion.

j. Facemask. Loose-fitting, disposable masks that cover the mouth and nose. These include products labeled as surgical, dental, medical procedure, isolation and laser masks. Facemasks help stop droplets from being spread by the person wearing them. They also keep splashes and sprays from reaching the mouth and nose of the person wearing the facemask. They are not designed to protect you against breathing in very small particles. Facemasks should be used once then thrown away in the trash.

k. Respirator. N95, or higher filtering face piece respirator. Is designed to protect you from breathing in very small particles, which might contain viruses. These types of respirators fit tightly to the face so that most air is inhaled through the filter material. To work most effectively, the N95 mask must be fitted for each person who wears one. Like surgical masks the N95 should be worn once and thrown away in the trash. Compared with a facemask it is harder to breathe through a respirator for long periods of time. Respirators are not recommended for children or people who have facial hair.

l. Personal Protective Equipment (PPE). Employees who work closely (within 6 feet) of people known or suspected to be infected with pandemic influenza should wear PPE, examples of PPE are:

1) Gloves

2) Goggles

3) Face Shields

4) Surgical Masks and

5) Respirators e.g. N95

m. Incident Commander. The designated operations commander during a facility-wide emergency. The Incident Commander assumes control of the scene and takes immediate action to ensure continued operations, safety and security of the DOC.

n. DOC Medical Director or Designee. Is the responsible health authority for the DOC. In the event the medical director is unavailable during a pandemic, the contracted medical director for health services shall be designated to act in their stead.

o. The DC Department of Health (DOH) will, in general, follow the CDC guidelines for prevention and control. http://dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/information/influenza/pdf/dc_pandemic_influenza_plan.pdf

3. **RESPONSIBILITY OF THE DISTRICT OF COLUMBIA**

a. The District of Columbia has a city wide integrated Influenza Pandemic Plan that is under the command for the Director of the DOH in the event of an outbreak.

b. In addition to public health, the general strategy of the plan is to protect the infrastructure so to ensure that the health and medical community, as well as government and business, will continue to function. This decision will require allocation and redirection of scarce resources toward those who are needed to maintain optimal functioning and health of society.

c. The DOC Influenza Pandemic Plan is developed in accordance with CDC recommendations and in cooperative agreement to support and facilitate the District's Plan.

d. The above information was extracted from the District of Columbia Department of Health Pandemic Influenza Preparedness Plan (2005).

4. **OVERVIEW**

a. In the event of pandemic influenza, the DOC and other employers will play a key role in protecting employees' health and safety as well as limiting the negative impact to the economy and society. Planning for pandemic influenza is critical. As with any catastrophe, having a contingency plan is essential.

b. Strategies that delay or reduce the impact of a pandemic (also called non-pharmaceutical interventions) may help reduce the spread of disease until a vaccine is available.

c. HHS and the Centers for Disease Control and Prevention have developed guidelines, including checklists, to assist businesses, industries, and other employers in planning for a pandemic outbreak as well as for other comparable catastrophes. Please visit www.pandemicflu.gov and www.cdc.gov for information on planning, education and health related to the pandemic flu.

5. **PLANNING ASSUMPTIONS**

a. Vulnerability to the pandemic flu will be universal.

b. Efficient and sustained person to person transmissions signals an eminent pandemic.

c. The clinical disease attack rate will likely be 30% or higher in the overall population during the pandemic. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults, an average of 20% will become ill during a community outbreak.

d. Some persons will become infected but not develop clinically significant symptoms. Those who show no symptoms or minimal symptoms they can transmit infection and develop protection to later infections.

e. Of those who become ill with influenza, 50% will seek outpatient medical care.

f. With the availability of effective antiviral drugs for treatment, this amount may be higher in the next pandemic.

g. The number of hospitalizations and deaths will depend on the virulence of the pandemic virus. Estimates differ about 10-fold between more and less severe scenarios.

h. Risk groups for severe and fatal infection cannot be predicted with certainty but are likely to include infants, young people, the elderly, pregnant women, and persons with chronic medical conditions.

i. Rates of absenteeism will depend on the severity of the pandemic

j. In a severe pandemic, absenteeism is attributed to illness, the need to care for ill family members, and fear of infection may reach 40% during the peak weeks of a community outbreak, with lower rates of absenteeism during the weeks before and after the peak.

k. Certain public health measures (closing schools, quarantining household contacts of infected individuals, “snow days”) are likely to increase rates of absenteeism.

l. Persons who become ill may shed virus and can transmit infection for up to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest within (7) days of illness, though infectivity rapidly decreases after (5) days.

m. On average, infected persons will transmit infection to approximately two other people.

n. In an affected community, a pandemic outbreak will last about 6 to 8 weeks.

o. Multiple waves (periods during which community outbreaks occur across the country) of illness could occur with each wave lasting 2-3 months. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.

6. PANDEMIC OUTBREAK-COMMAND AND CONTROL

a. The incident command system/emergency (ICS) procedures shall be utilized to manage the response to a level of ILI cases, which **exceeds** the ability of the ranking supervisor on duty to effectively and safely manage. Factors to be considered may be the total number of ILI cases, the distribution of ILI cases throughout the facility and the impact of an increasing number of ILI cases on the overall health of staff and the entire inmate population.

b. The Incident Commander shall assume control of the scene, and take immediate actions as outlined below (¶13-14).

7. INITIAL RESPONSE ALERTS AND IMMEDIATE ACTION

a. Once the Incident Command System is established, the Incident Commander will make notification in accordance with PS 1280.2 *Reporting and Notification Procedures for Significant Incidents and Extraordinary Occurrences.*

b. The Incident Commander shall coordinate with the DOC Medical Director to make notification to the D.C. Department of Health, and other pertinent agencies. Additional notification will be made to the Warden of the CTF who may assist in providing supplies and additional resources.

c. The Incident Commander shall alert the Public Information Office to advance the alert to be sent out via electronic mail, if needed.

d. The Incident Commander shall open an Incident Command Post in the Warden's conference room or in the upper level of the Armory. Procedures for the operation of the Command Post are detailed in section 14 below.

e. The Incident Commander shall lock down impacted unit(s) and limit movement in order to mitigate the spread of ILI. Consideration will be focused on the protection of the public and visitation may be suspended at the discretion of Incident Commander. All personnel at all facilities will be briefed and advised to increase the staff awareness and precautionary infection control measures.

f. The Incident Commander shall coordinate efforts to quarantine the housing unit(s) where the ILI cases have been identified. In collaboration with the DOC Medical Director, the Incident Commander shall determine if the entire unit is placed on lockdown or if only those inmates with ILI cases will be isolated and confined to their cell(s). All movement from the impacted unit(s) will cease. This procedure will apply to males, females and juveniles.

g. All essential services (food service, laundry, medical care, canteen, etc.) shall be delivered to the unit(s).

h. All staff on the quarantine unit(s) shall be provided PPE.

i. The Incident Commander shall continue the ICS until such time as the level of ILI cases have subsided to a manageable level under normal operations. At such time the ICS will be deactivated and a debriefing of all staff will be prepared.

8. **PHASE 1-QUARANTINE AND LOCKDOWN**

a. Medical staff is responsible for providing appropriate medical treatment to the inmate population.

b. Medical shall provide inmates with ILI a mask and evaluate all other inmates on the housing unit with the ILI case. Medical may perform rapid Influenza A-B testing, and treat accordingly.

c. Inmates with ILI shall be placed in a single cell in his/her housing unit or if possible housed with another inmate who is also symptomatic. Medical shall supply these inmates with surgical masks. The masks shall be

properly disposed of within twenty-four (24) hours or sooner if needed and the inmate issued another.

d. Alert inmates in the unit where ILI case has been identified. Medical shall triage, including temperature checks, all inmates in the infected unit(s). Inmates in this unit shall be quarantined while medical personnel determine if they can be cleared for open population in the cellblock. Inmates with no symptoms of ILI shall be quarantined no less than (5) days.

e. Inmates identified by medical as being high risk for developing influenza shall be offered the vaccine, when the vaccine is available in accordance with CDC guidelines.

f. Clean and exchange all linen and clothing. Clean and disinfect the entire housing unit, including walls, railings, floors, table tops etc.

g. Heavily soiled items shall be disposed of by utilizing the red biohazard bags in accordance with the biohazard procedures governing the PS 6000.1 *Medical Management*.

h. The Incident Commander or designee shall ensure that Personal Protective Equipment (PPE) is obtained from CCA-CTF storage site and provided to the medical staff for immediate use: Gowns, Gloves and N-95 masks.

i. Universal Precautions shall remain in place for seven (7) days after the fever has been resolved.

9. **INTAKES**

a. When a pandemic influenza is medically confirmed, a member of the medical staff shall be present in R&D (male and female) at any time inmates are processed into the CDF or CTF. Intakes shall be assessed by medical and directed into either the quarantine or isolation or holding area based on their history and/or symptoms.

b. Juvenile and/or female intakes with ILI shall be transferred to the CCA wearing a surgical mask. Juveniles and/or females shall be housed in accordance with the CCA pandemic flu plan.

c. Male CDF Intakes with ILI shall first be housed in a safe cell on the 3rd floor medical unit wearing a surgical mask. When at capacity, those intakes shall be transferred to the CCA wearing a mask and housed in accordance with the CCA pandemic flu plan. When CCA housing for ILI cases reach capacity, those intakes shall be placed in the CDF North-3

under the direction of the DOC medical director and the Incident Coordinator.

d. Quarantined unit (s) shall not receive new intake inmates until officially cleared by medical staff.

10. **INMATES REQUIRING HOSPITALIZATION**

a. It will be the assumption that hospitals will be too ill-equipped to respond to a pandemic due to the sheer volume of cases. Hospitals will reach their limits. Therefore, the DOC will prepare to care for ill inmates within the facilities.

b. Medical staff shall arrange for the transfer of inmates who require emergency treatment to the hospital. The DOC shall comply escorts as directed in PS 4910.1 *Escorted Trips*.

c. All cases shall be transported wearing a mask.

d. Staff providing escort and transportation for ILI cases shall wear masks.

11. **COURT TRIPS AND INTERNAL LEGAL VISITS**

a. In the event that Inmates are scheduled for a court appearance:

1) DOC shall notify the courts of all ILI inmates prior to their arrival to court. Notification shall be made through an expanded medical alert. Those inmates shall be transferred to court wearing a surgical mask;

2) ILI cases shall be scratched from court via the medical alert system;

3) The DOC shall notify the courts of Inmates who present with ILI symptoms, and had appeared in court within (7) days of symptoms onset.

b. In the event that Inmates have internal Legal Visits:

1) The ILI inmates shall wear a surgical mask while attending legal visits;

2) The Inmates attorney shall be offered a surgical mask (without informing the attorney of any medical issues).

12. **OCCUPATIONAL SAFETY AND HEALTH**

a. Culinary shall serve the quarantined unit(s) with styrofoam and disposable items only.

b. The environmental team shall dispose all items in compliance with standard procedures governing disposal and OSHA guidelines.

c. Gloves are to be worn at all times during preparation, serving and disposal of food/dishes/utensils.

13. **CONVERTING NORTH-3 TO MEDICAL HOUSING UNIT**

a. The following procedures shall only take place under the direction of the Incident Commander and the DOC Medical Director.

b. Move all inmates assigned to North-3 (NO-3) to an alternate housing unit unaffected by the virus.

c. Upon removal of all inmates, the unit, to include walls, railings, cell doors, table tops, etc. shall be cleaned and disinfected in accordance with approved CDC guidelines for disinfecting agents.

d. All personnel assigned to NO-3 shall be issued PPE to include N-95 masks.

e. Both NO-3 and the housing unit where the ILI case was identified shall be cleaned and disinfected, subsequently all other housing units shall be disinfected in accordance with approved CDC guidelines for disinfecting agents.

f. Only Inmates affected by the virus shall be housed in the quarantined unit, per medical staff direction.

14. **PHASE 2-COMMAND POST**

a. Only authorized staff shall be permitted in the Armory during the emergency, as outlined in PS 5031.1 *Emergency Plan*.

b. The Incident Commander shall control movement of designated personnel in and out of the Operations Command Post.

c. The Incident Commander shall conduct roll call. Staff present shall include: Deputy Wardens, Majors, Medical Director or designee, Maintenance, Food Service Manager, etc.

d. Incident Commander shall coordinate scheduling of briefings to ensure safety, count status, and employee status.

e. Incident Commander shall ensure that all essential employees are notified to report for duty.

f. Upon assessment of the seriousness of the emergency, the Incident Commander shall make immediate notification to the MPD, Courts and USMS if the DOC is unable to accept commitments, or if access to the facility is prohibited.

g. The Incident Commander shall meet with the DOC Medical Director or designee, no less than once each shift, for an update of the situation and to receive reports on new or resolved cases.

h. The Incident Commander shall ensure that all correctional staff radios and vehicles are operational.

i. Main communications channel that must be operational are:

1) Existing phone/fax lines

2) Cell phones

3) Internet

4) Email

5) Wireless email capability

6) Radios

j. The Perimeter Officer shall maintain external security around the facility.

k. The Incident Commander shall determine who enters the Staff and Visitor Control Entrances.

15. **COMMUNICATIONS**

a. Assuming that communications may be stressed or even inoperable, employees shall maintain contact by:

1) Use of facility land lines and/or cell phones.

2) Radios shall be used for on-going communication with the command center.

16. **MEDICAL MANAGEMENT OF STAFF**

a. Management of DOC, and medical personnel assigned to the quarantined unit(s) shall include:

1) No less than daily temperature checks and monitoring for ILI symptoms.

2) Coordination between the Medical Contractor, DOC and CCA to ensure appropriate monitoring of symptoms and temperature checks take place.

3) Any employee with a temperature of more than 100.4, or shows signs and symptoms of ILI, must immediately remove themselves from the area and make notification to their supervisor.

4) Medical shall instruct these employees with the flu-like symptoms and a temperature of more than 100.4 degrees to seek medical attention.

5) D.C. Fire and Emergency Medical Services shall be notified if medical has deemed the employees condition to be in need of hospitalization.

6) Medical Contractor shall make notification to the DOC Medical Director and Warden of the status of employees identified with ILI.

17. **FLU VACCINATIONS FOR STAFF**

a. The DOH has deemed the DOC and CCA staff as priority employees to receive the flu vaccination. In the event of a pandemic outbreak the DOH will offer the DOC and CCA employees the flu vaccination.

b. Medical staff is deemed priority in receiving the vaccination.

c. Vaccinations shall be administered in accordance with CDC guidelines.

18. **FLU VACCINATIONS FOR INMATES**

a. The Medical Contractor shall vaccinate in accordance with CDC guidelines for clinicians in vaccinating the high-risk individuals.

b. In accordance with CDC guidelines, the DOC deems the following inmates high-risk and will be offered the flu vaccine first:

1) Juveniles, pregnant females and inmates with chronic conditions.

2) Medical staff shall seek parental/guardian consent for juveniles before the vaccination may be administered.

19. **ABSENTEEISM**

a. Personnel are expected to report for duty if they are not ill. The facilities Incident Commander shall implement the recall plan to notify all essential employees.

b. Designated Essential Employees are:

1) All correctional security staff;

2) Warrant squad investigators;

3) See Executive Agencies Recall Roster.

c. Under the direction of the Incident Commander or designee the following shall occur:

1) Housing Unit officers staffing shall be adjusted to maintain security.

2) Medical Unit officers staffing shall be adjusted to maintain security.

3) Other staff shall be redeployed to meet and maintain safety and security in the facility.

20. **ALTERNATE POSITIONS**

a. The Incident Commander shall designate, redeploy and assign the appropriate staff in order to maintain operations, safety and security of the DOC.

21. **CONTINUED OPERATIONS WITHIN FACILITY**

a. In the event of a lock-down, the facility shall:

1) Maintain lock down status until the Incident Commander has cleared the facility to resume normal operations;

2) Conduct count in accordance with department policy;

3) Maintain one (1) Officer on the housing unit floor at all times;

4) Develop a relief schedule for posts in the infected housing units. Frequent rotation of the post shall occur based on the limited wear of the N95 masks.

5) Ensure that all count sheets are collected from the housing units and delivered to the count book.

6) Conduct radio checks every hour.

7) Ensure correctional officers assigned to isolation or quarantine units have limited access to other areas in the facility.

b. The Incident Commander has the authority to modify the procedural steps in section 21 as deemed appropriate and necessary to ensure safety and security.

22. **SERVICES TO CONTINUE DURING LOCK DOWN:**

a. Medical

1) Medical Staff shall maintain necessary medical sick call services in accordance to the inmates' immediate needs.

b. Medication

1) Medication shall be issued to inmates as ordered by a qualified licensed provider.

2) Bedside medication shall be distributed for (10) days at a time. Medication issued thru sick call shall increase from (3) days to (6) days. Medications prescribed for (5-7) days shall increase to (10-14) days.

3) Watch take medication shall be administered by a licensed medical professional during the scheduled times as described in the physicians orders.

c. Environmental

1) All garbage shall be properly disposed of in common areas, such as housing units, culinary, medical, at least every shift.

2) Housing units shall be cleaned in accordance with approved CDC guidelines for disinfecting agents at least daily and before another inmate occupies a cell.

3) In addition, common areas, including rails, tabletops, floors, bedrails, TVs shall be cleaned and disinfected daily. Disposable disinfectant wipes shall be used on smooth metal surfaces, tabletops.

4) A damp cloth, not dry dusting or sweeping, shall be used to minimize the possibility of airborne exposure to infected material.

5) Gloves and surgical masks shall be worn at all times while cleaning and disinfecting.

6) Blood and body fluids shall be cleaned and disinfected immediately, as currently recommended by the CDC and/or Occupational Safety and Health Administration (OSHA).

d. Food Service

1) The food service vendor shall prepare foods with Styrofoam trays and adhere to strict infection control guidelines.

2) Inmates shall receive three (3) meals a day.

3) All reusable dishes shall be washed in hot water in dishwasher.

4) After each wash cycle, the dishwasher shall be disinfected in accordance with approved CDC guidelines for disinfecting agents before the next wash.

5) All trash is to be disposed of in compliance with OSHA standards.

23. **LAUNDRY OPERATIONS**

a. Gowns and gloves shall be worn at all times when directly handling to include transporting soiled linen and laundry.

b. For laundry contaminated with the virus, soiled linen shall be placed directly into a laundry bag in the inmates' cell. The Bag shall remain sealed until time of laundering.

c. Laundry shall be collected and cleaned daily (when applicable). The dryer shall maintain a temperature of 110 degrees.

d. Hands shall be washed with soap and water for at least twenty (20) seconds while hands and wrists are under the water.

24. **TEMPORARY MORGUE**

a. In the event deaths occur from this pandemic and the need arises for a temporary morgue the following shall occur:

1) PPE (mask, face shield, gown and gloves), shall be worn at all times when handling the deceased.

2) The deceased shall be sealed in an impermeable (water tight) body bag before transfer. The exterior of the bag shall remain clean and dry.

3) The Incident Commander or designee shall relocate the refrigerated box truck from the motor pool to the CDF loading dock area for storage of the deceased.

4) If for any reason the refrigerated box truck is not accessible, a secondary plan shall be the walk-in freezer located in the CDF warehouse area adjacent to the loading dock.

5) The Incident Commander shall coordinate with the CCA command to have the deceased from the CTF transferred to these sites. When the CDF sites reach capacity, the space identified at the CTF shall be utilized.

6) The areas identified above, shall maintain approximately forty (40) deceased persons.

7) These areas shall be temporary until arrangements are made with the city morgue.

25. **RELEASES**

a. In the event an inmate is released to the community, the following measures shall be taken:

1) If a quarantined inmate does not present with symptoms of ILI, he/she shall be released home.

2) Inmate’s positive for ILI and have a home, medical shall notify the Department of Health (DOH).

3) Inmates positive with ILI and do not have a home, the medical contractor’s Discharge Planning Coordinator and the DOC Medical Director shall contact the DOH to arrange for appropriate medical housing in the community.

26. **REPORTING**

a. All information in the event of a rapidly spreading pandemic flu requires accurate reporting. The DOC medical director and medical contractor shall review all lab reports and make notification of all identified ILI cases to the Department of Health.

27. **PHASE 3- RESUME NORMAL OPERATIONS**

a. The DOC medical director shall evaluate the pandemic situation and make proper notification to the Incident Commander.

28. **SUPPLIES**

In the event of a pandemic outbreak supplies shall be readily available to the staff and inmates. The DOC and CCA shall maintain a stockpile for immediate use. The medical contractor shall maintain the medications. All supplies shall be maintained at the designated space at the CTF. Supplies shall be plentiful enough to sustain staff and inmates for at least four (4) weeks. Below is a list of items that are required to build a stockpile:

a. Disposable N95 Masks

b. Saccharine Fit Test Kits

c. Disposable Exposure Control Gowns

d. Intravenous Catheters (IV's)

e. Intravenous Fluids

f. Thermometers and Covers

g. Rapid Test Kits for Influenza

h. Tamiflu

i. Disposable eye Shields

j. Alcohol Based Hand Sanitizer

k. Germicide Wipes (surface cleaners)

l. Sharps Disposable Containers

m. Bio-Hazard Waste Bags

n. Body Bags

o. Safety Glasses

p. Disposable Surgical Masks

q. Oxygen Cannulas

GLOSSARY OF TERMS

1. **Avian flu**. A highly contagious viral disease with up to 100% mortality in domestic fowl caused by influenza A virus subtypes H5 and H7. All types of birds are susceptible to the virus but outbreaks occur most often in chickens and turkeys. The infection may be carried by migratory wild birds, which can carry the virus but show no signs of disease. Humans are only rarely affected.

2. **Absenteeism rate**. Proportion of employed persons absent from work at a given point in time or over a defined period of time.

3. **CDC**. Centers for Disease Control and Prevention, the U.S. government agency at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats. CDC is one of 13 major operating components of the Department of Health and Human Services.

4. **Cleaning**. The removal of visible soil (e.g., organic and inorganic material) from objects and surfaces and normally is accomplished manually or mechanically using water with detergents or enzymatic products. Thorough cleaning is essential before high-level disinfection and sterilization because inorganic and organic materials that remain on the surfaces of instruments interfere with the effectiveness of these processes.

5. **Contagious**. A contagious disease is easily spread from one person to another by contact with the infectious agent that causes the disease. The agent may be in droplets of liquid particles made by coughing or sneezing, contaminated food utensils, water or food.

6. **Cough etiquette**. Covering the mouth and nose while coughing or sneezing; using tissues and disposing in no-touch receptacles; and washing of hands often to avoid spreading an infection to others.

7. **Decontamination**. Removes pathogenic microorganisms from objects so they are safe to handle, use, or discard.

8. **Disinfection**. Describes a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. In health-care settings, objects usually are disinfected by liquid chemicals or wet pasteurization.

9. **Epidemic**. A disease occurring suddenly in humans in a community, region or country in numbers clearly in excess of normal. See epizootic and pandemic.

10. **Face mask**. Disposable surgical or procedure mask covering the nose and mouth of the wearer and designed to prevent the transmission of large respiratory droplets that may contain infectious material.

11. **Hand hygiene**. Hand washing with either plain soap or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams containing an emollient) that do not require the use of water.

12. **Incubation period**. The interval (in hours, days, or weeks) between the initial, effective exposure to an infectious organism and the first appearance of symptoms of the infection.

13. **Infection control**. Hygiene and protective measures to reduce the risk of transmission of an infectious agent from an infected person to uninfected persons (e.g., hand hygiene, cough etiquette, use of personal protective equipment, such as face masks and respirators, and disinfection).

14. **Influenza**. A serious disease caused by viruses that infect the respiratory tract.

15. **Influenza pandemic**. worldwide epidemic caused by the emergence of a new or novel influenza strain to which humans have little or no immunity and which develops the ability to infect and be transmitted efficiently and between humans for a sustained period of time in the community.

16. **Isolation**. A state of separation between persons or groups to prevent the spread of disease. The first published recommendations for isolation precautions in United States hospitals appeared as early as 1877, when a handbook recommended placing patients with infectious diseases in separate facilities. Isolation measures can be undertaken in hospitals or homes, as well as in alternative facilities.

17. **Pandemic**. The worldwide outbreak of a disease in humans in numbers clearly in excess of normal.

18. **Personal protective equipment (PPE)**. PPE is any type of clothing, equipment, or respiratory protection device (respirators) used to protect workers against hazards they encounter while doing their jobs. PPE can include protection for eyes, face, head, torso, and extremities. Gowns, face shields, gloves, face masks, and respirators are examples of PPE commonly used within healthcare facilities. When PPE is used in a workplace setting to protect workers against workplace hazards, its use must be consistent with regulations issued by the Occupational Safety and Health Administration (www.osha.gov/index.html).

19. **Quarantine**. The period of isolation decreed to control the spread of disease. Before the era of antibiotics, quarantine was one of the few available means of halting the spread of infectious disease. It is still employed today as needed.

The list of quarantinable diseases in the U.S. is established by Executive Order of the President, on recommendation of the Secretary of the Department of Health and Human Services, and includes cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, and viral hemorrhagic fevers (such as Marburg, Ebola, and Congo-Crimean disease). In 2003, SARS (severe acute respiratory syndrome) was added as a quarantinable disease. In 2005 another disease was added to the list, influenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic.

20. **Seasonal flu**. A respiratory illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available. This is also known as the common flu or winter flu.

21. **Sterilization**. A process that destroys or eliminates all forms of microbial life and is carried out in health-care facilities by physical or chemical methods. Steam under pressure, dry heat, and liquid chemicals are the major sterilizing agents used in health-care facilities.

22. **Surgical mask**. Disposable face mask that covers the mouth and nose and comes in two basic types. The first type is affixed to the head with two ties and typically has a flexible adjustment for the nose bridge. This type of surgical mask may be flat/pleated or duck-billed in shape. The second type of surgical mask is pre-molded, or cup shaped, and adheres to the head with a single elastic strap and usually has a flexible adjustment for the nose bridge. Surgical masks are used to prevent the transmission of large particles.

23. **Vaccine**. A preparation consisting of antigens of a disease-causing organism which, when introduced into the body, stimulates the production of specific antibodies or altered cells. This produces immunity to the disease-causing organism. The antigen in the preparation can be whole disease-causing organisms (killed or weakened) or parts of these organisms.

24. **Virus**. Any of various simple submicroscopic parasites of plants, animals, and bacteria that often cause disease and that consist essentially of a core of RNA or DNA surrounded by a protein coat. Unable to replicate without a host cell, viruses are typically not considered living organisms.

25. **WHO**. World Health Organization, an agency of the United Nations established in 1948 to further international cooperation in improving health conditions.

Devon Brown
Director

EXHIBIT B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.*, Plaintiffs-Petitioners, v. QUINCY BOOTH, in his official capacity as Director of the District of Columbia Department of Corrections, *et al.*, Defendants-Respondents.	No. 1:20-cv-00849 (CKK)

DECLARATION OF LENNETTE NESBITT

1. My name is Lennette Nesbitt. I am competent to make this declaration and I make these statements based on personal knowledge.
2. I work as a case manager for the D.C. Department of Corrections (DOC) at the Correctional Treatment Facility (CTF). I have held this position since 2017. From 2005 to 2012, I also worked at CTF, during which time I was employed by Correction Corporation of America.
3. When I learned that covid-19 had reached D.C., I knew my job put me at a high risk of contracting the illness. The nature of our facility, the lack of protective gear, my inability to obtain adequate cleaning supplies all left me afraid to come to work—so much so that I would have to sit in my car for about thirty minutes every day so I could calm myself down before entering the building.
4. Despite my fears, I had worked all but two days in March until last Friday, March 27. That day, I reported that I had been in close proximity with someone who had been in direct contact with a person suffering from the virus. Since then, I have not returned to the CTF. Fortunately, my medical provider helped me secure covid-19 testing, and thankfully, my test came back

negative Wednesday afternoon.

5. The risks I face are magnified for the inmates I serve.
6. I have observed the conditions at DOC closely. My job requires me to walk through housing units and, from my office window, I can see into one of the recreational areas. This vantage point has allowed me to view cleaning practices and note the availability of protective gear.
7. DOC does not have a professional cleaning service working in the housing units. Instead, the Department relies on inmates to clean the units themselves.
8. The unit I work on is reserved for people 50 and over. Many inmates in my unit have health conditions and spent significant amounts of time in the medical unit even before covid-19 reached the United States. Nonetheless, with the exception of one occasion where I saw an officer cleaning a surface with solution earlier this month, the only individuals I have ever seen cleaning the housing unit during my nine and a half years of service are inmates.
9. To my knowledge, the inmates do not receive any training from staff on how to clean or sanitize. In all my years working at CTF, I have never seen any such training occur—not even this March, when the dangers of covd-19 became well-known.
10. As I have watched inmates clean, I have not seen any of them wearing gowns or masks. In fact, I only know of one inmate in the entire CTF who was in possession of a mask.
11. Personally, I have had trouble getting a mask too. I asked my supervisor for protective gear but never received any. I also asked my supervisor for cleaning solution and didn't get that either. My supervisor told me that she only had five bottles of solution for the eleven case managers she oversaw. She did not provide me with one of the bottles, nor, to my knowledge, did she give a bottle to one of my colleagues. As of March 26, 2020, I still didn't have access to cleaning solution capable of killing covid-19.

12. On March 17, the warden sent a notice to all staff informing us that we could bring our own sanitizing wipes to work to clean our offices. I brought my own wipes but quickly ran out.
13. During the week of March 23, multiple inmates came to my office to make legal calls. After they left, I did not have any cleaning solution capable of killing covid-19 that I could use to wipe down surfaces. As a result, any virus particles any inmate left on my phone remained there, where each successive inmate's face could come into contact with it.
14. Social distancing is not happening in my unit. From my office window, I can see one of the recreation areas, and have routinely seen inmates sitting or standing close to one another, rather than six feet apart. Chairs are clustered together and inmates will frequently sit next to each other to play cards or chat. The recreational area also has a television room; that room is small enough that when more than four people sit there it gets warm. I regularly noticed inmates crowded in that room as recently as last week.
15. I don't recall ever having heard announcements instructing inmates to social distance from one another.
16. Another factor that creates risk is the lack of fresh air coming into the CTF. To enter the housing units from outside the facility, people must pass through layers of thick, secured doors. None of the windows inside the facility open. As a result, old air circulates throughout the building and fresh air rarely enters. Any particles of virus in the air put all of us at risk.

I, Michael Perloff, certify that I have read the foregoing to Ms. Nesbitt and that she affirmed that the foregoing is true and correct on April 3, 2020. I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 3, 2020

/s/ Michael Perloff
Michael Perloff
American Civil Liberties Union Foundation
of the District of Columbia
915 15th Street NW, 2nd Floor
Washington, D.C. 20005

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.*,

Plaintiffs-Petitioners

v.

QUINCY BOOTH, in their official capacity as Director of the District of Columbia Department of Corrections, *et al.*,

Defendants-Respondents.

No. 1:20-cv-00849 (CKK)

[Proposed]
ORDER

Upon consideration of Plaintiffs' Emergency Motion to Convert April 6, 2020 Status Conference into Merits Hearing on Plaintiffs' Application for a Temporary Restraining Order, and any response thereto, it is hereby

ORDERED that the motion is granted. The telephonic status conference scheduled for 9:30 a.m. on Monday, April 6, 2020, shall be a hearing on the merits of Plaintiffs' application for a temporary restraining order. It is further

ORDERED that Plaintiffs shall file their reply memorandum not later than 5:00 p.m. on Saturday, April 4, 2020.

Dated: April ___, 2020

_____
Colleen Kollar-Kotelly
United States District Judge