COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK, ss. No. SJC-12935

STEPHEN FOSTER, et al.,
Plaintiffs,

v.

CAROL MICI, COMMISSIONER OF CORRECTION, et al.,
Defendants.

ANSWER OF DEFENDANTS, CAROL MICI AND THOMAS TURCO, TO PLAINTIFFS' CLASS ACTION COMPLAINT

Defendants, Carol Mici, Commissioner of Correction, and Thomas Turco, Secretary of the Executive Office of Public Safety and Security, answer the numbered paragraphs of plaintiffs' Class Action Complaint as follows:

INTRODUCTION

1. Paragraph 1 contains conclusions of law, to which no responsive pleading is required. To the extent that any response is required, defendants deny the allegations.
2. Defendants deny the allegations set forth in paragraph 2 of the Complaint.
3. Defendants deny the allegations set forth in paragraph 3 of the Complaint.
4. Defendants are without sufficient knowledge or information to admit or deny the allegations in paragraph 4 and they are therefore denied. Further answering, defendants state that the April 1, 2020 New England Public Radio broadcast speaks for itself.
5. Defendants admit that the Supreme Judicial Court ("SJC") recently noted that correctional institutions face unique difficulties in keeping their populations safe during this pandemic. Further answering, defendants state that the SJC decision speaks for itself. Defendants deny the remaining allegations set forth in paragraph 5 of the Complaint.

Defendants further state that as a primary mechanism to ensure sanitation, each correctional facility is required by Department policy to create a housekeeping schedule, which outline cleaning schedules for all areas, instructions on proper cleaning, and specific assignments and duties. Defendants state that additionally, ongoing cleaning is happening at all facilities, with inmates and staff ensuring, as much as practicable, that sufficient amounts of bleach and other cleaners are used to kill the virus and prevent its spread. Defendants state that at all facilities, inmate common areas and high-touch areas are frequently cleaned and disinfected with bleach and disinfectants, inmates are being provided with bar soap, and are being told that they may request additional soap, at no charge, as needed, and alcohol-based hand sanitizer is readily available to inmates and staff in all areas of the facilities.

6. Defendants admit that five COVID positive inmates with underlying medical conditions have died since (date). Defendants deny the remaining allegations set forth in paragraph 6 of the Complaint.
7. Defendants deny the allegations set forth in paragraph 7 of the Complaint.
8. Defendants deny the allegations set forth in paragraph 8 of the Complaint.
9. Defendants deny the allegations set forth in paragraph 9 of the Complaint.
10. Paragraph 10 contains conclusions of law to which no responsive pleading is required. To the extent any response is required, defendants deny the allegations set forth in paragraph 10 of the Complaint.

PARTIES

11. Defendants admit that Stephen Foster is an inmate at Old Colony Correctional Center ("OCCC"). Defendants admit that Stephen Foster has a pending medical parole petition.

Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 11 of the Complaint and they are therefore denied.

12. Defendants admit that Michael Gomes is an inmate at MCI-Concord. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 12 of the Complaint and they are therefore denied.
13. Defendants admit that Peter Kyriakides is an inmate at Pondville Correctional Center ("PCC"). Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 13 of the Complaint and they are therefore denied.
14. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 14 of the Complaint and they are therefore denied.
15. Defendants admit that Steven Palladino is an inmate at MCI-Norfolk. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 15 of the Complaint and they are therefore denied.
16. Defendants admit that Mark Santos was previously a patient at MASAC, located at MCI-Plymouth, who was relased from MASAC on April 9, 2020. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 16 of the Complaint and they are therefore denied.
17. Defendants admit that David Sibnich is an inmate at PCC. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 17 of the Complaint and they are therefore denied.

18. Defendants admit that Michelle Tourigny is an inmate at MCI-Framingham and has a pending medical parole petition. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 18 of the Complaint and they are therefore denied.
19. Defendants admit that Michael White is an inmate at MCI-Concord in the L2 housing unit, which currently houses 56 inmates, as of April 24, 2020. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 19 of the Complaint and they are therefore denied.
20. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 20 of the Complaint and they are therefore denied.
21. Defendants admit that Hendrick Davis is an inmate at the Massachusetts Treatment Center ("MTC"). Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 21 of the Complaint and they are therefore denied.
22. Defendants admit that Carol Mici is the Commissioner of Correction with an office at 50 Maple Street Milford, MA 01757 and that her duties are set forth in G.L. c. 124, sec. 1. The remaining allegations set forth in paragraph 22 of the Complaint contain conclusions of law to which no responsive pleading is required.
23. Defendants admit that Gloriann Moroney is the chair of the Massachusetts Parole Board with a regular place of business at 12 Mercer Road, Natick, MA 01760 and that her statutory duties are set forth in G.L. c. 27, sec.4.The remaining allegations in paragraph 23 of the Complaint contain conclusions of law to which no responsive pleading is required.

24. Defendants admit that Thomas Turco is the Secretary of the Executive Office of Public Safety and Security (EOPSS) with an office at One Ashburton Place, Boston, MA 02108 and that the Department of Correction is a state agency within EOPSS. Defendants further state that G.L. c. 6A, sec. 18 speaks for itself. The remaining allegations set forth in paragraph 24 of the Complaint contain conclusions of law to which no responsive pleading is required.
25. Defendants admit that Charles Baker is the Governor of the Commonwealth of Massachusetts with an office at the State House in Boston, MA. The remaining allegations set forth in paragraph 25 contain conclusions of law to which no responsive pleading is required.

FACTS

26. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 26 of the Complaint and they are therefore denied.
27. Defendants deny the allegations set forth in paragraph 27 of the Complaint and further answer that the ACLU's April 17, 2020 report speaks for itself.
28. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 28 pertaining to Hampshire County Jail and House of Correction and they are therefore denied. Further answering, defendants state that on April 13, 2020, there were 22 inmates who tested positive for COVID-19 at MCI Framingham and as of April 22, 2020, there were 27 inmates who tested positive. Defendants deny the remaining allegations set forth in paragraph 28 of the Complaint.

29. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 29 of the Complaint and they are therefore denied. Further answering, defendants state that the cited articles speak for themselves.
30. Defendants admit that the common symptoms of COVID-19 may include fever, cough and shortness of breath. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 30 of the Complaint and they are therefore denied.
31. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 31 of the Complaint and they are therefore denied. Further answering, defendants state that the cited articles speak for themselves.
32. Defendants deny the allegations set forth in paragraph 32 of the Complaint, except to note that the cited document speaks for itself.
33. Defendants deny the allegations set forth in paragraph 33 of the Complaint.
34. Defendants admit to the allegations to the extent that the CDC has issued guidelines for mitigating the spread of COVID-19. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 34 of the Complaint.
35. Defendants admit the allegations set forth in paragraph 35 to the extent that the CDC guidelines and SJC opinion speak for themselves. Defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 35 of the Complaint and they are therefore denied.
36. Defendants deny the allegations set forth in paragraph 36 of the Complaint.

37. Defendants admit to the allegations set forth in paragraph 37 of the Complaint to the extent that the April 2, 2020 letter submitted to the SJC speaks for itself. The remaining allegations set forth in paragraph 37 of the Complaint are denied.
38. Defendants deny the allegations set forth in paragraph 38 of the Complaint.
39. Defendants deny the allegations set forth in paragraph 39 of the Complaint, except admit that the Clinical Stabilization Unit ("CSU") at MCI-Norfolk has a total of sixteen (16) beds, thirteen (13) in CSU and three (3) additional medical observation beds.
40. Defendants deny the allegations set forth in paragraph 40 of the Complaint.
41. Defendants admit that on April 3, 2020, the Department of Correction instituted a Department wide lock down. Defendants deny the remaining allegations set forth in paragraph 41 of the Complaint.
42. Defendants are without sufficient knowledge or information to admit or deny the allegations in paragraph 42 pertaining to county facilities and they are therefore denied. Further answering, defendants state that the inmate referenced in paragraph 42 was housed in the Health Services Unit prior to going to an outside hospital by ambulance. The inmate tested negative at the outside hospital for COVID-19, and upon her return to MCI Framingham on April 5, 2020, was kept in the Closed Custody Unit ("CCU") as a precaution due to her potential COVID exposure at the outside hospital. On April 10, 2020, she tested positive for COVID-19.
43. Defendants deny the allegations set forth in paragraph 43 of the Complaint, except admit that at most facilities, all medications are being provided either in cell or on a one-person-at-a-time basis in a common area and inmates must wear masks and stand at least six feet away from each other.

44. Defendants deny the allegations set forth in paragraph 44 of the Complaint except to admit that some inmates eat meals in their housing units instead of in the dining hall.
45. Defendants deny the allegations set forth in paragraph 45 of the plaintiffs' Complaint. Further answering, in response to COVID-19, institutions have implemented additional plans for institutional cleaning and sanitation, and have increased available products such as hand sanitizer and soap to inmates.
46. Defendants deny the allegations set forth in paragraph 46 of the Complaint. Further answering, at PCC, all inmates are offered cleaning supplies daily during the day shift and showers and telephones are cleaned by each inmate after use.
47. Defendants deny the allegations set forth in paragraph 47 of the Complaint. Further answering, defendants state that the referenced documents speak for themselves.
48. Defendants deny the allegations set forth in paragraph 48 of the Complaint.
49. Defendants deny the allegations set forth in paragraph 49 of the Complaint. Further answering, insulin injections at MCI Shirley are administered in the unit sallyport by the assigned nurse who is in full PPE equipment, masked and gloved. Further, the nurse dons a new pair of gloves and gown between each insulin injection, and cleans the area before and after each inmate.
50. Defendants admit that the federal court findings speak for themselves. Defendants deny the allegations set forth in paragraph 50 of the Complaint. Further answering, defendants state that the cited federal case speaks for itself.
51. Defendants admit that the Massachusetts Office of the State Auditor audit released an audit pertaining to DOC medical care. Further answering, defendants state that the audit

speaks for itself. To the extent that any response is required, defendants deny the remaining allegations set forth in paragraph 51 of the Complaint.

52. Defendants deny the allegations set forth in paragraph 52 of the Complaint.

53. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 53 and they are therefore denied. Further answering, defendants state that the cited audio series speaks for itself.

54. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 54 of the Complaint and they are therefore denied.

55. Defendants deny the allegations set forth in paragraph 55 of the Complaint.

56. Defendants deny the allegations set forth in paragraph 56 of the Complaint.

57. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 57 of the Complaint and they are therefore denied.

58. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 58 of the Complaint and they are therefore denied. Further answering, defendants state that the cited memorandum speaks for itself.

59. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 59 of the Complaint and they are therefore denied.

60. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 60 of the Complaint and they are therefore denied.

61. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 61 of the Complaint and they are therefore denied.

62. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 62 of the Complaint and they are therefore denied.

63. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 63 of the Complaint and they are therefore denied.
64. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 64 of the Complaint and they are therefore denied.
65. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 65 of the Complaint and they are therefore denied.
66. Defendants are without sufficient knowledge to admit or deny the allegations set forth in paragraph 66 of the Complaint and they are therefore denied.
67. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 67 of the Complaint and they are therefore denied.
68. Defendants deny the allegations set forth in paragraph 68 of the Complaint.
69. Defendants deny the allegations set forth in paragraph 69 of the Complaint except to state that the SJC opinion and transcript of the oral argument, and the Special Master's April 12 report speak for themselves.
70. Defendants deny the allegations set forth in paragraph 70 of the Complaint to the extent that they pertain to these defendants. Further answering, defendants state that DOC's population decreased by a total of 255 inmates from April 6, 2020 through April 23, 2020; 164 sentenced inmates, 71 civil commitments, and 10 pretrial detainees. Defendants state that they are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 70 of the Complaint and they are therefore denied.
71. Defendants answer by stating that G.L. c. 123, § 35 speaks for itself.
72. Defendants answer by stating that G.L. c. 123, § 35 speaks for itself.

73. Defendants admit the allegations set forth in paragraph 73 of the Complaint, except state that the Memorandum of Understanding references the facilities as Stonybrook Springfield and Stonybrook Ludlow.

74. The first sentence of this paragraph is denied, as in 2019, the number of Section 35 commitments to MASAC at Plymouth and Hampden County totaled 1643. Defendants admit the second sentence of paragraph 74. The defendants are without sufficient knowledge or information to admit or deny the remaining allegations set forth in paragraph 74 and they are therefore denied.

75. The 2017 Acts of the Legislature and 2019 Legislative Commission Report speak for themselves. The defendants deny any remaining allegations contained in paragraph 75 of the Complaint.

76. The March 2020 Substance Abuse and Mental Health Services Administration ("SAMHSA") statement of "Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic" speaks for itself and defendants deny any remaining allegations contained in paragraph 76 of the Complaint.

77. The DOC policy and DPH regulations speak for themselves. The defendants deny the remaining allegations contained in paragraph 77, except to admit that for a three-day period during the weekend of April 4 through April 6, 2020, there were no groups held at MASAC as a Department-wide lockdown took effect and a new operational plan was developed and on April 7, 2020, the facility modified the daily facility and program schedule.

78. The defendants deny the allegations contained in paragraph 78, except to admit that prior to April 2, 2020, newly admitted patients were most often housed in the C-Dorm Ward

Room during detoxification. Further answering, defendants state that the DPH sanitation inspection speaks for itself.

79. The defendants deny the allegations set forth in paragraph 79 of the Complaint as the C-Dorm Ward is currently not in use.

80. The defendants deny the allegations contained in paragraph 80 of the Complaint as patients are not currently double bunked. Further answering, defendants state that the DPH standards speak for themselves.

81. The defendants deny the allegations contained in paragraph 81 of the Complaint, except to admit that for a three-day period during the weekend of April 4 through April 6, 2020 movement was generally restricted to use of the bathroom, to receive medication, or to use the telephone.

82. The defendants deny the allegations contained in paragraph 82 of the Complaint, except to admit that most patients take some kind of medication.

83. The defendants deny the allegations contained in paragraph 83, except admit that patients are required to bring their personally issued soap to the bathroom and are not provided with masks.

84. The defendants deny the allegations contained in paragraph 84 of the Complaint.

85. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 85 of the Complaint and they are therefore denied. Further answering, defendants state that G.L. c. 123, § 35 speaks for itself.

86. The allegations contained in this paragraph state conclusions of law to which no responsive pleading is required. Further answering, defendants state that G.L. c. 123, § 35 speaks for itself. Defendants admit that release reviews for patients who have not

satisfactorily completed programming as determined by clinical staff and who do not have an adequate discharge plan, have not been released prior to a thirty day review.

CLASS ACTION ALLEGATIONS

87. The defendants deny the allegations set forth in paragraph of the Complaint. Further answering, the defendants assert that the class should not be certified and that the named plaintiffs are not appropriate class representatives in any event.

88. Paragraph 88 sets forth plaintiffs' claims seeking to represent individuals as a class action, to which no response is required. Defendants further assert that the requested class should not be certified.

89. Defendants deny the allegations set forth in paragraph 89 of the Complaint. Further answering, the defendants assert that the class should not be certified.

90. Defendants deny the allegations set forth in paragraph 90 of the Complaint.

91. Defendants deny the allegations set forth in paragraph 91 of the Complaint.

92. Defendants deny the allegations set forth in paragraph 92 of the Complaint.

93. Defendants are without sufficient knowledge or information to admit or deny the allegations set forth in paragraph 93 of the Complaint and they are therefore denied.

CLAIMS FOR RELIEF

First Cause of Action

Violation of the Rights of Incarcerated Persons As Guaranteed by Articles 1, 10, 12, and 26 of the Massachusetts Declaration of Rights

94. Defendants incorporate by reference their responses to paragraphs 1 through 93 of the Complaint.

95. Defendants deny the allegations set forth in paragraph 95 of the Complaint.

Second Cause of Action

Violation of the Rights of Incarcerated Persons under the Eighth and Fourteenth Amendments of the U.S. Constitution

96. Defendants incorporate by reference their responses to paragraphs 1 through 93 of the Complaint.

97. Defendants deny the allegations set forth in paragraph 97 of the Complaint.

Third Cause of Action

Violation of the Rights of Persons Incarcerated under G.L. c. 123, § 35, under Substantive Due Process Provisions of the Massachusetts Declaration of Rights and the U.S. Constitution

98. Defendants incorporate by reference their responses to paragraphs 1 through 93 of the Complaint.

99. Defendants deny the allegations set forth in paragraph 99 of the Complaint.

100. Defendants deny the allegations set forth in paragraph 100 of the Complaint.

101. Defendants deny the allegations set forth in paragraph 101 of the Complaint.

102. Defendants deny the allegations set forth in paragraph 102 of the Complaint.

PRAYERS FOR RELIEF

1. Paragraph 1, a. through e., sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.
2. Paragraph 2 sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.
3. Paragraph 3, a. through f., sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.
4. Paragraph 4, a. through f., sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.

5. Paragraph 5 sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.
6. Paragraph 6 sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.
7. Paragraph 7 sets forth plaintiffs' claims for relief to which no response is required. Defendants further deny that plaintiffs are entitled to the relief requested.

AFFIRMATIVE DEFENSES

First Defense

Plaintiffs' Complaint fails to state a claim upon which relief can be granted.

Second Defense

Defendants are entitled to qualified immunity.

Third Defense

By their own acts and omissions, plaintiffs have waived any claims that they have had or may have against the defendants for any of the matters asserted in their Complaint, and, therefore, plaintiffs cannot recover.

Fourth Defense

By their own acts and omissions, plaintiffs are estopped from raising any of the claims they might have had against the defendants for any of the matters asserted in their Complaint.

Fifth Defense

Plaintiffs, through their own acts or omissions, are responsible for any injury suffered by them if any injury actually occurred.

Sixth Defense

Insofar as the defendants are named in their official capacity, the suit is barred by sovereign immunity.

Seventh Defense

The injuries allegedly sustained by the plaintiffs result from dangers, the risk of which the plaintiffs assumed, and therefore, they cannot recover.

Eighth Defense

Any actions taken by the defendants were performed within the scope of their employment, authority and jurisdiction and made in good faith, without malice and without corruption and the defendants are entitled to common law good faith immunity.

Ninth Defense

Plaintiffs' have failed to exhaust their administrative remedies.

Tenth Defense

Plaintiffs' claims are barred, in whole or in part, by the Prison Litigation Reform Act, Pub. L. No. 104-134, 110 Stat. 1321 (1996), amending 42 U.S.C. § 1997(e).

Eleventh Defense

Plaintiffs' claims are barred, in whole or in part, by M.G.L. c. 127, §§ 38(e)-(h).

Twelfth Defense

To the extent that plaintiffs suffered injuries, such injuries or damage were caused by someone for whose conduct the defendants were not and are not legally responsible.

Thirteenth Defense

Plaintiffs do not have standing to bring this Complaint.

Fourteenth Defense

Plaintiffs have failed to allege any physical injuries.

Fifteenth Defense

Defendants reserve the right to add additional defenses.

JURY DEMAND

Defendants claim a trial by jury on all issues so triable.

Respectfully submitted,

NANCY ANKERS WHITE
Special Assistant Attorney General

/s/ Stephen G. Dietrick
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CERTIFICATE OF SERVICE

I, Stephen G. Dietrick, hereby certify, under the penalties of perjury, that on April 24, 2020, I caused a true and accurate copy of the foregoing to be filed and served on all counsel of record by email.

/s/ Stephen G. Dietrick
Stephen G. Dietrick

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK, ss. No. SJC-12935

STEPHEN FOSTER, et al.,)
Plaintiffs,)
)
v.)
)
CAROL MICI, COMMISSIONER OF CORRECTION, et al.,)
Defendants.)

AFFIDAVIT OF CAROL MICI

I, Carol Mici, hereby depose and state as follows:

1. I am the Massachusetts Commissioner of Correction. I was appointed Acting Commissioner of Correction on December 6, 2018, and then appointed Commissioner of Correction on January 22, 2019. I have worked for the Massachusetts Department of Correction (Department) since 1987. The statements in this affidavit are based upon my own personal knowledge, my discussions conducted in the course of my professional duties, and my review of records maintained in the usual course of the Department.
2. As Commissioner, I am responsible for administration of all state correctional facilities. M.G.L. c. 124, § 1.
3. The COVID-19 virus pandemic is affecting all levels of government. Here at the Department, our primary focus during this pandemic has been on the health and safety of inmates and staff.
4. The Department, utilizing external and internal regulation and policy enforcement bodies, provides a safe and hygienic environment for both staff and incarcerated offenders.

5. As detailed more fully below, by utilizing the following agencies, units and staff members, the Department ensures that its diverse infrastructure and facilities are maintained in such a manner as to provide a high standard of quality of life for incarcerated offenders and working conditions for its staff members.
6. The Department's COVID-19 plans and procedures are frequently reviewed and updated to reflect the continual changes in this public health emergency situation.
7. The correctional institutions in the Commonwealth of Massachusetts are subject to external and internal regulations that govern sanitation and hygiene.
8. Externally, the Department of Public Health (DPH) inspects Department of Correction facilities twice per year.
9. These comprehensive DPH inspections are conducted by sanitation code compliance experts. 105 CMR 451.
10. 105 CMR 451 contains standards for diverse operations such as food services, housekeeping, living area requirements, washroom minimum requirements, etc.
11. At the conclusion of these inspections, each institution must submit a plan of corrective action addressing each deficiency cited in the inspection report.
12. These plans of action are submitted to DPH for review and acceptance.
13. Certain DPH regulations are recommendations and not requirements. Among these is 105 CMR 451.320, Cell Size: Existing Facilities, which suggests, but does not require, that each inmate cell be at least 60 square feet.
14. In addition to the external inspections, each institution is required to have a trained environmental health and safety officer (EHSO).

15. Department policy requires that these officers conduct a comprehensive monthly inspection of the entire institution to identify and address sanitation and hygiene concerns.
16. These officers are also tasked with training other institution staff members to conduct required weekly sanitation and hygiene inspections throughout the entire institution.
17. The Department conducts a comprehensive training course for all new EHSOs.
18. Upon the declaration of a State of Emergency by Governor Baker on March 10, 2020, the Department began implementing its COVID-19 epidemic control plans.
19. The Department also used the Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, issued by the Centers for Disease Control and Prevention (CDC) on March 23, 2020 and March 30, 2020, as a guide to implementing procedures for preventing the spread of the virus in its correctional facilities. Exhibit 1.
20. The Department had already implemented most of the recommendations contained in the Interim Guidance. The Department has continued to adjust its operations during the pandemic. Working with its medical providers, the Department has closely followed CDC recommendations, and adapted new procedures as needed.
21. Since March 12, 2020, inmates and staff have received several directives regarding COVID-19 and efforts to prevent its spread.
22. On March 12, 2020, I issued an advisory to employees describing the coronavirus's symptoms, and who was most at risk of exposure. The advisory also provided the necessary steps to be taken to prevent infection by the virus, as detailed by the CDC and the Massachusetts Department of Public Health (DPH). Exhibit 2.

23. On March 13, 2020, I issued a COVID-19 preparedness advisory (in English and Spanish) to all inmates and patients. The advisory assured them that all necessary steps were being taken to provide them with a safe, secure environment. Among the information given to inmates and patients: the importance of frequent hand washing, social distancing, use of soaps and cleaning supplies, availability of additional information about the virus, additional cleaning plans, and access to medical providers. Exhibit 3.

24. On March 20, 2020, I issued a COVID-19 update (in English and Spanish) to all inmates and patients. This update informed inmates that they would be provided two free 30-minute phone calls a week, that phone privileges for inmates serving a loss-of-phone sanction would be restored, that all medical co-pays were waived, the importance of social distancing, and letting them know that mental health services, as always, were available to them. Exhibit 4.

25. Also on March 20, 2020, I issued an update to all staff. Among the steps taken by the Department to assist staff: screening of all staff prior to entry in accordance with CDC/DPH guidelines; limiting of inmate transports and transports between facilities; authorizing staff in areas with high risk of infection to wear personal protective equipment (PPE), based on specific evaluations of need; working with individual facilities to ensure sufficient infectious disease plans are in place; upgraded cleaning/disinfection protocols; determining what staff might telecommute; and allowing staff to bring in their own disinfecting wipes. The March 20, 2020 update also included flyers illustrating the CDC's recommended infection control procedures and the proper use of PPE. Exhibit 5.

26. On March 27, 2020, I issued an updated memo (in English and Spanish) to patients, supplementing my March 20, 2020 memo, informing them that: all staff are required to wear masks; PPE would be provided to inmates at the Massachusetts Treatment Center (MTC) working in infected areas; all persons entering DOC facilities would be screened for health, including self-administered temperature checks; hand sanitizer would now be alcohol based; and attorney visits would continue; inmate transfers and releases would continue. Exhibit 6.
27. Also on March 27, 2020, I issued an update to DOC staff regarding efforts to prevent the virus. Among the steps: delivery of multiple gallons of hand sanitizer to all facilities; screening tents being set up at most facilities; requirement that all staff wear masks while in areas where inmates are active; requirement that all staff take their own temperature before entering a facility; limiting inmate transportation details; upgrading of cleaning plans; and allowing staff to bring their own disinfectant wipes. Exhibit 7.
28. On April 3, 2020, I issued another memo to inmates regarding a 14-day lockdown as a safety precaution. Inmates were reminded that they should reach out to health professionals if they showed and COVID symptoms. Exhibit 8.
29. On April 3, 2020, I issued a poster for staff outlining all the precautions that had been taken to date to protect them and inmates at all facilities. This included PPE distribution, N95 respirators for security staff, screening tents outside each facility, and access to hand sanitizer. It also explained staff requirements such as wearing masks and self-administered temperature testing. Exhibit 9.

30. On April 10, 2020, I issued an information sheet in English and Spanish updating inmates and patients on COVID-19 prevention, including hand-washing, the availability of soap and hand sanitizer, and social distancing. Exhibit 10.
31. In addition to the Department-wide memoranda and flyers, I also issued facility specific memos to inmates and staff indicating the precautions being taken at each facility.
32. On April 1, 2020, in response to an inmate testing positive at MCI-Shirley, I informed inmates that the facility would be locked down for 14 days to prevent the spread of the virus. The inmate testing positive, who contracted the virus while at an outside hospital, was placed in quarantine. The inmates were informed that food and medicine would be provided in housing units, showers and telephone use would be provided, and laundry, mail, and other services would not be interrupted. Additionally, I also reminded inmates of ways to prevent the virus, such as handwashing and social distancing. Exhibit 11.
33. On April 4, 2020, I issued a memo to patients and persons served at Bridgewater State Hospital (BSH) that movement would be restricted for 14 days to slow the spread of the virus and prevent infection. Patients were also reminded to wash their hands frequently and to keep their living areas clean and sanitary. Exhibit 12.
34. On April 3, 2020, Secretary of Public Safety Thomas Turco informed DOC staff that priority COVID-19 testing would begin on April 5, 2020 for correction officers who were experiencing one or more specific symptoms of the virus. Exhibit 13.
35. On April 7, 2020, Secretary Turco notified DOC staff that testing sites would assist correction officers, regardless of whether they had symptoms of COVID. Exhibit 14.
36. On April 22, 2020, all inmates at MCI-Framingham and South Middlesex Correctional Center were offered voluntary COVID-19 testing via mobile testing. Of the 191 inmates

at MCI-Framingham, 123 agreed to be tested. At South Middlesex Correctional Center, 46 of 52 inmates agreed to be tested.

37. On April 24, I issued a memo to staff, alerting them that, beginning April 25, 2020, mobile testing sites are being set up at MCI-Shirley and then the Massachusetts Treatment Center. Voluntary testing will be available for all staff and inmates. Exhibit 15.

38. As of April 23, 2020, 136 inmates and 72 staff across 16 DOC facilities have tested positive for the virus.

39. As of April 23, 2020, of those who contracted the virus, 10 inmates and 17 staff have recovered.

40. Should additional inmates test positive, DOC has plans in place to designate additional areas for quarantine and isolation purposes.

41. Additionally, the Department delivered a shipment of surgical masks to all superintendents this afternoon for distribution to the inmate/civil populations. Each inmate/civil commitment will receive a mask. The receiving facilities (MCI Cedar Junction, MCI Framingham, and MASAC) will receive an additional 100 masks, each of which is intended to be used for any new admissions going forward.

<u>COVID Prevention and Inmate Care</u>

42. Under procedures enacted in response to COVID-19, all persons entering a correctional facility—whether employee, vendor, contractor, or attorney—must successfully pass an enhanced entrance screening prior to access being granted. Exhibit 7.

43. Each facility has reduced access points to one Single Point of Entry (SPE). The National Guard has assisted the Department at the SPEs by setting up tents, generators, lighting, and heaters to run the SPE. Exhibit 7.
44. At the SPE, a staff member and a manager are assigned to supervise an entrance screening of every individual seeking entrance into the facility.
45. Staff members assigned to the SPE are clothed in PPE consisting of gloves and a mask.
46. Screening is based on CDC/DPH recommendations, and consists of a series of health-related questions and a self-administered non-intrusive temperature check for fever conducted by the employee, visitor, or vendor. Exhibit 16.
47. Each person entering is required to fill out the questionnaire and a thermometer is available for each employee to take their own temperature. The thermometer is disinfected between each use. Exhibit 16.
48. Completed questionnaires are handed to the on-site manager and upon review, the manager makes the final determination to approve/deny the person entrance.
49. No person with a temperature reading above 99.9 degrees Fahrenheit is permitted to enter the facility. Any person denied entrance is advised to consult with a medical professional. Exhibit 16.
50. All correctional and medical staff are wearing appropriate PPEs. Masks are mandatory for all staff working in facilities. Supervisors and security personnel are monitoring PPE use to ensure compliance by all staff. Visitors are also required to wear masks.
51. All non-attorney visits were suspended, to prevent visitors from introducing COVID-19 into the facilities. See Mass.gov/DOC.

52. Due to COVID-19, all new inmate admissions are being quarantined for 14 days as a precaution.

53. Inmates suspected of COVID-19 infection are quarantined away from the general population, meaning they are placed in a separate housing unit set aside only for inmates who have tested positive or who are suspected of having the virus.

54. Inmates testing positive for COVID-19 are being housed away from uninfected inmates.

55. Units housing COVID-19-positive inmates are quarantined.

56. To the extent possible in correctional facilities, the Department is meeting its responsibility to enable social distancing. In addition to the memos issued to inmates and staff, I have discussed social distancing with the Assistant Deputy Commissioners of the north and south sectors, and issued a directive that superintendents were to remind inmates to socially distance from one another.

57. Inmates in two-person cells are sleeping head to foot to limit exposure to one another, per CDC guidelines.

58. Alcohol-based hand sanitizer is available for staff and inmates. Facilities receive regular deliveries of hand sanitizer.

59. Inmates are being served their meals in their cells to avoid gathering them in inmate dining halls.

60. Medication lines have largely been eliminated. At most facilities, all medications are being provided either in cell or on a one-person-at-a-time basis in a common area. Inmates must wear masks and stand at least six feet away from each other. All medical staff wear appropriate PPE when interacting with others, as recommended by the CDC and other health officials. Exhibit 17.

61. Inmates requiring insulin are either injected by medical staff in their cells or individually in a private, secure area. Medical personnel change their gloves before injecting each inmate.

62. Inmates continue to have access to timely, appropriate medical care, and may request to see medical professionals at any time. The same is true of inmates' mental health needs. Inmates are frequently reminded that mental health care is available to them.

63. Prison recreation areas, such as gymnasiums, have been closed to prevent close contact between groups of inmates.

64. Wellpath providers are closely following CDC and DPH protocols for the prevention and treatment of COVID-19. Exhibit 17.

65. This includes procedures for PPE use, triage and quarantine for inmates who may have contracted the virus, protection for health care and correction staff, and techniques for preventing COVID's spread. Exhibit 17.

66. These procedures include detailed instructions for health care providers regarding the proper way to use masks and gloves, and how to avoid potential contact with COVID-infected areas. Exhibit 17.

67. Based on its own testing and observations, Wellpath's guidelines for returning potentially COVID-positive inmates to general population are more stringent than those recommended by the CDC. Exhibit 18.

68. The CDC suggests that a person who shows no symptoms after 72 hours may be returned to population; Wellpath has determined that it will not return an inmate until 7 days after they are asymptomatic. Exhibit 18.

69. The mental health of quarantined inmates is a concern for both DOC and Wellpath, and protocols have been initiated to ensure inmates receive optimum mental health care, as needed, while quarantined.

70. When an inmate is quarantined due to either testing positive or pending test results for the Coronavirus, the medical or mental health team leader immediately notifies the mental health director (MHD) or his or her designee. Exhibit 19. DPH is also notified.

71. The MHD or designee conducts a chart review of the inmate, including whenever possible a triage with the inmate's direct providers (e.g., primary care provider, assigned psychiatrist, medical staff who have interacted with the patient most recently, etc.) to establish/update working knowledge of their diagnosis, risk factors, likelihood of accessing mental health if needed, and current mental status. Exhibit 20.

72. Based on a triage with the MHD (or designated mental health leader), mental health staff determines whether an inmate needs an emergent mental health assessment. If the determination is indeed that this inmate needs to be seen emergently by mental health, mental health staff will provide an assessment, carefully observing safety protocols. Exhibit 20.

73. The on-site mental health department continues to monitor these inmates over the course of their quarantine/illness to provide ongoing clinical consultation and assessment for them. For some inmates, the determination may be that they need more frequent evaluation while for others the determination may be that they can be seen per typical crisis protocols until normal mental health operations resume. Exhibit 20.

Cleaning and Disinfection of Facilities

74. Frequent cleaning of areas accessible to inmates and staff is among the most important defenses against COVID-19, according to the CDC.

75. As a primary mechanism to ensure sanitation, each correctional facility is required by Department policy to create a housekeeping schedule.

76. These housekeeping plans outline cleaning schedules for all areas, instructions on proper cleaning, and specific assignments and duties.

77. Per the CDC recommendations, ongoing cleaning is happening at all facilities, with inmates and staff ensuring, as much as practicable, that sufficient amounts of bleach and other cleaners are used to kill the virus and prevent its spread.

78. Inmate showers, restrooms, and sinks are kept clean and sanitary. Each facility has implemented protocols for frequent cleaning and disinfecting, during the day and after hours.

79. Additionally, at all facilities, inmate common areas and high-touch areas are frequently cleaned and disinfected with bleach and disinfectants. Facility staff is using sprayers to ensure large areas are regularly disinfected, and Kaivac machines with high-powered sprays and disinfectants are used multiple times a week.

80. At all facilities, high-touch areas are sprayed daily with disinfectant and correction officers disinfect high-touch surfaces in the living units.

81. Cleaning supplies are readily available to inmates daily for use in their cells.

82. Cleaning supplies are available in all inmate restrooms and shower facilities, for inmates to use in cleaning after each use. Inmate workers are disinfecting showers and bathrooms every evening.

83. Inmates are required to clean phones with provided disinfectant before and after each use.

84. Inmates are also being provided with bar soap, and are being told that they may request additional soap as needed. Alcohol-based hand sanitizer is readily available to inmates and staff in all areas of the facilities.

MASAC and Hampden County Treatment Facilities

85. The Massachusetts Alcohol and Substance Abuse Center in Plymouth (MASAC), Massachusetts is operated by the Department of Correction. It is a secure facility that houses men civilly committed pursuant to G.L. c. 123, § 35 due their substance use disorder. The Department of Correction has entered into a Memorandum of Understanding with the Hampden County Sheriff's Department to treat and house Section 35 commitments from the counties of Hampden, Hampshire, Franklin, Berkshire and Worcester in two facilities operated by the Hampden County Sheriff, Stonybrook Springfield and Stonybrook Ludlow (Hampden). In 2019, the number of Section 35 commitments to MASAC at Plymouth and Hampden totaled 1643.

86. Although the census at MASAC and Hampden was respectively 159 patients and 108 patients on March 13, 2020, as of April 23, 2020 there are 28 committed patients at MASAC, an 82 percent decline, and 46 committed patients at Hampden, a 57.5 percent decline. Since March 13, 2020, there have been 14 new admissions to MASAC and 31 new admissions to Hampden. The courts, not the Department of Correction, determine the secure facility to which a person is committed with the assistance of expert testimony.

87. As of April 23, 2020, with unlimited testing capacity, no patient has had a positive test result for COVID-19 at either MASAC or Hampden.

88. Patients on each unit continue to have access to substance abuse groups, activity groups, and open recreation activities on a rotating basis.

89. On March 30, 2020, the size of group programs was reduced to 15 patients per group to allow for social distancing. This required a temporary reduction in structured substance abuse groups to two per day, one in the morning and one in the afternoon. In addition, patients were provided with homework and individual sessions with Substance Abuse Counselors or Mental Health Professionals.

90. Patients are seen individually on a daily basis by Substance Abuse Counselors and are routinely seen by Mental Health Professionals as all patients are viewed as open mental health cases.

91. During these sessions treatment materials are reviewed, reentry plans developed, and coping skills learned.

92. During the week of March 30 through April 3, 2020, patients had the opportunity to participate in a minimum of five hours of treatment each day.

93. For a three-day period during the weekend of April 4 through April 6, 2020 there were no groups held as a Department-wide lockdown took effect and a new operational plan was developed.

94. On April 7, 2020, the size of group programs was further reduced to 10 patients. That same day group activity was restricted so that patients from different housing units did not attend groups together to further reduce the risk of virus spread.

95. The census continued to decrease, and as of approximately April 15, 2020, each patient was able to attend four structured groups instead of two per day. Patients continue to be

provided with homework packets containing materials related to substance use treatment, mental health, and wellness.

96. In addition to structured groups, daily individual appointments with Substance Use Counselors and routine sessions with Mental Health Professionals are provided. Including all of these modalities, the current total treatment time provided per patient is seven hours per day.

97. The Superintendent of MASAC monitors patient participation in groups and, based upon the satisfactory completion of programming, as recommended by clinical staff, an adequate discharge plan determines whether a patient meets the criteria for release.

98. Most civil commitments are currently released around the thirty day point of their commitment.

99. All correction officers will be removed from MASAC on May 10, 2020.

Medical Parole

100. G.L. c. 127, § 119A permits inmates who are "terminally ill or permanently incapacitated" to petition for release from custody on medical parole. Per the statute, "[i]f the commissioner determines that a prisoner is terminally ill or permanently incapacitated such that if the prisoner is released the prisoner will live and remain at liberty without violating the law and that the release will not be incompatible with the welfare of society, the prisoner shall be released on medical parole." G.L. c. 127, § 119A(e). Exhibit 21.

101. Upon receipt of a medical parole petition, the superintendent completes a public safety risk assessment by reviewing the inmate's file for criminal and institutional history, including circumstances of the crime, disciplinary and classification reports, and the inmate's participation in education, work and recommended programming. At the same

time, the Department's contracted medical provider, Wellpath, is asked to provide an updated clinical review as to the inmate's medical condition.

102. The medical parole statute contains definite timelines: the superintendent must issue a recommendation to me "*not more than* 21 days after receipt of the petition" and "[t]he commissioner shall issue a written decision *not later than* 45 days after receipt of a petition" (italics added). Exhibit 21.4

103. These timelines only represent the outer limit of what is permitted; there is nothing preventing superintendents from exercising their discretion and making recommendations in less than 21 days; nor am I prohibited from rendering my decision in less than 45 days. Department staff typically expedites decisions on medical parole petitions if the inmate's condition is significantly dire.

104. Pursuant to the statute, petitioner's victims and District Attorney (DA) offices have the right to submit written statements or, where a murderer is under consideration, request a hearing.

105. In order to expedite the process, I am requiring victims and DAs' offices wishing to submit statements for or against the medical parole, or to request a hearing, to respond within five business days of notification that the petition is under consideration. Since March 10, 2020, I have granted nine inmate petitions for medical parole. Of these, seven inmates have been released and two more are awaiting community placement.

Inmate Processing

106. Inmates are processed in accordance with the Department's Booking and Admissions policy, 103 DOC 401. Exhibit 22.

107. The Booking and Admissions policy requires that incoming inmates receive a medical, dental and psychological screening. Exhibit 22.

108. This screening is done in accordance with the Department's Medical Service policy, 103 DOC 630, which requires thorough medical screening and physical examination. Exhibit 23.

109. This screening includes the questions asked of anybody entering the facility, and should determine whether any new admissions are at risk of COVID-19. Exhibit 23.

110. All new commitments to the Department receive a complete physical examination American Correctional Association and N.C.C.H.C. standards, as well as the contract between the Department and its medical vendor.

111. Finally, both the Booking and Admissions and Medical Services policy provide for the quarantining of incoming inmates with proper medical authorization. Exhibits 26 and 27.

Signed under pains and penalties of perjury this 24th day of April 2020,

Carol A. Mici

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

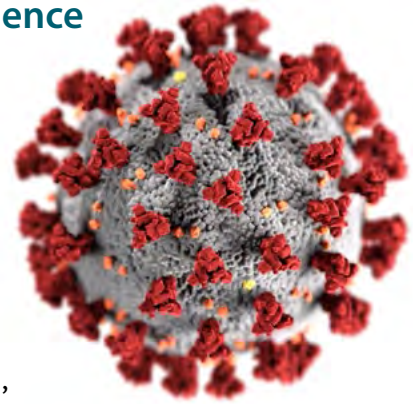
The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

In this guidance

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

Who is the intended audience for this guidance?



This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., US Immigration and Customs Enforcement and US Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of COVID-19 in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. **The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

Exhibit 1.1

CS 316182-A 03/27/2020

Why is this guidance being issued?

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

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

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

Exhibit 1.2

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

What topics does this guidance include?

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

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

Definitions of Commonly Used Terms

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

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

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

Exhibit 1.3

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

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

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

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

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

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

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

Facilities with Limited Onsite Healthcare Services

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

Exhibit 1.4

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

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

COVID-19 Guidance for Correctional Facilities

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

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

Operational Preparedness

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

Communication & Coordination

√ **Develop information-sharing systems with partners.**

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

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
- Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

√ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**

- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
- Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
- Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
- Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.

√ **Coordinate with local law enforcement and court officials.**

- Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
- Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.

√ **Post signage throughout the facility communicating the following:**

- **For all:** symptoms of COVID-19 and hand hygiene instructions
- **For incarcerated/detained persons:** report symptoms to staff
- **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
- Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

√ **Review the sick leave policies of each employer that operates in the facility.**

- Review policies to ensure that they actively encourage staff to stay home when sick.
- If these policies do not encourage staff to stay home when sick, discuss with the contract company.
- Determine which officials will have the authority to send symptomatic staff home.

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

Operations & Supplies

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

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
- Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

√ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**

- See CDC guidance optimizing PPE supplies.

√ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.

√ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)

- Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.

√ **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**

√ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

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

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

Operations

√ **Stay in communication with partners about your facility's current situation.**

- State, local, territorial, and/or tribal health departments
- Other correctional facilities

√ **Communicate with the public about any changes to facility operations, including visitation programs.**

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

Cleaning and Disinfecting Practices

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

Hygiene

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

Prevention Practices for Incarcerated/Detained Persons

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

- **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**
  - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

√ **Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

- **Common areas:**
  - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
- **Recreation:**
  - Choose recreation spaces where individuals can spread out
  - Stagger time in recreation spaces
  - Restrict recreation space usage to a single housing unit per space (where feasible)
- **Meals:**
  - Stagger meals
  - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
  - Provide meals inside housing units or cells
- **Group activities:**
  - Limit the size of group activities
  - Increase space between individuals during group activities
  - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
  - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
- **Housing:**
  - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
  - Arrange bunks so that individuals sleep head to foot to increase the distance between them
  - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
- **Medical:**
  - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
  - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

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

Prevention Practices for Staff

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

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

Prevention Practices for Visitors

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

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

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

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

Management

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

Operations

√ **Implement alternate work arrangements deemed feasible in the** Operational Preparedness **section.**

√ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**

- o If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.

√ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.

√ **When possible, arrange lawful alternatives to in-person court appearances.**

√ **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**

- o Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
  - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
  - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
  - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

- √ **Coordinate with state, local, tribal, and/or territorial health departments.**
  - o When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below.
  - o When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below.
  - o Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See Facilities with Limited Onsite Healthcare Services section.

Hygiene

- √ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)
- √ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

- √ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)
- √ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

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

- √ **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**
- √ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**
  - o Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
  - o Serve meals to cases inside the medical isolation space.
  - o Exclude the individual from all group activities.
  - o Assign the isolated individual a dedicated bathroom when possible.
- √ **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.
- √ **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** Cohorting should only be practiced if there are no other available options.

- If cohorting is necessary:
  - **Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
  - Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection.
  - Ensure that cohorted cases wear face masks at all times.

√ **In order of preference, individuals under medical isolation should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements
  (NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative.

√ **If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)

- Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
- Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.

√ **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.

√ **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**

√ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:

- **Cover** their mouth and nose with a tissue when they cough or sneeze
- **Dispose** of used tissues immediately in the lined trash receptacle
- **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

√ **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria.**

For individuals who will be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart

For individuals who will NOT be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- At least 7 days have passed since the first symptoms appeared

For individuals who had a confirmed positive COVID-19 test but never showed symptoms:

- At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
- The individual has had no subsequent illness

√ **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**

- If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.

- Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
- Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).

√ **Hard (non-porous) surface cleaning and disinfection**

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

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

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

√ **Electronics cleaning and disinfection**

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

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

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

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

√ Laundry from a COVID-19 cases **can be washed with other individuals' laundry.**

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

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

√ **Consult** cleaning recommendations above **to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

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

√ **Incarcerated/detained persons who are close contacts of a** confirmed or suspected COVID-19 case **(whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**

- If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.

√ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**

- Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
- Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

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

√ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**

- Provide medical evaluation and care inside or near the quarantine space when possible.
- Serve meals inside the quarantine space.
- Exclude the quarantined individual from all group activities.
- Assign the quarantined individual a dedicated bathroom when possible.

√ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.

- If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation immediately.
- If an entire housing unit is under quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
- Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.

- If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.

√ **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.)

√ **In order of preference, multiple quarantined individuals should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements

(NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

√ **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see PPE section and Table 1):

- If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
- If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
- All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
- Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.

√ **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).

- Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.

- √ **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - o If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical Isolation section above.)
  - o See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- √ **If an individual who is part of a quarantined cohort becomes symptomatic:**
  - o **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - o **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
  - o **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- √ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- √ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- √ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- √ **Laundry from quarantined individuals can be washed with other individuals' laundry.**
  - o Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
  - o Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - o Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - o Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

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

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

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

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

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

Management Strategies for Staff

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

Infection Control

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

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

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).

√ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).

√ **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

√ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**

- If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
- The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.

√ **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**

√ **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask.**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.

√ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**

√ **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**

√ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

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

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

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program.
- For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.

√ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**

√ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (**see Table 1). **Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**

√ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**

√ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**

See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.

- **Face mask**
- **Eye protection—**goggles or disposable face shield that fully covers the front and sides of the face
- **A single pair of disposable patient examination gloves**

Gloves should be changed if they become torn or heavily contaminated.

- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
  - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.

√ **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**

- **Guidance in the event of a shortage of N95 respirators**
  - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
- **Guidance in the event of a shortage of face masks**
- **Guidance in the event of a shortage of eye protection**
- **Guidance in the event of a shortage of gowns/coveralls**

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	–	✓	–	–	–
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)	–	Face mask, eye protection, and gloves as local supply and scope of duties allow.			–
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons	–	✓	✓	✓	✓
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	✓**		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	✓	–	✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Exhibit 1.25

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, and visitors who enter correctional and detention facilities, as well as incarcerated/detained persons who are transferred to another facility or released from custody. Below, verbal screening questions for COVID-19 symptoms and contact with known cases, and a safe temperature check procedure are detailed.

- √ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**
  - *Today or in the past 24 hours, have you had any of the following symptoms?*
    - *Fever, felt feverish, or had chills?*
    - *Cough?*
    - *Difficulty breathing?*
  - *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*
- √ **The following is a protocol to safely check an individual's temperature:**
  - Perform hand hygiene
  - Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
  - Check individual's temperature
  - **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
  - Remove and discard PPE
  - Perform hand hygiene

Exhibit 1.26

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TO: All DOC Employees

FR: Carol A. Mici, Commissioner

DA: March 12, 2020

RE: Coronavirus (COVID-19) Employee Advisory

Governor Baker has recently announced a state of emergency (see attached link: https://www.mass.gov/executive-orders/no-591-declaration-of-a-state-of-emergency-to-respond-to-covid-19) regarding the Coronavirus (COVID-19). In conjunction with the Governor's announcement, and in an effort to mitigate the spread of the Coronavirus (COVID-19), we are taking the following proactive steps at the Massachusetts Department of Correction. The actions noted below are being implemented to ensure our work environment is safe for staff, visitors and incarcerated individuals.

The following precautionary measures are effective immediately until further notice:

Facilities:

• Facilities are required to actively screen and restrict anyone, visitors and staff, who meet the following criteria.

- Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat.
- In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory illness.
- International travel within the prior 14 days to countries with sustained community transmission. For updated information on affected countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html.
- Residing in a community where community-based spread of COVID-19 is occurring.

Exhibit 2.1

If a visitor shows the above signs or symptoms, or answers in the affirmative to the other questions, the Shift Commander/building supervisor should be called and the person should not be allowed into the facility/building. An incident report should be authored.

In the event staff meet the above criteria, they must contact his/her supervisor BEFORE attempting to return to work. The supervisor shall advise the employee not to return to work until contacting the local Department of Public Health in order to be cleared for return to work. You can find your local Public Health department by accessing this link: https://www.naccho.org/membership/lhd-directory.

The employee must have a document from a qualified medical provider, the CDC or the Public Health department stating that they are cleared from infection by the Coronavirus (COVID-19) before returning to work.

The employee is allowed to use any paid time off during the quarantine period (vacation, sick, PTO, LTI, FH, etc.) unless otherwise addressed by state law.

Employee Travel, Conferences, Seminars, and Meetings:

•All work-related travel is to be discontinued until further notice. Staff with outstanding travel commitments or concerns about cancelling scheduled travel should bring such concerns to the attention of their Facility or Division head. The Governor, along with public health officials, strongly encourages individuals to avoid any personal international travel.

•All work-related conferences, seminars and large-scale gatherings hosted by DOC involving external participants are to be held virtually or cancelled.

•Employees should not attend external work-related conferences, seminars and large-scale gatherings and instead should attempt to participate remotely, if feasible.

•Regular internal business shall continue, including but not limited to mandated public hearings and board meetings. Meeting organizers are encouraged to utilize alternatives like conference calls, WebEx and other group communication tools.

Employee Self-Care:

•Employees feeling sick with fever or flu symptoms (fever with cough and/or sore throat) should not report to work and should immediately contact their health care provider for guidance and further instruction. If the recommendation of a health care provider is that the employee remain at home, then current DOC policies regarding sick time usage remain in effect. Employees should also immediately report this information to HR Director Kelley Correira.

•Regular internal work shall continue and employees are required to report to work unless they are feeling sick with fever or flu symptoms as noted above.

•Employees are strongly encouraged to practice proper self-care and hygiene including, but not limited to, the following to ensure a safer workplace:

*Regular handwashing with soap and warm water for at least 20 seconds, especially after sneezing, coughing or touching the face.
*Use alcohol-based sanitizing gel on your hands when handwashing is not viable.
*Sneeze/cough into a tissue or inner elbow and NOT your hands. Avoid touching your eyes, nose or mouth.
*Avoid close contact with individuals with fever or flu symptoms (fever with cough and/or sore throat).

•Employees who have traveled internationally since February 28, 2020 and/or who have come in contact with individuals who have traveled internationally since February 28, 2020, should contact their health care provider for guidance and further instruction.

•All staff are asked to self-disclose to the Department and their direct supervisor if they have traveled to or through COVID-19 risk areas. This includes those areas the Centers for Disease Control and Prevention (CDC) define as:

- Warning Level 3, Avoid Nonessential Travel
- Alert Level 2, Practice Enhanced Precautions
- Watch Level 1, Practice Usual Precautions

These Levels can change without notice based on the CDC Travel Health Notices and are posted here: https://wwwnc.cdc.gov/travel/notices.

Additional information will be communicated to all staff on further developments. Thank you for your cooperation as we continue to work together to address the evolving challenges of the Coronavirus.

Coronavirus (COVID-19)

The Center for Disease Control (CDC) is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in almost 90 locations internationally, including in the United States. The virus has been named "SARS-CoV-2" and the disease it causes has been named "coronavirus disease 2019" (abbreviated "COVID-19").

Coronaviruses are respiratory viruses and are generally spread through respiratory secretions (such as droplets from coughs and sneezes) of an infected person to another person. Information about how this novel coronavirus spreads is still limited. Symptoms of this infection include:

- fever
- coughing
- shortness of breath
- in severe cases, pneumonia (infection in the lungs).

Although risk to Massachusetts residents from 2019 Novel Coronavirus is low, the same precautions to help prevent colds and the flu can help protect against other respiratory viruses:

- Wash your hands often with soap and warm water for at least 20 seconds.
- Cover your coughs and sneezes.
- Stay home if you are sick.

All staff are asked to self-disclose to the Department and their direct supervisor if they have traveled to or through COVID-19 risk areas. This includes those areas the Centers for Disease Control and Prevention (CDC) define as:

- Warning Level 3, Avoid Nonessential Travel
- Alert Level 2, Practice Enhanced Precautions
- Watch Level 1, Practice Usual Precautions

These Levels can change without notice based on the CDC Travel Health Notices and are posted here: https://wwwnc.cdc.gov/travel/notices .

Facilities are required to actively screen and restrict anyone who meets the following criteria. In the event staff can answer in the affirmative to any of the following question, they must contact his/her supervisor BEFORE attempting to return to work:

- Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat.
- In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory illness.
- International travel within the prior 14 days to countries with sustained community transmission. For updated information on affected countries, visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html.
- Residing in a community where community-based spread of COVID-19 is occurring.

The supervisor shall advise the employee not to return to work until contacting the local Department of Public Health in order to be cleared for return to work. You can find your local Public Health department by accessing this link: https://www.naccho.org/membership/lhd-directory.

The employee must have a document from a qualified medical provider, the CDC or the Public Health department stating that they are cleared from infection by the Coronavirus before returning to work.

Employee is allowed to use any paid time off during the quarantine period (vacation, sick, PTO, LTI, FH, etc.) unless otherwise addressed by state law.

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TO: All Inmate Population

FROM: Carol A. Mici, Commissioner Carol A. Mici

DATE: March 13, 2020

RE: COVID-19 Preparedness

While we are currently experiencing an unprecedented situation with a declared International pandemic, my primary focus is on the health and safety of staff and inmates of the Department of Correction. It is important to me that you are kept informed of all of the steps we are taking toward this important goal. The situation is fluid and I will continue to make assessments, consult my team and the Department of Public Health and Center for Disease Control for necessary change and best practices. I want to assure you that we are not panicked, but we are prepared.

- Our agency has and will continue to use the same precautions to help the spread of germs like proper hand washing, covering coughs and sneezes.
- Dedicated staff members are trained in the prevention and containment of infectious diseases and educational flyers are posted for all to prevent the spread of infectious disease, including COVID-19.
- Access to soap and cleaning supplies is available to the inmate population.
- Additional cleaning and disinfecting of facilities is being completed with a focus on high-touch areas.
- Inmates are being screened upon admission and upon transferring to another jurisdiction.
- We have limited all non-essential entrance into facilities. While this has affected volunteer services and family and friend visiting, I have approved 2 free phone calls per inmate/per week to ensure family ties and support remain intact without placing an extra financial burden on your loved ones.
- Attorney visits are not currently affected.
- Any person who enters a facility is required to self-report if they have had recent travel in a high risk area or if they have been in direct contact or exposed to someone who is suspected of having or has a confirmed diagnosis of COVID-19.
- Inmate access to healthcare will continue to meet or exceed national standards.

I thank you all for your cooperation during this time, and I assure you that we are prepared to continue to provide a safe, secure environment for all.

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A: Toda La Población de Presos

DE: Carol A. Mici, Comisionada Carol A. Mici

FECHA: 13 de marzo de 2020

RE: Preparación Para COVID-19

Actualmente estamos experimentando una situación sin precedentes con una pandemia internacional declarada, mi enfoque principal es la salud y la seguridad del personal y los presos/presas del Departamento de Corrección. Es importante para mí que esté informado de todos los pasos que estamos tomando para alcanzar este importante objetivo. La situación es fluida y continuaré haciendo evaluaciones, consulte a mi equipo, al Departamento de Salud Pública y al Centro para el Control de Enfermedades para conocer los cambios necesarios y las mejores prácticas. Quiero asegurarles que mientras estamos preparados, no estamos en pánico.

- Nuestra agencia tiene y seguirá usando las mismas precauciones para ayudar a la propagación de gérmenes, como lavarse las manos adecuadamente, cubrirse la tos y los estornudos,
- El personal dedicado está capacitado en la prevención y contención de enfermedades infecciosas y se publican folletos educativos para todos para prevenir la propagación de enfermedades infecciosas, incluido COVID-19.
- El acceso a jabón y artículos de limpieza está disponible para la población de presos y presas.
- Se está completando la limpieza y desinfección adicional de todas las instituciones correccionales con un enfoque en áreas de alto contacto.
- Los presos/presas están siendo evaluados al momento de la admisión y al ser transferidos a otra jurisdicción.
- Hemos limitado todas las entradas no esenciales a todas las instituciones correccionales. Se que esto ha afectado los servicios voluntarios y las visitas de familiares y amigos, y he aprobado dos (2) llamadas telefónicas gratuitas por preso/presa por semana para garantizar que los lazos familiares y el apoyo permanezcan intactos sin poner una carga financiera adicional para sus seres queridos.
- Las visitas de abogados no están afectadas actualmente.
- Cualquier persona que ingrese a una institucion correccional debe autoinformarse si ha viajado recientemente en un área de alto riesgo o si ha estado en contacto directo o expuesto a alguien sospechoso de tener un diagnóstico confirmado de COVID-19.
- El acceso de los presos/presas a la atención médica seguirá cumpliendo o superando los estándares nacionales.

Les agradezco a todos por su cooperación durante este tiempo y les aseguro que estamos preparados para continuar brindando un entorno seguro para todos.

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JENNIFER A. GAFFNEY
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PAUL J. HENDERSON
THOMAS J. PRESTON
Deputy Commissioners

TO: All Inmates

FROM: Carol A. Mici, Commissioner Carol A Mici

DATE: March 20, 2020

RE: COVID-19 Update

As we continue to maneuver the day to day evolution of managing the COVID-19 virus, I want to take this opportunity to thank you for your cooperation during this unprecedented situation and to provide an update on this very fluid situation.

The Massachusetts Department of Correction (MADOC) continues to closely monitor developments associated with the spread of this virus along with our contracted inmate medical provider. I am confident that our medical vendor Wellpath is prepared and ready to respond as appropriate. The following steps have been taken to ease burdens, protect staff and inmates while maintaining normal operations as much as possible.

- Non-essential entrance into the facility continues to be limited. For those who do need to enter, a screening protocol has been implemented to ensure that no one exhibiting any concerning symptoms is allowed in.
- In addition to the 2 free phone calls per inmate per week, I have reinstated phone privileges to those inmates serving a loss of phone sanction.
- I have waived all medical co-pays until further notice.
- Hand sanitizer pump stations are installed throughout all facilities.
- Attorney visits remain unaffected at this time.
- Inmate transfers continue to occur, particularly transfers to lower security.
- Inmate releases have occurred without interruption.

The experts have emphasized the importance of social distancing. While institutional settings may sometimes be challenging, please do your part. The shaking of hands, hugging, fist bumps, sharing of food/drink etc. should not be happening.

Wash your hands often; if you need more soap, it will be provided to you.

Feeling anxious during these times is normal; however, if you feel you need to talk with someone, I encourage you to reach out to our mental health professionals.

Thank you again for your cooperation during this time. I will continue to provide weekly updates and ask that you continue to work together toward our goal of maintaining a safe, secure environment for all.

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Deputy Commissioners

A: Toda La Población de Presos

DE: Carol A. Mici, Comisionada Carol A Mici

FECHA: 20 de marzo de 2020

RE: COVID-19 Actualizaciones

A medida que continuamos maniobrando la evolución diaria del manejo del virus COVID-19, quiero aprovechar esta oportunidad para agradecerles su cooperación durante esta situación sin precedentes y proporcionarles una actualización sobre esta situación tan fluida.

El Departamento de Corrección de Massachusetts (MADOC) continúa monitoreando los desarrollos asociados con la propagación de este virus junto con nuestro proveedor contratado médico de los presos/presas. Estoy segura de que nuestro proveedor médico Wellpath está preparado y listo para responder según corresponda. Se han tomado los siguientes pasos para aliviar las cargas y proteger al personal y a los presos/presas, mientras se mantienen las operaciones normales tanto como sea posible.

- La entrada no esencial a las instituciones correccionales siguen siendo limitada. Para aquellos que necesitan ingresar, se ha implementado un protocolo de detección para garantizar que nadie que muestre ningún síntoma relacionado esté permitido entrar.
- Además de las 2 llamadas telefónicas gratuitas por preso/presa por semana, he restablecido los privilegios telefónicos a aquellos presos/presas que tienen que cumplir una sanción de pérdida de teléfono.
- He renunciado todos los copagos médicos hasta nuevo aviso.
- Los desinfectante de manos están instaladas en todas las instituciones correccionales.
- Las visitas de abogados no se ven afectadas en este momento.
- Las transferencias de presos continúan ocurriendo, particularmente transferencias a una seguridad más baja.
- Las liberaciones de presos han ocurrido sin interrupción.

Los expertos han enfatizado la importancia del distanciamiento social. Aunque las instituciones correccionales a veces pueden ser desafiantes, haga su parte. No deberían ocurrir saludos de manos, abrazos, chocar los puños, compartir comida / bebida, etc.

Lávate las manos con frecuencia; Si necesita más jabón, se le proporcionará.

Sentirse ansioso durante estos tiempos es normal; sin embargo, si siente que necesita hablar con alguien, te animo a que te comuniques con nuestros profesionales de la salud mental.
Gracias nuevamente por su cooperación durante este tiempo. Continuaré brindando actualizaciones semanales y le pediré que continúen trabajando juntos hacia nuestro objetivo de mantener un entorno seguro para todos.

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Deputy Commissioners

TO: All Patients

FROM: Carol A. Mici, Commissioner Carol A Mici

DATE: March 20, 2020

RE: COVID-19 Update

As we continue to maneuver the day to day evolution of managing the COVID-19 virus, I want to take this opportunity to thank you for your cooperation during this unprecedented situation and to provide an update on this very fluid situation.

The Massachusetts Department of Correction (MADOC) continues to close monitor developments associated with the spread of this virus along with our contracted patient medical provider. I am confident that our medical vendor Wellpath is prepared and ready to respond as appropriate. The following steps have been taken to ease burdens and protect staff and patients, while maintaining normal operations as much as possible.

- Non-essential entrance into the facility continues to be limited. For those who do need to enter, a screening protocol has been implemented to ensure that no one exhibiting any concerning symptoms is allowed in.
- Two free phone calls per patient per week has been initiated.
- Medical co-pays have been waived until further notice.
- Hand sanitizer pump stations are installed throughout all facilities.
- Attorney visits remain unaffected at this time.
- Patient releases have occurred without interruption.

The experts have emphasized the importance of social distancing. While institutional settings may sometimes be challenging, please do your part. The shaking of hands, hugging, fist bumps, sharing of food/drink etc. should not be happening.

Wash your hands often; if you need more soap, it will be provided to you.

Feeling anxious during these times is normal; however, if you feel you need to talk with someone, I encourage you to reach out to our mental health professionals.

Thank you again for your cooperation during this time. I will continue to provide weekly updates and ask that you continue to work together toward our goal of maintaining a safe, secure environment for all.

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A: Todos los Pacientes

DE: Carol A. Mici, Comisionada Carol A Mici

FECHA: 20 de marzo de 2020

RE: COVID-19 Actualizaciones

A medida que continuamos maniobrando la evolución diaria del manejo del virus COVID-19, quiero aprovechar esta oportunidad para agradecerles su cooperación durante esta situación sin precedentes y proporcionarles una actualización sobre esta situación tan fluida.

El Departamento de Corrección de Massachusetts (MADOC) continúa monitoreando los desarrollos asociados con la propagación de este virus junto con nuestro proveedor médico del paciente contratado. Estoy segura de que nuestro proveedor médico Wellpath está preparado y listo para responder según corresponda. Se han tomado los siguientes pasos para aliviar las cargas y proteger al personal y a los pacientes, mientras se mantienen las operaciones normales tanto como sea posible.

- La entrada no esencial a las instituciones correccionales siguen siendo limitada. Para aquellos que necesitan ingresar, se ha implementado un protocolo de detección para garantizar que nadie que muestre ningún síntoma relacionado esté permitido entrar.
- Se iniciaron dos llamadas telefónicas gratuitas por paciente por semana.
- Los copagos médicos se han renunciado hasta nuevo aviso.
- Los desinfectante de manos están instaladas en todas las instituciones correccionales.
- Las visitas de abogados no se ven afectadas en este momento.
- Se han producido liberaciones de pacientes sin interrupción.

Los expertos han enfatizado la importancia del distanciamiento social. Aunque las instituciones correccionales a veces pueden ser desafiantes, haga su parte.. No deberían ocurrir saludo de manos, abrazos, chocar de puños, compartir comida / bebida, etc.

Lávate las manos con frecuencia; Si necesita más jabón, se le proporcionará.

Sentirse ansioso durante estos tiempos es normal; sin embargo, si siente que necesita hablar con alguien, te animo a que te comuniques con nuestros profesionales de la salud mental.

Gracias nuevamente por su cooperación durante este tiempo. Continuaré brindando actualizaciones semanales y le pediré que continúen trabajando juntos hacia nuestro objetivo de mantener un entorno seguro para todos.

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TO: **All DOC Employees**

FR: **Carol A. Mici, Commissioner** Carol A Mici

DA: **March 20, 2020**

RE: **Coronavirus (COVID-19) Employee Advisory**

I want to thank you all for your continued efforts during this time as we manage through the COVID-19 virus pandemic.

The DOC has taken the following steps with regard to staff members at the facilities:

- Relaxed the restriction on bottled water size;
- Screen staff upon entry to all DOC facilities in accordance with CDC/DPH recommendations;
- Worked with hospitals and courts to limit the number of inmate transportation details;
- Limited the number of interagency transfers between facilities;
- Authorized staff working in areas with high risk of infection to wear (PPE) personal protective equipment (this directive may be expanded at specific sites based upon evaluation of ongoing infection rates and quarantine protocols);
- Working with suppliers to source PPE materials, cleaning materials and other items related to the COVID-19 outbreak;
- Developed a specific infectious disease 560 reaction plan at each facility in order to deal with the ongoing threat;
- In the process of scheduling tabletop drills in the upcoming days to identify response and operation flaws that need to be rectified.

- We continue to work closely with the medical vendor to develop response plans as infections develop;
- We have upgraded facility cleaning/disinfecting protocols and will continue to ramp up cleaning as necessary;
- MassCor is packaging sanitizer for first responders;
- Working daily with outside stakeholders to define Core Functions to determine who can work remotely;
- Working with all Unions to address staff complaints and concerns about returning to work i.e. – working remotely, gaining access to VPN, acquiring equipment to be able to work from home;
- In process of gaining Idaptive HR/CMS integration. Idaptive Services is a Multi-Factor Authentication (MFA) method to allow DHR staff access to HR/CMS to increase the amount of time staff are working remotely;
- Posted information on the Intranet regarding Mass 4 you, DHR is posting in common areas and e-mailing the flyer to all Superintendents/Division Heads.
- Tracking self-disclosed quarantined staff;
- Tracking consumption rate of PPE by facility;
- Notified all staff that for pay-period March 1, 2020 – March 14, 2020, OT worked during the second week March 8th through March 14th will be paid in the next possible payroll;
- Exempt Emergency Child Care Program will be posting a list of all approved Day Care providers on Saturday, March 21, 2020. All providers listed will be open for emergency drop in service starting Monday March 23, 2020. Employees are encouraged to exhaust all other avenues; this program is not for everyday daycare. They are encouraging families to try to find non-group settings for day care.
- Staff will be allowed to bring in their own disinfectant wipes if they chose.

Additional information on further developments will be posted on the Intranet to all employees Thank you again for your continued cooperation.

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TO: All Patients

FROM: Carol A. Mici, Commissioner

DATE: March 27, 2020

RE: COVID-19 Update

As we continue to maneuver the day to day evolution of managing the COVID-19 virus, I want to take this opportunity to thank you for your cooperation during this unprecedented situation and to provide an update on this very fluid situation.

The Massachusetts Department of Correction (MADOC) continues to close monitor developments associated with the spread of this virus along with our contracted patient medical provider. I am confident that our medical vendor Wellpath is prepared and ready to respond as appropriate. The following steps have been taken to ease burdens and protect staff and patients, while maintaining normal operations as much as possible.

- All staff and vendors are being screened before being allowed to enter the any DOC facility in accordance with DPH/CDC recommendations.
- Non-essential entrance into the facility continues to be limited. For those who do need to enter, a screening protocol has been implemented to ensure that no one exhibiting any concerning symptoms is allowed in.
- In addition to the 2 free phone calls per patient per week.
- I have waived all medical co-pays until further notice.
- Hand sanitizer pump stations are installed throughout all facilities and pump stations are now being supplied with isopropanol (alcohol based) gel.
- Attorney visits remain unaffected at this time with the exception of the Massachusetts Treatment Center
- Patient releases have occurred without interruption.

The experts have emphasized the importance of social distancing. While institutional settings may sometimes be challenging, please do your part. The shaking of hands, hugging, fist bumps, sharing of food/drink etc. should not be happening.

Wash your hands often; if you need more soap, it will be provided to you. The use of soap and water should be the primary way of cleaning and disinfecting your hands and body.

Feeling anxious during these times is normal; however, if you feel you need to talk with someone, I encourage you to reach out to our mental health professionals.

Thank you again for your cooperation during this time. I will continue to provide weekly updates and ask that you continue to work together toward our goal of maintaining a safe, secure environment for all.

Exhibit 6.1

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Deputy Commissioners

TO: All DOC Employees

FR: Carol A. Mici, Commissioner

DA: March 27, 2020

RE: Coronavirus (COVID-19) Employee Advisory

I want to thank you all for your continued efforts during this time as we manage through the COVID-19 virus pandemic.

The DOC has taken the following steps with regard to DOC staff members working within correctional facilities:

- MassCor has distributed portable hand sanitizer spray bottles to staff, refill gallon bottles have been delivered to facilities.
- MassCor has been distributing isopropanol based hand cleaner gel for inmates in housing units.
- MassCor is currently producing surgical style masks and gowns for distribution as needed.
- N95 respirators have been distributed to all security staff.
- COVID-19 screening tents are being set up at most prisons, some facilities may use other screening areas.
- Staff MUST wear a mask when entering a tent area to be screened due to being in close proximity with others.
- Staff MUST wear a mask inside the facility when they will be within six feet of another individual or in an area where inmates are active or have tested positive with COVID 19.
- Staff MUST take their own temperature when they enter the tent and record their temperature on the form.
- Relaxed the restriction on bottled water size;
- Worked with hospitals and courts to limit the number of inmate transportation details;
- Limited the number of interagency transfers between facilities;

- Working with suppliers to source PPE materials, cleaning materials and other items related to the COVID-19 outbreak;
- Developed a specific infectious disease 560 reaction plan at each facility in order to deal with the ongoing threat;
- We continue to work closely with the medical vendor to develop response plans as infections develop;
- We have upgraded facility cleaning/disinfecting protocols and will continue to ramp up cleaning as necessary;
- Working with all Unions to address staff complaints and concerns about returning to work i.e. – working remotely, gaining access to VPN, acquiring equipment to be able to work from home;
- In process of gaining Idaptive HR/CMS integration. Idaptive Services is a Multi-Factor Authentication (MFA) method to allow DHR staff access to HR/CMS to increase the amount of time staff are working remotely;
- Posted information on the Intranet regarding Mass 4 you; DHR is posting in common areas and e-mailing the flyer to all Superintendents/Division Heads.
- Tracking self-disclosed quarantined staff;
- Tracking consumption rate of PPE by facility;
- Notified all staff that for pay-period March 1, 2020 – March 14, 2020, OT worked during the second week March 8th through March 14th will be paid in the next possible payroll;
- Exempt Emergency Child Care Program was posted on Saturday, March 21, 2020 on the mass.gov website, with a list of all approved Day Care providers. All providers listed have been open for emergency drop in service starting Monday March 23, 2020. Employees are encouraged to exhaust all other avenues; this program is not for everyday daycare. They are encouraging families to try to find non-group settings for daycare.
- Staff will be allowed to bring in their own disinfectant wipes if they choose.

Additional information on further developments will be posted on the Intranet to all employees. Thank you again for your continued cooperation.

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To: All Inmates

From: Carol A. Mici, Commissioner

Date: April 3, 2020

Subject: COVID-19 LOCKDOWN

The Department has had a number of staff and inmates who have tested positive for COVID-19. This information has been communicated to the MA Department of Health and the local health departments with jurisdiction over affected prisons and they are taking necessary steps. In an effort to slow the spread of the virus and deter infections, all DOC facilities will remain locked down for 14 days, at which time, we will reevaluate the need to remain in lock down, based on the number of infections and/or infection rates.

All necessary precautions are being taken as the health of our staff and inmate population continues to be of paramount importance. As a reminder, steps that you can take to prevent the spread of germs and protect yourself include:

- Avoid unnecessary contact with other inmates to as great an extent as possible, i.e. handshaking, hugs, etc.
- Avoid touching your eyes, nose, and mouth.
- Alert a staff member immediately if you are feeling ill.
- Cover your cough or sneeze.
- Clean and disinfect your cell or living area with soap and water or cleaning products regularly.
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing. If you need more soap, please ask unit staff.

Additionally:

- While locked down, you will receive food and medication in your housing units, have an opportunity to shower, clean your room and use the telephone. Laundry, mail and other required services will not be interrupted.

You should self-monitor for symptoms (i.e., fever, cough, or shortness of breath). If you have symptoms associated with COVID-19, you should immediately alert correctional staff or a health care provider.

Thank you for your anticipated cooperation during this very difficult time.

STEPS THE MA DOC HAS TAKEN SINCE THE ONSET OF COVID-19

What are we are doing to help thwart the threat?

Protecting

COVID-19 screening tents are set up at most prisons
*some may use other screening areas

Upgrading facility cleaning/disinfecting protocols and will continue to ramp up cleaning as necessary

Working with suppliers to source PPE materials, cleaning materials and other items related to the COVID-19 outbreak

Tracking consumption rate of PPE by facility and self-disclosed quarantined staff

Limiting & Developing

Working with hospitals and courts to limit the number of inmate transportation details

Trying to limit the number of inter-agency transfers between facilities

Developed specific infectious disease reaction plans at each facility

Worked closely with the medical vendor to develop response plans as infections developed

Increasing Accessibility

- Working with all Unions to address staff concerns (i.e. – access to VPN, acquiring equipment to tele-work, etc.)

- In process of gaining Idaptive HR/CMS integration for HR staff to tele-work

Promoting Mass4You -an Employee Assistance Program available to all active, state and municipal employees and their families who are eligible for GIC benefits, to help achieve better work/life balance

Exempt Emergency Child Care Program info was posted on mass.gov with a list of all approved day care providers to help staff

MassCor

N95 respirators have been distributed to all security staff

MassCor has distributed portable hand sanitizer spray bottles and refills to staff,

MassCor has been distributing isopropanol based hand cleaner gel for inmates in housing units.

MassCor is currently producing surgical style masks and gowns for distribution as needed.

Emergency Sick Leave (EPSL)

All Executive Branch employees who are sick, regardless of their roles, are strongly directed to stay home. To help, up to 10 free additional sick days will be available for any core employee who needs to use sick time due to their own need to quarantine or to care for a family member who has been quarantined related to COVID-19 and will be paid at their full salary rate. A form will be posted out on the intranet and will be available at all institutions. All questions should be referred to their payroll contact person.

Public Health Emergency Leave (PHEL)

For those Executive Branch employees reporting to their workplaces to perform core services a new program was launched this week to provide core employees free emergency childcare. Over 450 Exempt Emergency Child Care Programs have been established across Massachusetts under the direction of the Department of Early Education and Care

Staff MUST

Wear a mask when entering a tent area to be screened due to proximity with others

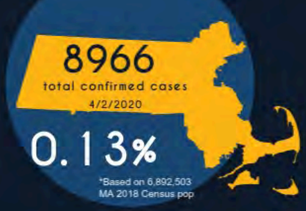
Wear a mask inside the facility when they will be within six feet of another individual or in an area where inmates are active or have tested positive with COVID 19

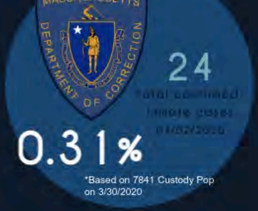
Take their own temperature when they enter the tent and record their temperature on the form

Remember that there is a relaxed restriction on bottled water size and are allowing staff to bring in their own disinfecting wipes if they choose to

The Spread of COVID-19

Infected countries as of 12:00 p.m. ET March 31, 2020
*CDC World map online





Thank you for your continued efforts during this time as we navigate through this COVID-19 virus pandemic together.

Additional information on further developments will be posted on the Intranet for staff and www.mass.gov/doc

• MA DOC AND COVID-19 •

Inmates

ADDITIONAL INFO

April 10, 2020

FOR YOUR PATIENCE

It's been 30 days since the state of emergency was called by Governor Baker and the 1st full week of limited DOC movement. We appreciate your patience. It is making a difference.

EARNED GOOD TIME & PHONE

An April Journaling Program has been developed for this time and will provide 7.5 days upon completion. Talk to your Director of Treatment about it. Phone calls are still limited to 20 minutes.

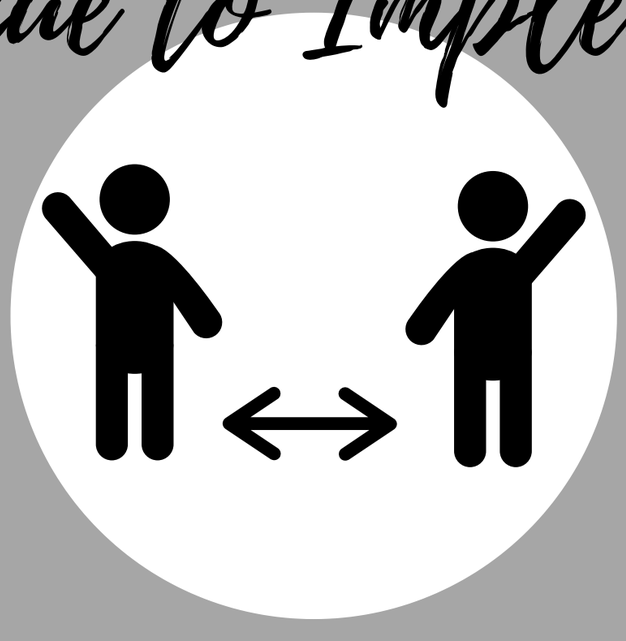
FOOD

There will be larger portions of some meal items.

Continue to Implement

HANDWASHING

Everyone needs to wash their hands often! This is our primary means of disinfecting. if you need more soap, it will be provided to you.



SOCIAL DISTANCING

While institutional settings may be challenging, please do your part. The shaking of hands, hugging, fist bumps, sharing of food/drink etc. should not be happening.

HAND SANITIZING

Alcohol based hand sanitizer pump stations are installed throughout all facilities.

Exhibit 10.1

• MA DOC AND COVID-19 •

Pacientes

INFORMACIÓN ADICIONAL

April 10, 2020

POR TU PACIENCIA

Han pasado 30 días desde que el Gobernador Baker llamó el estado de emergencia y la primera semana completa del movimiento limitado en el departamento de corrección. Nosotros apreciamos su paciencia. Esta haciendo la diferencia

TELÉFONO

Las llamadas telefónicas todavía están limitadas a 20 minutos.

COMIDA

Habrá porciones más grandes de algunos artículos de comida.

Continuar implementando

LAVARSE LAS MANOS

¡Todos deben lavarse las manos a menudo! Este es nuestro medio prinicpal de desinfección, si necesita más jabón, se le proporcionará

DISTANCIAMIENTO SOCIAL

Aunque las instituciones correccionales a veces pueden ser desafiantes, haga su parte. No deberían ocurrir saludos de manos, abrazos, chocar de puños, compartir comida / bebida, etc.

DESINFECCIÓN DE MANOS

Las estaciones de bombeo desinfectante de manos están instaladas en todas las instituciones correccionales y las estaciones de bombeo ahora se suministran con gel de isopropanol (a base de alcohol).

• MA DOC AND COVID-19 •

Presos

INFORMACIÓN ADICIONAL

April 10, 2020

POR TU PACIENCIA

Han pasado 30 días desde que el Gobernador Baker llamó el estado de emergencia y la primera semana completa del movimiento limitado en el departamento de corrección. Nosotros apreciamos su paciencia. Esta haciendo la diferencia

BUEN TIEMPO GANADO Y TELÉFONO

Un Programa de Diario se ha desarrollado para abril. Durante este tiempo se le proporcionará 7.5 días una vez que hayas completado el programa. Hable con su Director de Tratamiento al respecto. Las llamadas telefónicas todavía están limitadas a 20 minutos.

COMIDA

Habrá porciones más grandes de algunos artículos de comida.

Continuar implementando

LAVARSE LAS MANOS

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• MA DOC AND COVID-19 •

Patients

ADDITIONAL INFO

April 10, 2020

FOR YOUR PATIENCE

It's been 30 days since the state of emergency was called by Governor Baker and the 1st full week of limited DOC movement. We appreciate your patience. It is making a difference.

PHONE

Phone calls are still limited to 20 minutes.

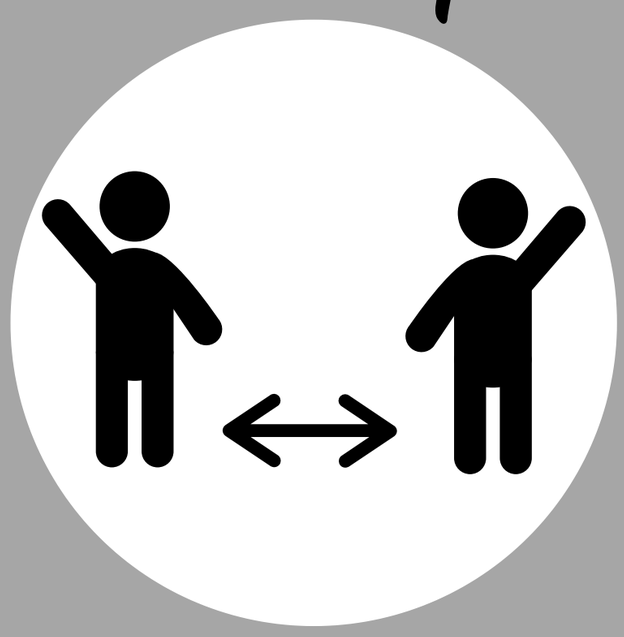
FOOD

There will be larger portions of some meal items.

Continue to Implement

HANDWASHING

Everyone needs to wash their hands often! This is our primary means of disinfecting. if you need more soap, it will be provided to you.



SOCIAL DISTANCING

While institutional settings may be challenging, please do your part. The shaking of hands, hugging, fist bumps, sharing of food/drink etc. should not be happening.

HAND SANITIZING

Alcohol based hand sanitizer pump stations are installed throughout all facilities.

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Commissioner

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THOMAS J. PRESTON
Deputy Commissioners

To: All Inmates - MCI Shirley Medium

From: Carol A. Mici, Commissioner Carol A. Mici

Date: April 1, 2020

Subject: COVID-19 UPDATE

The Department has received notification and confirmed that an inmate at MCI Shirley Medium has tested positive for COVID-19 on March 31, 2020 and he remains under quarantine. This information has been communicated to the MA Department of Health and the local health department with jurisdiction over this prison and they are taking necessary steps. In an effort to ensure the virus is not spread, MCI Shirley will remain locked down for 14 days, at which time, we will reevaluate the need to remain in lock down, based on the number of infections and/or infection rates.

All necessary precautions are being taken as the health of our staff and inmate population continues to be of paramount importance. As a reminder, steps that you can take to prevent the spread of germs and protect yourself include:

- Avoid unnecessary contact with other inmates to as great an extent as possible, i.e. handshaking, hugs, etc.
- Avoid touching your eyes, nose, and mouth.
- Alert a staff member immediately if you are feeling ill.
- Cover your cough or sneeze.
- Clean and disinfect your cell or living area with soap and water or cleaning products regularly.
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing. If you need more soap, please ask unit staff.

Additionally:

- While locked down, you will receive food and medication in your housing units, have an opportunity to shower, clean your room and use the telephone. Laundry, mail and other required services will not be interrupted.

You should self-monitor for symptoms (i.e., fever, cough, or shortness of breath). If you have symptoms associated with COVID-19, you should immediately alert correctional staff or a health care provider.

Thank you for your anticipated cooperation during this very difficult time.

Exhibit 11.1

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Deputy Commissioners

To: All Patients/Persons Served

From: Carol A. Mici, Commissioner

Date: April 4, 2020

Subject: COVID-19 Modified Status and restricted movement at BSH

The Department has had a number of staff, inmates and patients who have tested positive for COVID-19. This information has been communicated to the MA Department of Public Health and the local health departments with jurisdiction over affected prisons/facilities and they are taking necessary steps. In an effort to slow the spread of the virus and deter infections, Bridgewater State Hospital will be placed on modified status where movement may be significantly restricted for 14 days, at which time we will reevaluate the need to remain in a modified status, based on the number of infections and/or infection rates.

All necessary precautions are being taken as the health of our staff and patients/persons served population continues to be of paramount importance. As a reminder, steps that you can take to prevent the spread of germs and protect yourself include:

- Avoid unnecessary contact with other patients/persons served to as great an extent as possible, i.e. handshaking, hugs, etc.
- Avoid touching your eyes, nose, and mouth.
- Alert a staff member immediately if you are feeling ill.
- Cover your cough or sneeze.
- Clean and disinfect your cell or living area with soap and water or cleaning products regularly.
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing. If you need more soap, please ask unit staff.

Additionally:

- While on modified status, you will receive food and medication in your housing units. You will have an opportunity to shower, clean your room and use the telephone, comfort rooms, and

treatment rooms on a rotating basis. Laundry, mail, forensic evaluations and other required services will not be interrupted.

You should self-monitor for symptoms (i.e., fever, cough, tiredness or shortness of breath). If you have symptoms associated with COVID-19, you should immediately alert correctional staff or a health care provider.

Thank you for your anticipated cooperation during this very difficult time.

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CHARLES D. BAKER
Governor

KARYN E. POLITO
Lt. Governor

THOMAS A. TURCO, III
Secretary

April 3, 2020

Dear Colleague:

This is to inform you of priority COVID-19 testing being made available by appointment for symptomatic first responders and other public safety personnel.

The men and women of our public safety services are indispensable, and your expertise will be especially important in the days and weeks to come. The Baker-Polito Administration and the Executive Office of Public Safety and Security recognize the urgency of ensuring your health and safety as you fulfill your critically important duties. Toward that end, EOPSS has partnered with the New England Patriots, the Department of Correction, Wellpath, and Quest Diagnostics to provide this service at no charge.

Beginning on Sunday, April 5, the priority testing site will conduct up to 200 drive-through tests each day for police officers, firefighters, municipal EMS and PSAP personnel, correction officers, mortuary service providers, and state active duty National Guard personnel who perform critical public safety functions and who are experiencing one or more designated symptoms. Due to anticipated demand, this service will be by appointment only, and appointments must be scheduled by the chief executive of your department or his/her designee. Appointments may be made beginning at 8:00 am on Saturday, April 4.

The COVID-19 pandemic has upended daily life across the Commonwealth and around the globe. While the effects of this public health emergency are being keenly felt by everyone, some of the greatest challenges are being met head-on by you, the public safety professionals who work in high-risk environments to protect our communities. As we confront this unprecedented crisis together, please accept my thanks and deep appreciation for your commitment to serve our Commonwealth and all its residents.

Sincerely,

Tom Turco
Secretary of Public Safety and Security

Exhibit 13.1

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THOMAS A. TURCO, III
Secretary

COVID-19 Public Safety Priority Testing Site: What You Need to Know

For Department Chiefs

- The testing site is available to state and municipal police and fire personnel; municipal EMS and PSAP personnel; Massachusetts National Guard personnel on state active duty; correction officers; and mortuary service providers.
- To be eligible, personnel must currently be exhibiting one or more of the following symptoms, as affirmed by a supervising officer or staff member:
  - Dry, persistent cough
  - Sore throat
  - Difficulty breathing
  - Shortness of breath
  - Fever of 99.4°F or higher
- Department chiefs or their designees must make appointments for their staff, providing the employee's first and last name, date of birth, gender, street address, city, state, zip code, email address, and primary telephone number.
- In the event that multiple employees of the same agency are seeking testing, some may be scheduled for a later date in order to accommodate more agencies.
- To schedule an appointment for a member of your staff, please call 855-563-7510. The call center will be active from 8:00 am to 4:00 pm, seven days per week, beginning Saturday, April 4.

For Eligible Personnel

- Call your doctor and notify a supervisor in the event that you feel sick. Follow your doctor's instructions and provide your supervisor with the identifying information he or she may request on behalf of the testing site.
- Bring your driver's license and valid public safety ID to the testing site. You must have these materials for your appointment.
- The testing site will operate from 9:00 am to 5:00 pm, seven days per week, in Parking Lot P-10 at 2 Patriot Place in Foxboro. Please note that this location is only accessible from Route 1 southbound.
- You will not need to exit your vehicle.
- Testing is provided at no cost.
- Test results are expected within 24-48 hours and will be provided electronically.

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CHARLES D. BAKER
Governor

KARYN E. POLITO
Lt. Governor

Thomas Turco
Secretary

April 7, 2020

Dear Colleague:

To more effectively serve our public safety professionals and protect the Commonwealth's communities, the Baker-Polito Administration and the Executive Office of Public Safety and Security are increasing our COVID-19 testing capacity for police officers, firefighters, EMS and PSAP personnel, correction officers, mortuary service providers, and state active duty National Guard personnel who perform critical public safety functions and, in the course of their duties, may unavoidably have close contact with others. Priority testing is critical to ensuring their safety and the well-being of the people we serve.

As you know, the first priority testing site opened on Sunday at Gillette Stadium in Foxborough. This site will continue to operate from 9:00am to 5:00 pm, seven days per week. Beginning on Thursday, April 9, however, it will expand its services to asymptomatic personnel. **Members of your agency will not need to be showing symptoms to be tested.**

Also on April 9, we will open a second public safety priority testing site at the Big E fairgrounds in West Springfield. Like the Foxborough site, it will operate from 9:00 am to 5:00 pm, seven days per week, and will provide COVID-19 testing for public safety personnel, **regardless of whether they are showing symptoms.**

Each site will conduct up to 200 tests per day. Due to ongoing demand, this service will remain available by appointment only, and appointments must still be scheduled by the chief executive of your department or his/her designee. **Please ensure that your staff, including your designee, are aware of this requirement.** The call center is currently scheduling appointments for the Foxborough site and will begin scheduling appointments for West Springfield on Wednesday, April 8.

We are deeply grateful to The Big E, Brewster Ambulance Service, the Department of Correction, the Department of Fire Services, the New England Patriots, the New England Revolution, Wellpath, and Quest Diagnostics for their assistance as we expand this important service.

Sincerely,

Tom Turco
Secretary of Public Safety and Security

EOPSS Update 04.07.20

Exhibit 14.1

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Thomas Turco
Secretary

COVID-19 Public Safety Priority Testing Sites: What Department Chiefs Need to Know
Please read closely. Some instructions have changed.

- The testing sites are available to public safety professionals, including state and municipal police and fire personnel; EMS and PSAP personnel; Massachusetts National Guard personnel on state active duty; correction officers; and mortuary service providers.
- Personnel **do not need to be symptomatic** to be eligible, but please make a note of whether they are currently showing symptoms. This will assist the testing staff.
- Department chiefs or their designees must make appointments for their staff, providing the employee's first and last name, date of birth, gender, street address, city, state, zip code, email address, and primary telephone number.
- Agencies that do not issue official IDs should provide a letter on letterhead confirming the test recipient's employment.
- To schedule an appointment for a member of your staff, please call 855-563-7510. **You will have the option to select either the Foxborough or West Springfield site.**
- The call center is open from 8:00 am to 4:00 pm, seven days per week.
- In the event that multiple employees of the same agency are seeking testing, some may be scheduled for a later date in order to accommodate more agencies.
- Call center personnel are not able to answer medical or procedural questions pertaining to COVID-19 or DPH/CDC recommendations or guidance.

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COVID-19 Public Safety Priority Testing Sites: What Eligible Personnel Need to Know
Please read closely. Some instructions have changed.

- Notify your supervisor if you wish to receive testing. You will have the option to select a testing site in either Foxborough or West Springfield.
- Inform your supervisor of your preferred testing site and provide the identifying information he or she will request. This information will be used to confirm your appointment at the testing site.
- Your supervisor will need to know whether you are currently showing symptoms such as sore throat, dry cough, fever, difficulty breathing, or shortness of breath. **Public safety personnel are eligible for testing regardless of whether they are showing symptoms.**
- Bring your driver's license and valid public safety ID to the correct testing site. If your agency does not issue official IDs, you may provide a letter on letterhead confirming your employment. You must have these materials for your appointment.
- The **Foxborough testing site** is located in Gillette Stadium Parking Lot P-10 at 2 Patriot Place in Foxborough. Please note that this location is only accessible from Route 1 southbound.
- The **West Springfield site** is located at Gate 1 of the Big E Fairgrounds, at 1761 Memorial Ave. in West Springfield.
- You will not need to exit your vehicle.
- Testing is provided at no cost.
- Test results for symptomatic personnel will be expedited and provided in 24 to 48 hours. Test results for asymptomatic personnel will be provided within three to five days. All test results will be provided electronically.
- Call center personnel are not able to answer medical or procedural questions pertaining to COVID-19 or DPH/CDC recommendations or guidance.

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Deputy Commissioners

TO: All DOC Employees

FR: Carol A. Mici, Commissioner

DA: April 24, 2020

RE: Mobile Testing Units (COVID-19)

As we all continue to battle the impact that COVID-19 has had on both our professional and personal lives, I want you to know I am committed to working collaboratively with all employees, Unions, and vendor staff throughout the agency. I continue to update the entrance screening form based upon nationally accepted practices for law enforcement agencies in order to appropriately screen all persons entering a correctional facility or other DOC building.

This week, the DOC began utilizing Mobile Testing Units in conjunction with the Department of Fire Services, Brewster Ambulance and Wellpath. The Mobile Testing Unit started at MCI Framingham and South Middlesex Correctional Center and will move to MCI Shirley starting Saturday, April 25, 2020 and then the Massachusetts Treatment Center towards the end of next week. The DOC is working with Wellpath to strategically plan mobile testing at other sites as appropriate. Testing is for all staff and inmates; staff will be tested in a designated area in the facility, while inmates will be tested within their units. I **strongly** urge you to avail yourself of this opportunity to be tested. Each employee's results are confidential and there is no cost to you. The agency continues to study the evolution and effects of this virus. The infection can be spread by people who are asymptomatic; therefore, any one of us can unknowingly spread the virus to co-workers, family and friends, and the inmate population.

Please continue to adhere to the requirement of wearing PPE's within the facilities or anytime you are within six feet of others, regardless of your work location within the agency.

All of these changes will go a long way to deter the spread of this insidious infection.

I thank you for your professionalism, dedication and your anticipated cooperation as we work together to minimize the impact of this virus.

VERBAL SCREENING AND SELF-TEMPERATURE CHECK PROTOCOLS

Name: _____ Employee/Visitor/Vendor/Other:_____

Affiliation: _____ Date of Visit: _____ Time: _____

Based upon the Centers for Disease Control Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities the following is required.

- Vigorous hand washing
- Social Distancing
- Wearing of masks by all employees and visitors at all times.

Guidance from the CDC recommends that all personnel self-monitor twice daily (both on and off duty) to identify any potential signs or symptoms.

1.) All individuals will conduct self-screening upon entry to the building. Screening will include temperature monitoring.

Today or in the past 24 hours, have you had any of the following symptoms?

Uncontrolled nasal secretions/excretions not attributed to season allergies	**YES**	**NO**
Sore throat not attributed to seasonal allergies	**YES**	**NO**
Productive/uncontrolled cough not attributed to seasonal allergies	**YES**	**NO**
Diarrhea associated with an acute illness	**YES**	**NO**
Influenza or COVID-19 like illness, fever and/or shortness of breath	**YES**	**NO**

If yes to any of the above, the person should not be allowed to enter and shall seek medical advice.

- *In the past 14 days, have you had direct contact with a person known to be infected with the novel coronavirus (COVID-19)?* **YES** **NO**

If yes (but no COVID-19 symptoms), the person may be allowed entrance, but must wear a PPE at all times.

Note: If the person is denied entrance they shall be advised contact their health provider and be given a denied entrance form.

Temperature Reading: _____ (No entry if greater than 99.9 F)

Allowed to Enter: Yes/No

Verified By: _____

COVID-19 Isolation and PPE

COVID-19 Mode of Transmission

Early reports suggest person-to-person transmission most commonly occurs through close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes or inhaled into the lungs of those in close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain; however, airborne transmission from person-to-person over long distances is unlikely.

Standard Precautions

The following applies when caring for all patients – not just those suspected or confirmed as being infected by COVID-19. If the patient is afebrile (temperature less than 100.0°F) or has mild symptoms that might be consistent with COVID-19 (i.e., cough, sore throat, shortness of breath), COVID-19 precautions are not required. Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting.

Hand Hygiene:

Healthcare providers should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove pathogens that may have been transferred to bare hands during the removal process. The Centers for Disease Control and Prevention (CDC) recommends using alcohol-based hand sanitizers that have greater than 60% ethanol or 70% isopropanol as the preferred method of hand hygiene in healthcare settings. Healthcare providers who use alcohol-based hand sanitizers as part of their hand hygiene routine can inform patients that they are following CDC guidelines.

The CDC recommends taking airborne and contact precautions when caring for patients with known or suspected COVID-19.

Setting	Target Personnel	Activity	Type of PPE or procedure
Triage	Healthcare personnel	Preliminary screening (not direct contact)	Maintain spatial distance of >3 ft No specific PPE required for HCP
	Patient with respiratory symptoms	Any	Place surgical mask on patient Minimize time in waiting room
Patient Room	Healthcare personnel	Direct patient care	Gown, gloves, facemask, eye protection (goggles or face shield)
	Healthcare personnel	Specimen collection[1]	Gown, gloves, facemask, eye protection (goggles or face shield) *Depending on PPE supply, consider use of N-95 respirator if there is concern about aerosol generation during specimen collection (no AIIR required)
	Healthcare personnel	Aerosol-generating procedures[2]	Gown, gloves, N-95 respirator, eye protection (goggles or face shield)
	Patient with respiratory symptoms	Routine clinical care	To the degree possible, patients with respiratory symptoms should wear a surgical mask during encounters with the healthcare team

[1] Preferred specimen type is an NP swab and OP swab combined into a single collection vial.

[2] Aerosol generating procedures include (but are not limited to) sputum induction, airway suctioning, endotracheal intubation, bronchoscopy, positive pressure ventilation (BiPAP, CPAP), nebulizer treatment and tracheostomy care.

COVID-19 Isolation and PPE

Screening and Triage
Ensure rapid safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough).

- Prioritize triage of patients with respiratory symptoms
- Triage personnel should have a supply of Respiratory Hygiene kits for patients with symptoms of respiratory infection; these should be provided to patients with symptoms of respiratory infection at booking; source control (putting a facemask over the mouth and nose of a symptomatic patient) can help to prevent transmission to others
- Ask all patients at check-in about symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVID-19 or contact with possible COVID-19 patients
- Isolate patients known and/or suspected of COVID-19 infection in a negative pressure room if available; if no room is available, isolate the patient in a room with the door closed

Respiratory Hygiene Kit:
In a paper lunch sack place- tissues, hand sanitizer, face mask, and instructions on respiratory hygiene (e.g., cover your cough). Provide bag to any patient with symptoms on identification, when moving, or in booking. Patient may use bag to dispose of used tissues while in a holding cell.

Collection of Diagnostic Respiratory Specimens
When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 patient, take the following precautions:

- HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown
- Limit HCP present during the procedure to only those essential for patient care and procedure support; visitors should not be present for specimen collection

Patient Housing
Evaluate the need for hospitalizing patients with known or suspected COVID-19 or other respiratory infections. If hospitalization is not medically necessary, and patient cannot/will not be released home, then:

- Place in Airborne Infection Isolation Room (AIIR) if available
- Place in a single-person cell with the door closed if AIIR is not available
- If a single cell is not available, house patients with same known conditions together; if condition is not known, avoid housing patients together if possible.

It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. Patients with different respiratory pathogens will likely be housed on the same unit. Only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should not be housed in the same room as a patient with an undiagnosed respiratory infection; however, a patient with COVID-19 may be housed with others diagnosed with COVID-19.

- Limit transport and movement of the patient outside of the room to essential movement only. Patient will wear face mask when out of the cell. Clean all equipment used (medical and custody restraints) between patients

- Patients with known or suspected COVID-19 should be housed in the same cell for the duration of their stay in the facility to the extent possible
- Personnel entering the room should use PPE as described above
- Perform procedures/tests in the patient's room whenever possible.
- Use dedicated medical equipment when caring for patients with known or suspected COVID-19

Housekeeping: All staff should follow universal/standard precautions by wearing gloves, aprons, and masks as appropriate when cleaning the area.

- Clean and disinfect non-dedicated, non-disposable medical equipment used for patient care according to manufacturer's instructions and facility policies
- When the patient is released or moved, staff should not enter the vacated room for 138 to 207 minutes (at two air exchanges per hour) to allow for removal of potentially infectious particles. Only then will the room and surfaces be cleaned and disinfected. Allow all cleaning/disinfecting products to dry naturally and completely before housing another patient in the cell.
- Refer to the EPA's List N for registered disinfectants that have qualified under the EPA's emerging viral pathogens program for use against SARS-CoV-2 (the cause of COVID-19).

Laundry: Laundry workers should follow universal/standard precautions and wear gloves and aprons when handling dirty linens. Soiled linens should be placed immediately in a water-soluble bag and then into a contaminated linen bag. Both bags should be tied shut. If water-soluble bags are not available, place dirty linens directly into a yellow contaminated linen bag and tie shut. Hold laundry bags and linens away from the body to avoid contact with contaminated surfaces. Hold yellow bags over the laundry machine and empty directly into the machine; do not reach into the bag to retrieve linens. If a water-soluble bag is used, drop all contents, including water soluble bag, into the laundry. Remove apron and gloves, and wash hands after loading machine. Washed linens may be treated as any other clean item.

Food Services: All used food service trays and utensils should be retrieved using universal/standard precautions wearing gloves and aprons. Hold contaminated items away from the body. Load items into dishwasher and wash at high temperature as normal. Wipe down and disinfect carts used to retrieve items; allow to airdry before clean trays are loaded back onto the cart. Alternatively, disposable trays and utensils may be used and discarded in brown bags at the cell, then tied shut and disposed of as normal.

Personal Protective Equipment

Isolation Gowns: Non-sterile, disposable patient isolation gowns used for routine patient care in healthcare settings are appropriate for use by patients with suspected or confirmed COVID-19.

Eye Protection: Remove eye protection and perform hand hygiene if eye protection is damaged or soiled, and when leaving the unit.

Use of N-95 Respirators: Recommend use of N95 or higher-level respirators for HCP who have been medically cleared, trained, and fit-tested. Ensure supplies are available.

COVID-19 Isolation and PPE

PPE Shortage
Major distributors in the United States have reported shortages of PPE, specifically N95 respirators, facemasks, and gowns. The anticipated timeline for return to routine levels of PPE will be shared when available.

In times of shortages, take special care to ensure respirators are reserved for situations where respiratory protection is most important, such as performance of aerosol-generating procedures on suspected or confirmed COVID-19 patients, or provision of care to patients with other infections requiring respiratory protection, such as tuberculosis, measles, and varicella.

Use of respirators beyond the manufacturer-designated shelf life for healthcare delivery
N95 respirators beyond the expiration date may be used during times of shortage for care of patients with COVID-19, tuberculosis, measles, and varicella. These respirators have been found to continue to perform in accordance with NIOSH performance standards. However, components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal. Users should complete a fit check prior to each use to ensure a good fit.

Re-Use of N95 Respirators: Limited extended use and re-use of N95 respirators when caring for patients with COVID-19 might become necessary. Use caution, as it is unknown what the potential contribution of contact transmission is for SARS-CoV-2.

- **Extended** use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several patients, without removing the respirator between patient encounters. Extended use may be implemented when multiple patients are infected with the same respiratory pathogen and patients are placed together in dedicated housing area. Extended use is favored over reuse because it is expected to involve less touching of the respirator and therefore less risk of contact transmission. The maximum length of continuous use in non-dusty healthcare workplaces is dictated by hygiene or practical needs rather than a set number of hours. Use the following as a guide.

    - Avoid unnecessary touching of the respirator
    - Discard N95 respirators following use during aerosol generating procedures
    - Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other patient bodily fluids
    - Discard N95 respirators following close contact with, or exit from, the care area of any patient co-infected with an infectious disease requiring contact precautions
    - Consider use of a cleanable face shield over an N95 respirator and/or masking patients simultaneously to reduce surface contamination
    - Perform hand hygiene with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary, for comfort or to maintain fit)
    - Discard any respirator that is obviously damaged or hard to breathe through

- **Reuse** refers to the practice of using the same N95 respirator for multiple encounters with patients but removing it ("doffing") after each encounter. The respirator is stored in between encounters to be put on again ("donned") before the next patient encounter. For pathogens where contact transmission (e.g., fomites) is not a concern, non-emergency reuse has been practiced for decades. For example, for tuberculosis prevention, CDC recommends that a respirator classified as disposable can be reused by the same worker as long as it remains functional. There is no way to determine the maximum possible number of safe reuses for an N95 respirator. The recommendations below provide practical advice, so that N95 respirators are discarded before they become a significant risk for contact transmission, or their functionality is reduced.

    - Avoid unnecessary touching of the respirator and maintain strict adherence to hand hygiene practices, and proper PPE donning/doffing technique
    - Discard N95 respirators after use during aerosol generating procedures
    - Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other patient bodily fluids
    - Discard N95 respirators following close contact with any patient co-infected with an infectious disease requiring contact precautions
    - Discard any respirator that is obviously damaged or becomes hard to breathe through
    - Consider using a cleanable face shield over an N95 respirator and/or masking patients simultaneously to reduce surface contamination
    - Clearly identify the person using the respirator
    - Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses
    - Store respirators so that they do not touch each other, and become damaged or deformed; storage containers should be disposed of or cleaned regularly
    - Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary, for comfort or to maintain fit)
    - Avoid touching inside of the respirator; if inadvertent contact is made with the inside of the respirator, perform hand hygiene as described above
    - Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check; discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on the face and has a good seal
    - Limit the number of reuses to no more than five per device (or fewer, if recommended by the manufacturer)

Facemask or respirator determination

HCP planned proximity to the case patient during encounter	Facemask or respirator determination	
	Patient masked for entire encounter (i.e., with source control)	Unmasked patient or mask needs to be removed for any period of time during the patient encounter
HCP will remain at greater than 6 feet from symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator
HCP will be within 3 to 6 feet of symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask
HCP will be within 3 feet of symptomatic patient, including providing direct patient care	Facemask	N95 respirator/ elastomeric /PAPR, based on availability
HCP will be present in the room during aerosol generating procedures performed on symptomatic persons	N95 respirator/ elastomeric /PAPR, based on availability	N95 respirator/ elastomeric /PAPR, based on availability

Donning and Doffing PPE

- Don PPE in this sequence: wash hands, gown, mask, eye protection/face shield-gloves
- Doff PPE in this sequence: gloves and gown inside out, eye protection/face shield- mask, wash hands
- Doffing IF necessary to maintain mask/face shield for future use/re-entry: Wash hands after removing gown, don gloves, remove mask, place in paper bag/storage. Consider that the exterior of the mask may have droplets and the inside to be “clean.: Disinfect shield/goggles on removal and store separate from mask.

For additional information

CDC: **Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings.**
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

CDC: **Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.**
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/crisis-alternate-strategies.html

CDC: **Healthcare Infection Prevention and Control FAQs for COVID-19**
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html

CDC: **CDC Statement for Healthcare Personnel on Hand Hygiene during the Response to the International Emergence of COVID-19**
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/hcp-hand-sanitizer.html

CDC: **Sequence for Donning and Doffing Personal Protective Equipment**
https://www.cdc.gov/niosh/npptl/pdfs/PPE-Sequence-508.pdf

CDC: **Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings**
https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting

Related Pages

Background

Infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. Prompt detection and effective triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. All healthcare facilities must ensure that their personnel are correctly trained and capable of implementing infection control procedures; individual healthcare personnel should ensure they understand and can adhere to infection control requirements.

This guidance is based on the currently limited information available about 2019-nCoV related to disease severity, transmission efficiency, and shedding duration. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States. This guidance is applicable to all U.S. healthcare settings. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.** For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC 2019-nCoV website.

Definition of Healthcare Personnel (HCP) – For the purposes of this guidance, HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in patient care activities, including: patient assessment for triage, entering examination rooms or patient rooms to provide care or clean and disinfect the environment, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces.

Recommendations

1. Minimize Chance for Exposures

Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including 2019-nCoV. Measures should be implemented before patient arrival, upon arrival, and throughout the duration of the affected patient's presence in the healthcare setting.

- **Before Arrival**
  - When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever[1]) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).
  - If a patient is arriving via transport by emergency medical services (EMS), the driver should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.

- **Upon Arrival and During the Visit**
  - Take steps to ensure all persons with symptoms of suspected 2019-nCoV or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. Consider posting visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use facemasks (See definition of facemask in Appendix) or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
  - Ensure that patients with symptoms of suspected 2019-nCoV or other respiratory infection (e.g., fever, cough) are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.
  - Ensure rapid triage and isolation of patients with symptoms of suspected 2019-nCoV or other respiratory infection (e.g., fever, cough):
    - Identify patients at risk for having 2019-nCoV infection before or immediately upon arrival to the healthcare facility.

- Implement triage procedures to detect patients under investigation (PUI) for 2019-nCoV during or before patient triage or registration (e.g., at the time of patient check-in)

and ensure that all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of 2019-nCoV or contact with possible 2019-nCoV patients.

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    -
        - Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the PUI for 2019-nCoV in an Airborne Infection Isolation Room (AIIR), if available. See recommendations for "Patient Placement" below. Additional guidance for evaluating patients in U.S. for 2019-nCoV infection can be found on the CDC 2019-nCoV website.
        - Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a patient under investigation for 2019-nCoV.
    - Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand rub (ABHR), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

2. Adherence to Standard, Contact and Airborne Precautions, Including the Use of Eye Protection

Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including those caused by 2019-nCoV, are summarized below. Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. All HCP (see section 3 for measures for non-HCP visitors) who enter the room of a patient with suspected or confirmed 2019-nCoV should adhere to Standard, Contact, and Airborne Precautions, including the following:

- **Patient Placement**
    - Place a patient with known or suspected 2019-nCoV (i.e., PUI) in an AIIR that has been constructed and maintained in accordance with current guidelines.
        - AIIRs are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

        - If an AIIR is not available, the patient should be transferred as soon as is feasible to a facility where an AIIR is available or discharged to home (in consultation with state or local public health authorities) if deemed medically appropriate. Pending transfer, place a facemask on the patient and isolate him/her in an examination room with the door closed. The patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Once in an AIIR, the patient's facemask may be removed. Limit transport and movement of the patient outside of the AIIR to medically-essential purposes. When not in an AIIR (e.g., during transport or if an AIIR is not available), patients should wear a facemask to contain secretions.
    - Personnel entering the room should use PPE, including respiratory protection, as described below.
    - Only essential personnel should enter the AIIR. Implement staffing policies to minimize the number of HCP who enter the room.
        - Facilities should consider caring for these patients with dedicated HCP to minimize risk of transmission and exposure to other patients and other HCP.
    - Facilities should keep a log of all persons who care for or enter the rooms or care area of these patients.

- Use dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs). If equipment will be used for more than one patient, clean and disinfect such equipment before use on another patient according to manufacturer's instructions.

    - HCP entering the AIIR soon after a patient vacates the room should use respiratory protection. (See personal protective equipment section below) Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). We do not yet know how long 2019-nCoV remains infectious in the air. In the interim, it is reasonable to apply a similar time period before entering the room without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis). In addition, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.
- **Hand Hygiene**
    - HCP should perform hand hygiene using ABHR before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
    - Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.

- **Personal Protective Equipment**
  Employers should select appropriate PPE and provide it to HCP in accordance with OSHA's PPE standards (29 CFR 1910 Subpart I)external icon. HCP must receive training on and demonstrate an understanding of when to use PPE; what PPE is necessary; how to properly don, use, and doff PPE in a manner to prevent self-contamination; how to properly dispose of or disinfect and maintain PPE; and the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE:
  - **Gloves**
    - Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
    - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
  - **Gowns**
    - Put on a clean disposable gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown before leaving the patient room or care area.
  - **Respiratory Protection**
    - Use respiratory protection (i.e., a respirator) that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator before entry into the patient room or care area. See appendix for respirator definition.
    - Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator.
    - If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
    - Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (29 CFR 1910.134external icon). Staff should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
  - **Eye Protection**
    - Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.

- **Use Caution When Performing Aerosol-Generating Procedures**
    - Some procedures performed on 2019-nCoV patients could generate infectious aerosols. In particular, procedures that are likely to induce coughing; e.g., nasopharyngeal specimen collection, sputum induction, and open suctioning of airways should be performed cautiously and avoided if possible.
    - If performed, these procedures should take place in an AIIR, and personnel should use respiratory protection as described above. In addition:
        - Limit the number of HCP present during the procedure to only those essential for patient care and procedural support.
        - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.
- **Duration of Isolation Precautions**
    - Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.
    - Factors that should be considered include: presence of symptoms related to 2019-nCoV, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, *Clostridioides difficile),* other laboratory information reflecting clinical status, alternatives to inpatient isolation, such as the possibility of safe recovery at home.

3. Manage Visitor Access and Movement Within the Facility

- Establish procedures for monitoring, managing and training visitors.
- Restrict visitors from entering the room of known or suspected 2019-nCoV patients (i.e., PUI). Alternative mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets should be explored. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.
- Visitors to known or suspected 2019-nCoV (i.e., PUI) patients should be scheduled and controlled to allow for:
    - Screening visitors for symptoms of acute respiratory illness before entering the healthcare facility.
    - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for 2019-nCoV) and ability to comply with precautions.
    - Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
    - Facilities should maintain a record (e.g., log book) of all visitors who enter patient rooms.
    - Visitors should not be present during aerosol-generating procedures.
    - Visitors should be instructed to limit their movement within the facility.
    - Exposed visitors (e.g., contact with symptomatic 2019-nCoV patient prior to admission) should be advised to report any signs and symptoms of acute illness to

their health care provider for a period of at least 14 days after the last known exposure to the sick patient.

- All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.

4. Implement Engineering Controls

- Consider designing and installing engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include physical barriers or partitions to guide patients through triage areas, curtains between patients in shared areas, closed suctioning systems for airway suctioning for intubated patients, as well as appropriate air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained.

5. Monitor and Manage Ill and Exposed Healthcare Personnel

- Movement and monitoring decisions for HCP with exposure to 2019-nCoV should be made in consultation with public health authorities.

- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.

6. Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- HCP must be medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering facepiece respirators), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., Powered Air-Purifying Respirator, PAPR) whenever respirators are required. OSHA has a number of respiratory training videosexternal icon.
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

7. Implement Environmental Infection Control

- Dedicated medical equipment should be used for patient care.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's

label) are appropriate for 2019-nCoV in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with EPA-approved emerging viral pathogens claims are recommended for use against 2019-nCoV. These products can be identified by the following claim:
    - "[Product name] has demonstrated effectiveness against viruses similar to 2019-nCoV on hard non-porous surfaces. Therefore, this product can be used against 2019-nCoV when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces."
    -
    - This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, "1-800" consumer information services, social media sites and company websites (non-label related). Specific claims for "2019-nCoV" will not appear on the product or master label.
    - Additional information about EPA-approved emerging viral pathogens claims can be found here: https://www.epa.gov/pesticide-registration/guidance-registrants-process-making-claims-against-emerging-viral-pathogensexternal icon
    -
    - If there are no available EPA-registered products that have an approved emerging viral pathogen claim for 2019-nCoV, products with label claims against human coronaviruses should be used according to label instructions.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment].

8. Establish Reporting within Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promptly alert key facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected 2019-nCoV patients (i.e., PUI).
- Communicate and collaborate with public health authorities.
    - Promptly notify state or local public health authorities of known or suspected 2019-nCoV patients (i.e., PUI). Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.

Appendix: Additional Information about Respirators and Facemasks

Information about Respirators:

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134external icon). HCP should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- NIOSH information about respirators
- OSHA Respiratory Protection eToolexternal icon

Filtering Facepiece Respirators (FFR) including N95 Respirators

- A commonly used respirator is a filtering facepiece respirator (commonly referred to as an N95). Filtering facepiece respirators are disposable half facepiece respirators that filter out particles.
- To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one (this is called "fit-testing" and is usually done in a workplace where respirators are used).
- Three key factors for an N95 respirator to be effective: (https://www.cdc.gov/niosh/npptl/pdfs/KeyFactorsRequiedResp01042018-508.pdfpdf icon)
- FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- For more information on how to perform a user seal check: https://www.cdc.gov/niosh/docs/2018-130/pdfs/2018-130.pdf?id=10.26616/NIOSHPUB2018130pdf icon

A list of NIOSH-approved N95 respirators is located here: https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/n95list1.html

Powered Air-Purifying Respirators (PAPRs)

- Powered air-purifying respirators (PAPRs) have a battery-powered blower that pulls air through attached filters, canisters, or cartridges. They provide protection against gases, vapors, or particles, when equipped with the appropriate cartridge, canister, or filter.
- Loose-fitting PAPRs do not require fit testing and can be used with facial hair.
- A list of NIOSH-approved PAPRs is located on the NIOSH Certified Equipment List: https://www.cdc.gov/niosh/npptl/topics/respirators/cel/

Information about Facemasks:

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).

- Facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
SARS	Airborne + Droplet + Contact + Standard	Duration of illness plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving.	Airborne preferred; Droplet if Negative Pressure Room unavailable. N95 mask or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol-generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets

Centers for Disease Control and Prevention.
www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html
Accessed 1/28/2020

April 23, 2020

Updated recommendations for clearing patients from isolation for confirmed or suspected COVID19 infection:

In departure from CDC guidelines, we recommend longer isolation of inmates diagnosed with COVID19 before returning them to general population. Our own testing has shown that returning patients to general population after just 72 hours of normal temperature as the CDC had recommended would not be adequate. Currently our plan is to manage inmates diagnosed with COVID19 as follows:

- Afebrile (99.0 or below) for **seven consecutive days**, unless immunocompromised
  - AND
- Resolution of cough, headache, myalgia, and malaise
- Onset of symptoms at least 14 days ago

THEN: test again for COVID19.

If negative, clear patient to general population

If still positive, keep the patient in isolation for another 7 days

- Retest at day 21

If negative, clear the patient to general population.

If still positive, keep the patient in isolation for another 7 days

- Retest at day 28

ETC

At this time, we do not recommend clearing any patient to general population unless a negative test has been achieved.

Before moving any patient with a negative result back to general population, please consult with your site's ID case manager.

Thank you,

Steven Descoteaux MD

Statewide Medical Director

Wellpath

wellpath

Mental Health Protocol for COVID-19 Notification

1. Infectious Disease team notifies Wellpath site leaders (including Mental Health Director) when patient quarantined for suspected COVID-19.
2. Site HSA confirms patient information with MHD or designee (secondary notification as safeguard).
3. Mental Health team reviews patient records and assesses/monitors patient per protocol.
4. All quarantined patients reviewed during Wellpath whiteboard/huddle meetings (Monday-Friday).
5. All quarantined patients reviewed during morning meeting with Superintendent and DOC leadership.
6. All quarantined patients reviewed during site clinical team triage meetings (Monday-Friday).

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Please see the following protocol for assessing quarantined patients:

- If a patient is quarantined due to either testing positive or pending test results for Coronavirus the medical or ID leader should immediately notify the MHD or designee.
- The MHD or designee will conduct a chart review of the patient in question including whenever possible triage with patient's direct providers (e.g. PCC, assigned psychiatrist, medical staff that have interacted with the patient most recently, etc.) to establish/update working knowledge of the patient's diagnosis, risk factors, likelihood of accessing MH if needed, and current mental status.
- Based on triage with the MHD (or designated MH leader), the determination will be made as to whether the patient in question is in need of an emergent mental health assessment. If the determination is indeed that this patient needs to be seen emergently by MH, MH staff will utilize available safe protocol to provide this assessment to the patient. If there is not a safe mechanism to do this, e.g. PPE is not available, tele mental health is not available, phone is not available, etc., the clinician should work with the medical department to provide the best clinical assessment possible based on collateral data as noted above. This should also include close collaboration with nursing so that the assigned nurse can provide a mental status assessment in the course of his/her medical evaluation/protocols with that patient and report out to the crisis MHP/MHD or designee.
- If the patient is determined not to be in need of an urgent/emergent mental health assessment, an administrative note should be placed in the patient's behavioral health section of ERMA that outlines the current patient assessment and that highlights plan for care, e.g. on-going monitoring via communication with collaterals, provision of MH related materials, as needed access to mental health, etc.
- The MH department should continue to monitor these patients over the course of their quarantine/illness to provide on-going clinical consultation and assessment for these patients. For some patients, the determination may be that they need more frequent evaluation while for others the determination may be that they can be seen per typical crisis protocols until we resume normal MH operations.
- The MHD or designee will provide any additional services that are identified by the site HSA and clinical leadership.

https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVIII/Chapter127/Section119A

SECTION 119A

Section 119A: Release of prisoner on medical parole due to terminal illness or permanent incapacitation; petition; written decision; conditions of parole; appeal; rules and regulations; report

Section 119A. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:—

"Medical parole plan", a comprehensive written medical and psychosocial care plan specific to a prisoner and including, but not limited to: (i) the proposed course of treatment; (ii) the proposed site for treatment and post-treatment care; (iii) documentation that medical providers qualified to provide the medical services identified in the medical parole plan are prepared to provide such services; and (iv) the financial program in place to cover the cost of the plan for the duration of the medical parole, which shall include eligibility for enrollment in commercial insurance, Medicare or Medicaid or access to other adequate financial resources for the duration of the medical parole.

"Department", the department of correction.

"Permanent incapacitation", a physical or cognitive incapacitation that appears irreversible, as determined by a licensed physician, and that is so debilitating that the prisoner does not pose a public safety risk.

"Secretary", the secretary of the executive office of public safety and security.

"Terminal illness", a condition that appears incurable, as determined by a licensed physician, that will likely cause the death of the prisoner in not more than 18 months and that is so debilitating that the prisoner does not pose a public safety risk.

(b) Notwithstanding any general or special law to the contrary, a prisoner may be eligible for medical parole due to a terminal illness or permanent incapacitation pursuant to subsections (c) and (d).

(c)(1) The superintendent of a correctional facility shall consider a prisoner for medical parole upon a written petition by the prisoner, the prisoner's attorney, the prisoner's next of kin, a medical provider of the correctional facility or a member of the department's staff. The superintendent shall review the petition and develop a recommendation as to the release of the prisoner. Whether or not the superintendent recommends in favor of medical parole, the superintendent shall, not more than 21 days after receipt of the petition, transmit the petition and the recommendation to the commissioner. The superintendent shall transmit with the recommendation: (i) a medical parole plan; (ii) a written diagnosis by a physician licensed to practice medicine under section 2 of chapter 112; and (iii) an assessment of the risk for violence that the prisoner poses to society.

(2) Upon receipt of the petition and recommendation pursuant to paragraph (1), the commissioner shall notify, in writing, the district attorney for the jurisdiction where the offense resulting in the prisoner being committed to the correctional facility occurred, the prisoner, the person who petitioned for medical parole, if not the prisoner and, if applicable under chapter 258B, the victim or the victim's family that the prisoner is being considered for medical parole. The parties who receive the notice shall have an opportunity to provide written statements; provided, however, that if the prisoner was convicted and is serving a sentence under section 1 of chapter 265, the district attorney or victim's family may request a hearing.

(d)(1) A sheriff shall consider a prisoner for medical parole upon a written petition filed by the prisoner, the prisoner's attorney, the prisoner's next of kin, a medical provider of the house of correction or jail or a member of the sheriff's staff. The sheriff shall review the request and develop a recommendation as to the release of the prisoner. Whether or not the sheriff recommends in favor of medical parole, the sheriff shall, not more than 21 days after receipt of the petition, transmit the petition and the recommendation to the commissioner. The sheriff shall transmit with the petition: (i) a medical parole plan; (ii) a written diagnosis by a physician licensed to practice medicine under section 2 of chapter 112; and (iii) an assessment of the risk for violence that the prisoner poses to society.

(2) Upon receipt of the petition and recommendation pursuant to paragraph (1), the commissioner shall notify, in writing, the district attorney for the jurisdiction where the offense resulting in the prisoner being committed to the correctional facility occurred, the prisoner, the person who petitioned for medical parole, if not the prisoner and, if applicable under chapter 258B, the victim or the victim's family that the prisoner is being considered for medical parole. The parties who receive the notice shall have an opportunity to submit written statements.

(e) The commissioner shall issue a written decision not later than 45 days after receipt of a petition, which shall be accompanied by a statement of reasons for the commissioner's decision. If the commissioner determines that a prisoner is terminally ill or permanently incapacitated such that if the prisoner is released the prisoner will live and remain at liberty without violating the law and that the release will not be incompatible with the welfare of society, the prisoner shall be released on medical parole. The parole board shall impose terms and conditions for medical parole that shall apply through the date upon which the prisoner's sentence would have expired.

Not less than 24 hours before the date of a prisoner's release on medical parole, the commissioner shall notify, in writing, the district attorney for the jurisdiction where the offense resulting in the prisoner being committed to the correctional facility occurred, the department of state police, the police department in the city or town in which the prisoner shall reside and, if applicable under chapter 258B, the victim or the victim's family of the prisoner's release and the terms and conditions of the release.

(f) A prisoner granted release under this section shall be under the jurisdiction, supervision and control of the parole board, as if the prisoner had been paroled pursuant to section 130 of chapter 127. The parole board may revise, alter or amend the terms and conditions of a medical parole at any time. If a parole officer receives credible information that a prisoner has failed to comply with a condition of the prisoner's medical parole or upon discovery that the terminal illness or permanent incapacitation has improved to the extent that the prisoner would no longer be eligible for medical parole under this section, the parole officer shall immediately arrest the prisoner and bring the prisoner before the board for a hearing. If the board determines that the prisoner violated a

condition of the prisoner's medical parole or that the terminal illness or permanent incapacitation has improved to the extent that the prisoner would no longer be eligible for medical parole pursuant to this section, the prisoner shall resume serving the balance of the sentence with credit given only for the duration of the prisoner's medical parole that was served in compliance with all conditions of their medical parole pursuant to subsection (e). Revocation of a prisoner's medical parole due to a change in the prisoner's medical condition shall not preclude a prisoner's eligibility for medical parole in the future or for another form of release permitted by law.

(g) A prisoner, sheriff or superintendent aggrieved by a decision denying or granting medical parole made under this section may petition for relief pursuant to section 4 of chapter 249. A decision by the court affirming or reversing the commissioner's grant or denial of medical parole shall not affect a prisoner's eligibility for any other form of release permitted by law. A decision by the court pursuant to this subsection shall not preclude a prisoner's eligibility for medical parole in the future.

(h) The secretary shall promulgate rules and regulations necessary for the enforcement and administration of this section.

(i) The commissioner and the secretary shall file an annual report not later than March 1 with the clerks of the senate and the house of representatives, the senate and house committees on ways and means and the joint committee on the judiciary detailing, for the prior fiscal year: (i) the number of prisoners in the custody of the department or of the sheriffs who applied for medical parole under this section and the race and ethnicity of each applicant; (ii) the number of prisoners who have been granted medical parole and the race and ethnicity of each prisoner; (iii) the nature of the illness of the applicants for medical parole; (iv) the counties to which the prisoners have been released; (v) the number of prisoners who have been denied medical parole, the reason for the denial and the race and ethnicity of each prisoner; (vi) the number of prisoners who have petitioned for medical parole more than once; (vii) the number of prisoners released who have been returned to the custody of the department or the sheriff and the reason for each prisoner's return; and (viii) the number of petitions for

relief sought pursuant to subsection (g). Nothing in this report shall include personally identifiable information of the prisoners.

MASSACHUSETTS DEPARTMENT OF CORRECTION

BOOKING AND ADMISSIONS

103 DOC 401

TABLE OF CONTENTS

401.01 Reception.....2

401.02 DNA Collection.....7

401.03 Orientation.....8

401.04 Inmate Telephones.....13

401.05 Housing Cell Assignments.....13

ATTACHMENT I: IMS Offender Face Sheet.....17

ATTACHMENT II: PREA Orientation (English).....20

ATTACHMENT II: PREA Orientation (Spanish).....25

MASSACHUSETTS DEPARTMENT OF CORRECTION	DIVISION: PDCU
TITLE: BOOKING AND ADMISSIONS	NUMBER: 103 DOC 401

PURPOSE: The purpose of this document is to establish Department of Correction booking and admissions procedures.

REFERENCES: M.G.L., C. 124, §§ 1(c) (g) (q), M.G.L. C. 127, § 23, M.G.L. C. 22E.

APPLICABILITY: Staff/Inmates. This policy is applicable to civil commitments, 52As, and awaiting trial inmates at MCI-Framingham.

PUBLIC ACCESS: Yes

LOCATION: DOC Central Policy File/Each Institution's Policy File/Special Unit Director's Policy File

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:

- Director of the Policy Development and Compliance Unit
- Superintendents

EFFECTIVE DATE: August 20, 2019

CANCELLATION: 103 DOC 401 cancels all previous Department of Correction policy statements, bulletins, directives, orders, notices, rules or regulations regarding booking and admissions which are inconsistent with this policy.

SEVERABILITY CLAUSE: If any part of this policy is, for any reason, held to be in excess of the authority of the Commissioner, such decision shall not affect any other part of this policy.

401.01 Reception

1. The Superintendent at each correctional institution shall ensure that written procedures are developed for the reception of new commitments and admissions which shall provide for, but not be limited to, the following:

   A. The identification of the staff member(s) who shall admit all new commitments or admissions during business and non-business hours.

   B. A method of identifying and of determining the legality of the commitment or admission.

   C. A system of entering the admission into the Inmate Management System (IMS).

   D. The telephonic interpreter service information shall be provided during the standard reception process. If an inmate requests an interpreter or staff believe the use of an interpreter is necessary, the telephonic interpreter service shall be utilized in accordance with 103 DOC 488.00 Telephonic Interpreter Service. Staff shall document the use of the service in the IMS booking/intake comments section of the Inmate Data screen.

   E. An unclothed search of the inmate and a thorough search of his/her personal effects. This initial unclothed search and all additional searches will be conducted according to the gender of the committing facility unless the inmate identifies, and is verified as gender non-conforming (pursuant to 103 DOC 653). Once verified, the gender of the searching staff member shall be noted on the inmates' identification card.

   F. A complete inventory of the inmate's personal property under the requirements of 103 CMR 403, Inmate Property.

   G. For committing institutions, assignment of the Departmental commitment number via the IMS Unidentified Arrivals and Inmates Pending Identification screens.

1. Before generating a new commitment number, booking staff shall conduct a search on the IMS Inmates Pending Identification screen for prior commitments. If prior commitments are found, the most recent one shall be selected and copied to the current record utilizing the “copy prior record” button. When records are copied in this manner, the inmate shall still be interviewed and the screens updated as necessary in accordance with 401.01 (2) (A).

   Note: Use of the “copy prior record” function populates IMS screens with information from the inmates’ prior commitment. For inmates for whom a “full copy” is possible, booking staff shall review the “Suicide Query” screen, “Mental Health Watch” screen, and the “Mental Health/Substance Abuse” screen. For inmates for whom only a “partial copy” of records is possible, booking staff shall review the “Suicide Query” screen and “Mental Health/Substance Abuse” screen. If evidence of past mental health issues are found as part of this review (e.g., Q5 entries, past mental health watches, suicidal ideation), booking staff shall contact the Shift Commander.

   During business hours, the Shift Commander shall notify the Director of Security and contact the Director of Mental Health to determine appropriate placement and/or need for action or follow-up. During non-business hours, the Shift Commander shall contact the Institution Duty Officer and the on-call Mental Health Clinician.

2. When an inmate is released from one sentence to serve another (e.g., from and after sentences), the assignment of the new commitment number shall be completed by the facility at which the inmate is housed.

H. For receiving institutions, a process to ensure the Booking Officer/staff interviews the inmate and updates the IMS screens upon admission in accordance with 401.01 (2) (A).

I. Issuance of clean bedding and clean clothes as necessary.

J. Articles necessary for maintaining proper personal hygiene are available to all offenders and provided to those who are indigent. Each offender shall be provided soap, toilet paper, a toothbrush and toothpaste, and denture cleaner and adhesives, if needed. Shaving equipment should be made available upon request, and the special hygiene needs of all offenders shall be met.

K. Availability of showers and hair care.

L. Medical, dental and psychological screening shall be conducted in accordance with 103 DOC 630.00 Medical Services. No inmate shall be quarantined for medical reasons in excess of twenty-four (24) hours without proper medical authorization. Results shall be entered into the Mental Health/Substance Abuse History, Medical Orders, and Medical Restrictions screens by medical staff utilizing the IMS medical modules. If as a result of the immediate medical/mental health screening process, booking and/or medical staff have reason to believe that the inmate has potential mental health issues, the notification process outlines in 401.01 (1) (G) (1) shall be followed.

M. A process for the notification to the inmate's family or next of kin of the inmate's current placement.

N. At both committing and reception facilities, a Q5 query by a certified LEAPS user shall be conducted immediately upon arrival and prior to the inmate's placement into general population. Results shall be entered in the IMS Suicide Query Screen. Positive Q5 results shall be communicated to the Shift Commander and the

Director of Mental Health during business hours or the Shift Commander and the on-call Mental Health Clinician during non-business hours for appropriate placement and/or need for action or follow-up.

O. A determination of the appropriateness of a release into general population.

P. Housing or unit assignment via the Internal Risk Housing Placement form within seventy two (72) hours.

Q. At reception facilities or facilities receiving an Inter-Departmental Transfer (e.g., a transfer from a county, federal, and a state facility other than Massachusetts), a determination as to whether the inmate is required to provide a DNA sample. All guidelines established in 103 DOC 487.00 DNA Sample Collection shall be followed.

2. The following procedures shall be adhered to concerning the booking and admissions process for all facilities.

A. Staff shall interview all inmates, detainees, and civil commitments and complete the following IMS screens upon admission:

- Unidentified Arrivals and Inmates Pending Identification (for new commits)
- Arrival Processing (if admitted on same commit number),
- Inmate Data,
- Family/Emergency Contacts (Note: If the individual is or was previously incarcerated, staff shall utilize the Inmate Search screen to obtain the commitment number and enter it in this screen. If the inmate refuses to provide an emergency contact, staff shall enter “refused to provide” in the Name field on the Friends tab and enter a flag in the Emergency Contact checkbox),
- Enemies (Note: If enemies are claimed, staff shall utilize the Inmate Search screen to

obtain the current or most recent prior commitment number if it exists and enter it on this screen. If none are claimed, the “claims none” checkbox shall be entered),

- Escape History (Note: The “claims none” checkbox shall be entered if there is no history),
- Alias Information (Note: the “claims none” checkbox shall be entered if no alias names, dates of birth, or social security numbers are indicated),
- STG/Staff Assaults (Note: If no STG affiliations are reported, the “claims none” checkbox shall be entered),
- Military History (Note: If there is no history, the “claims none” checkbox shall be entered),
- Suicide Query,
- Medical restrictions verification (for committing sites, when assigning a commitment number, the medical comments screen should include deaf, blind, hearing and/or visually impaired identification),
- Photos (Facial & Marks, Scars, Tattoos),
- Outstanding Legal Issues (for detainees)
- Link Prior Commitments (if applicable)
- Inmate Health Insurance (If the inmate states that he/she does have health insurance, ensure all fields are completed on this screen),
- Orientation Checklist (if applicable)

B. Once the above noted screens have been completed, an “offender face sheet” report shall be generated (see attachment I) and placed in the inmate’s six part folder.

If an inmate has been identified as deaf, blind, hearing and/or visually impaired in the Medical Restrictions Screen in IMS, a red dot shall be placed on the lower right corner of his bed book card for use by the housing unit officer. This will alert staff that the inmate has a hearing impairment, and may need additional assistance during an evacuation. In addition, pursuant to 103 DOC 730, Fire Prevention and Safety, each Superintendent shall develop a written fire and

emergency evacuation plan that contains a process to assist inmates in evacuating who may have medical restrictions, including, but not limited to, deaf and hearing impaired, blind and visually impaired, and those with physical disabilities.

3. All facilities shall develop written procedures that include the identification of a review mechanism for oversight of the utilization of IMS during the booking process and assurance of data quality. The procedures shall include:

A. The identification of a supervising staff person responsible for the daily oversight of the booking process. He/She shall:

1. Run a morning report or a new inmate list report to identify newly admitted inmates, detainees, and civil commitments;

2. View the Navigation screen for each new inmate (e.g. new commitment, transfer, return) to determine if all required screens identified in 401.01 (2) (A) were accessed;

3. Check each screen to determine if all required fields are completed and if there are any obvious errors in accuracy;

4. If any screens or required fields were not completed, ensure that they are properly completed;

5. If there are any obvious errors in accuracy, ensure that they are corrected; and,

6. Ensure that all data entry is completed on the inmate's day of arrival. When it has not been done due to the inmate's inability to complete the process (e.g., placement in the health services or special management unit), the Supervisor shall ensure that the inmate is interviewed and completion of screens occurs as soon as possible.

401.02 DNA Collection

The identification, collection, and processing of inmate DNA samples shall be done in accordance with 103 DOC 487, DNA Sample Collection.

401.03 Orientation

A. Each Superintendent shall develop written procedures to ensure that each inmate receives an orientation upon admission within the following time periods:

Within twenty-four (24) hours after arrival:

Written information regarding procedures governing visitation shall be made available. This requirement may be satisfied by providing a copy of the institution's visiting rules developed pursuant to 103 CMR 483, Inmate Visits which is available in English and Spanish.

Inmates transferred from other institutions within the correctional system shall receive an orientation to the new institution. Except in unusual circumstances, this orientation is completed within seven (7) calendar days after admission. New inmates entering the correctional system for the first time receive an initial reception and orientation to the institution. Except in unusual circumstances, this orientation is completed within thirty (30) calendar days after admission.

The following topics shall be included:

1. Mail procedures, including an explanation of the prohibition of inmate to inmate correspondence as well as notice that disciplinary action may be taken for violations of that rule. Inmates transferred from another facility shall be asked if approval for inmate to inmate correspondence was previously given.
2. Disciplinary procedures (copy of 103 CMR 430, Inmate Discipline to all inmates at committing institutions which the inmate may keep if he/she chooses);
3. Canteen services;
4. Inmate counts and mass movement;
5. Recreation;
6. Personal property;

7. Housing regulations;
8. Medical attention/sick calls, medical copayment fees, and access to medical grievances (NOTE: Medical care is not denied based on an inmate's ability to pay);
9. Communicable diseases: Inmates shall receive information and training as a part of their orientation program;
10. Institution rules and regulations, to include a written schedule of staff access hours to encourage staff/inmate interaction;
11. Information concerning Department and institution grievance procedures;
12. Prohibition of smoking or possession of tobacco and tobacco related products;
13. Prohibition of the possession and/or use of cell phones, other unauthorized electronic devices, and cell phone and other unauthorized electronic device paraphernalia; (including cell phone chargers, chargers, SIM cards and any other related products.
14. Emergency evacuation plans;
15. Procedures for securing inmate identity documents;
16. Shower access in accordance with 103 DOC 750, Hygiene Standards.
17. The following shall be included in all correctional facilities' inmate orientation manuals:
    a. All PREA orientation information contained within attachment II.
    b. The section concerning Cell Phones, other unauthorized electronic devices, and Cell Phone and other unauthorized electronic device paraphernalia, shall include the following statements:

       Inmate use and or possession of any type of cell phone, other unauthorized electronic devise, or cell phone or other unauthorized electronic device paraphernalia (including cell phone chargers, chargers, SIM cards, and any other related products), is strictly prohibited and considered a serious security issue. Inmates found in possession of said items shall be subject to formal disciplinary action. Use and/or possession

of cell phones or cell phone paraphernalia shall be considered a category 2 disciplinary infraction.

c. The section including inmate identity documents shall include the following statements:

Proper documentation of one’s identity at the point of discharge from the Massachusetts Department of Correction (DOC) and or classification to a Pre-release facility is necessary for successful reentry to your community. Documentation such as a state issued ID, social security card, birth and marriage certificates, military release documentation (DD214) and education credentials are necessary to access or activate services and benefits upon release. These documents are often necessary to secure housing, open a bank account, secure employment and access health benefits. You have likely entered the Massachusetts Department of Correction without this documentation. Securing these documents prior to release or classification to a Pre-release facility should be a priority, as once you are released or classified to a Pre-release facility it may be difficult and time consuming. Please begin planning for this now by securing items so you can access them at pre-release or upon your release. These documents can be secured in your property to be made available to you at Pre-release or at discharge.

18. Telephonic interpreter service information.

19. The following shall be included in all medium and maximum security correctional facilities' inmate orientation booklets:

a. An inmate shall be considered attempting to escape at the point when he/she enters the "no mans zone" without proper notification and authorization by the Superintendent or

his/her designee. The "no mans zone" shall be the area between two (2) security barriers which separates the inner perimeter from the outer perimeter at medium and maximum security correctional facilities. The two (2) security barriers may be a combination of fences, walls and/or other permanent structures intended as security barriers. Upon entering the "no mans zone" the inmate shall be considered a threat to public safety and will invoke the "shoot to stop" procedures.

20. The following shall be included in all minimum and pre-release correctional facilities' inmate orientation booklet:

    a. Inmates shall be informed of Departmental policy and procedures that cover collection of required fees in accordance with 103 CMR 405, Inmate Funds.
    b. In accordance with 103 DOC 521, Outside Hospital Security Procedures, any time an inmate is admitted to an outside hospital while on any form of authorized release from an institution, (e.g., work release, education release, Program Related Activity, etc.), who has not been transported to said hospital by a Department employee, shall be responsible for ensuring that the parent institution is notified. Failure to notify may result in disciplinary action.

       Pre-release inmates hospitalized without security coverage shall be required to notify the parent institution Superintendent/ designee, when scheduled to be away from their room for testing or treatment.

21. The following shall apply to reception centers conducting an initial inmate intake and orientation:

    a. A parent identification process.
    b. Information regarding access to basic needs programming (e.g., substance abuse, violence reduction, life skills).

c. An introduction to the Department's child support enforcement monitoring program.
d. Access to the Department's parenting services, if applicable.
e. A review of other community resources to address an inmate's individual parenting needs.

The above noted orientation subjects shall be recorded in the IMS Orientation Checklist screen (Note: "responsible parenthood" shall be selected in the orientation type field as applicable).

22. The following shall apply to reception centers conducting an initial inmate intake and orientation regarding the Security Threat Group (STG) Orientation: Security Threat Group Program Orientation:

a. The goal of the STG orientation program is to reduce affiliation and recruitment activities of newly incarcerated inmates by informing and educating inmates about the risks associated with STG involvement during their incarceration.
b. The STG orientation program may include, but is not limited to, an introduction to STG group management, identification of STG members, the notification process, consequences of engaging in STG activities, placement of those involved in STG activities, and the disassociation process.

B. Each Superintendent/designee shall ensure that new inmates receive written orientation materials in English or Spanish. When necessary, other non-English speaking inmates shall receive translation into their own language via the telephonic interpreter service. When a literacy problem exists, a staff member may assist the inmate in understanding the problem. In addition, institutions shall conspicuously post, in at least one (1) location, both the institution rules and 103 CMR 430, Inmate Discipline.

C. Completion of all types of orientation and receipt of all materials shall be documented in the IMS Orientation Checklist screen. Reception Centers, if

using an approved alternative orientation checklist that is signed and dated by the inmate, shall be exempt from signing and dating an IMS printout. It shall also be documented by the inmate signing and dating a printout of the completed IMS Orientation Checklist screen. If the inmate refuses or is incapable of reading and signing for the information included in the orientation manual, the staff member providing the inmate with the copy shall indicate such refusal/incapability in the IMS Orientation Checklist Screen, as well as the assistance offered/given to an inmate who is incapable of reading and signing. The checklist shall be filed in the inmate's case record.

D. In addition to the required orientation topics, all institutions shall be required to provide training for the inmates during the orientation sessions that covers, but is not limited to, the following:

1. How to avoid becoming a victim while incarcerated.
2. Treatment available for victims of sexual abuse.
3. How to report sexual misconduct incidents.

401.04 Inmate Telephones

Each Superintendent shall ensure that written procedures are developed to ensure that all new commitments and admissions are allowed access to telephone communication within twenty-four (24) hours of arrival, unless existing conditions at the time warrant a delay. All exceptions to this rule shall be documented in the IMS booking/intake comments section of the Inmate Data Screen.

401.05 Housing Cell Assignments

In compliance with the National Prison Rape Elimination Act (PREA) standards, all incoming inmates shall be assessed for their risk of being sexually abused by others and for sexually abusive behavior. The admissions officer and medical/mental health staff shall conduct this initial assessment within 72 hours utilizing the electronic PREA screening instrument, found within IMS. Additionally, the Correctional Program Officer and medical/mental health staff shall conduct a subsequent assessment within 30 days after

arrival. Moreover, an assessment shall be completed every six months for Gender Dysphoria inmates. Lastly, an assessment may be completed any time deemed necessary by the respective Superintendent.

1. Single occupancy cells/rooms may be made available, when indicated, to the following:

    - Inmates with severe medical disabilities;
    - Inmates suffering from serious and persistent mental illness;
    - Inmates with a documented history of predatory behavior;
    - Inmates with a documented history of being sexually victimized;
    - Inmates likely to be exploited by others;
    - Inmates who are developmentally disabled;
    - Inmates who have other special needs for single housing.

    Note: “When indicated” refers to determinations made by the classification system, medical/mental health diagnosis, or other professional conclusions.

2. Double occupancy cells/rooms or dormitory beds may be assigned where single cells are not available or appropriate. When authorizing housing and cellmate assignments, staff members shall consider the following guidelines which are put forth in this policy to ensure staff and inmate safety.

    (a) An inmate’s legal status may restrict and therefore limit his/her housing assignment options within a Department institution. These include, but are not limited to: Awaiting trial inmates excluding inmates incarcerated pursuant to M.G.L. c. 276 § 52A, civil cases pursuant to M.G.L. c. 123, § 35, Bridgewater State Hospital commitments and sexually dangerous persons. The Department shall abide by all applicable laws in this regard.

(b) All new arrivals to an institution shall be housed in an orientation unit or in housing areas that provide for intensive sight and sound supervision before and during their initial orientation to that institution. The Superintendent or the Deputy Superintendent may consider an alternative placement for security, programmatic or medical reasons.

(c) Staff shall avoid placing known or potential victims with known or potential predators. Further, staff shall consider matching other factors such as length of sentence, age, medical, and mental health issues, size and weight, as matching these characteristics may result in a positive housing situation.

(d) Staff shall make different housing unit assignments for inmates who are known or potential victims from those who are known or potential predators. The Superintendent may make exceptions to this strategy for security, medical/mental health, or programmatic reasons. The Superintendent shall document these exceptions.

(e) Inmates who are known or potential victims should, whenever possible, be housed with similar inmates on the first tier or in dormitory beds closest to the Officer’s/CPO’s Station.

(f) Inmates who are known or potential predators should, whenever possible, be housed with similar inmates in units which allow for close observation.

(g) Staff shall document each inmate’s reported perception of his/her safety and housing requests normally during the intake process. Inmates who report conflicts with other inmates or staff members shall be processed in accordance with 103 DOC 426, Conflicts. Housing assignments should consider the outcome of any documented conflict.

(h) Inmates who report language barriers shall be assessed and, when possible, matched with cellmates who understand their native language or a similar dialect.

COMMONWEALTH OF MASSACHUSETTS ATTACHMENT I
Department of Correction
Offender Face Sheet

Date:
Commitment # Admit Date:
Inmate's Name

LEGAL NAME :
DATE OF BIRTH :
PLACE OF BIRTH CITY :
PLACE OF BIRTH STATE :
SID # :

FBI # : PRIOR COMMIT #

PRIMARY SSN :

DRV LICENSE NO # : STATE OF ISSUE :

STREET :
CITY :
STATE :
ZIP :
PHONE :

INMATE'S CHARACTERISTICS
SEX :

HEIGHT :

WEIGHT :

BUILD :

GLASSES :

CONTACT LENSES :

DEXTERITY :

FACIAL HAIR :

HAIR COLOR :

HAIR LENGTH :

EYE COLOR :

COMPLEXION :

RACE :

LANGUAGE :

LANGUAGE 2ND :

COMPREHEND ENGLISH :

CULTURE :

RELIGION :

MARITAL STATUS :

CITIZENSHIP :

SCARS/MARKS/TATTOOS : TRK MARKS
SUICIDE QUERY :

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION
OFFENDER FACE SHEET

INMATE BOOKING INFORMATION

ORIG. COURT NAME	:	EFFECTIVE DATE	:
ORIG. SOURCE	:	DATE SENTENCED	:
SENTENCE TYPE	:	PAROLE ELIG. DATE	:
MIN TERM LIFE	:	PAROLE VIOL. DATE	:
MAX TERM LIFE	:	DAYS OF JAIL CREDIT	:
LOCATION OF OFFENSE	:	DATE OF OFFENSE:	
WEAPON USED	:		
OFFENSE	:		
EMERGENCY CONTACT	:	RELATIONSHIP	:
STREET	:	TELEPHONE	:
CITY	:		
STATE	:		
ZIP	:		
EMERGENCY CONTACT	:	RELATIONSHIP	:
STREET	:	TELEPHONE	:
CITY	:		
STATE	:		
ZIP	:		

INMATE’S ALIASES

Attachment II

PRISON RAPE ELIMINATION ACT (PREA)
SEXUAL MISCONDUCT/STAFF SEXUAL MISCONDUCT

A) The Prison Rape Elimination Act, otherwise known as PREA, is a Federal statute which was passed unanimously by the United States Congress and signed into law in 2003 by President George W. Bush. The Act supports the elimination, reduction, and prevention of sexual assault and rape in correctional systems across the country. This includes federal, state, county facilities and all other law enforcement detention facilities.

The Massachusetts Department of Correction is committed to enforcement of the PREA law. We have a zero tolerance policy for any incidence of sexually abusive behavior by a staff member, vendor, volunteer or inmate in any facility and we afford a number of internal and external methods for victims and third parties to report abuse or suspicions of abuse. All reports/allegations of sexual abuse or sexual threats are taken seriously and investigated in a thorough and objective manner. The Department will aggressively pursue the discipline and prosecution of any perpetrator of sexual abuse. Victims and reporters of sexual assault will be afforded ongoing medical, mental health, and victim services and will be protected from retaliation.

All new admissions to the Department of Correction will be scheduled for mandatory orientation to review this information and be educated on important issues. Additionally, refresher information shall be made available as will updated information following any intra-system transfer.

B) The institution PREA Manager is the Deputy Superintendent of Reentry.

C) The Department of Correction and **ADD FACILITY NAME** strive to create and maintain a safe institutional environment for both inmates and staff through the prevention, detection, and appropriate response to Sexually Abusive Behavior. Inmates are forewarned that our workforce is highly integrated in terms of the gender of our staff. As such, staff members of the opposite sex may be present and conducting rounds in housing units at any and all times. To ensure the highest level of privacy, inmates are encouraged to be appropriately dressed at all

times. Should an inmate need to change clothing, the inmate bathroom or other private area should be used to do so. An announcement shall be made to signify that an opposite gender staff person is present in your housing unit. These announcements will be made only whenever there is a status change to alert you.

D) Inmates are responsible for familiarizing themselves with Department of Correction's orientation material on sexual abuse prevention and intervention and 103 DOC 519, SEXUAL HARRASMENT/ABUSE RESPONSE AND PREVENTION POLICY (SHARPP).

E) The Department has established multiple internal ways for inmates to privately report sexual abuse and sexual harassment or retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. A Department hotline has been designated within the inmate telephone system. The number is 508-422-3486 and shall allow for universal and unimpeded access by all inmates within the Department. It is not recorded and is available to all inmates without using their PIN numbers. Additionally, this facility has a site specific IPS hotline **INSERT # HERE**, which may be utilized. Other methods to report include the inmate grievance system, staff access periods, the facility PREA manager, and inner perimeter security staff members.

The Boston Area Rape Crisis Center (BARCC) provides inmates with access to outside victim advocates for emotional support services related to sexual abuse. This abuse does not need to have occurred during incarceration in order for you to seek support from BARCC. An inmate can contact BARCC either in writing or via use of a dedicated hotline. All calls are free of charge from any inmate telephone. Hours of operation are seven days a week from 9:00 a.m. to 9:00 p.m. These confidential support services can be provided in English and in Spanish.

BARCC PREA HOTLINE
99 Bishop Allen Drive
Cambridge, MA 02139
(844) 774-7732

BARCC is NOT a third party entity to which you should report allegations of abuse. BARCC's purpose is to provide confidential support to victims.

Inmates may also report sexual abuse or harassment to external public or private agencies via correspondence or use of the inmate telephone system. Calls to “privileged” numbers including universally approved legal assistance phone numbers (i.e., Prison Legal Services), pre-authorized personal attorney telephone numbers, a foreign national’s pre-authorized telephone number to his/her consular officer or diplomat, pre-authorized clergy telephone numbers and pre-authorized licensed psychologist, social worker and/or mental health professional telephone numbers are not subject to telephone monitoring and are not recorded.

Inmates shall be permitted to send confidential information or correspondence to the DOJ PREA auditor in the same manner as if they were communicating with legal counsel.

Prison Legal Services is identified as an external advocacy group that acts upon the interests of inmates housed in the Massachusetts Department of Correction. Prison Legal Services can be reached at 617-482-2773 and is considered a privileged number. The State Prisoner Speed Dial Number is *9004#

The Department shall accept and investigate verbal, written and anonymous third party reports of sexual abuse and harassment. Third party entities may report abuse to the Department Duty Station at 508-422-3481 or 508-422-3483. These reports will be immediately forwarded to the proper Superintendent or Division head.

Should you report of an allegation that you were sexually abused while confined at another facility or agency, the Superintendent of this facility shall notify the appropriate Superintendent or Chief Administrative Officer of the agency where the alleged abuse occurred no later than 72 hours after receiving the allegation. The incident site is responsible for the investigation of that matter.

F) All acts of sexually abusive behavior between an inmate and a Department employee, contractor, or volunteer or an inmate and an inmate, regardless of consensual status, are prohibited; and the perpetrator shall be subject to administrative, criminal, and/or disciplinary sanctions. The Department of Correction is committed to investigating, disciplining and referring for prosecution, Department employees, contractors, volunteers, and inmates who engage in sexually abusive behavior. The Department is equally

committed to providing crisis intervention and ongoing treatment or referrals to the victims of these acts.

G) If the investigation reveals that an inmate has knowingly made false allegations or made a material statement which he/she, in good faith could not have believed to be true, the Department may take appropriate disciplinary action.

H) All Department employees, contractors, and volunteers are responsible for contributing to the prevention of sexually abusive behavior perpetrated by staff on inmates or by inmates on inmates as outlined in 103 DOC 519, Sexual Harassment/Abuse Response and Prevention Policy (SHARPP).

I) All allegations and incidents of inmate-on-inmate or staff-on-inmate sexually abusive behavior shall immediately be reported by Department employees, contractors and volunteers in accordance with 103 DOC 519 Sexual Harassment/Abuse Response and Prevention Policy (SHARPP). The Shift Commander shall ensure that the Superintendent is immediately notified. Failure of any Department employee, contractor or volunteer to report these allegations may result in disciplinary action, up to and including termination.

Ways to avoid becoming the victim of sexual abuse:

1. Be aware of situations that make you feel uncomfortable. Trust your instincts.

2. If something feels wrong about the environment or situation you find yourself in, leave the area.

3. Don’t let your manners get in the way of keeping you safe. Don’t be afraid to say ‘NO!” “Stop it now,” or “Get lost!”

4. Walk and stand with confidence. Many rapists choose victims who look like they won’t fight back or are emotionally weak. Keep your head up and don’t avoid eye contact.

5. Avoid talking about sex and casual nudity. These things may be viewed as a come-on or make another inmate believe you have an interest in a sexual relationship.

6. Do not accept any food, clothing, or other gifts from other inmates. Being in debt to another inmate may lead to the expectation that you will repay the debt with sex.

7. Avoid secluded areas like closets, storage areas, stairwells, isolated showers or unoccupied bathrooms. Position yourself in plain view of staff members.

8. If you are being pressured for sex, talk to a staff member immediately.

9. If you become aware that another inmate is being sexually abused, report it to a staff member. Next time it could be you.

10. Beware of inmates who offer to protect you. Protection frequently has a cost.

11. Do not give out information about your family, friends, or financial support.

12. Do not buy large quantities of canteen items.

Adjunto II

ACTO DE ELIMINACION DE VIOLACION EN PRISION
(PRISON RAPE ELIMINATION ACT, PREA)
MALA CONDUCTA SEXUAL/MALA CONDUCTA SEXUAL DEL PERSONAL

A) El Acto de Eliminación de Violación en Prisión conocido de otra manera como PREA es un estatuto Federal que fue pasado unánimemente por el Congreso de los Estados Unidos y firmado como ley en el 2003 por el Presidente George W. Bush. El acto apoya la eliminación, reducción, y prevención de asalto sexual y violación en sistemas correccionales a través del país. Esto incluye facilidades federales, estatales, de condados y todas otras facilidades de detención de cumplimiento de la ley.

El Departamento de Corrección de Massachusetts está comprometido a hacer cumplir la ley PREA. Nosotros tenemos una política de cero tolerancia para cualquier incidente de conducta sexualmente abusiva por un miembro del personal, vendedor, voluntario o preso(a) en cualquiera facilidad y nos podemos permitir un número de métodos internos y externos para víctimas y terceras partes para reportar abuso o sospechas de abuso. Todos los reportes/alegatos de abuso sexual o amenazas sexuales son tomados seriamente e investigados de una manera detallada y objetiva. El Departamento perseguirá agresivamente la disciplina y enjuiciamiento de cualquier perpetrador de abuso sexual. Víctimas y denunciantes de abuso sexual recibirán continuos servicios médicos continuos, de salud mental, servicios para víctimas y serán protegidos de venganza.

Todas las nuevas admisiones al Departamento de Corrección serán programadas para orientación mandataria para revisar esta información y ser educados en asuntos importantes. Además, información actualizada deberá hacerse disponible tal como información puesta al día lo hará siguiendo cualquier traslado dentro del sistema.

B) El Gerente de PREA de la institución es el Diputado de Reentrada del Superintendente.

C) El Departamento de Corrección y **ADD FACILITY NAME** se esfuerzan para crear y mantener un medio ambiente institucional seguro para ambos, los presos(as) y personal a través de la prevención, detección, y respuesta apropiada

a Conducta Sexualmente Abusiva. Sean advertidos los presos que nuestra fuerza de trabajo está altamente integrada en términos del género de nuestro personal. Como tal, miembros del personal del sexo opuesto pueden estar presentes y podrán conducir rondas en las unidades de alojamiento en cualquier y todo tiempo. Para asegurar el nivel más alto de privacidad, los presos serán alentados a vestirse de manera apropiada en todo momento. Si un preso necesita cambiar su vestuario, el baño del preso o otra área privada n deberían ser utilizados para ese propósito. Un anuncio será hecho para significar que un miembro del personal del sexo opuesto está presente en su unidad de alojamiento. Estos anuncios serán hechos para alertarlo a usted solamente cuando quiera que haya un cambio en el estatus.

D) Los presos(as) son responsables por familiarizarse ellos/ellas mismos con material de orientación del Departamento de Corrección en prevención e intervención de abuso sexual y 103 DOC 519; POLÍTICA DE RESPUESTA Y PREVENCIÓN DE ACOSO / ABUSO SEXUAL.

E) El Departamento ha establecido múltiples formas internas para que los presos(as) reporten privadamente abuso sexual y acoso sexual o venganza por otros presos(as) o personal por reportar abuso sexual y acoso sexual, y negligencia del personal o violación de responsabilidades que pueden haber contribuido a tales incidentes. Una línea de emergencia ("hotline") en el Departamento ha sido designada dentro del sistema de teléfono de presos. El número es 508-422-3486 y deberá permitir por acceso universal e irrestricto para todos los presos(as) dentro del Departamento. (Este número) no es grabado y está disponible a todos los presos/as sin usar sus números PIN. Además, esta facilidad tiene una línea de emergencia especifica de IPS INSERT # HERE, la cual puede ser utilizada. Otros métodos para reportar incluyen el sistema de queja de preso(a), periodos de acceso al personal. El administrados PREA de la facilidad, y los miembros del personal de seguridad del perímetro interno.

El Centro de Crisis de Violaciones de Boston (BARCC) les provee a los presos con acceso a intercesoras de victimas para servicios de apoyo emocional relacionado al abuso sexual. Este abuso no tuvo que ocurrir durante encarcelación para que puedas buscar ayuda de BARCC. Un preso puede contactar a BARCC o por escrito o atreves del uso de la una línea de emergencia ("hotline"). Todas las

llamadas son gratuitas desde el teléfono de los presos. Horas de operación son los siete días de la semana de 9:00 a.m. a 9:00 p.m. Estos servicios de apoyo con confidenciales y pueden ser proveídos en Ingles o Español.

Línea de Emergencia de BARCC
99 Bishop Allen Drive
Cambridge, MA 02139
(844) 774-7732

BARCC no es una tercera identidad a la que debes de reportar alegaciones de abuso. El propósito de BARCC es proveer apoyo confidencial a víctimas.

Los presos(as) pueden también reportar abuso sexual o acoso a agencia externas públicas o privadas a través de correspondencia o el uso del sistema de teléfono de preso. Llamadas a números “privilegiados” incluyendo números de teléfonos de asistencia legal universalmente aprobados (ej. Servicios Legales de Prisión), pre autorizados números de teléfonos de un abogado personal, un número de teléfono pre-autorizado de un nacional extranjero a su oficial consular o diplomático, pre autorizados números de teléfono de clérigos y pre autorizados números de teléfonos de psicólogos licenciados, trabajador social y/o profesional de salud mental no están sujetos a monitoreo de teléfono y no son grabados.

A los reclusos se les permitirá enviar información confidencial o correspondencia al auditor DOJ PREA de la misma manera que si estuvieran comunicándose con un asesor legal.

Servicios Legales de Prisión es identificado como un grupo de apoyo externa que actúan con el interés de los presos alojados en el Departamento de Corrección de Massachusetts. Servicios Legales de Prisión pueden ser localizados con llamar al 617-482-2773 y este teléfono es considerado un número privilegiado. El Numero de Marcación Rápida para Presos Estatales es *9004#.

El Departamento deberá aceptar e investigar reportes verbales, escritos y anónimos de terceras partes de abuso y acoso sexual. Entidades de terceras partes pueden reportar abuso a la Estación de Turno del Departamento (Department Duty Station) al teléfono **508-422-3481 o 508-422-3483**.

Estos reportes serán inmediatamente dirigidos al Superintendente apropiado o Jefe de la División.

Si usted reporta una denuncia que usted fue sexualmente abusado(a) mientras estaba confinado en otra facilidad o agencia, el Superintendente de esta facilidad deberá notificar al superintendente apropiado u oficial administrativo jefe de la agencia donde el abuso denunciado ocurrió a no más tardar de 72 horas después de haber recibido la denuncia. El sitio del incidente es responsable por la investigación de tal materia.

F) Todos los actos de Conducta Sexualmente Abusiva entre un preso(a) y un empleado del Departamento, contratista, o voluntario o un preso(a) y un preso(a), sin importar el estatus de consentimiento, están prohibidos; y el perpetrador deberá ser sujeto de sanciones administrativas, criminales y/o disciplinarias. El Departamento de Corrección se ha comprometido a investigar, disciplinar y referir a proceso judicial, a empleados del Departamento, contratistas, voluntarios y presos(as) que se envuelvan en Conducta Sexualmente Abusiva. El Departamento está igualmente comprometido a proveer intervención de crisis y tratamiento continuo o referir a las víctimas de estos actos.

G) El Departamento puede tomar acción disciplinaria apropiada si la investigación revela que un preso(a) ha hecho a sabiendas denuncias falsas o hecho una declaración material que él/ella, de buena fe no pudo haber creído ser verdad.

H) Todos los empleados del Departamento, contratistas, y voluntarios son responsables por contribuir a la prevención de Conducta Sexualmente Abusiva perpetrado por personal sobre presos(as) o por presos(as) sobre presos(as) como delineado en 103 DOC 519, Política de Respuesta y Prevención de Acoso / Abuso Sexual.

I) Todas las denuncias e incidentes de Conducta Sexualmente Abusiva de preso(a) sobre preso(a) o de personal sobre preso(a) deberán ser inmediatamente reportados por empleados del Departamento, contratistas y voluntarios de acuerdo con 103 DOC 519 Política de Respuesta y Prevención de Acoso / Abuso Sexual. El Comandante del Turno deberá asegurar que el Superintendente es inmediatamente notificado. La falla de cualquier empleado del Departamento, contratista o voluntario de reportar estas

denuncias puede resultar en acción disciplinaria hasta e incluyendo terminación.

Maneras de evitar de llegar a ser una víctima de abuso sexual:

1. Sea consciente de situaciones que lo/la hacen sentirse inconfortable. Confíe en sus instintos.

2. Si algo se siente equivocado acerca del medio ambiente o situación en la que usted se encuentra, abandone el área.

3. No deje que sus (buenos) modales le impidan mantenerse seguro(a). No tenga miedo de decir "NO", "Para ahora mismo", o "Vete de aquí".

4. Camine y párese con confianza. Muchos violadores escogen victimas que dan la apariencia que no se defenderán o que son emocionalmente débiles. Mantenga su cabeza en alto y no evite el contacto de ojos.

5. Evite; hablar acerca de sexo o desnudez ocasional. Estas cosas pueden ser vistas como una invitación o hacer creer a otro preso(a) que usted tiene interés en una relación sexual.

6. No acepte ningún alimento, vestuario, u otro regalo de otros presos(as). Estar en deuda con otro preso(a) puede conducir a la expectación que usted pagará la deuda con sexo.

7. Evite áreas aisladas como closets, áreas de almacenaje, escaleras, duchas aisladas o baños no ocupados. Posiciónese a sí mismo(a) a plena vista de miembros del personal.

8. Si usted está siendo presionado(a) por sexo, converse inmediatamente con un miembro del personal.

9. Si usted se da cuenta que otro preso(a) está siendo sexualmente abusado(a), repórtelo a un miembro del personal. La próxima vez podría ser usted.

10. Tenga cuidado con presos(as) que se ofrecen para protegerlo(a). Protección frecuentemente tiene un costo.

11. No de información acerca de su familia, amigos, o apoyo financiero.

12. No compre grandes cantidades de artículos de cantina.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION (DOC)
HEALTH SERVICES DIVISION
103 DOC 630
MEDICAL SERVICES
TABLE OF CONTENTS

630.01 Treatment Philosophy..... 2
630.02 General Policy..... 2
Access to Health Care (Procedure Required)..... 2
630.03 On-Site Physical Examination by Outside Physician (non-DOC, non-contractual provider physician)..... 4
630.04 Outpatient Health Services Units (OHSU)..... 5
630.05 Inpatient Health Services Units (IHSU)..... 6
630.06 Medical Entrance Screen (Procedure Required)..... 7
630.07 Ectoparasite (Scabies and Lice) Control Guidelines.. 9
630.08 Inmate Health Orientation..... 9
630.09 Intake Physical Examination..... 10
630.10 Sick Call (Procedure Required)..... 11
630.11 Periodic Physical Examinations..... 12
630.12 Specialty Consultations..... 13
630.13 Authorized/Unauthorized Health Care for inmates in/on Pre-Release, Release Programs 14
630.14 Inmate Co-Payment of Medical Services..... 15
630.15 Emergency Services..... 15
Medical Disaster Plans..... 15
Disaster Box..... 16
630.16 Intra-System Transfers..... 16
630.17 Inmates in Segregation (Procedure Required)..... 18
630.18 Use of Therapeutic Restraints..... 19
630.19 Refusal of Treatment at a Department Facility (Procedure Required)..... 19
630.20 Refusal of Treatment at an Outside Hospital or Outside Clinic..... 20
630.21 Release Procedures..... 21
Attachment A: Sample Letter from the Director of Health Services ... 23
Attachment B: Physician Release for Outside Medical Services 24
Attachment C: Inmate Release for Outside Medical Services 25
Attachment D: 105 CMR 205 Standards Governing Physical Examinations 26
Attachment E: Code 99 Red Bag Contents 31
Attachment F: Medical Disaster Box Minimum Contents 32
Attachments G - L are provided to facilities under separate cover .. 33
Attachment G: Medical History and Screening Form
Attachment H: Medical Restrictions Form
Attachment I: Classification Health Status Report Form
Attachment J: Intra System Transfer Form
Attachment K: Medical Entrance Inquiry Form
Attachment L: Release of Responsibility

MASSACHUSETTS DEPARTMENT OF CORRECTION	DIVISION: HEALTH SERVICES
TITLE: MEDICAL SERVICES	NUMBER: 103 DOC 630

PURPOSE: The purpose of this policy is to define levels of medical care provided to inmates in all Department facilities.

REFERENCES: MGL c.124 §1(c), (q); MGL c.127, §16A
NCCHC Standards: P-07,P-09,P-17,P-28,P-29 P-31,P-32,P-33, P-34,P-37,P-38,P-39,P-40,P-41,P-44,P-45,P-46,P-52,P-66,P-68,P-70,P-71

APPLICABILITY: Public **PUBLIC ACCESS:** Yes

LOCATION: Central Policy File, Facilities' Policy Files
Health Services Division Policy File
Inmate Libraries

RESPONSIBLE STAFF FOR IMPLEMENTATION AND MONITORING OF POLICY:
Director of Health Services
Superintendent

PROMULGATION DATE: 03/03/2005 **EFFECTIVE DATE:** 04/03/2005

CANCELLATION: This policy cancels all previous Department policy statements, bulletins, directives, orders, notices, rules, and regulations regarding inmate medical services.

SEVERABILITY CLAUSE: If any part of this policy is for any reason held to be in excess of the authority of the commissioner, such decision will not affect any other part of this policy.

630.01 Treatment Philosophy

Each facility shall provide access to medical, dental, and mental health services needed to maintain the basic health of inmates.

1. Access to health care is an inmate's right and not a privilege.

2. All health care services shall be provided in an atmosphere that assures privacy and dignity for both the inmate and the provider.

3. All health care services shall be comparable in quality to that available in the community.

630.02 General Policy

1. Each Superintendent shall develop written procedures for providing a system to insure unimpeded access to health care. The procedure does not need to define levels of care, but the way that inmates access health care, including how they are informed regarding accessing health care (i.e., via orientation.)

   Levels of health care to be provided are listed below. These levels of care may be provided either on-site, off-site in the community or at another Department facility.

   a. Self Care;
   b. First-aid;
   c. Emergency Care;
   d. Clinic Care;
   e. Infirmary Care;
   f. Hospital.

2. The contractual medical provider shall ensure that continuity of care is maintained by assuring the proper flow of patient health information between the facility and other Department facilities or health care providers.

3. The Department through the contractual medical provider shall ensure that the delivery of all health care is to be preceded by an explanation of the nature of such treatment.

The Department and the contractual medical provider shall comply with all applicable statutes relating to informed consent procedures (M.G.L. c.111 §70E). The contractual medical provider shall have written guidelines for informed consent procedures.

4. All treatment provided by contractual health care personnel shall be performed in accordance with Massachusetts General Laws, and the regulations of the following organizations/agencies:

   a. MA Boards of Registration in Medicine;
   b. MA Boards of Registration in Dentistry;
   c. MA Boards of Registration in Nursing;
   d. MA Boards of Registration in Pharmacy;
   e. MA Boards of Registration of Psychologists;
   f. MA Boards of Registration in Optometry;
   g. MA Boards of Registration of Dispensing Opticians;
   h. MA Boards of Registration in Physical Therapy;
   i. MA Boards of Registration in Podiatry;
   j. MA Boards of Registration of Social Workers;
   k. Massachusetts Department of Public Health;
   l. Massachusetts Department of Mental Health; and
   m. Any other applicable Federal or State Agency.

5. Each facility shall have access to a contractual physician on-call 24 hours a day, seven days per week.

6. The collection of health history information shall be conducted only by health trained or qualified health personnel. The collection of all other health appraisal data shall be performed only by qualified health personnel. This data shall be recorded only on current forms and/or electronic screens approved by the Director of Health Services or his/her designee and the Program Director of the contractual medical provider, and in accordance with 103 DOC 607, Medical Records.

7. Each facility shall have provision for the immediate medical examination of any inmate suspected of having a communicable disease. All diseases covered by Department of Public Health (DPH) regulation 105 CMR 300 are to be reported by physicians to the local board of health in which the facility is located. For further information on communicable diseases please refer to 103 DOC 631, Communicable Disease Policy.

8. Generally, the contractual medical provider shall not be involved in the collection of forensic information from inmates. Requests for such services should be forwarded to the DOC Health Services Division, who will contract another vendor for these services. Any deviations shall be as governed by 103 DOC 620 Special Health Care Practices.

9. All Facilities shall post a sign, in the intake area, instructing inmates on how to access care for immediate health needs.

10. The contractual medical provider shall develop written procedures for processing complaints regarding health care. The procedure shall be communicated orally and in writing to inmates upon arrival in the facility.

630.03 On-Site Physical Examination by Outside Physician (non-DOC, non-contractual provider physician)

When a request is received for a non-contractual provider physician to examine an inmate all facilities shall instruct the person/inmate to submit a written request to the Director of Health Services. The person shall also be informed that the written request is to include the reason for the examination, the name, address, and license number of the physician who will be performing the examination and the exact equipment to be used. Please note that Inmates in pre-release status may request community based health care visits pursuant to 630.13.

The Health Service Division shall:

1. Forward a letter, from the Director of Health Services, (attachment A) to the party requesting the examination, or to the physician who is to perform the examination, informing him/her of the following specific requirements of the DOC:

   a. A waiver of liability (attachment B) must be signed by the physician and witnessed prior to the examination releasing both the Massachusetts Department of Correction and the contractual medical provider from any fees or medical liability.
   b. The inmate involved must sign an authorization for the examination and waiver of liability (attachment C) releasing both the Department and the contractual medical provider from any costs or medical liability involved in or as a result of the examination. The inmate must also sign an authorization to release

medical information in order for the outside physician to examine the medical record (103 DOC 607, Medical Records, Attachment A & B).

c. The outside physician will be informed that s/he may perform only a non intrusive examination; may write recommendations on a consultation form; that neither the Department nor the contractual medical provider is obligated to comply with any consultation recommendations; that consultation reports will be reviewed by the on-site senior physician and that they may not write any orders or notes in any part of the medical record.

3. The Health Services Division will contact the Board of Registration which governs physicians to confirm the current licensure of the physician to perform the examination and to confirm that there are no restrictions on his/her license to practice medicine.

4. Upon completion of the steps one through three above the Health Services Division will approve or deny the request.

5. The Health Services Division will contact the Health Services Administrator, at the facility involved, to arrange a date for the approved examinations, entry of physician, and notification of facility administration.

630.04 Outpatient Health Services Units (OHSU)

1. Each facility Health Services Unit shall have a contractual physician who possesses a current, valid, unrestricted license to practice in Massachusetts and shall meet the following requirements:

a. Is a graduate of a Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school in the United States or Canada or an international medical graduate who has completed either a fifth pathway year or a valid Educational Commission of Foreign Medical Graduates (ECFMG) certificate; and

b. Has completed an Accreditation Council for Graduate Medical Education Approved Residency Program in the United States;

c. Physicians designated as site medical directors shall be board certified in family practice, internal medicine, preventive medicine, infectious diseases, surgery, or emergency medicine.

d. Specialty physicians shall be board certified in the respective specialty or board eligible or board certified in the respective subspecialty.

The contractual agreement with the medical provider details more specific information regarding qualification requirements of contractual medical staff, including per diem (PRN) physicians and exceptions to specific qualification requirements.

2. Each facility Health Services Unit (HSU) shall meet the following additional requirements:

a. All health care services shall be delivered only by clinically trained medical personnel. All treatment performed by contractual health care personnel other than a physician or mid-level provider shall be performed pursuant to direct orders written and signed by a contractual physician or a mid-level provider.
b. The HSU shall have examination rooms which meet the requirements of 103 DOC 660, Medical Supplies and Equipment, and 105 CMR 205, Minimum Standards Governing Medical Records and The Conduct of Physical Examinations in Correctional Facilities (attachment D).
c. All contractual health care providers shall have access to a full range of laboratory and diagnostic support services.
d. A medical record shall be maintained for each inmate in accordance with 103 DOC 607, Medical Records.
e. Each HSU shall have access to a pharmacy service.

630.05 Inpatient Health Services Units (IHSU)

Inpatient Health Services Units are to be in compliance with applicable state statutes and local licensing requirements (see 630.02(4)). Inpatient Health Services Units are of two types: those which offer infirmary care and those which do not. Those IHSUs which offer infirmary care provide skilled nursing care for patients not in need of hospitalization. Those which do not, are special housing units which offer outpatient level of care but in an inpatient setting. IHSU'S shall meet the minimum requirements listed below in addition to those listed in section 630.04 of this policy.

1. A contractual physician shall be available on-site and/or on-call 24 hours a day, 7 days a week.

2. Nursing and/or paramedical services shall be provided under the direct supervision of a registered nurse and/or physician assistant and/or nurse practitioner.

   Those IHSUs that offer infirmary care shall provide 24 hour nursing service, 7 days a week.

3. All orders for care are signed or co-signed by a contractual physician.

4. Admission and Discharge to the IHSU, that offer Infirmary care, shall be initiated only upon the order of a licensed contractual physician.

5. All IHSUs shall have clinically trained health care personnel on site 24 hours per day, 7 days a week.

6. The contractual medical provider shall establish a manual of nursing care procedures/protocols.

7. A separate and complete medical record shall be generated for each patient admitted to an infirmary IHSU, other than at Bridgewater State Hospital (BSH).

8. Physicians shall make daily rounds (including weekends) of all patients in the infirmary.

9. Meals shall be served to patients within the IHSU.

10. All patients in IHSUs, that offer infirmary care, shall be within sight or sound of a health care staff member at all times.

630.06 Medical Entrance Screen

1. Each Superintendent shall develop a procedure to identify all new arrivals at the facility. All inmates shall be medically screened prior to placement in the general population by qualified contractual health care personnel. All findings are to be recorded on a screening form. At facilities utilizing the Inmate Management System (IMS), the Mental Health/Substance Abuse History, Medical Orders, and Restrictions/Special Needs screens shall be completed. These screens shall subsequently be updated as necessary.

2. The medical history and screening form shall include the following (attachment D, 105 CMR 205):

   a. Inquiry into current illness and health problems,

including:
- communicable diseases;
- venereal diseases;
- dental problems;
- current medications;
- chronic health problems;
- mental health issues, including history of treatment, medication, or hospitalization as well as current assessment for suicidality;
- use of alcohol and other drugs, including types of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of any problems that may have occurred after ceasing use (i.e. convulsions);
- possibility of pregnancy (females);
- other health problems identified by the contractual program director and the director of health services.

b. Observation of general behavior, including:
- state of consciousness;
- mental status;
- appearance, including tremor or sweating, body deformities and ease of movement;
- condition of skin, including trauma, bruises, lesions, jaundice, rashes, infestations, needle marks or other signs of drug abuse.

c. Recommendations for disposition and placement to:
- immediate medical emergency;
- admit to infirmary;
- discharged to general population; and/or
- general population with referral to health services; Mental Health, Dental, or Medical;

d. Female inmates/detainees/civil commitments are to be tested for pregnancy upon admission.

e. Documented Explanation of the procedures for access to health and dental services.

f.

3. When chemical dependency is suspected, the inmate is to be referred to a physician. If the contractual physician diagnoses the inmate as chemically dependent, the facility shall follow Department policy 103 DOC 620, Special Health Care Practices.

4. A medical quarantine for new inmates shall not exceed 24 hours unless specifically ordered by a contractual physician.

630.07 Ectoparasite (Scabies and Lice) Control Guidelines

Each Superintendent, in conjunction with the Health Service Administrator (HSA), will develop procedures for the examination for lice and for delousing.

1. Inmates will be screened for scabies and lice at the time of admission or transfer to each facility (see medical history and screening form, attachment F). The procedure should state who is responsible for this screening and how it is documented.

2. Treatment will be carried out as ordered by the physician on an individual basis. The procedure to carry out physician orders should be detailed in site-specific procedure, including correction staff involvement.

3. Treatment will not be initiated on female inmates until pregnancy is ruled out.

4. Inmates and staff will receive health care education material related to ectoparasite when indicated. Materials should be maintained in contractual medical provider infection control manual. The procedure should specify circumstance that indicates the need for this material to be distributed and how distribution is accomplished.

5. Facility health and safety officer will be notified when ectoparasite control measures are needed in specific housing units. Procedure should detail notification process and action to be taken by correction staff to carry out necessary measures.

6. Personal clothing, bedding, etc., of infested inmates will be placed in appropriately labeled laundry bag and laundered in hot water and machine dried. The procedure should detail direction as to who is responsible for tasks involved.

630.08 Inmate Health Orientation

Upon the arrival of an inmate at a facility, following commitment, return, or transfer, the facility shall provide the inmate with both verbal and written instructions that explain the procedures for gaining access to health care when needed. In the event that an inmate is unable to read, facility staff will make arrangements for the procedures to be explained verbally.

At facilities utilizing the Inmate Management System (IMS), documentation of orientation shall be via the Orientation Check List screen.

630.09 Intake Physical Examination

1. Each Superintendent shall develop a written procedure to identify all new arrivals at the facility (also see 630.06 §1). The following inmates shall receive a complete physical examination within seven days of admission to the facility:

   a. new commitments;
   b. parole violators;
   c. inmates returned from escape;
   d. when indicated, inmates returned to higher custody from sites that do not have an HSU;
   e. probation violators.

2. When the inmate is accompanied by a medical record that documents a complete physical examination was conducted within 90 days prior to admission, the need for a new examination shall be determined by the facility medical director or his/her designee. If a full physical examination is not performed, the inmate shall be seen by a contractual physician, physician assistant, or a nurse practitioner, who shall do the following:

   a. Review and co-sign inmate's record;
   b. Examine the inmate for signs of recent trauma or disease;
   c. Conduct any examination and tests which are medically indicated;
   d. Review the findings with the inmate.

3. The physical examination shall be conducted by a contractual physician, physician assistant or nurse practitioner. The results of an exam conducted by a physician assistant or nurse practitioner shall be reviewed and signed by a physician.

4. Upon completion of the physical examination and all required and ordered laboratory tests, a qualified health care professional shall discuss with the inmate results of the examination, its implication, and suggestions for further diagnoses and/or treatment.

5. The contents of the physical examination shall be in compliance with the most recent DOC/Vendor contract, Massachusetts DPH regulations 105 CMR 205.200 (attachment D), ACA, NCCHC, and in the case of BSH, JCAHO Standards.

6. Should an inmate's physical condition warrant special consideration for housing, job assignment or program participation, the contractual physician or his/her designee shall complete a Medical Restrictions Form (attachment H) and forward the form to the facility Classification Supervisor.

   At facilities utilizing the Inmate Management System (IMS), medical restrictions shall be written on the Physician Order Sheet, and the data entered on the Medical Restrictions/Special Needs screen.

630.10 Sick Call

Access to daily sick call is an inmate's right and not a privilege.

1. Each facility shall have written procedures for processing inmate health requests included in its sick call procedure.

2. Each Superintendent, in conjunction with the HSA shall have written procedures for sick call conducted by a contractual physician or other qualified health personnel. The sick call procedure shall include how often and during what hours sick call is held at that facility. Sick call may be conducted on-site, off-site at another facility, or off-site at an outside health care facility.

3. Sick call shall be available to each inmate five days per week. A physician shall be on site seeing patients/inmates a minimum of three and one half-hours per week per 100 inmates. Actual physician coverage for sick call at each site shall be determined by written agreement between the department and the contractual medical provider (staffing matrix). Nurse practitioners or physician assistants under the supervision of a physician can substitute for a portion of the physician’s time seeing patients, with the approval of the director of health services.

4. All requests must be processed and triaged by a qualified healthcare professional within twenty-four (24) hours or seventy-two (72) on week-ends. All inmates who submit a sick call request shall be seen by a qualified healthcare

professional on a priority basis that will not exceed seven (7) calendar days from the day of submission of the request. All sick call slips will be placed in the medical record.

Sick call/physician clinic services shall be available to Inmates within all Facilities, including those in general population, restricted housing units, and special management units. The sick call schedule shall be entered on the Inmate Management System (IMS) Inmate Schedule screen by contractual health care personnel.

5. During non-business hours and weekends, medical problems which cannot be deferred until the next regularly scheduled sick call shall be handled in accordance with Department Policy 103 DOC 604, Outside Hospital Relations.

630.11 Periodic Physical Examinations

The goal of the Health Services Division is to provide periodic physical examinations to all inmates. Complete periodic physical examinations shall be performed on the following time schedule determined by inmate age:

Age Group	Schedule of Complete Physical Exams
Inmates 20-29 years	Every five years
Inmates 30-39 years	Every three years
Inmates 40-49 years	Every two years, including rectal exam and stool for occult blood
Inmates 50+ years	Annually, including EKG, rectal exam and stool for occult blood

It is required that all female inmates have annual pelvic and breast examinations. Women between ages 40-49 will receive a mammogram biennially and after age 50 annually.

1. The Health Services Administrator for the contractual medical provider will forward, on a quarterly basis, a report to the Superintendent indicating the following:

   a. Number of physical examinations due and conducted for each month;

   b. The number of physical examinations that are past due and why they are past due; and

   c. An action plan to complete all past due physical examinations.

The Superintendent shall report to the Health Services Division, Regional Administrator any issues relative to the completion of the past due physical exams.

2. A qualified health professional shall review medical records of inmates who are in age groups not requiring the periodic physical examinations on an annual basis. The review shall ensure that all inmates receive annual blood pressure checks and TB screening. At the discretion of the contractual health professional, the inmate shall be scheduled for a complete physical examination as deemed medically necessary.

3. Upon completion of the physical examination, and all required/ordered laboratory tests, a qualified health professional shall discuss with the inmate results of the examination, its implications, and suggestions for further diagnosis and/or treatment.

4. The content of all physical examinations shall be in compliance with the most recent DOC/Vendor contract, Massachusetts DPH Regulations 103 CMR 205, Section 205.200 (attachment D), ACA, NCCHC, and in the case of BSH, JCAHO Standards.

630.12 Specialty Consultations

Specialty consultations shall be available to each facility through on-site clinics, specialty clinics at the Lemuel Shattuck Hospital (LSH), other Department HSUs, or outside consultants. The specialty clinics shall include, but not be limited to, Orthopedic, General Surgery, ENT, Endocrinology, Dermatology, Optometry, Ophthalmology, Cardiology, Physical Therapy, OB-GYN, Podiatry, Radiology, Infectious Disease, and Mammography.

All consultation services shall be performed only at the request of a contractual physician and only after a consultation request has been prepared in writing and signed by the responsible contractual physician. A consultation summary will be expected from all specialists.

1. On-site specialty clinics shall be scheduled at facilities as deemed necessary to meet the needs of the population by the HSA. The schedule of on-site specialty clinics will be approved by the Director of Health Services.

2. With the exception of on-site specialty clinics, LSH outpatient clinics will be the designated source of

specialty consultations. All consultations shall be scheduled and facility transportation forms will be required. Transportation between the facility and LSH shall be the responsibility of the Superintendent or his/her designee, unless a contractual physician determines that transportation by ambulance is necessary.

At facilities utilizing the Inmate Management System (IMS), consultation schedules shall be entered on the Inmate Schedule screen detailing on-site medical visit (internal) versus off-site hospital/medical trip (external) by contractual health care personnel. Additionally, the Medical Restrictions/Special Needs screen shall be updated and printed instead of the facility transportation forms.

3. Consultations may be arranged with outside non-LSH specialists only when it is determined that required services are not available at the facility nor at LSH, and the services are recommended by the contractual physician. Locations of such consultations shall be subject to approval by the contractual Program Director or his/her designee, with the exception of medical emergencies.

4. Patients referred to consultants by contractual physicians for diagnostic evaluation and continuing treatment, and who are accepted by the consultant as a patient for continuing treatment will remain the responsibility of the contractual attending physician. The contractual physician shall record in the progress notes of the inmate’s medical record all consultant recommendations being followed. All consultant recommendations not being followed shall also be recorded by the contractual physician in the progress notes with specific reasons written as to why those recommendations are not being followed.

   All changes in physician’s orders will be written on the physician order sheet in the inmate’s medical record and signed, timed, and dated by the contractual physician.

630.13 Authorized/Unauthorized Health Care for Inmates In/On Pre-Release, Release Programs

1. When an inmate is approved for work release, furloughs, or other release programs, the inmate shall be advised by the facility staff, both verbally and in writing, that the Department will not be responsible for the payment of unauthorized health care services.

2. All health care services for inmates (except for those provided on-site at the facility, at LSH or at another Department facility) must be approved in advance by the Director of Health Services or his/her designee. The only exception to this rule shall be medical emergencies and work related injuries covered by the inmate employer's Workman's Compensation insurance plans.

630.14 Inmate Co-Payment of Medical Services

A Co-Payment Policy exists which details the specific protocol for adhering to the policy in its entirety. Please refer to Policy 103 DC 763 Inmate Medical Co-Payments.

630.15 Emergency Services

1. Each facility will be provided with emergency medical and dental care twenty-four (24) hours a day, seven (7) days a week via an on-call physician service and/or on-site health care staff. The provision of these services shall be outlined in procedures written by the contractual medical provider that meet the specifications of Department policies 103 DOC 604, Outside Hospital Relations, and 103 DOC 105, Department Duty Officer.

2. Each facility shall use the designation "Code 99" whenever a life-threatening emergency exists. Each facility shall have a written Code 99 Procedure applicable to its facility as required by 103 DOC 622, Death Procedures. An emergency "Code 99" or "red bag" will be available in HSUs for all emergency responses. (See attachment E for required contents of the Red Bag.)

3. The Department's Medical Disaster Plan (see 103 DOC 560.04) shall be implemented upon the authority of the Director of Health Services, when s/he is notified by the Commissioner that a state of emergency has been declared.

   a. Site specific Medical Disaster Plans, developed jointly by the facility's security staff and the contractual medical provider, must be approved by the Director of Health Services, as required in 103 DOC 604, Outside Hospital Relations, and 103 DOC 560, Disorder Management. The Director of Operations and Security must also approve each site specific Medical Disaster Plan.

b. Each facility is responsible to have a disaster box readily available should a medical disaster occur. The disaster box must be built for easy transport to any area of the facility. It will be sealed and located in a secure, strategic and easily accessible area outside the medical unit. This box is to be opened only for disasters, drills and restocking contents.

The contractual medical provider will maintain the disaster box. A list of contents will be determined by the contractual medical director. The content list, with expiration dates, will be affixed to the outside of the disaster box. Medical staff, accompanied by security staff, will check the seal and expiration dates on a quarterly basis, replacing expired supplies as needed. (See attachment F for minimum contents requirements.)

630.16 Intra-System Transfers

The contractual medical provider shall ensure that the continuity and availability of health care is maintained when inmates are transferred between facilities.

1. The Department's classification process shall include consideration of inmates' medical and mental health status.

a. Names of inmates scheduled for initial classification, reclassification and/or any classification hearing that may result in a transfer will be submitted to the HSU at the facility by classification staff two weeks prior to scheduled classification board appearance dates.

b. Upon receipt of notification, contractual health and contractual mental health staff will initiate a Classification Health Status Report (attachment I) by reviewing the medical record.

At facilities utilizing the Inmate Management System (IMS), the Medical Restrictions/Special Needs screen shall be updated instead, including the minimum health care coverage necessary.

c. If medically indicated the inmate will be examined by a psychiatrist or mental health clinician, and/or physician, physician assistant or nurse

practitioner. Current medical data will be obtained and reviewed.

d. At sites not utilizing the Inmate Management System (IMS), when all pertinent medical and mental health information is gathered, the Classification Health Status Report form (attachment I) will be completed and sent to the facility classification supervisor prior to the scheduled appearance date.

2. Whenever feasible the designated contractual health service personnel shall be notified at least three days prior to the transfer of an inmate.

Notification via Inmate Management System (IMS) is made by use of the Notification screen and/or Institution Schedule Query screen under Inter Institution Transfer.

3. At the time of transfer, each inmate will be accompanied by his/her medical record, as set forth in DOC policy 103 DOC 607, Medical Records. Also, the sending facility's health service staff will make every effort to complete an Intra-system Transfer form (attachment J) prior to transfer to send with the medical record.

4. If an inmate arrives at the receiving facility without the appropriate records and/or medications, the sending facility's health service staff shall immediately be notified.

5. All intra-system transfers shall be screened by health trained or qualified health care personnel immediately upon arrival. An inquiry of whether the inmate is being treated for a medical, dental or a mental health problem shall be made. There shall also be an inquiry as to whether the inmate is presently on medication or whether the inmate has any current medical, dental or mental health complaints. Observation and listing of findings of general behavior, physical deformities or any signs of trauma shall be documented on the Medical Entrance Inquiry form (attachment K) or Intra-system Transfer form (attachment J). A recommended disposition based on observations, inquiry and findings must also be included (i.e. place in general population, place in general population with appropriate referral to routine or emergency health care services).

At facilities utilizing the Inmate Management System (IMS), disposition shall be updated via the Medical Orders

screen. Additionally, the Mental Health/Substance Abuse History, Medical Orders, and Medical Restrictions/Special Needs screens shall be updated if necessary.

630.17 Inmates in Segregation

Each facility that maintains a segregation unit shall develop written procedures that require any inmate in segregation to have access to health care services which are equal to that of the general population.

1. Inmates who are segregated from the general population for disciplinary reasons are to be medically evaluated by qualified health care personnel prior to placement in segregation.

   In IMS, medical staff will enter onto the SMU Inmate Information screen the name of the staff person conducting the physical screening and check the applicable button. The date of the screening shall be entered into the comment box by entering, “physical screening on” and the date.

2. If security status precludes the inmate's attendance at sick call at the facility HSU, provisions shall be made for the inmate to be seen by a qualified health care professional in the segregation unit.

3. In addition, a qualified health care professional shall visit any facility segregation unit on a daily basis to determine if there are any unattended medical complaints. These visits shall be recorded in the appropriate medical logbook by medical staff.

   In IMS, the daily visits will be entered on the SMU Daily Log screen by security staff.

4. Periodic physical examinations shall be performed for inmates in segregation units in accordance with section 630.11 of this policy.

5. All inmates in segregation shall have access to mental health services pursuant to 103 DOC 650, Mental Health policy.

6. If qualified health care personnel determine that a medical condition exists which is a contra-indication to admission or continued placement in segregation, this information must be documented in the medical record and

immediately communicated to the superintendent or his/her designee or shift commander during non-business hours, for appropriate action, and to the Health Services Director.

630.18 Use of Therapeutic Restraints

Medical personnel shall utilize restraints pursuant to 103 DOC 650 Mental Health Services and only as a last resort for patients who are determined to be of danger to self or others. Under no circumstances shall therapeutic restraints be used as a disciplinary measure or as a convenience for facility medical staff.

630.19 Refusal of Treatment at a Department Facility

Each facility shall have written procedures for circumstances in which an inmate decides not to follow the advice of a health care professional.

1. The following actions constitute examples of refusal of treatment by an inmate, but are not limited to these examples:

   a. Refusal to take medication prescribed by a contractual physician;
   b. Refusal to keep a medical, dental, or psychiatric appointment recommended by a qualified health professional.

2. Whenever an inmate refuses treatment as defined above, s/he will sign a "release of responsibility" form (attachment L). A qualified health care professional shall witness the inmate's signature. In the event that the inmate refuses to sign the form two staff members shall sign the form as witnesses; at least one of whom must be a medical professional.

3. The completed refusal of treatment form shall be included in the inmate's medical record. In all cases of refusal, documentation shall be written in the progress notes and on the release of responsibility form that the inmate was informed of the medical risks and possible consequences of his/her refusal.

4. In any refusal situation medical, mental health and facility staff should attempt to persuade the inmate to consent to necessary treatment and clearly outline the risks of continued refusals. In most cases, the inmate can be persuaded to consent to treatment.

The Department and contractual medical provider shall comply with all applicable statutes relating to informed consent procedures (M.G.L. c.111 §70E). The Department, through the contractual medical provider, shall ensure that the delivery of all health care is to be preceded by an explanation of the nature of such treatment.

In such cases where the inmate continues to refuse treatment and a life threatening emergency does exist, the Director of Health Services, or designee, will contact the DOC Legal Division to seek a court order for forced treatment.

5. When it is deemed by a qualified health care professional that refusal of treatment will result in an immediately life threatening situation, the facility shall notify the contractual physician, on call where applicable, and the Director of Health services or his/her designee. During non-business hours, the facility shall notify the contractual physician on call and the Health Services Duty Officer in accordance with Department policy 103 DOC 105, Duty Officer. The Health Service Duty Officer will notify the Director of Health Services.

6. Discharges from an IHSU cannot occur as a result of a "refusal of treatment" by an inmate. A contractual physician must deem that close observation/monitoring of the medical condition is no longer necessary.

630.20 Refusal of Treatment at an Outside Hospital or Outside Clinic

The contractual medical provider is responsible for scheduling and arranging for outside hospital specialty appointments and/or clinic treatment visits for inmates based on a medical order.

1. In general, if an inmate wishes to refuse an outside medical appointment he/she may do so only at the outside hospital or clinic (point of service).

2. Whenever an inmate refuses treatment at an outside hospital, s/he will sign a hospital "release of responsibility" form as per hospital policy.

3. The completed refusal of treatment form shall be included in the inmate's hospital medical record and a copy sent to the Health Services Unit at the receiving prison facility.

4. In any refusal situation hospital/clinic medical and mental health staff should attempt to persuade the inmate to consent to necessary treatment and clearly outline the risks of continued refusals.

5. In cases where the inmate continues to refuse treatment at an outside hospital, the attending or consulting physician shall contact the contractual medical provider to determine an appropriate course of action.

6. Each DOC facility shall have a written policy for circumstances in which an inmate attempts to refuse an outside hospital/clinic appointment prior to being transported to the hospital or clinic. The policy shall address the following:

   a. Procedures for notification of on-site facility health staff by security staff that an inmate is attempting to refuse a scheduled outside appointment prior to transport.

   b. Procedures for notification of the responsible medical director or designee by on-site facility health staff that an inmate is attempting to refuse an outside appointment.

630.21 Release Procedures

Whenever an inmate is released from a maximum or medium security facility, the inmate shall, whenever possible, be given a physical examination prior to discharge. At a minimum security facility, the inmate's medical record will be reviewed and a health status report completed.

1. When an inmate is discharged from a facility with on-site medical staff, a health status report should be completed by qualified health care staff, who should explain it fully to the inmate being discharged; a copy of the health status report should be provided to him/her. The original health status report shall be placed in the inmate's medical record. If, after completing the health status report, it is felt that a referral to an outside provider is necessary to continue medical care this shall be discussed with the inmate.

2. When an inmate is being referred to an outside designated health care provider, the inmate should sign an authorization for release of medical records (see 103 DOC 607, medical records, attachment A & B) and a copy of the inmate's medical record should be sent to the provider.

At facilities utilizing the Inmate Management System (IMS), referral information shall be documented on the Release/Aftercare Plan screen.

3. Medications for released inmates shall be governed by 103 DOC 661, Pharmacy and Medications.

4. Additional information relative to an inmate’s release may be found in 103 DOC 493 Release and Lower Security Preparation Program policy.

Date

Dear

Enclosed are release forms which are necessary to request consideration for an on site medical examination by an outside physician in a Massachusetts Department of Correction facility. Along with these releases it will be necessary for you to return to the Director Health Services, a written request for the on site examination stating specifically the nature of the examination you are requesting. Your request should include the name of the physician as well as his Massachusetts certification number.

This is also to advise you that only the Department's contractual medical staff determine when outside examinations or testing are medically necessary. However, in accordance with established Health Services procedures, a medical examination on site at a facility by an outside physician may be arranged with the permission of the Director of Health Services. If approved, the outside physician will be allowed to perform a non-intrusive examination of your client and review his Department of correction medical record, provided your client signs the necessary release of liability and costs. Please note that if approved, the cost of such examinations is to be borne by the inmate, not the Department of Correction nor its contractual medical provider.

Further, any outside physician must also sign a waiver of liability and costs. Any outside medical consultation reports would be reviewed by the on site medical director. Outside physicians may write their medical recommendations for treatment on consultation forms, but they may not write any medical orders or notes in any part of the medical record. Further, neither the Department of Correction nor its contractual medical provider is required to comply with any consultation recommendations made by an outside physician.

By copy of this letter, the medical director will be made aware of your request for an outside physician examination. If you have any questions regarding the process, please feel free to contact this office.

Sincerely,

Director of Health Services

cc: Medical Director, (contractual medical provider)
HSA, (appropriate facility)
Counsel, DOC Legal Division

MASSACHUSETTS DEPARTMENT OF CORRECTION
HEALTH SERVICES DIVISION
RELEASE (Physician)
Outside Medical Services

I, _____, agree to perform or cause to perform the medical services listed below on_____ an inmate in the custody of the Massachusetts Department of Correction. In so doing, I understand that neither the Commonwealth of Massachusetts, nor the Massachusetts Department of Correction, nor any of their agents, officials, or employees, nor the medical provider for the Department of Correction, will incur any financial obligation for said services. Further, I for myself and my agents heirs, employees, successors, and assigns agree to release and forever discharge the Department of Correction and all its agents, officials, and employees, and the medical provider for the Department of Correction from any and all liability, causes of action, claims, suits, damages, obligations, agreements, debts, judgments, or any other matter arising out of or in any way connected directly or indirectly, with said medical services except as otherwise provided by state law.

Name and Address of Provider (Type or print clearly):

_____

_____

_____

Nature of Services (Please type or print clearly):

_____

_____

Signed:_____
(Physician's Signature)

Certification Number:_____

Date:_____

Witness: _____

Title: _____

Date: _____

MASSACHUSETTS DEPARTMENT OF CORRECTION - HEALTH SERVICES DIVISION
RELEASE (Inmate)
(OUTSIDE MEDICAL SERVICES)

I, _____, wish to obtain the medical services listed below. I agree to assume full responsibility for payment for said services. In so doing, I understand that neither the Commonwealth of Massachusetts Department of Correction, nor any of its agents, officials, employees, nor the medical provider for the Department of Correction, will incur any financial obligations for said services. Further, I, for myself and my agents, heirs, employees, successors, and assigns, agree to release and forever discharge the Department Of Correction and all its agents, officials, employees, and the medical provider for the Department of Correction, from any and all liability, causes of action, claims, suits, damages, obligations, agreements, debts, judgments, or any other matter arising out of or in any way connected directly or indirectly, with said medical services except as otherwise provided by state law.

Name and Address of Provider _____

_____

_____

Nature of Services: _____

_____

Signed, _____
(Inmate's Signature)

Date: _____

Witness: _____

Title: _____

Date: _____

105 CMR 205:100-200
Department of Public Health Minimum Standards Governing The Conduct of Physical Examinations in Correctional Facilities

Physical Examinations

205.100 Inmates to be Screened
205.101 Inmates to Have Physical Examination
205.102 Examinations to be Conducted by Licensed Personnel
205.103 Examinations to be Conducted in Privacy
205.104 Results of Examination to be Discussed with Inmate
205.105 Equipment Necessary for Physical Examination
205.200 Content of Physical Examination

205.001 Purpose: The purpose of 105 CMR 205.000 is to establish minimum standards relative to the conduct of the physical examinations within correctional facilities and to prescribe the medical record utilized therein.

205.002 Authority: 105 CMR 205.000 is adopted under the authority of MGL c. 111, S. 2,3,5,6 and c. 127, S. 17.

205.003 Citation: 105 CMR 205.000 shall be known and may be cited as 105 CMR 205.000: Minimum Standards Governing Medical Records and the Conduct of Physical Examination in Correctional Facilities.

205.010 Scope: 105 CMR 205.000 shall apply to all correctional facilities, institutions, jails and houses of correction, as defined by MGL c. 125, S. 1, operated by the Commonwealth or any subdivision thereof.

205.020 Definitions:

Correctional facility shall mean any correctional facility or correctional institution as defined by MGL c. 125, S. 1, operated by the Commonwealth or any subdivision thereof, including jails and houses of detention.

Inmate shall mean a committed offender or other such person placed in a correctional facility as defined in MGL c. 125, S. 1.

Medical Care shall mean all services which are provided for the purpose of securing the prevention, diagnosis and treatment of illness or disability.

205.100 Inmates to be Screened
Immediately upon admission to the correctional facility, and prior to being placed in the general inmate population, an Admission Health Screening Report Form, (105 CMR 205.600 Appendix B) shall be completed for each inmate by a person trained in the completion of such Form. Whenever possible such person shall be a member of the medical staff.

205.101 Inmates to Have Physical Examination

Each individual committed to a correctional facility for a term of 30 days or more shall receive a complete physical examination no later than fourteen days after admission to said facility. However, an inmate entering a correctional facility who is accompanied by a medical record containing a record of a complete physical examination conducted less than three months prior to his admission need not be given a complete physical examination. Each such inmate not receiving a complete physical examination shall, however, be seen by a physician, or by a physician's assistant or nurse practitioner under the supervision of a physician, who shall:

(A) Review the inmate's medical record
(B) Examine the inmate for any signs of trauma or disease which may have been incurred by the inmate after his most recent physical examination.
(C) Conduct any examinations and tests which are medically indicated.
(D) Review his findings and any required follow up services with the inmate.

205.102 Examinations to be Conducted by Licensed Personnel

All physical examinations shall be conducted by a physician licensed to practice medicine in the Commonwealth of Massachusetts or by a properly licensed nurse practitioner or physician assistant under the supervision of said physician.

205.103 Examinations to be Conducted in Privacy

Inmates shall be examined in a room which provides for privacy and dignity to the inmate and examiner. When necessitated for security reasons, a correctional officer may be present.

205.104 (A) In existing facilities, physical examinations shall be conducted in a room which should be used solely for the purpose of providing health care. This examination room shall contain a handwash sink with hot and cold running water. The handwash sink shall be equipped with non-hand operated controls such as elbow, knee or foot controls. If, in an existing facility, the required handwash sink cannot be located in the examination room because of preexisting structural obstructions, the sink shall be located in close proximity to the examination room.

(B) In new or renovated facilities, physical examinations shall be conducted in a room which shall be used solely for the purpose of providing health care. This examination room shall contain a handwash sink with hot and cold running water. The handwash sink shall be equipped with non-hand operated controls such as elbow, knee or foot controls.

205.104 Results of Examination to be Discussed with Inmate

Upon completion of the physical examination and all required and ordered laboratory tests a qualified person shall discuss with the inmate the results of said examination, its implications, and suggestions for further diagnosis and/or treatment.

205.105 Equipment Necessary for Physical Examination

The following equipment, at a minimum, must be available to the person conducting the physical examination:

(A) Thermometer;
(B) Blood Pressure Cuff and Sphygmomanometer;
(C) Stethoscope;
(D) Ophthalmoscope;
(E) Otoscope;
(F) Percussion Hammer;
(G) Scale;
(H) Examining Table with a disposable covering which shall be replaced after each use;
(I) Goose Neck Light;
(J) Pelvic Speculum (for female exams).

205.200 Content of Physical Examination

(A) Inquiry concerning:
  (1) Headache, recent head injury and loss of consciousness;
  (2) Use of prescribed medicines;
  (3) Chronic health problems such as heart disease, hypertension, seizure disorders, asthma, sickle cell disease, diabetes mellitus and tuberculosis;
  (4) Regular use of barbiturates, sedatives, opiates, alcohol, and non-prescribed drugs including tobacco;
  (5) Unusual bleeding or discharge;
  (6) Recent fever or chills;
  (7) Allergy to medication or other substances;
  (8) Lacerations, bruises, abscesses, ulcers and itchiness;
  (9) Prior significant illness and hospitalization;
  (10) Familial and domiciliary disease of significance;
  (11) Immunization status;
  (12) Current symptoms and abnormalities in the nervous, gastrointestinal, and respiratory, auditory, integumentary, endocrine, cardiovascular, ophthalmic, musculoskeletal and hemopoietic systems.

(B) Observation concerning:
  (1) Behavior which includes state of consciousness, mental status, appearance, conduct, tremor and sweating;
  (2) Signs of trauma, recent surgery, abscesses, open wounds, parenteral drug use, jaundice, pediculosis and communicable disease;
  (3) Body deformities, ease of movement, scars;
  (4) Dental decay, filled and missing teeth.

(C) Physical inspection and examination of organs and structures, with emphasis on the presence or absence of the following abnormalities of the:
  (1) Head defects, contusions, lacerations and dried blood;
  (2) Mouth lesions, decay;
  (3) Ears gross hearing loss, blood/discharge fluid, eardrum, infection;
  (4) Nose blood and other discharges, recent injury;
  (5) Eyes bruises, jaundice, gross movement, pupil reactivity, visual acuity;
  (6) Chest labored or unusual breathing, penetrating wounds, heart, breast;

(7) Abdomen tenderness, rigidity, signs of blunt injury, surgical scars;
(8) Genitalia discharge, lesions, lice, a pelvic examination (female);
(9) Extremities sign of drug use, hyper pigmentation of anticultutal fossa, abscesses, deformity;
(10) Back scoliosis, kyphosis.

(D) Diagnostic tests: The following diagnostic tests shall be performed on each inmate:
(1) Complete Blood Count (CBC);
(2) PPD skin test for tuberculosis infection by the Mantoux technique and/or chest film as appropriate;
(3) Serology for syphilis;
(4) Urine for the detection of glucose. Ketones, blood proteins and white blood cells. In males, if the results of the white blood cell test is positive, a test for Chlamydia trachomatous shall be conducted.
(5) Female - culture for gonorrhea and test for Chlamydia trachomatous infection;
(6) Female Papanicolaou smear of the uterine cervix;
(7) Female pregnancy test;
(8) Mammogram - For all females over the age of 50 and those women between the ages of 40-49 who have a personal history of breast cancer or a first degree relative (mother, sister or daughter) with pre-menopausal breast cancer and who have been committed for a term of 90 days and have not had a mammogram within the previous 12 months;
(9) HIV counseling and voluntary HIV testing.

(E) Measurement of:
(1) Weight;
(2) Height;
(3) Blood Pressure;
(4) Respiration;
(5) Pulse;
(6) Temperature

8/23/96 (Effective 9-1-96) 105 CMR -1156

MASSACHUSETTS DEPARTMENT OF CORRECTION - HEALTH SERVICES DIVISION
CODE 99 Red Bag Contents

Basic Life Support Equipment (Required at all sites):

1	½" Adhesive Tape	1	Small Flashlight and Batteries
1	1" Silk Tape	2	Pen Lights
2	Band-Aids, 2" x 4"	4 Pr	Gloves, non-sterile
6	Band-Aids, 3/4" x 3" strips	1	Aneroid sphygmomanometer w/adult cuff
6	Gauze sponges, sterile 4"x 4″	1	Stethoscope
1	Multi-trauma dressing 10"x 20"	1	Splint (limb immobilizer)
2	Kling, 3" conforming bandage	1	Neck immobilizer, adjustable
2	Eye dressing, oval	4	Tongue blades
2	Occlusive sterile gel dressing,large	1	Ambu bag with adult mask
1	Ace wrap	1	Oxygen tank (portable)w/regulator
3	Triangular bandages	1	Oxygen tubing
1	Cold pack, instant ice pack	1	Oxygen mask (adult size)
1	Rescue blanket, disposable	1	Nasal oxygen cannula
1	Burn sheet, sterile 60"x 90"	1	Microshield CPR shield
2	Ammonia inhalants	1	Saline eye irrigation, 4 oz.
1	Trauma (EMT) Scissors	3	Health Services Authorization in envelope with pen
1	Safety knife	1	Gown – disposable/fluid impervious
3	Berman oral airways (small, medium and large)	1	Mask w/eye shield OR mask and goggles
1	Oral glucose solution (instaGlucose 30 gm)	1	Glucometer with lancets and test strips and small sharps container
1	Suction machine with tubing and suction catheter	1	Automatic External Defibrillator (AED)

Advanced Life Support Equipment Required to be kept in the Trauma Department of sites providing 24-hour nursing coverage. Optional for sites with less than 24-hour nursing coverage.

2	IV Solution administration sets	1	IV Arm board
3	Angiocatheters 20 G x 1 ½″	1	Tourniquet
1	500 cc Normal Saline IV Solution [0.9% sodium chloride]	6	Betadine [Povidone iodine] wipes
1	Dextrose 50% 50 ml injection [pre-filled syringe]	1	Narcan ampule [0.4 mg/ml]
1	½″ Adhesive tape	1	1 cc Syringe w/22 Gx1″ needle
		1	EpiPen [epinephrine hydrochloride]

Exhibit 23.32

Medical Disaster Box Minimum Contents

1 box/100	Non-sterile gloves, large
1 box/100	Non-sterile gloves, medium
1 box/20	Masks w/ eye protection
12	Gowns, disposable
1 set	Air splints
2	Cervical collars, adjustable
1 box/50	Sterile 4 x 4 gauze pads
4	Blankets
1 box/50	Butterfly closures
6	Tourniquets
4 rolls	½" Adhesive tape
1 box/20	Combine (ABD) pads
2	Aneroid sphygmomanometers w/adult cuffs
2	Stethoscopes
4	Flashlights w/batteries
1	Ambu bag
2	Microshield CPR shield
4	Oral airways, 2 medium, 2 large
50	Triage tags
24	Red biohazard trash bags
12	Indelible markers
1	Clipboard w/paper and pen

Intravenous supplies:

The following intravenous fluid-replacement supplies are required for all sites providing 24 hour nursing coverage. These supplies are optional for smaller sites with less than 24 hr. nursing coverage.

6	1000 ml lactated ringers solution
6	1000 ml normal saline solution
10	Angiocatheters, 20 G x 1 ½"
10	IV starter kits: tubing, betadine wipes, dressings, tape, etc.

References: NCCHC, P-12; ACA, 3-4208, 3-4212, 3-4209

MEDICAL SERVICE PROVIDER FORM

MEDICAL RESTRICTIONS

_____
INSTITUTION

_____ _____ _____
NAME **ID #** **D.O.B.**

_____
DATE

TO:_____
((D.O.C. DESIGNEE)

The above named inmate has been determined to have the following needs/restrictions due to a current medical condition:

TYPE	**DATE**	**(FROM)**	**(TO)**
NO WORK STATUS	_____	_____	_____
LIGHT WORK STATUS	_____	_____	_____
BOTTOM BUNK	_____	_____	_____
SPECIAL EQUIPMENT (DESCRIBE BELOW)			
_____		_____	_____
OTHER (DESCRIBE BELOW)			
_____		_____	_____

TRANSPORTATION RESTRICTIONS:

MODIFIED RESTRAINTS TYPE:
_____ _____ _____

SEDAN:
WHEELCHAIR VAN:
_____ _____

MEDICAL REASON:
_____
_____
_____

SUBMITTED BY: _____ DATE: _____ TIME: _____
MD/PA/NP

REVIEWED BY: _____ DATE: _____ TIME: _____
HSA

APPROVED BY: _____ DATE: _____ TIME: _____
SITE MEDICAL DIRECTOR

REVIEWED BY: _____ DATE: _____ TIME: _____
DEPUTY SUPT, IAC

The following forms have been deemed part of 103 DOC 630. However, they have been forwarded to institutions separately. Please contact your Facility Policy Coordinator or Health Services Administrator for copies.

Attachment G: Medical History and Screening Form (UMCHP form)
Attachment H: Medical Restrictions Form (UMCHP–form)
Attachment I: Classification Health Status Report Form (UMCHP form)
Attachment J: Intra System Transfer Form (UMCHP form)
Attachment K: Medical Entrance Inquiry Form (UMCHP form)
Attachment L: Release of Responsibility (UMCHP form)

COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT

SUFFOLK, ss. No. SJC-12935

STEPHEN FOSTER, et al.,
Plaintiffs,

v.

CAROL MICI, COMMISSIONER OF CORRECTION, et al.,

Defendants.

Affidavit of Jennifer Gaffney

I, Jennifer Gaffney, hereby depose and state that:

1. I have been employed by the Massachusetts Department of Correction ("Department") since September of 1989. In January of 2019, I was promoted to Deputy Commissioner of Clinical Services and Reentry, a position that I currently hold. Prior to being appointed Deputy Commissioner, I held various positions at the Department, such as Assistant Deputy Commissioner of the Central Sector, Director of the Policy Development and Compliance Unit, Deputy Director of Labor Relations, Director of Classification, Unit Manager and Corrections Counselor.

2. The statements contained in this affidavit are based upon my personal knowledge and review of Department of Correction records that are maintained in the normal course of business.

3. The Massachusetts Alcohol and Substance Abuse Center in Plymouth (MASAC), Massachusetts is operated by the Department of Correction. It is a secure facility that houses men who are civilly committed pursuant to M.G.L. c. 123, sec.35 due to their substance use disorders. The Department of Correction has entered into a Memorandum of Understanding with the Hampden County Sheriff's Department to treat and house Section 35 commitments from the counties of Hampden, Hampshire, Franklin, Berkshire and Worcester in two facilities operated by the Hampden County Sheriff, Stonybrook Springfield and Stonybrook Ludlow (Hampden). In 2019, the number of Section 35 commitments to MASAC at Plymouth and Hampden totaled 1643.

4. Although the census at MASAC and Hampden was respectively 159 patients and 108 patients on March 13, 2020, as of April 23, 2020 there are 28 committed patients at MASAC, an 82% decline, and 46 committed patients at Hampden, a 57.5% decline. Since March 13, 2020, there have been 14 new admissions to MASAC and 31 new admissions to Hampden. The courts, not the Department of Correction, determine the secure facility to which a person is committed with the assistance of expert testimony.

5. As of April 23, 2020, with unlimited testing capacity, no patient has had a positive test result for COVID-19 at either MASAC or Hampden.

6. Prior to April 2, 2020, newly admitted patients to MASAC were most often housed in the C-Dorm Ward Room during detoxification. However, as of April 2, 2020, newly admitted patients are no longer housed in the Ward Room.

7. At MASAC, newly admitted patients spend the first 72 hours undergoing observation and detoxification in a single room with a private toilet and sink. If the patient is asymptomatic after 72 hours, he is placed in a single room for self-quarantine for the next 11 days. Testing is available for any symptomatic patient.

8. During the initial detoxification treatment a patient is not required to undergo "cold turkey withdrawal." Medication assisted treatment and comfort medications are used to treat patients as needed based upon medical history and clinical assessments.

9. After 14 days, asymptomatic patients are assigned to a separate room in either the A or B housing unit. Given the patient population of 28, no patients are currently double bunked. Although there is a second bed in each room, there have only been rare occasions since the fall of 2018 in which patients have been double bunked.

10. Effective April 4, 2020, MASAC program changes included delivery of meals and medication to each patient on the housing units. To receive meals and medication, patients are called

individually with the exception of medication assisted treatment, for which patients are called six at a time and social distancing is observed. Each patient is asked to follow social distancing and handwashing guidelines.

11. A private vendor provides cleaning services at MASAC and has been diligently sanitizing common areas and high touch areas. The vendor also provides daily cleaning of the patient rooms. Each unit is provided with a disinfectant spray bottle to clean the telephone and other areas after use.

12. Each patient is provided with a bar of soap each week and other necessary hygiene products. Patients may receive additional soap or other items upon request. There is a hand sanitizer station for patients in each housing area.

13. While there is only one bathroom on both the A and B housing unit housing areas, each is equipped with eight separate showers. There are also eight toilets, all with stall doors, and an additional two urinals in the bathroom.

14. Patients on each unit continue to have access to substance abuse groups, activity groups, and open recreation activities on a rotating basis.

15. On March 30, 2020, the size of group programs was reduced to 15 patients per group to allow for social distancing. This required a temporary reduction in structured substance abuse groups to two per day, one in the morning and one in the

afternoon. In addition, patients were provided with homework and individual sessions with Substance Abuse Counselors or Mental Health Professionals. Patients are seen individually on a daily basis by Substance Abuse Counselors and are routinely seen by Mental Health Professionals as all patients are viewed as open mental health cases. During these sessions treatment materials are reviewed, reentry plans developed, and coping skills learned. During the week of March 30 through April 3, 2020, patients had the opportunity to participate in a minimum of five hours of treatment each day.

16. For a three-day period during the weekend of April 4 through April 6, 2020 there were no groups held as a Department-wide lockdown took effect and a new operational plan was developed. On April 7, 2020, the size of group programs was further reduced to 10 patients. That same day, group activity was restricted so that patients from different housing units did not attend groups together to further reduce the risk of virus spread.

17. The census continued to decrease and as of approximately April 15, 2020, each patient was able to attend four structured groups instead of two per day. Patients continue to be provided with homework packets containing materials related to substance use treatment, mental health, and wellness. In addition to structured groups, daily individual

appointments with Substance Use Counselors and routine sessions with Mental Health Professionals are provided. Including all of these modalities, the current total treatment time provided per patient is seven hours per day.

18. MASAC staff monitor patient participation in groups and based upon the satisfactory completion of programming and an adequate discharge plan, as recommended by clinical staff, the Superintendent determines whether a patient meets the criteria for release.

19. Most civil commitments are currently released around the thirty day point of their commitment.

20. All correction officers will be removed from MASAC on May 10, 2020.

Signed under the pains and penalties of perjury this 24th day of April, 2020

Jennifer Gaffney
Deputy Commissioner of Clinical Services and Reentry
Massachusetts Department of Correction

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK, ss. No. SJC-12935

STEPHEN FOSTER, et al.,
Plaintiffs,

v.

CAROL MICI, COMMISSIONER OF CORRECTION, et al.,
Defendants.

AFFIDAVIT OF JAMES FERREIRA

I, James Ferreira, hereby depose and state as follows:

1. I have been employed with the Massachusetts Department of Correction ("Department") since April of 1986. At present, I am the Assistant Deputy Commissioner ("ADC") for the Northern Sector, a position I have held since May 6, 2018.
2. I began my employment with the Department as a correction officer and then later rose through the ranks to the positions of sergeant and lieutenant. I have also served with the Department in various management positions including as Director of the Central Transportation Unit, Director of the Policy Development and Compliance Unit, and as the Deputy Superintendent of Operations at Bridgewater State Hospital, the Deputy Superintendent of Operations at Old Colony Correctional Center, and the Deputy Superintendent at Bay State Correctional Center.
3. The statements contained in this affidavit are based upon my personal knowledge and review of Department of Correction records that are maintained in the normal course of business.

Job Duties and Responsibilities

4. The ADC of the Northern Sector is a senior level manager who reports directly to the

Deputy Commissioner of the Prison Division.

5. Generally speaking, the ADC for the Northern Sector is responsible for supervising and managing the correctional facilities in the Northern Sector. These include: MCI-Concord, MCI-Framingham, MCI-Shirley, North Central Correctional Institution, Northeastern Correctional Center, South Middlesex Correctional Center, Lemuel Shattuck Hospital Correctional Unit, and Souza Baranowski Correctional Center.
6. The primary focus of the ADC is to ensure the protection of the public by incarcerating criminal offenders in a safe, secure, humane environment by overall planning, organization, direction, and supervision of staff and inmates.
7. The ADC's goals include establishing consistency in institutional operations, increasing efficiency, safety of institutional operations and promoting reintegration efforts. As the ADC, I identify and resolve issues identified by the Commissioner, and support superintendents in their efforts to resolve problems common to facility operations.

MCI-Framingham

8. As discussed above, MCI-Framingham is one of the Northern Sector correctional facilities that I oversee.
9. I am aware that the plaintiffs in this lawsuit make a number of allegations regarding the Department's response to COVID-19 at MCI-Framingham.
10. All showers at MCI-Framingham are cleaned daily after the last evening count by an inmate runner who wears Personal Protective Equipment (PPE) that consists of an N95 mask and gloves. In addition, the showers are disinfected after each use, and maintenance staff utilize a Kaivac cleaning machine each week in each housing unit to ensure showers are clean at all times.

11. In response to the COVID-19 emergency, staff at MCI-Framingham have been wearing proper PPE to minimize the likelihood of them contracting the disease or, conversely, if they are asymptomatic carriers, from passing it on to others. The Closed Custody Unit (CCU) has additional PPE to include gowns/suits and face shields for direct contact.
12. The Department purchased three (3) bug sprayers for staff at MCI-Framingham to disinfect high touch areas throughout the facility, which is done multiple times per day and night.
13. MCI-Framingham also supplies staff and inmates with hand sanitizer.
14. Inmates at MCI-Framingham who were exposed to someone who is being tested for COVID-19 are provided surgical masks and are considered in-cell medical isolation for fourteen (14) days in the CCU. Exposed inmates are allowed out of their cells with inmates on the same status only and must wear their mask as a precaution whenever outside of their cell.
15. All inmates in CCU have a surgical mask to wear at all times. Initially, exposed inmates in CCU were directed to wear masks whenever they were out of cell, but this has recently changed to at all times.
16. Inmate cleaning supplies are offered to each inmate every day for proper cell cleaning. A tracking sheet is now used to ensure that it is documented whenever an inmate refuses.
17. All inmates who are double-bunked have been directed to sleep head-to-toe to minimize the risk of spread amongst cellmates.
18. Staff have offered inmates additional time out of cell and one (1) additional fifteen (15) minute phone call per week. This is on top of the other free phone calls that are given to all inmates on a weekly basis.

19. Laundry machines at MCI-Framingham are disinfected after each use, and inmates working in the laundry are provided N95 masks and gloves.
20. At least one manager is making a round of housing units daily, including on weekends and holidays, to speak with inmates and address any COVID-19 concerns.
21. Prior to the lockdown, staff at MCI-Framingham released one housing unit at a time for meals in the chow hall to maintain social distancing. Since the facility has been on lockdown, all inmates are now fed in their cells.
22. Since the lockdown, staff have closed the gym and other recreation areas to limit contact and encourage social distancing. Inmates are also prohibited from playing table games unless in cell with a cellmate prior to the lockdown.
23. I am aware that plaintiff Michelle Tourigny makes several allegations in the complaint about the conditions of confinement at MCI-Framingham.
24. Ms. Tourigny alleges that she has filed a petition for release on medical parole. Complaint at ¶ 19. Ms. Tourigny's petition for release on medical parole was received by the superintendent's office. Superintendent Ladouceur has submitted her recommendation on this petition to Commissioner Mici. Commissioner Mici is currently in the process of rendering a final decision on this petition pursuant to the medical parole statute, G.L. c. 127, § 119A.
25. I am also aware that the complaint contains allegations regarding the number of COVID-19 positive inmates incarcerated at MCI-Framingham. Complaint at ¶ 28. To date, sixty two (62) inmates at MCI-Framingham have tested positive. There have been no positive COVID-19 tests at South Middlesex Correctional Center to date.
26. I am aware that the complaint alleges that staff at MCI-Framingham quarantined

individuals who may have been exposed to COVID-19 in the same housing unit as individuals with confirmed cases. Complaint at ¶ 42.

27. The inmate referenced in paragraph 42 of the Complaint was housed in the Health Services Unit prior to going to an outside hospital by ambulance. She tested negative at the outside hospital for COVID-19, and upon her return on April 5, 2020, was kept in the CCU single cell as a precaution due to her potential COVID exposure at the outside hospital. On April 10, 2020, she tested positive for COVID-19.

MCI-Shirley

28. As discussed above, MCI-Shirley is one of the Northern Sector correctional facilities that I oversee.

29. I am aware that the complaint alleges that diabetic prisoners at MCI-Shirley receive insulin injections in their cells from nurses wearing the same gloves used when giving injections to other prisoners. Complaint at ¶ 49. This is not accurate.

30. Since the lockdown at MCI-Shirley, insulin injections are administered in the unit sallyport by the assigned nurse who is in full PPE equipment, masked and gloved. Further, the nurse dons a new pair of gloves and gown between each insulin injection, and cleans the area before and after each inmate.

31. I am also aware that Ariel Pena, an inmate at MCI-Shirley, has submitted an affidavit in this case.

32. Mr. Pena claims that inmates in his unit are "not given cleaning supplies daily, or even every few days to clean our cells." Pena Affidavit at ¶ 4.

33. The F1 unit where Mr. Pena resides has two (2) biohazard inmate runners who clean after the morning and evening major counts. These biohazard runners have been trained and

instructed by the EHSO on how to thoroughly clean and disinfect the entire unit to include, but not limited to, phones, kiosk, showers, tables, handrails and door handles. Cleaning and disinfecting is expected to be conducted throughout the day, to include between phases of inmates being let out of their cells.

34. The unit is equipped with mops, brooms, dust pans, mop sink, hot water, toilet brushes, small scrub brushes, as well as a shower swivel brush. The type of cleaning chemicals that are provided are as follows: detergent/disinfectant, glass cleaner, and floor cleaner. A bleach/water solution (with the manufacturer-recommended solution mixture) was added in order to provide additional disinfectant.
35. Mr. Pena also states that the phones in F1 are very close together and are not sanitized in between uses. Pena Affidavit at ¶ 5.
36. At this time, only ten (10) F1 unit inmates at a time are allowed out of their cell one hour, which gives those ten inmates ample time to shower, clean their cell, and use the phone or any combination of those activities, while maintaining appropriate social distance from one another.
37. There are eight (8) phones in F1 available for use at any given time by the ten (10) inmates who are allowed out. As phones become available, inmates can make a phone call during their recreation time. Inmates are encouraged to stagger phone use by selecting the phones that are across from each other, which is at a minimum of eight (8) feet apart. In addition, all inmates have access to cleaning products that they can personally use to clean their cells and phone if they choose to during their recreation period.
38. I am also aware that Mr. Pena alleges that many staff do not wear masks. Pena Affidavit

at ¶ 6. Contrary to this assertion, the Commissioner has outlined when masks or face coverings should be worn, and compliance with the Commissioner's directive is monitored and vigorously enforced.

North Central Correctional Center

39. As discussed above, North Central Correctional Center (NCCI) at Gardner is one of the Northern Sector correctional facilities that I oversee.
40. As of April 23, 2020, NCCI has no confirmed positive COVID-19 cases. Additionally, there are no symptomatic inmates at the facility.
41. All persons entering NCCI continue to be screened according to CDC recommendations; this includes temperature readings.
42. All NCCI staff must don a mask prior to entering the facility and continue to wear the mask when within six feet of any person. Administration and security supervisors monitor this with frequent rounds and video surveillance. PPE have been acquired and are issued to staff as needed.
43. Extraordinary cleaning measures have been instituted for NCCI.
44. Two-gallon pump sprayers for the units were purchased and continually sanitize all areas including walls, floors, showers, and rails. This starts in the morning and continues through the evening count.
45. Hand sanitizer is readily available in all NCCI units located centrally. Disinfectant and bleach mixtures are readily available to all units for personal cleaning. Disinfectant and paper towels are at each phone kiosk for constant cleaning.
46. Medication lines are being done in each unit at NCCI. However, a ranking supervisor oversees the medication lines to ensure that social distancing is being practiced. Sick slips

are gathered at the medication line and are triaged by HSU staff, and inmates are seen on the unit if possible.

47. Chronic care appointments at NCCI are held in the HSU, and inmates going to the HSU are escorted individually to the appointment.

48. Due to the physical layout of NCCI, and the timeliness of insulin and mealtimes, insulin injections for diabetic inmates are done in the HSU. No more than six (6) inmates from each unit are escorted to the HSU at any given time for insulin injections, and at all times inmates going to HSU must remain six (6) feet apart. While conducting insulin, each inmate waits in the waiting area practicing proper distancing; there are markings on the floor indicating proper distance.

49. All group activities at NCCI have been currently suspended, and all meals are brought to the housing units.

50. While programs and education have been ceased, Earned Good Time opportunities are obtainable on the unit.

51. The gym and weight room at NCCI are closed, but inmates can request the law library and are brought one at a time for use.

52. Dormitory-style units share common areas on a set schedule to include cleaning between periods.

53. Rounds are being done daily by a manager in all housing units to ensure that directives are being followed. The efficient and thorough screening process, coupled with the cleaning measures taken at NCCI, have to this date been successful.

54. I am aware that Dana Durfee, an inmate at NCCI, has made a number of statements in an affidavit regarding the facility's response to COVID-19.

55. Mr. Durfee claims in his affidavit that he is currently housed in G1 and that this unit "holds 71 other men and is approximately 24 feet by 40 feet." Affidavit of Durfee at ¶ 2.

56. Department records show that Mr. Durfee is currently housed in G1, bed 30A. Unit G1 houses 34 inmates, not 71.

57. The dimensions of the G1 living area are 66' x 28', with a ceiling height of 10.5' – not 24' x 40' as Mr. Durfee alleges. This equals 1,848 square feet of total living space, or 54.35 square feet per inmate.

58. This more than meets American Correctional Association ("ACA") standard 4-4132, which states that rooms used for housing inmates should provide, at a minimum, 25 square feet of unencumbered space per occupant.

59. Mr. Durfee also insinuates in his affidavit that there are not enough toilets in the G1 unit at NCCI. Durfee Affidavit at ¶ 2.

60. Unit G1 has one (1) urinal, four (4) toilets, and four (4) sinks, equating to 6.8 inmates per toilet.

61. ACA standard 4-4137 states that toilets should be provided to inmates at a minimum ratio of 1 for every 12 inmates in male facilities, urinals accounting for up to one half of the toilets. Thus, G1 more than meets the ACA standards.

62. Mr. Durfee also claims in his affidavit that there is "a line of people every morning to use the limited number of toilets and sinks." Durfee Affidavit at ¶ 2. I have had staff at NCCI review video from G1 for the past several days with goal of determining whether there was in fact a line during active bathroom times on the mornings of April 19-23, 2020. It was reported that there were no waiting lines.

63. Mr. Durfee also claims that he observed many inmates playing cards in the dayroom and

not social distancing. Durfee Affidavit at ¶ 6. Staff at NCCI have given numerous directives to all inmates to observe social distancing practices. Unit officers conduct hourly rounds for which they have been directed to encourage social distancing when possible.

64. Mr. Durfee also claims that many correction officers are not wearing the masks that have been issued by the Department. Durfee Affidavit at ¶ 6. All officers have been issued masks and have been given the mandated directive from the Commissioner to don the mask at all times. Staff at NCCI have been consistently wearing masks at all times, not just the recommended six foot CDC recommendation. The NCCI administration has been monitoring video and addressing staff who do not comply.

Subscribed under the pains and penalties of perjury this the 24th day of April, 2020.

/s/ James Ferreira
James Ferreira
Assistant Deputy Commissioner, Northern Sector

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK, ss. No. SJC-12935

STEPHEN FOSTER, et al.,)
Plaintiffs,)
)
v.)
)
CAROL MICI, COMMISSIONER OF CORRECTION, et al.,)
Defendants.)

AFFIDAVIT OF SEAN MEDEIROS

I, Sean Medeiros, hereby depose and state as follows:

1. I have been employed by the Massachusetts Department of Correction ("Department") since September 1987. On May 6, 2018, I was promoted to Assistant Deputy Commissioner ("ADC") for the Southern Sector, a position that I currently hold. Prior to being appointed ADC for the Southern Sector, I held various jobs at the Department, such as the Superintendent of the Massachusetts Correctional Institution at Norfolk ("MCI-Norfolk") from 2014 until 2018, the Deputy Superintendent of Operations at MCI-Norfolk from 2011 until 2014, and the Director of Security at MCI-Norfolk.
2. The statements contained in this affidavit are based upon my personal knowledge and review of Department of Correction records that are maintained in the normal course of business.

Job Duties and Responsibilities

3. The ADC of the Southern Sector is a senior level manager who reports directly to the Deputy Commissioner of Prison Division.
4. Generally speaking, the ADC for the Southern Sector is responsible for supervising and managing the correctional facilities in the Southern Sector. These include: Bridgewater

State Hospital, Old Colony Correctional Center, Massachusetts Treatment Center, MCI-Cedar Junction, MCI-Norfolk, Massachusetts Alcohol and Substance Abuse Center, and Pondville Correctional Center.

5. All of these facilities are accredited by the American Correctional Association (ACA).
6. The primary focus of the ADC is to ensure the protection of the public by incarcerating criminal offenders in a safe, secure, humane environment by overall planning, organization, direction, and supervision of staff and inmates.
7. The ADC's goals include establishing consistency in institutional operations, increasing efficiency, safety of institutional operations and promoting reintegration efforts. As the ADC, I identify and resolve issues identified by the Commissioner, and support superintendents in their efforts to resolve problems common to facility operations.

Pondville Correctional Center

8. As discussed above, Pondville Correctional Center ("PCC") is one of the Southern Sector correctional facilities that I oversee.
9. I am aware that there are numerous allegations in this case concerning the steps that correctional staff at PCC have taken during the COVID emergency.
10. Specifically, plaintiff Peter Kyriakides states that he resides in a 5' x 5' cell at PCC.
11. According to Department records, Mr. Kyriakides resides in Cell 209 at PCC.
12. According to Department records, Cell 209 is not 5' x 5' as Mr. Kyriakides claims. Rather, Cell 209 at PCC is 7 ½' x 10'.
13. I am also aware that the plaintiffs in this case allege that the bathrooms at PCC are "regularly covered in urine." Complaint at ¶ 46.

14. The showers and bathrooms at PCC are thoroughly cleaned once a day by the assigned workers. In addition, during this pandemic, cleaning supplies/materials and mops are available in the bathroom for inmates to clean after uses.
15. In addition, all inmates are offered cleaning supplies daily during the day shift and showers and telephones are cleaned by each inmate after use.
16. The Department also purchased compact sprayers for use at PCC. Throughout the day, staff spray the showers, bathrooms and high touch areas with bleach and water mixture.
17. Moreover, a staff member is specifically assigned to clean door knobs at PCC with bleach and water throughout the day.

Massachusetts Treatment Center

18. As discussed above, at the Massachusetts Treatment Center ("MTC") is one of the Southern Sector correctional facilities that I oversee.
19. I am aware that the plaintiffs point to a Department of Public Health inspection report as evidence that the bathrooms and showers at the MTC were poorly maintained and unsanitary. Complaint at ¶ 8.
20. The MTC is cleaned and maintained throughout the year. In accordance with departmental policy, all DOC facilities, including the MTC, have developed house-keeping plans approved by the reviewing authority.
21. After each DPH inspection, a plan of action is developed by the facility and submitted for DPH approval.
22. As a result of the COVID-19 pandemic, a cleaning plan was established at the MTC.
23. Under this plan, the Environmental Health and Safety Officer ("EHSO") monitors the cleaning of the facility and ensures that all high touch areas in the common areas of the

facility are sprayed down with a disinfectant daily. The unit officers clean all high touch areas in the living units.

24. Twice per week, the EHSO sprays down the showers and toilets throughout the facility with a Kaivac cleaning machine.

25. All living unit showers at the MTC are cleaned by the unit runners twice per day, and the unit runners are given masks and gloves.

26. Additionally, cleaning disinfectant spray is available for MTC inmates to spray the showers down after each use. At the end of the day, the showers and bathrooms are thoroughly cleaned again and sprayed down with disinfectant.

27. In the modular unit of the MTC where there are shared toilets, the unit runners clean them many times throughout the day.

28. I am aware that there are allegations in the complaint that MTC inmates who need medication or medical care are forced to wait in medication lines, where they stand in close proximity to one another. This is not accurate.

29. Medication at the MTC is dispensed cell to cell. In the modular unit, which houses six man rooms, the nurse is stationed on the tier and inmates are called out individually to pick up their medication.

30. There is currently no lining up of MTC inmates in medication lines.

31. I am aware that Ryan Duntin, an inmate in one of the modular units at MTC, has submitted an affidavit in which he alleges that he "stood in the medication line with ten or fifteen prisoners." Duntin Affidavit at ¶ 4. While this may have been true prior to March 20, 2020, since March 20th, strict social distancing when dispensing medication in the modular units is enforced.

32. Mr. Duntin also claims that staff at MTC are using "a cleaning solution that has no bleach." Duntin Affidavit at ¶ 9. While some bleach products are used at the MTC, most surfaces are disinfected with Maquat 64, an extremely powerful disinfectant and sanitizer. Also, scented disinfectant called Respond is now being used.
33. Mr. Duntin also claims that "no staff has cleaned the unit." Duntin Affidavit at ¶ 12. However, the EHSO and inmate workers are cleaning the unit and bathrooms. The staff and inmates continue to clean daily. Twice a day, the bathrooms are cleaned and chemicals cleaning solutions are replaced.
34. Mr. Duntin also claims that correctional staff do not wear masks or some have homemade masks. Duntin Affidavit at ¶ 15. All MTC staff have been issued N-95 masks; some staff use cloth masks over the N-95 to preserve the life expectancy of the N-95 mask.
35. As of yesterday, only MTC inmates who are part of the cleaning crew were given masks and gloves, as well as inmates who are being transferred to outside hospitals.
36. Mr. Duntin also insinuates that he should be tested for COVID-19. Duntin Affidavit at ¶ 2. However, the contractual medical provider determines who is to receive a test in accordance with DPH regulations. Many MTC inmates have been tested to date.

MCI-Norfolk

37. As discussed above, at the Massachusetts Correctional Institution at Norfolk ("MCI-Norfolk") is one of the Southern Sector correctional facilities that I oversee.
38. At MCI-Norfolk, the EHSO oversees all cleaning operations of the facility to include delivery of cleaning supplies and chemicals to all areas of the facility.
39. Cleaning/disinfecting is emphasized for showers, common bathrooms, high touch areas and areas where infection was identified.

40. Hand sanitizer and soap is available to MCI-Norfolk inmates as well as staff. Both inmates and staff have been notified of the importance of hand washing.

41. I am aware that there are allegations in the complaint that the use of dormitory-style housing in medical units at MCI-Norfolk is problematic. Complaint at ¶ 39.

42. The Clinical Stabilization Unit ("CSU") at MCI-Norfolk is a dormitory-style unit with a total of sixteen (16) beds, thirteen (13) in CSU and three (3) additional medical observation beds. The hospital beds are close together; however, the count is not at sixteen inmates at this time, but rather eight (8) inmates. I am also aware that the plaintiffs in this case allege a poor record at MCI-Norfolk with respect to DPH violations. Complaint at ¶ 47.

43. In accordance with Department policy, all DOC facilities have developed housekeeping plans approved by the reviewing authority. After each DPH inspection, a plan of action is developed by the facility and submitted for DPH approval.

Old Colony Correctional Center

44. As discussed above, at the Old Colony Correctional Center ("OCCC") is one of the Southern Sector correctional facilities that I oversee.

45. At OCCC, general cleaning using sprayers on areas such as railings, ramps and doorknobs are conducted at least twice per day and evening shifts in all areas.

46. Housing units are sanitized every day and evening shift, and inmates are offered cleaning supplies for their cells daily during the evening shift.

47. Since March 25, 2020, approximately 26 gallons of hand sanitizer has been refilled at inmate hand sanitizer stations at OCCC.

Subscribed under the pains and penalties of perjury this the 24th day of April, 2020.

/s/ Sean Medeiros
Sean Medeiros
Assistant Deputy Commissioner, Southern Sector

I, Kevin Crowley hereby depose and say:

1. I am the Superintendent of the Hampden County Sheriff's Department (HCSD) which encompasses the Stonybrook Stabilization and Treatment Centers (SSTC), two facilities in Ludlow and Springfield which provides substance use treatment for civilly committed men.

2. The SSTC provides treatment for civilly committed men from all over the Commonwealth of Massachusetts, and primarily those from Hampden, Hampshire, Franklin, Berkshire and Worcester Counties through a Memorandum of Understanding with the Department of Correction (DOC).

3. SSTC has agreed to accept transfers from Massachusetts Addiction Treatment Center (MATC) in Brockton, MA if they have clients with difficult behavior management issues. Our approach and safety protocols are stringent enough for the Department of Public Health to be willing to refer their most difficult Section 35 cases to us because we are equipped to handle problematic clients who exhibit behaviors such as vandalizing property, threatening to elope, using foul and abusive language towards staff and anyone who has engaged in physical altercations which may have posed a risk to the safety of MATC staff or clients.

4. Although the SSTC census was 108 on March 13, 2020, as of April 23, 2020 there are 46 clients at SSTC, a 57.5% decline. Since March 13, 2020 there have been 31 new admissions to SSTC.

5. Every Section 35 client, like all staff and incarcerated individuals in our care, are issued masks prior to transport to our facility.

6. Every Section 35 client is medically screened upon entering our care to include being thoroughly checked for COVID-19 symptoms by a qualified medical professional. Clients entering the SSTC program are housed in a precautionary medical quarantine unit for observation and provided a single room for the first 14 days of their commitment. All clients are provided substance use treatment during this time frame. During this time, clients are medically monitored for both COVID-19 symptoms as well as any necessary medically managed withdrawal. Clients are assessed by counseling staff and receive daily substance use programming. Most clients continue to have single rooms for the rest of the quarantine period. Due to the program census, a few clients have been in double rooms, but are able to sleep head to feet for 6 feet social distancing per CDC guidelines. There have been a few instances where clients have shared rooms outside of the 14 day quarantine time frame if medically appropriate. Due to the recent increased number of discharges, all clients have their own rooms at this time.

7. All clients are able to eat in the living area while social distancing at 6 feet apart or more.

8. All staff are medically screened before every shift and if anyone shows any symptom potentially linked to COVID-19 they are sent home. Whether they have the virus or not, no one is authorized to return until they are medically cleared by medical team to include our health service administrator, medical director, and nursing staff to include the HCSD Infection Control Nurse.

9. We have unlimited testing capacity, and to date, we have zero positive cases of COVID-19 among the Section 35 clients, and zero positive cases among the incarcerated individuals in our care.

10. All clients and all staff providing treatment in the unit wear masks and are encouraged to practice social distancing when they are out of their rooms. Masks are mandatory attire unless clients on the treatment unit are in their rooms or staff are in their offices alone.

11. Our recovery programming has changed since we are not currently allowing outside vendors or volunteers to enter our treatment center as a precautionary measure. However, we have reallocated staff from other areas of our department to fill those voids. In short- we continue to provide a dedicated effort to ensure that Section 35 clients in our care are receiving all the substance use disorder treatment and care they deserve while ensuring they remain healthy and free from COVID-19 exposure.

12. Clients have access to "on unit" medical care 24 hours a day, seven days a week.

13. Clients have access to mental health clinicians daily or as needed.

14. Information regarding proper hand washing and social distancing guidelines are posted in each living area and each client is asked to follow such guidelines to ensure client and staff safety.

15. The SSTC common living areas and commonly touched surfaces are thoroughly cleaned before and after each meal service as well as at staff shift change. Disinfectant spray bottles are available for client phones and other general areas after use by each client. Additionally, disinfectant spray bottles are provided to clients to clean their own rooms.

16. Each client is provided soap and other hygiene products upon entering the program. Additional soap or hygiene products are available by client request. Hand soap dispensers are available to clients in each living area. Soap and other hygiene items are provided to clients at no cost.

17. Each client room is equipped with a sink, hot water and toilet. Each living area has adequate shower space with our two larger living areas having 11 separate showers which undergo daily, regimented cleaning to avoid any spread of germs.

18. All clients are offered substance use programming and activities to include recreation & fitness classes on a daily basis. Clients are offered a minimum of 7 hours of programming per day. All programming is done while practicing social distance guidelines. Group size does not exceed 10 clients. Clients from each unit do not integrate with clients in other unit for any reason to include programming.

19. Counseling staff is available to meet with clients on a daily basis either by appointment or as needed. Clients and counseling staff meet regularly to participate in individual counseling, group therapy and individual "client specific" discharge planning. These daily meetings are in addition to the 7 hours of substance use programming and activities provided daily.

20. The SSTC Program Director monitors client participation in groups and based upon the satisfactory completion of programming, proper medical and mental health clearance, and a thorough, carefully reviewed discharge plan (to include review and approval from the MASAC Superintendent or designee), SSTC clients are approved for discharge from their civil commitment.

Signed under the pains and penalties of perjury this 23rd day of April 2020.

Kevin Crowley,
Superintendent, Hampden County Sheriff's Department