SCPW-21-_____

IN THE SUPREME COURT OF THE STATE OF HAWAI‘I

IN THE MATTER OF INDIVIDUALS IN CUSTODY OF THE STATE OF HAWAI`I	ORIGINAL PROCEEDINGS HONORABLE MARK E. RECKTENWALD Chief Justice HONORABLE PAULA A. NAKAYAMA HONORABLE SABRINA S. MCKENNA HONORABLE MICHAEL D. WILSON HONORABLE TODD W. EDDINS Associate Justices

PETITION FOR EXTRAORDINARY WRIT PURSUANT TO HRS §§ 602-4, 602-5(5), AND 602-5(6) AND/OR FOR WRIT OF MANDAMUS

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PETITION FOR EXTRAORDINARY WRIT
PURSUANT TO HRS §§ 602-4, 602-5(5), AND 602-5(6)
AND/OR FOR WRIT OF MANDAMUS

I.

STATEMENT OF FACTS

In late March 2020, the Office of the Public Defender ("OPD") sought emergency action by this Court to address the threat the pandemic posed to incarcerated persons and staff in Hawai`i correctional facilities.[1] At that time, the impact of the pandemic on our State, our communities, our citizens, and our correctional facilities was not determinable. However, in anticipation of a potentially catastrophic public health crisis, the OPD petitioned this Court to take swift and decisive emergency action on the release of incarcerated persons to alleviate overcrowded conditions. The Court declined to order a blanket release of certain categories of incarcerated persons and, instead, appointed a Special Master to work with the parties in a collaborative and expeditious manner to address the issues raised in the two petitions filed by the OPD and to facilitate a resolution while protecting public health and safety. The process was cumbersome and time-consuming (when time was most certainly of the essence) and the stakeholders were unable to find common ground. Ultimately, this Court established criteria and ordered lists to be generated by the Department of Public Safety ("DPS") of incarcerated persons eligible for release.

[1] Halawa Correctional Facility ("HCF"), Special Needs Facility ("SNF"), Waiawa Correctional Facility ("WCF"), Oahu Community Correctional Center ("OCCC"), Laumaka Work Furlough Center ("LWFC"), Women's Community Correctional Center ("WCCC"), Maui Community Correctional Center ("MCCC"), Kauai Community Correctional Center ("KCCC"), Hawai`i Community Correctional Center, Kulani Correctional Facility ("KCF"), Saguaro Correctional Center ("SCC"), Federal Detention Center ("FDC") and any other correctional facility, jail or other holding facility in Hawai`i or the Mainland which houses incarcerated persons from Hawai`i will be referred to collectively herein as "Hawai`i correctional facilities."

By early June 2020, this Court noted that, although the pandemic continued, the rate of new infections in Hawai`i remained at very low levels. This Court determined that much of the urgent relief sought in the two petitions had been addressed, concluded the consolidated proceedings, and recommended that further issues regarding populations at Hawai`i correctional facilities be addressed through alternative means, specifically, the Hawai`i Correctional System Oversight Commission ("HCSOC").

In August 2020, the OPD filed a petition in the Hawai`i Supreme Court once again seeking this Court's intervention in, *inter alia*, improving conditions, complying with CDC guidelines and releasing certain categories of incarcerated persons.[2] Between February 28, 2020, and August 31, 2020, there were a total of 8,472 cases statewide and daily case counts would occasionally reach triple digits.[3] This Court recognized that, "[t]he COVID-19 pandemic has caused a public health emergency" in the community. This Court further recognized the "impact of COVID-19 on Hawai`i's community correctional centers and facilities."[4]

> Given the rising number of COVID-19 cases at OCCC and the difficulties with social distancing, there is urgent and immediate concern in reducing the inmate populations at OCCC to protect those who work at or are detained at OCCC, their families, and the community. The immediacy of this concern is also exacerbated in that the rising numbers of COVID-19 cases at OCCC will tax the limited resources of community health care providers, including hospital beds, ventilators, and personal protective equipment, and will also require the expenditure of additional resources to provide constitutionally mandated medical care.[5]

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[2] SCPW-20-0000509, Petition For Extraordinary Writ Pursuant To HRS §§ 602-4, 602-5(5), And 602-5(6) And/Or For Writ Of Mandamus, filed on August 12, 2020 ("2020 Writ" herein).

[3] State of Hawai`i, Department of Health, Hawai`i COVID-19 Daily News Digest August 31, 2020. https://health.hawaii.gov/news/covid-19/hawaii-covid-19-daily-news-digest-august-31-2020/

[4] SCPW-20-0000509, Interim Order, filed on August 14, 2020 at p. 3.

[5] Id. at pp. 3-4.

This Court took swift and decisive action to protect incarcerated persons and staff at OCCC, their families and the community.[6] Citing the surge in cases in Hawai`i, record number of positive cases and increased hospitalizations, rising case counts at OCCC and "the difficulties with social distancing," this Court issued a series of orders for release and/or expedited processes for release of certain categories of individuals and release of information to the parties.[7] As a result of these orders, the populations at Hawai'i correctional facilities decreased. Based on its belief that the COVID-19 crisis in the community and in the correctional facilities had begun to abate, this Court concluded the proceedings.

> Today, according to recent filings in this case, it appears that the rate of positive cases in Hawai`i's correctional centers and facilities has significantly declined since the petition was filed in August 2020, testing and other health and safety measures have been implemented within the correctional centers and facilities, and a vaccination program to vaccinate inmates is underway. Thus, it appears that the conditions that necessitated swift action by this court in August 2020 are no longer prevalent. Conclusion of this proceeding is therefore appropriate.[8]

Today the situation that faces the State is exponentially more dire than that which prompted this Court's swift action in August 2020. The necessity for this Court to once again intervene is urgent. Rather than being in a downturn in case counts as was the case in August 2020, we are facing a rapid upswing of unknown severity. Since January 2020, there have been

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[6] SCPW-20-0000509, Order Re: Felony Defendants, filed on August 17, 2020 at p. 2.

[7] See generally JEFS record for SCPW-20-0000509.

[8] SCPW-20-0000509, Order Concluding Proceeding, filed on April 16, 2021 at p. 2.

37,085,000 COVID-19 cases documented in the United States.[9] New cases are on the rise in the U.S.; there was an average of 43.0 new daily cases of the virus for every 100,000 Americans over the past week, up from an average of 38.00 new daily cases per 100,000 the week before.[10] The seven-day average of daily new cases in the U.S. is 138,364.[11]

The pandemic in Hawai`i is following the same concerning upward trend. The statewide case count as of August 26, 2021, stands at 59,613 and there have been 9.790 new cases of COVID-19 in the past fourteen days.[12] The fourteen-day average of new cases is currently 727 cases per day.[13] Significantly, the sharp rise in COVID-19 cases in July was attributed to correctional facilities, restaurants and an indoor wedding reception and concert.[14]

These staggering numbers far outweigh the case counts which compelled the Court to describe the conditions as a "public health emergency" in August 2020 and prompted the Court to take swift and decisive action. Indeed, there have been more cases in the last fourteen days (9,790 cases) than the statewide cumulative total (8,472 cases) in August 2020. The seven-day average case count for August 27, 2021 (727 cases) has risen by 493 cases since August 25, 2020

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[9] Stebbins, S., "States Where COVID-19 Cases Are Climbing Fastest." *MSN News*, August 24, 2021. https://www.msn.com/en-us/news/us/states-where-covid-19-cases-are-climbing-fastest/ss-AANG1nd?ocid=uxbndlbing

[10] Id..

[11] *USA Facts*, U.S. COVID-19 cases and deaths by state (updated August 25, 2021). https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/

[12] Hawai`i Department of Health, Hawaii COVID-19 Data (cumulative totals as of August 27, 2021). https://health.hawaii.gov/coronavirusdisease2019/current-situation-in-hawaii/

[13] Id..

[14] Hofschneider, A., "Hawaii COVID Hospitalizations Climb As Delta Variant Rages," Honolulu Civil Beat, August 19, 2021. https://www.civilbeat.org/2021/08/hawaii-covid-hospitalizations-peak-as-delta-variant-rages/

(234 cases).[15] In August 2020, 49% of the State's ICU beds were filled.[16] Today, due to the COVID-19 surge, hospitals statewide are at capacity in emergency rooms and ICUs and are being forced to set up triage tents in their parking lots.[17] Lieutenant Governor Josh Green has threatened stricter rules in a matter of weeks due to the limited space in Hawai`i hospitals.[18]

The game-changer in Hawai`i has been the Delta variant. Labeled as a "variant of concern"[19] by the Centers for Disease Control and Prevention ("CDC"), the hallmarks of the Delta variant are increased transmissibility and reduced responsiveness to antibodies from previous infections and vaccinations.[20] Currently, the Delta variant accounts for 93% of new

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[15] *The New York Times*, "Tracking Coronavirus in Hawaii: Latest Map and Case Count." https://www.nytimes.com/interactive/2021/us/hawaii-covid-cases.html

[16] Schaefers, A., "Hawaii health officials say more triple-digit coronavirus cases will compromise hospitals." *Honolulu Star Advertiser*, August 24, 2020. https://www.staradvertiser.com/2020/08/24/hawaii-news/officials-say-continuing-triple-digit-rise-in-covid-19-cases-will-put-a-strain-on-hospitals/

[17] Cocke, S., "Queen's Health Systems declare state of emergency as COVID-19 patients surge in Hawaii hospitals." *Honolulu Star Advertiser*, August 21, 2021. https://www.staradvertiser.com/2021/08/21/hawaii-news/queens-declares-state-of-emergency-as-covid-19-surges-in-hawaii/

[18] Ancheta, D., "Green: Unvaccinated are to blame if new, strict rules needed to curb hospitalizations." *Hawai`i News Now*, August 15, 2021. https://www.hawaiinewsnow.com/2021/08/16/green-unvaccinated-are-blame-if-new-strict-rules-needed-curb-hospitalizations/?outputType=apps

[19] The CDC describes a "variant of concern" as, "A variant for which there is evidence of an increase in transmissibility, more severe disease (e.g., increased hospitalizations or deaths), significant reduction in neutralization by antibodies generated during previous infection or vaccination, reduced effectiveness of treatments or vaccines, or diagnostic detection failures." Centers for Disease Control and Prevention, SARS-CoV2 Variant Classifications and Definitions (updated August 24, 2021). https://www.cdc.gov/coronavirus/2019-ncov/variants/variant-info.html#Interest

[20] Id..

infections in Hawai`i[21] and the Delta variant is the predominant strain of the virus in the United States.[22] The Delta variant is two times more contagious than other variants and might cause more severe illness than previous strains in unvaccinated persons.[23] Even fully vaccinated people with Delta variant breakthrough infections can spread the virus to others.[24] The high transmissibility of the virus can be attributed to the fact that the median viral load of the Delta variant is up to 1,000 times higher than the original COVID-19 strains.[25] Moreover, fully vaccinated people with the Delta variant carry just as high a viral load in the first five to six days of infection as unvaccinated people.[26]

Due to the skyrocketing number of cases fueled by the emergence of the Delta variant, Governor David Ige has discouraged tourists from visiting the State and has limited indoor social gatherings to ten people with masking and social-distancing requirements.[27] The Governor has also threatened "extreme measures" if case counts continue to rise, such as "lockdowns and

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[21] Hawai`i Department of Health, "Hawaii sequencing and variants of SARS-Cov-2" (rev. 8/18/21). https://health.hawaii.gov/coronavirusdisease2019/files/2021/08/Variant_report_20210818.pdf

[22] CDC, "Delta Variant: What We Know About the Science" (updated August 19, 2021). https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html

[23] Id..

[24] Id..

[25] Wu, N., "Infectious disease expert says stricter measures are needed to stop the delta variant in Hawaii," *Honolulu Star Advertiser*, August 15, 2021.

[26] Id..

[27] Dayton, K., "Ige Imposes New Restrictions On The Size Of Gatherings As Caseloads Mount." *Honolulu Civil Beat*, August 10, 2021. https://www.civilbeat.org/2021/08/ige-imposes-new-restrictions-on-the-size-of-gatherings-as-caseloads-mount/

potentially shutting down businesses."[28] Honolulu Mayor Rick Blangiardi has cancelled all large gatherings for four weeks beginning August 25.[29] Unfortunately, the ameliorative measures touted as mitigating the COVID-19 crisis in the community – wearing masks, social distancing, limiting the size of gatherings, socializing within social "bubbles" – cannot be implemented within Hawai'i correctional facilities.

> People who are incarcerated are at great risk of sickness and death as a result of the Covid-19 pandemic and more must be done to release people who are imprisoned and are not a threat to public safety or are elderly or infirm. The inability to quarantine or practice social distancing, together with overcrowding, imperils the lives of many people incarcerated in jails and prisons.
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> Incarcerated people are infected by the coronavirus at a rate more than five times higher than the nation's overall rate, according to research reported in the Journal of the American Medical Association in July 2020. The reported death rate of inmates (39 deaths per 100,000) is also higher than the national rate (29 deaths per 100,000). [30]

Prisons have a unique mix of aggravating factors that make incarcerated persons especially vulnerable to COVID-19 infections – overcrowding, insufficient sanitation, poor ventilation, and inadequate healthcare.[31]

> Detention and incarceration of any kind involves large groups of people living in cohorts in confined spaces creating many challenges for curbing the spread of

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[28] Richardson, M., "Governor says 'extreme measures' possible if COVID surge worsens." *Hawai`i News Now*, August 26, 2021. https://www.hawaiinewsnow.com/2021/08/27/ige-says-extreme-measures-possible-if-covid-surge-worsens/

[29] Staff, "Mayor Blangiardi suspends large gatherings on Oahu starting Wednesday." *Honolulu Star Advertiser*, August 23, 2021. https://www.staradvertiser.com/2021/08/23/breaking-news/mayor-blangiardi-suspends-large-gatherings-on-oahu-starting-wednesday/

[30] Equal Justice Initiative, "Covid-19's Impact on People in Prison" (updated April 16, 2021). https://eji.org/news/covid-19s-impact-on-people-in-prison/

[31] Franco-Paredes, et al., "COVID-19 in jails and prisons: A neglected infection in a marginalized population." plos.org, June, 22, 2020. https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0008409

> COVID-19. The number of single rooms in jails or prisons are insufficient to adhere to the recommended isolation and quarantine guidelines and limits the ability to implement strict infection prevention protocols.[32]

Indeed, it is the ongoing crisis at Hawai`i correctional facilities that creates the urgency which once again requires immediate and decisive judicial relief. Recently, several plaintiffs filed a putative class action in the U.S. District Court for the District of Hawai`i.[33] In her order granting provisional class certification and granting in part and denying in part a preliminary injunction and temporary restraining order, U.S. District Judge, the Honorable Jill A. Otake plainly stated, "As they currently exist, DPS's practices – exacerbated by the shared and confined spaces in carceral settings – are likely to cause irreparable harm because they present a considerable risk of COVID-19, with or without an outbreak."[34] Judge Otake found credible the reports by the plaintiffs[35] that exposed significant breaches of DPS's own Pandemic Response Plan – COVID-19.[36] These breaches included: mixing COVID-positive individuals in a "COVID-negative quad" with COVID-negative individuals; failing to enforce mask-wearing requirements for staff or incarcerated persons; not enforcing social distancing during recreation, dining, or in common areas and cells; transferring asymptomatic individuals into cells previously

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[32] Id..

[33] Chatman, et al. v. Otani, Civil No. 21-00268 JAO-KIM (U.S. Dist. Ct., Haw. Dist.).

[34] Chatman, *supra*. Order (1) Granting Plaintiffs' Motion For Provisional Class Certification And (2) Granting In Part And Denying In Part Plaintiffs' Motion For Preliminary Injunction And Temporary Restraining Order, filed on July 13, 2021 ("Chatman Order"). A copy of the Chatman Order is attached hereto as Exhibit "B".

[35] Judge Otake found "credible the declarations Plaintiffs submitted" detailing the conditions. Chatman Order at p. 39. These declarations were from not only incarcerated person but staff at the facilities.

[36] A copy of the State of Hawai`i, DPS, Pandemic Response Plan – COVID-19 (May 28, 2021, rev.) is attached hereto as Exhibit "A".

occupied by COVID-positive individuals without sanitizing the cells first; and failing to provide masks or sanitizing supplies.[37] While Judge Otake required DPS to "fully comply with the Response Plan," she recognized that the "issues will persist and that future outbreaks are likely, driven in part by the inmates' inter-facility movement and constant introduction of new inmates into the facilities."[38] These overcrowded conditions and the transfer of individuals between facilities must be addressed if any COVID-19 response plan in Hawai'i correctional facilities is to have any chance of success.

Population numbers at the facilities as of August 16, 2021, confirm that overcrowding is still prevalent. In the eleven facilities (HCCC, SNF, HMSF, KCCC, KCF, MCCC, OCCC, WCCC, WCF) and two contracted facilities (SCF, FDC) housing incarcerated persons from Hawai'i, five are above design capacity (HCCC, HMSF, KCCC, MCCC, OCCC) and two are above both design and operational capacity (HCCC, MCCC).[39] In fact, the Hawai'i Correctional System Oversight Commission ("HCSOC") formulated "Infectious Disease Emergency Capacities" based on specific guidelines included in the CDC's Interim Guidance on Management of Coronavirus 2019 (COVID-19) in Correctional and Detention Facilities,[40] that

[37] See generally, Chatman Order; Exhibit "B", attached.

[38] Chatman Order at p. 56. Exhibit "B", attached.

[39] DPS, Department of Public Safety Weekly Population Report (August 16, 2021). https://dps.hawaii.gov/wp-content/uploads/2021/08/Pop-Reports-Weekly-2021-08-16.pdf

[40] See www.cdc.gov, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

are generally below both design and operational capacities.[41] These emergency capacities were formulated to allow: (a) medical isolation of confirmed or suspected COVID-19 cases; (b) quarantine of the newly admitted; (c) quarantine of those who had close contacts of COVID-19; and (d) range of housing alternatives for medical isolation, in order of preference, from single cells with solid doors to cohorting in multi-person cells/dormitories.[42] In its Order Concluding Proceedings in SCPW-20-0000509, this Court stated, "[i]ssues regarding inmate populations may be addressed through alternative means, including by the [HCSOC], which was established by the Hawai`i Legislature … to, among other things, establish maximum inmate population limits for each correctional facility and formulate policies and procedures to prevent the inmate population from exceeding the capacity of each correctional facility." The HCSOC has established these population limits but they are not being followed.

In revealing that COVID-19 continues to spread in half of Hawai`i's eight in-state correctional facilities and in SCF in Arizona,[43] DPS Director Max Otani admitted that overcrowding in the State's enclosed correctional facilities has made it difficult to prevent new infections.[44] Otani further revealed that "staffing challenges" at all facilities, particularly medical

[41] HCSOC, Hawai`i Correctional Facilities – Infectious Disease Emergency Capacities (draft report, September 2020). https://ag.hawaii.gov/wp-content/uploads/2020/09/FINAL-REPORT-091120.pdf

[42] Id..

[43] Dayton, K., "Problems Persist As Corrections Officials Struggle To Comply With Federal Order." *Honolulu Civil Beat*, August 19, 2021. https://www.civilbeat.org/2021/08/problems-persist-as-corrections-officials-struggle-to-comply-with-federal-order/

[44] Id..

staff, are exacerbating the situation.[45] In 2020, former Director of DPS, Nolan P. Espinda confessed,

> Unfortunately, the critical overcrowding situation must be addressed right now. Since the 1990s, Hawai'i's prison and jail population has grown well beyond capacity, during which time no new facilities were added. We are forced to triplebunk single cells, add beds to crowded dorms and convert spaces normally used for rehabilitative programs to housing. Overcrowding and inefficient infrastructure create safety and security risks to staff, inmates and the public.[46]

DPS's concession of the overcrowding at Hawai`i correctional facilities confirms that populations at those facilities are the critical piece of any COVID-19 response plan. Indeed, Phase I of DPS's Pandemic Response Plan – COVID-19 requires DPS to coordinate with local law enforcement and court officials to reduce populations at correctional facilities by, *inter alia*, "[c]ontinu[ing] to explore strategies to reduce new intakes to the correctional facility" and "[u]tiliz[ing] existing policies for alternatives to incarceration and consider other decompression strategies where allowable."[47] Petitioner is unaware of any such efforts being made by DPS to coordinate releases of individuals with the courts.

In recognition of these overcrowded conditions and the lapses by DPS in following their own response plan, Judge Otake observed:

> DPS's recent efforts to remediate egregious conditions – that never should have occurred in the first place – do not persuade the Court that DPS can and will successfully manage the pandemic moving forward. After all, five severe outbreaks demonstrate otherwise. Based on DPS's record of handling of COVID-19 in its facilities, it is not unreasonable to assume that issues will persist and that

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[45] Id..

[46] Espinda, N., "Dispelling myths about prison overcrowding." Honolulu Star Advertiser, Column, January 21, 2020. https://www.staradvertiser.com/2020/01/21/editorial/island-voices/dispelling-myths-about-prison-overcrowding/

[47] DPS, Pandemic Response Plan – COVID-19 (May 28, 2021 rev.). Exhibit "A", attached.

> future outbreaks are likely, driven in part by the inmates' inter-facility movement and constant introduction of new inmates into the facilities.[48]

In August 2021, COVID-19 outbreaks occurred at HCF and MCCC, with both staff and incarcerated persons testing positive.[49] Inmates were also quarantined at SCF in Arizona after testing positive for COVID-19.[50] The "COVID-19 TESTING: INMATE REPORT" issued by DPS on August 23, 2021, illustrates the gravity of the situation caused by the failure of DPS to adhere to safety protocols and limit populations within its facilities. There are active positive cases in five of the nine correctional facilities housing incarcerated persons from Hawai`i. In total, there have been 2,301 COVID-19 cases in Hawai`i correctional facilities, including nine deaths.

[48] Chatman Order at p. 56. Exhibit "B", attached.

[49] Dayton, K., "Maui Jail, Halawa Prison Report New COVID-19 Outbreaks." *Honolulu Civil Beat*, August 5, 2021. https://www.civilbeat.org/beat/maui-jail-halawa-prison-report-new-covid-19-outbreaks/

[50] Dayton, K., "Hawaii Inmates in Quarantine In Arizona Prison." Honolulu Civil Beat, August 3, 2021. https://www.civilbeat.org/beat/hawaii-inmates-in-quarantine-in-arizona-prison/

DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

COVID-19 INFORMATION | **Updated: 8/23/2021**

COVID-19 TESTING: INMATE REPORT

Facilities	Tested	Results Pending	Negative	Incon-clusive	Total Tested Positive	Active Positive	Number of Persons in Medical Isolation	Number of Persons in Quarantine	Hospitalization	Recovered	Deaths
HCF	4,533	0	3,879	6	640	48	48	352	2	597	7
HCCC	1,758	pending	1,492	2	262	0	0	4	0	234	0
KCCC	692	0	627	0	65	33	33	NA	0	30	0
KCF	295	0	295	0	0	0	0	0	0	0	0
MCCC	2,154	0	1,961	6	188	68	68	NA	0	118	0
OCCC	9,712	0	9,139	25	544	83	83	0	0	453	0
WCCC	1,128	0	1,128	0	0	0	0	0	0	0	0
WCF	1,198	0	981	1	214	0	0	0	0	214	0
SAGUARO	3,307	0	2,645	5	662	5	5	0	0	655	2

To reiterate, the Delta variant, which makes up 93% of recent COVID-19 cases in Hawai`i[51], is two times more contagious than previous strains of the virus.[52] Further, the Delta variant is not the only "variant of concern" that has been detected in Hawai`i. The Delta, Alpha, Gamma and Beta variants have all been detected in genomic testing of samples in Hawai`i. As the hallmark of the "of concern" variants is that they are either highly contagious/transmissible or less responsive to current vaccines and antibodies from a previous infection[53], the catastrophic effects of a highly-transmissible, vaccine/antibody-resistant variant in Hawai`i correctional facilities cannot be overemphasized. As this Court recognized previously and Judge Otake

[51] Hawai`i Department of Health, Hawaii sequencing and variants of SARS-Cov-2 (rev. 8/18/21).
https://health.hawaii.gov/coronavirusdisease2019/files/2021/08/Variant_report_20210818.pdf

[52] Id. at p. 4.

[53] Id. at p. 5.

emphasized, the conditions in Hawai‘i correctional facilities not only endanger the lives and health of incarcerated persons and staff but also the general public.

> With inmate COVID-19 infections far exceeding the general rate in Hawai‘i, and multiple severe outbreaks in DPS facilities throughout the course of the pandemic, [DPS] has not adequately protected the health and safety of the inmates. And the continued spread of COVID-19 in DPS facilities will impact DPS staff and other individuals who enter DPS facilities, along with their families and surrounding communities.[54]

The foregoing relevant facts confirm the gravity of the situation at hand. We are, once again, faced with a public health emergency and the trajectory of the current surge remains uncertain. The virulent spread of the virus within the close quarters of Hawai`i correctional facilities will inevitably lead to a public health emergency which will tax the capacities of the health care system and the limited resources of the State's hospitals and health providers on each of the islands. This situation requires that this Court once again take swift action to reduce the populations at Hawai`i correctional facilities in an effort to mitigate the harm that the current surge in the pandemic will inflict upon incarcerated persons, staff and the people of Hawai`i.

II.

STATEMENT OF JURISDICTION

This Petition seeks extraordinary relief under extraordinary circumstances. While the U.S. and Hawai`i constitutions demand safe and sanitary conditions of confinement under normal circumstances, this Petition asks the Court to directly exercise its fundamental judicial power,[55] its supervisory power over the judicial system,[56] and/or its mandamus power over

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[54] Chatman Order at p. 61. Exhibit "B", attached.

[55] Haw. Const., art. VI, § 1.

[56] Haw. Const., art. VI, § 7; HRS §§ 602-4, 602-5(5), 602-5(6).

respondent judges and public officials,[57] to reduce the number of people who are now in Hawai`i correctional facilities to prevent massive and unnecessary harm and loss of life during the COVID-19/Delta variant crisis. That this Court has the jurisdiction and power to order the relief sought herein cannot be questioned as this Petition seeks relief which this Court granted in the OPD's previous petitions.[58]

This Court has jurisdiction to provide the relief sought in this Petition, which includes taking necessary steps to avoid or mitigate impending catastrophe. The Court has broad powers to supervise the judicial system, including the power to both "make or issue any order or writ necessary or appropriate in aid of its jurisdiction[59] and "make and award such judgments, decrees, orders and mandates, issue such executions and other processes, and do such other acts and take such other steps as may be necessary to carry into full effect the powers which are or shall be given to it by law or for the promotion of justice in matters pending before it."[60] Separately, the Court "shall have the general superintendence of all courts of inferior jurisdiction."[61] This Court has stated that "public safety is always an important consideration for any judicial determination" that "invoke[s] our supervisory power." State v. Moniz, 69 Haw. 370, 373, 742 P.2d 373, 376 (1987). As explained herein, the ongoing crisis in Hawai'i correctional facilities warrants the Court's direct intervention here.

Separately, the present case warrants exercise of the Court's mandamus power over Respondents judges and public officials. Mandamus relief is proper where the petitioner

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[57] HRS § 602-5(3).

[58] See generally JEFS record for SCPW-20-0000509.

[59] HRS § 602-5(5).

[60] HRS § 602-5(6).

[61] HRS § 602-4.

demonstrates: (1) a clear and indisputable right to relief; and (2) a lack of other means to adequately address the alleged wrong or obtain the required action. Kema v. Gaddis, 91 Hawai‘i 200, 204, 982 P.2d 334, 338 (1999); Barnett v. Broderick, 84 Hawai‘i 109, 111, 929 P.2d 1359, 1361 (1996). No adequate means exists to redress the impending danger to public safety and the safety of persons incarcerated at Hawai‘i correctional facilities posed by the COVID-19/Delta variant crisis. While some detainees and prisoners may have the ability to file individual motions seeking release, that would be inadequate here given the dramatic pace at which the crisis is unfolding and the increased exposure that incarcerated persons in Hawai‘i correctional facilities face with each passing day. Further, as explained below, both pretrial detainees and persons incarcerated in correctional facilities have an indisputable right to relief under both the U.S. and Hawai‘i constitutions. Accordingly, the Court must exercise its power to issue an extraordinary writ, a writ of mandamus, or both, here.

III.

STATEMENT OF ISSUES PRESENTED AND RELIEF SOUGHT

This Petition presents the following issues – Whether present detention and incarceration practices for persons currently detained or incarcerated in Hawai‘i correctional facilities during the ongoing COVID-19/Delta variant crisis raise serious due process concerns, under the eighth and fourteenth amendments to the U.S. Constitution and article I, sections 5 and 12 of the Hawai‘i Constitution, which justify immediate, extraordinary relief?

Petitioner recognizes the necessity of balancing issues raised by the current public health emergency in our community and correctional facilities with “public safety and health concerns regarding the release of inmates … into the community.”[62] To mitigate the harms that the

[62] See e.g. SCPW-20-0000509, Order Re: Felony Defendants, filed August 17, 2020.

COVID-19/Delta variant crisis will inflict upon persons incarcerated in Hawai‘i correctional facilities, staff in those facilities and the people of Hawai‘i while still recognizing public safety and health concerns, Petitioner respectfully requests the following relief:

1) Order the Circuit, Family and District courts that when adjudicating motions for release: (a) release shall be presumed unless the court finds that the release of the individual would pose a significant risk to the safety of the individual or the public; (b) design capacity (as opposed to operational capacity) of the correctional facility shall be taken into consideration; (c) the health risk posed by the COVID-19 pandemic should be taken into consideration. Motions for release based on the foregoing are for the following categories of incarcerated persons:

    a. Individuals serving a sentence (not to exceed eighteen months) as a condition of felony deferral or probation, except for: (i) individuals serving a term of imprisonment for a sexual assault conviction or an attempted sexual assault conviction; or (ii) individuals serving a term of imprisonment for any felony offense set forth in HRS Chapter 707, burglary in the first degree (HRS §§ 708-810, 708-811), robbery in the first or second degree (HRS §§ 708-840, 708-841), abuse of family or household members (HRS §§ 709-906(7) and (8), and unauthorized entry in a dwelling in the first degree and in the second degree as a class C felony (HRS §§ 708-812.55, 708-812.6(1) and (2), including attempt to commit those specific offenses (HRS §§ 705-500, 705-501).

    b. Individuals serving sentences for misdemeanor or petty misdemeanor convictions, except those convicted of abuse of family or household members (HRS § 709-906), violation of a temporary restraining order (HRS § 586-4), violation of an order for protection (HRS § 586-11), or violation of a restraining order or injunction (HRS § 604-10.5).

    c. All pretrial detainees charged with a petty misdemeanor or a misdemeanor offense, except those charged with abuse of family or household members (HRS § 709-906), violation of a temporary restraining order (HRS § 586-4), violation of an order for protection (HRS § 586-11), or violation of a restraining order or injunction (HRS § 604-10.5).

    d. All pretrial detainees charged with a felony, except those charged with a sexual assault or an attempted sexual assault, any felony offense set forth in HRS Chapter 707, burglary in the first degree (HRS §§ 708-810, 708-811), robbery in the first or second degree (HRS §§ 708-840, 708-841), abuse of family or household members (HRS §§ 709-906(7) and (8), and unauthorized entry in a dwelling in the first degree and in the second degree as a class C felony (HRS §§ 708-812.55, 708-812.6(1), including attempt to commit those specific offenses (HRS §§ 705-500, 705-501).

2) Order the Circuit, Family and District courts, DPS, and the HPA to reduce the population of Hawai‘i’s correctional facilities to allow for the social separation and other measures recommended by the CDC to prevent the spread of COVID-19 by taking immediate steps to reduce the population those facilities to their design capacity and/or Infectious Disease Emergency Capacity as recommended by the Hawai`i Correctional System Oversight Commission.[63]

3) Appoint a public health expert to enter into all of Hawai`i correctional facilities and review protocols, the ability to social distance and make recommendations.

4) Order testing for COVID-19 for all incarcerated persons and staff at Hawai`i correctional facilities and to notify all parties of any positive or presumptive-positive test results for any incarcerated person. The information released to the parties should include the individual’s name, date of test and date of test result. [64]

5) Order the Circuit, Family and District courts to suspend the custodial portions of such sentence until the conclusion of the COVID-19 pandemic or until deemed satisfied for individuals serving intermittent sentences.

6) Order that the practice of no cash bail, including the release of individuals on their own recognizance, on signature bonds, or on supervised release, should be regularly employed, and pretrial detainees who are not a risk to public safety or a flight risk should not be held simply because they do not have the means to post cash bail.

7) Order the HPA to expeditiously address requests for early parole consideration, including conducting hearings using remote technology. The HPA should also consider release of incarcerated persons who are most vulnerable to the virus, which includes individuals who are 65 years old and older, have underlying health conditions, who are pregnant, and those individuals being held on technical parole violations (i.e. curfew violations, failure to report as directed, etc.) or who have been designated as having “minimum” or “community” security classifications and are near the maximum term of their sentences. The HPA shall prepare and provide periodic progress reports to the parties of their efforts and progress in the aforementioned areas. The reports should include a list of the names of individuals who have been granted release, the names of the individuals who are under

[63] HCSOC, Draft Report. https://ag.hawaii.gov/wp-content/uploads/2020/09/FINAL-REPORT-091120.pdf

[64] On August 2, 2021, Assistant Public Defender Lee S. Hayakawa sent an email to Director of DPS, Max Otani, requesting that DPS resume providing daily reports regarding COVID-19 tests, test results, and the names of individuals who had tested positive. The OPD reasoned that “it is our moral and ethical obligation to be able to assess and identify safety issues before we send our attorneys to the state jails and/or prisons. Without more information regarding testing/test results and the identities of those inmates that are positive for COVID-19, we are unable to meaningfully advise our attorneys on whether it is safe to enter any one of the state jails and/or prisons.” The request was denied.

consideration for release, and the names of the individuals who were considered for release but for whom release was denied.

8) Order DPS to adhere to the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities[65] in all Hawai'i correctional facilities.

9) Order DPS to adhere to its Pandemic Response Plan – COVID-19 (May 28, 2021 rev.)[66]

10) Order DPS to comply with the requirements of HRS § 353-6.2 and conduct periodic reviews to determine whether pretrial detainees should remain in custody or whether new information or a change in circumstances warrants reconsideration of a detainee's pretrial release or supervision.[67]

To reiterate, the foregoing relief sought by the OPD is in recognition of the delicate balance between public safety and protecting the health and welfare of the vulnerable population of incarcerated persons in Hawai`i correctional facilities. The blanket orders sought specifically exclude individuals charged with certain categories of offenses. The courts also retain the

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[65] See www.cdc.gov, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

[66] Exhibit "A", attached.

[67] HRS § 353-6.2 reads as follows:

> Community correctional centers; periodic reviews of pretrial detainees.
>
> (a) The relevant community correctional centers, on a periodic basis but no less frequently than every three months, shall conduct reviews of pretrial detainees to reassess whether a detainee should remain in custody or whether new information or a change in circumstances warrants reconsideration of a detainee's pretrial release or supervision.
>
> (b) For each review conducted pursuant to subsection (a), the relevant community correctional center shall transmit its findings and recommendations by correspondence or electronically to the appropriate court, prosecuting attorney, and defense counsel.
>
> (c) If a motion to modify bail is filed pursuant to a recommendation made pursuant to subsection (b), a hearing shall be scheduled at which the court shall consider the motion.

discretion to deny release even to individuals covered by the blanket orders based on significant risk to the individual or the public. Further, if the relief sought were to be granted, the State would continue to have the option of filing individual motions seeking to modify the release status of any individual for whom it deemed appropriate.

IV.

STATEMENT OF REASONS FOR ISSUING THE WRIT

A. PRESENT DETENTION AND INCARCERATION PRACTICES FOR INCARCERATED PERSONS IN HAWAIʻI CORRECTIONAL FACILITIES DURING THE ONGOING COVID-19/DELTA VARIANT CRISIS RAISE SERIOUS DUE PROCESS CONCERNS UNDER THE EIGHTH AND FOURTEENTH AMENDMENTS TO THE U.S. CONSTITUTION AND ARTICLE I, SECTIONS 5 AND 12 OF THE HAWAIʻI CONSTITUTION, JUSTIFYING IMMEDIATE, EXTRAORDINARY RELIEF.

The State of Hawaiʻi has a custodial responsibility to care for the health of incarcerated persons within its correctional facilities. This principle is embedded within the United Nations Standards Minimum Rules for the Treatment of Prisoners, known as "The Nelson Mandela Rule,"[68] as well as within the U.S. and Hawaiʻi constitutions. The dire situation we are facing in Hawaiʻi correctional facilities goes beyond simply care and treatment. We must not only care for the health of those in our institutional charge but also, certainly, not place them in greater peril

[68] United Nations Office on Drugs and Crime. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

by deliberately disregarding the excessive risk to incarcerated persons' health and safety.[69] Both pretrial detainees and persons sentenced to prison terms have a right to a sanitary and safe detention environment. As Judge Otake found without uncertainty, DPS is not following the health and safety requirements set forth in its own pandemic response plan. This is not simply an administrative omission, it is an omission of constitutional proportions. The eighth amendment to the U.S. Constitution and article I, section 12 of the Hawai'i Constitution impose on the government an affirmative duty to provide conditions of reasonable health and safety to the people that it holds in its custody:

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

DeShaney v. Winnebago County Dept. of Soc. Servs., 489 U.S. 189, 199-200, 109 S. Ct. 998, 1005, 103 L.Ed.2d 249 (1989). Conditions that pose an unreasonable risk of future harm violate the Eighth Amendment's prohibition against cruel and unusual punishment, even if that harm has not yet come to pass. Thus, the government cannot "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." Helling v. McKinney, 509 U.S. 25, 33, 113 S. Ct. 2475, 2480, 125 L. Ed. 2d 22 (1993). For example, inmates cannot be commingled with others having infectious maladies such as hepatitis and venereal disease. Hutto v. Finney, 437 U.S. 678, 682-83, 98 S. Ct. 2565, 2569, 57 L. Ed. 2d 522 (1978); Gates v. Collier, 501 F.2d 1291 (5th Cir. 1974). An Eighth Amendment

[69] Chatman Order at p. 50. Exhibit "B", attached.

violation is established even though the plaintiff cannot yet "prove that he is currently suffering serious medical problems caused by" the exposure. Helling, 509 U.S. at 32-33, 113 S. Ct. at 2480-81. Here, absent dramatic action by this Court and DPS, incarcerated persons in Hawai‘i correctional facilities are at high risk of contracting COVID-19 due to the failure to follow safety and health protocols and procedures exacerbated by overcrowded conditions in violation of their Eighth Amendment rights. See Wright v. Rushen, 642 F.2d 1129, 1133 (9th Cir. 1981) (conditions of confinement must be analyzed in context, and courts must "consider the effect of each condition in the context of the prison environment, especially when the ill-effects of particular conditions are exacerbated by other related conditions.")

The Due Process Clause of the Fourteenth Amendment and Article I, Section 5 provide at least as much protection to pretrial detainees (which include people held pretrial for misdemeanors).[70] While the Eighth Amendment prohibits punishment that is "cruel and unusual," the Fourteenth Amendment's due process protections do not allow "punishment" at all. Bell v. Wolfish, 441 U.S. 520, 535 n.16, 99 S. Ct. 1861, 1872 n. 16, 60 L. Ed. 2d. 447 (1979) ("Due process requires that a pretrial detainee not be punished."); Gordon v. Maesaka-Hirata, 143 Hawai`i 335, 348, 431 P.3d 708, 721 (2018). The due process rights of a pretrial detainee "are at least as great as the Eighth Amendment protections available to a convicted prisoner." City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244, 103 S. Ct. 2979, 2983, 77 L. Ed. 2d 605, (1983).[71] If placing an inmate in a situation creating an elevated risk of potentially lethal

[70] Id.

[71] Castro v. County of Los Angeles, 833 F.3d 1060, 1070-73 (9th Cir. 2016) (*en banc*) (holding that objective deliberate indifference standard applies to detainee's failure-to-protect claim under Fourteenth Amendment) (citing Kingsley v. Hendrickson, 576 U.S. 389, 135 S.Ct. 2466, 192 L. Ed. 2d.416 (2015) (suggesting that pretrial detainees need not satisfy deliberate indifference standard and holding that in excessive force claim brought by pretrial detainee, detainee need not

infection constitutes "cruel and unusual punishment" in violation of the Eighth Amendment, as was found in Hutto and Gates, placing a pretrial detainee in a situation presenting a serious risk of lethal infection is certainly unconstitutional in violation of the Fourteenth Amendment.[72] Here, absent immediate action by this Court and DPS, pretrial detainees are also presently at high risk of contracting COVID-19 by being held in overcrowded conditions of confinement in violation of their due process rights.

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prove deliberate indifference; objective evidence that governmental action was not rationally related to a legitimate governmental objective (or that it is excessive in relation to that objective) is sufficient)).

[72] In addition, a significant number of people in Hawai'i are being detained on cash bail they cannot afford. An order requiring an unattainable financial condition of release is a de facto order of pretrial detention that violates procedural due process and improperly circumvents the procedures laid out in Haw. Rev. Stat. § 804-3. See United States v. Leathers, 412 F.2d 169, 171 (D.C. Cir. 1969) (per curiam); United States v. Mantecon-Zayas, 949 F.2d 548, 550 (1st Cir. 1991) (per curiam) ("[O]nce a court finds itself in this situation—insisting on terms in a "release" order that will cause the defendant to be detained pending trial—it must satisfy the procedural requirements for a valid detention order . . . ."); O'Donnell v. Harris County, 892 F.3d 147, 162 (5th Cir. 2018) (holding that Defendants' practices result in the "absolute deprivation of [indigent misdemeanor arrestees'] most basic liberty interests—freedom from incarceration"); United States v. Leisure, 710 F.2d 422, 415 (8th Cir. 1983) ("[T]he amount of bail should not be used as an indirect, but effective, method of ensuring continued custody."); Brangan v. Commonwealth, 80 N.E.3d 949, 963 (Mass. 2017); State v. Brown, 338 P.3d 1276, 1292 (N.M. 2014 ("Intentionally setting bail so high as to be unattainable is simply a less honest method of unlawfully denying bail altogether."). If such de facto wealth-based detention orders violate procedural due process and equal protection under "normal circumstances," *de facto* wealth-based detention most certainly violates these same protections during a public health crisis where the individual interest at issue is not only liberty but also life and bodily integrity. See e.g.., ODonnell, 892 F.3d at 161 (holding unequal treatment of wealthy and poor in pretrial wealth-based detention is unconstitutional); Brangan, 80 N.E. 3d at 964-65 (finding that, when financial conditions of release will likely result in an individual's pretrial detention, the judge must provide "findings of fact and a statement of reasons for the bail decision," including consideration of the individual's financial resources, "explain how the bail amount was calculated," and state why "the defendant's risk of flight is so great that no alternative, less restrictive financial or nonfinancial conditions will suffice to assure his or her presence at future court proceedings"); In re Humphrey, 228 Cal. Rptr. 3d 513, 535 (Cal. Ct. App. 2018).

Detention and imprisonment during the pandemic not only deprives individuals of their freedom, but also places them at serious risk of loss of life or permanent injury. These significant risks, not accounted for in sentencing or determinations of pretrial detention, implicate substantive and procedural due process rights that demand coordinated, immediate, and comprehensive action by the government. Such action should be guided by both public safety and public health considerations,[73] including the correctional facilities' inability to adequately prepare, respond, and operate in the event of a COVID-19 outbreak due to limited resources and the overcrowded conditions in jails and prisons.[74] Given the stakes and the significant risks posed by COVID-19 to the persons held in Hawai'i correctional facilities and the corresponding risk to the public which will result if an outbreak occurs in those facilities, it is clear that significant action to prevent massive and unnecessary harm and loss of life is both necessary and appropriate.

In concluding the previous action (SCPW-20-0000509), this Court cited the following factors:

> Today, according to recent filings in this case, it appears that the rate of positive cases in Hawai'i's correctional centers and facilities has significantly declined since the petition was filed in August 2020, testing and other health and safety measures have been implemented within the correctional centers and facilities, and a vaccination program to vaccinate inmates is underway. Thus, it appears that the conditions that necessitated swift action by this court in August 2020 are not longer prevalent. Conclusion of this proceeding is therefore appropriate.[[75]]

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[73] See, e.g., Centers for Disease Control and Prevention, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[74] ACLU of Hawai'i, Complaint against the State of Hawai'i concerning unconstitutional prison conditions and overcrowding (Jan. 6. 2017). https://acluhawaii.files.wordpress.com/2017/01/acluhidojcomplaintprisonovercrowding.pdf; .

[75] SCPW-20-0000509, Order Concluding Proceeding, filed on April 16, 2021.

All of the factors which necessitated this Court's action in August 2020 and which ostensibly abated in April 2021 have now resurged at significantly more serious levels – daily case counts and total cases statewide have soared, case counts are rising within the overcrowded correctional facilities, hospitals and ICUs have reached capacity and the Delta variant is both vaccine and antibody resistant. Today we once again face a public health emergency and this Court must once again take swift action to mitigate the impact of this crisis in Hawai‘i's correctional centers and facilities and the resultant effect on the community.

IV.

CONCLUSION

Based on the foregoing arguments and authorities, Petitioner State of Hawai‘i, Office of the Public Defender, respectfully requests that this Court grant the instant Petition and immediately issue an Extraordinary Writ and/or Writ of Mandamus ordering the Circuit, Family and District Courts, the Department of Public Safety and the Hawai‘i Paroling Authority to take immediate steps to significantly reduce the population of persons being held in Hawai‘i correctional facilities to prevent the massive loss of life and irreparable harm that the spread of COVID-19 would cause in those facilities.

DATED: Honolulu, Hawaii, August 27, 2021.

OFFICE OF THE PUBLIC DEFENDER
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State of Hawai`i, Department of Public Safety

Pandemic Response Plan- COVID-19 (May 28, 2021 revision)

EXHIBIT "A"

State of Hawaii
Department of Public Safety

PANDEMIC RESPONSE PLAN
COVID-19

(May 28, 2021 Revision)

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Pandemic Response Plan Overview

The COVID-19 Pandemic Response Plan was developed by VitalCore Health Strategies and approved by Lannette Linthicum, M.D., and the Office of Correctional Health of the American Correctional Association (ACA). The Department of Public Safety reviewed the plan, which is based upon current guidance from the CDC, and adapted the plan for Hawaii's correctional system. The CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities and FAQs for Correctional and Detention Facilities provide additional detailed guidance. It is anticipated that the CDC guidance will continue to change so the plan will require revision accordingly.

COVID-19 presents unique challenges for prevention and containment in the correctional environment. Knowledge about COVID-19 and public health guidance for responding to the Pandemic is rapidly changing. Adaptable and updatable practical tools are needed to develop infection prevention and control plans for COVID-19 across a diverse array of U.S. jails and prisons.

The COVID-19 Pandemic Response Plan provides an outline of infection prevention and control information that should be considered for correctional facilities related to a COVID-19 response. The plan provides supplemental guidance to the previously distributed Infectious Disease Clinical Care Guide and existing policies. The plan outline is paired with a fillable MS WORD® Implementation Worksheet that can be customized to address facility-specific issues of concern.

The 1918-19 influenza pandemic provides important lessons for responding to COVID-19. During the 1918–19 influenza ("flu") pandemic, certain cities fared better than others. Those U.S. cities that both acted promptly to control the flu and implemented multiple layers of protective measures had fewer flu cases and lower overall mortality. The COVID-19 Pandemic Response Plan includes multiple layers of protective measures to minimize the impact of the virus in the correctional environment.

The Pandemic Response Plan includes 15 response elements. Each element is outlined in the plan with a corresponding section of the Implementation Worksheet. When completing the Worksheet, it is recommended to reference the corresponding text in the Pandemic Response Plan. The Worksheet can be readily adapted to meet the unique challenges of a specific facility. The CDC COVID-19 Management Assessment and Response Tool (CMAR) for Correctional and Detention Facilities may also be used to facilitate communication between the Department of Health and correctional facilities of the Department of Public Safety in preparation for introduction, transmission, and mitigation of COVID-19 in correctional facilities.

Effective response to the extraordinary challenge of COVID-19 requires that all disciplines in a correctional facility work collaboratively to develop, modify, and implement plans as information and conditions change. Swift, decisive, yet evidenced-based planning is paramount. The intent of this document is to advance our collective efforts to better ensure the health and safety of our correctional employees and our incarcerated population.

COVID-19 Overview

The Department of Public Safety is closely monitoring the spread of the novel coronavirus 2019 (COVID-19). Current information provided by the Center for Disease Control and Prevention (CDC) is included below.

What is Coronavirus Disease 2019 (COVID-19)?
Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person-to-person. The virus that causes COVID-19 is a Novel Coronavirus that was first identified during an investigation into an outbreak in Wuhan, China and is now causing an International pandemic.

How is the virus causing COVID-19 transmitted?
The virus is thought to spread mainly between people who are in close contact with one another (within approximately 6 feet) through respiratory droplets or small particles produced when an infected person coughs, sneezes, breathes, sings, or talks. Under certain circumstances (e.g., when people are in enclosed spaces with poor ventilation), COVID-19 can sometimes spread by airborne transmission. COVID-19 spreads less commonly through contact with contaminated surfaces (i.e., by touching a surface or object that has the virus, and then touching the mouth, nose, or eyes). The virus is spreading very easily and sustainably between people. In general, the more closely a person interacts with others and the longer that interaction, the higher the risk of COVID-19 spread.

What are the symptoms of COVID-19?
People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. People with the following symptoms may have COVID-19 (not all possible symptoms are listed):

- Fever or Chills
- Cough
- Shortness of Breath or Difficulty Breathing
- Fatigue
- Myalgia, Muscle or Body Aches
- Headache
- New Loss of Taste (ageusia) or Smell (anosmia)
- Sore throat
- Congestion or Runny Nose (Rhinorrhea)
- Nausea or Vomiting
- Diarrhea or Loose Stool

Emergency warning signs for COVID-19 include:

- Trouble Breathing
- Persistent Pain or Pressure in the Chest
- New Confusion
- Inability to Wake or Stay Awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

Seek emergency medical care immediately if someone is showing emergency warning signs. The list of emergency warning signs is not exhaustive. Contact medical if any other symptoms are severe or concerning. Complications of COVID-19 can include pneumonia, multi-organ failure, and in some cases death.

How can I help protect myself?
People can help protect themselves from respiratory illness with everyday preventive actions.

- Avoid close contact with people who are sick and people who do not live in your household; maintain good social distancing (about 6 feet).
- Wash your hands often with soap and water for at least 20 seconds.
- Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Routinely clean and disinfect frequently touched surfaces.
- Cover your mouth and nose with a mask when around others.
- Cover coughs and sneezes.
- Avoid crowded indoor spaces and ensure indoor spaces are properly ventilated by bringing in outdoor air as much as possible.
- Monitor your health daily. Be alert for symptoms of COVID-19 and take your temperature.

How long does it take for symptoms to develop?
The estimated *incubation period* (the time between being exposed and symptom onset) averages 4-5 days (median) and 5-6 days (mean) after exposure with a range of 2-14 days.

Is there a vaccine?
The U.S. Food and Drug Administration (FDA) has authorized the emergency use of several unapproved vaccines to prevent COVID-19 under an emergency access mechanism called Emergency Use Authorization (EUA). The FDA provides regularly updated information on COVID-19 Vaccines. The CDC provides COVID-19 vaccine information and guidance (see About COVID-19 Vaccines, Getting Your Vaccine, Types of Vaccines Available, Possible Side Effects, Safety and Monitoring, Effectiveness and When You've Been Fully Vaccinated.

Is there a treatment?
The Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), to treat certain patients who are hospitalized with COVID-19. The FDA has also issued emergency use authorization (EUA) to allow healthcare providers to use certain products that are not yet approved, or that are approved for other uses, to treat patients with COVID-19 if certain legal requirements are met. Any treatments that are used for COVID-19 should be taken under the care of a healthcare provider. People have been seriously harmed and even died after taking unapproved products to self-treat. The National Institutes of Health (NIH) has developed and regularly updates Treatment Guidelines to help guide healthcare providers caring for patients with COVID-19.

What are variants?
Viruses constantly change through mutation. New variants of a virus are expected to occur. Multiple variants of the virus that causes COVID-19 have been identified in the United States and globally during the pandemic. Scientists are working to learn more about how easily they spread, whether they could cause more severe illness, and whether currently authorized vaccines will protect people against them.

COVID-19 Pandemic Response Plan Elements

1. Administration/Coordination

The Administration/Coordination element provides an overview of the plan in two phases: Preparation Steps for COVID-19 and Response Steps for Managing COVID-19. PREPARATION STEPS for COVID- 19 summarizes activities that all correctional facilities should be engaged in while preparing for the possibility of COVID-19 in the facility. The steps can be used as an outline for daily meetings about COVID-19 to quickly review the status of plan implementation. RESPONSE STEPS for MANAGING COVID-19 summarizes activities that should be implemented after case(s) of suspected or confirmed COVID-19 have been identified in the facility in either a staff or inmate.

PHASE I. PREPARATION STEPS for COVID-19

a) Coordination of Facility Response

- Train staff on the facility's COVID-19 Pandemic Response Plan. All personnel should have a basic understanding of COVID-19, symptoms of COVID-19, how COVID-19 spreads, and what measures are being implemented and can be taken by individuals to prevent or minimize the transmission of SARS-CoV-2.
- All individuals who have the potential for direct or indirect exposure to someone with COVID-19 or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow and monitor infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic and Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings – Recommendations of the HICPAC, with adaptation to reflect facility operations and custody needs.
- It is critically important that correctional and health care leadership meet or consult regularly to review the current status of COVID-19, review updated guidance from the Centers for Disease Control and Prevention (CDC) and the Hawaii Department of Health, and flexibly respond to changes in current conditions.
- Regular meetings (through video- or tele-conference when social distancing is not possible), should be held, roles and responsibilities for various aspects of the local response determined, and plans developed and rapidly implemented.
- Consideration should be given to activating the Emergency Response Plan within the facility to coordinate response to a crisis. Review existing influenza, all-hazards, and disaster plans, and revise for COVID-19.
- Responsibility should be assigned for tracking National and Local COVID-19 updates.

b) Coordination with Local Law Enforcement and Court Officials to Minimize Crowding

- Identify and implement legally acceptable alternatives to in-person court appearances (e.g., virtual court, as a social distancing measure to reduce the risk of SARS-CoV-2 transmission).
- Continue to explore strategies to reduce new intakes to the correctional facility with local law enforcement and court officials.
- Utilize existing policies for alternatives to incarceration and consider other decompression strategies where allowable.

c) Review Personnel Policies and Practices

- Review the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers," currently Version #4, the CDC COVID-19 Critical Infrastructure Sector Response Planning, the CDC Interim Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 (COVID-19), and the Occupational Safety and Health Administration website.
- Review contingency plans for reduced staffing (e.g., Strategies to Mitigate Healthcare Personnel Staffing Shortages). Makes plans in advance for how to change staff duty assignments to prevent unnecessary movement between housing units and other areas of the facility, to the extent possible (e.g., ensure the same staff are assigned to the same housing unit across shifts to prevent cross-contamination from units where infected individuals have been identified to units with no infections).
- Consider offering alternative duties to staff at increased risk of severe illness with COVID-19.
- Remind staff to stay at home if they are sick. To the extent possible, ensure sick leave policies are flexible, non-punitive, and actively encourage staff not to report to work when sick.
- Implement employee screening (see Element #5).
- Send staff home if they experience COVID-19 symptoms (e.g., fever, cough, or shortness of breath), while at work, and advise to follow CDC recommended steps for persons with COVID-19 symptoms.
- Except for rare situations, a test-based strategy is no longer recommended by CDC and HDOH to determine when to allow staff with SARS-CoV-2 infection to return to work. CDC and HDOH recommend the following symptom-based strategy for determining return to work.
    - Staff, who experienced *mild to moderate illness* and *are not severely immunocompromised*, may return to work after:
        - At least 10 days have passed since symptoms first appeared; **AND**
        - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
        - Symptoms have improved* (e.g., cough, shortness of breath)

        * Loss of taste and sense of smell may persist for weeks or months after recovery and need not delay the end of medical isolation.
    - Staff, who were *asymptomatic* throughout the infection and *are not severely immunocompromised*, may return to work after:
        - At least 10 days have passed since the date of collection of the first positive viral diagnostic test

- Staff, who experienced *severe to critical illness* and *are severely immunocompromised*, may return to work after (consultation with an infectious diseases specialist is recommended):
  - At least 10 days and up to 20 days have passed since symptoms first appeared; **AND**
  - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
  - Symptoms have improved (e.g., cough, shortness of breath)
- Staff, who were *asymptomatic* throughout the infection and *are severely immunocompromised*, may return to work after (consultation with an infectious diseases specialist is recommended):
  - At least 10 days and up to 20 days have passed since the date of collection of the first positive viral diagnostic test

- Identify staff with COVID-19 Exposures (see definition of close contact in Element #12).
  - If a staff member has a confirmed COVID-19 infection:
    - [When testing on own] The staff member should adhere to the CDC guidance What to Do If You Are Sick.
    - [When testing at the facility] Immediately notify the individual of the positive result and advise the employee to adhere to the CDC guidance What to Do If You Are Sick.
    - Inform other staff about possible exposure to COVID-19 in the workplace (maintaining confidentiality in accordance with State and Federal laws, and as required by the Americans with Disabilities Act).
  - Employees, who are COVID-19 close contacts, should get tested, consult their healthcare provider, self-monitor for symptoms and, if feasible, self-quarantine for 14 days (see 3 Key Steps to Take While Waiting for Your COVID-19 Test Result and Contact Tracing). According to the CDC, "The best way to protect incarcerated/detained persons, staff, and visitors is to quarantine for 14 days." As an alternative to the 14-day quarantine period for identified close contacts who do not reside in a correctional facility, HDOH adopted the CDC option to shorten the quarantine period to 10 days, ONLY if the following criteria are met:
    - No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
    - Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
    - Close contacts who develop symptoms within 14 days of the last exposure should be tested for COVID-19 and self-isolate while awaiting results; **AND**
    - Close contacts are informed to strictly adhere to all recommended mitigation strategies, including:
      - ❖ Correct and consistent mask use
      - ❖ Physical distancing
      - ❖ Hand and cough hygiene
      - ❖ Avoiding crowds
      - ❖ Environmental cleaning and disinfection
      - ❖ Ensuring adequate indoor ventilation

- The fully vaccinated employee, who is identified as a COVID-19 close contact, does not require quarantine and may continue to report to work if no symptoms have been experienced since exposure and the employee remains asymptomatic. HDOH recommends that employers who exempt vaccinated employees from quarantine only accept written, dated records as evidence of vaccination (see Sample Letter). Employees who are unable to produce written documentation of vaccination(s) are subject to quarantine requirements. The fully vaccinated employee should get tested, consult their healthcare provider (people who have a condition or are taking medication that weaken the immune system may not be protected), self-monitor for symptoms, and strictly adhere to the mitigation strategies for close contacts detailed above. Symptomatic employees should be sent home. Note: in general, people are considered fully vaccinated two weeks after the second dose in a 2-dose series or two weeks after a single dose vaccine.
- Employees, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine if exposed to someone with COVID-19.
- As a last resort and only in limited circumstances when it is necessary to preserve the function of critical infrastructure workplaces (e.g., when cessation of operation of a facility may cause serious harm or danger to public health or safety), the facility Warden or Administrator, in collaboration with HDOH, may consider allowing an exposed and asymptomatic critical infrastructure worker (e.g., adult correctional officers, law enforcement officers, and healthcare workers), to continue to work following exposure to a person with suspected or confirmed COVID-19 provided the employee remain asymptomatic and has not tested positive.

  Additionally, the following risk mitigation precautions should be implemented to protect the critical infrastructure worker and others (see Returning to Work) prior to and during the work shift:

  - Pre-Screen: The employee should self-screen at home prior to arriving onsite. The employee should not attempt to enter the workplace if any of the following are present: symptoms of COVID-19; temperature equal to or higher than 100.0 °F; or are waiting for the results of a viral test.
  - Screen at the Workplace: Before the employee enters the facility, employers should conduct an on-site symptom assessment, including temperature screening, prior to each work shift.
  - Regular Monitoring: Under supervision, the employee should self-monitor and report to the supervisor the development of a temperature or other symptoms. To the extent possible, complete the self-monitoring form for asymptomatic workers with low risk exposure or the active monitoring form for asymptomatic workers with high risk exposure (see also Flowchart for management of HCWs with exposure to a person with COVID-19).

- Wear a Mask: The employee should wear a mask (unless contraindicated) at all times while in the workplace for 14 days after the last exposure and/or in accordance with CDC and OSHA guidance and any state or local requirements.
- Social Distance: The employee should maintain 6 feet of physical distance from others and practice social distancing as work duties permit in the workplace.
- Disinfect and Clean Workspaces: Continue enhanced cleaning and disinfecting practices in all areas, especially frequently touched surfaces and objects, including offices, bathrooms, common areas, and shared equipment (refer to CDC Cleaning and Disinfecting Your Facility).

d) Communication (Element #2)

- Initiate and maintain ongoing communication with local public health authorities.
- Communicate with community hospitals about procedures for transferring severely ill inmates.
- Develop and implement ongoing communication plans for staff, inmates, and families.

e) Implement General Prevention Measures (Element #3)

- Promote good health habits among employees (Table 1).
- Review protocols or practices regarding alcohol-based hand sanitizer use by employees.
- Conduct frequent environmental cleaning of high touch surfaces (refer to CDC Cleaning and Disinfecting Your Facility). Increase the number of inmate workers assigned to this duty.
- Implement social distancing measures to prevent the spread of germs. Review the list of possible social distancing measures in Element #3 and develop plans for individual facilities to implement at different levels of transmission intensity.
- Encourage the use of masks (unless contraindicated). Utilize no-contact barriers for inmate encounters as a supplement to the use of masks, where feasible.
- Minimize inmate movements within and between facilities. Consider limiting the transfer of inmates to and from other jurisdictions and facilities, unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release, or to prevent overcrowding. Depending on the degree of local community transmission and potential for patient harm, adhere to the CDC Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic.
- Implement infection prevention control guidance for screening of employees, visitors/vendors/volunteers, and new intakes (Element #3).

f) Visitors/Vendors/Volunteers (Element #4)

- Communicate with potential visitors.
- Conduct screening of visitors, vendors, and volunteers.

g) Continue to Conduct Employee Screening (Element #5)

h) Continue to Conduct New Intake Screening (Element #6)

i) Appropriately Manage and Test Symptomatic Inmates (Element #7)

- Provide education to all staff about source control and the importance of immediately providing a mask to inmates with symptoms of COVID-19.
- Suspend co-pays for inmates seeking medical evaluation for COVID-19 symptoms and implement COVID-19 testing of symptomatic inmates.

j) Attempt to Acquire Needed Personal Protective Equipment (PPE) and Other Supplies (Element #8)

- Ensure a sufficient stock of hygiene supplies, cleaning supplies, personal protective equipment (PPE), and medical supplies are available and plan for re-stocking.
- Review Table 3. COVID-19 Personal Protective Equipment Recommendations and post as needed in the facility.
- Implement staff and inmate training on donning, doffing, and disposing PPE relevant to the level of contact with infectious materials anticipated from inmates with suspected and confirmed COVID-19.

k) Provide Training to Transport Officers on Safe Transport Utilizing PPE (Element #9)

- Identify staff who will provide transport.
- Identify staff who will provide training and document the training.

l) Identify Cells and Housing to be used for Medical Isolation (Element #10**) and Quarantine (**Element #12**)**

Ensure that **separate** physical locations (dedicated housing areas and bathrooms) have been identified to 1) medically isolate inmates with confirmed COVID-19 (individually or cohorted), 2) medically isolate inmates with suspected COVID-19 (individually – do not cohort), and 3) quarantine close contacts of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary). The plan should include contingencies for multiple locations if numerous infected inmates and/or close contacts are identified and require medical isolation or quarantine simultaneously. Note: Cohorting refers to the practice of medically isolating multiple inmates with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells.

- Print out color CDC Contact Precautions and CDC Droplet Precautions signs (Attachments #3 and #4). Print out color Isolation and Quarantine signs (Attachments #5 and #6).
- Review how staff will be assigned to work in isolation/quarantine areas.
- Appropriately train staff and inmates who work in laundry and food service.
- Train staff and inmate workers on how to clean areas where COVID-19 inmates spent time.

m) Health Care Staff Should Review Medical and Nursing Procedures for Caring for the Sick (Element #11)

- Maintain communication with the Medical Director and the Hawaii Department of Health to determine how COVID-19 testing will be performed and recommended criteria for testing.
- Encourage the use of existing no-contact barriers for patient encounters.
- Explore options for expanding telehealth capabilities.

PHASE II. RESPONSE STEPS for MANAGING COVID-19

a) Implement alternative work arrangements for staff, as deemed feasible. Determine where inmates should be allowed to work, depending on exposure history.

b) Suspend all transfers of inmates to and from other jurisdiction and facilities unless necessary for medical evaluation, medical isolation/quarantine, health care, extenuating security concerns, release, or to prevent over-crowding.

c) When possible, arrange for lawful alternatives to in-person court appearances.

d) Implement Routine Intake Quarantine of new admissions to the facility for 14 days before housed with the existing population, if possible.

e) Incorporate screening for COVID-19 symptoms and a temperature check into release planning. Provide releasing inmates with COVID-19 Re-entry Care Packs, which include one mask, the COVID-19 Re-entry Information Handout (see Attachment 7), and county-specific community resources handouts. Provide releasing inmates, who are under medical isolation or quarantine, with education about recommended follow-up.

f) Communicate with community hospitals about the potential need to transfer severely ill inmates.

g) Hygiene

- Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.
- Continue to emphasize proper hand hygiene practices and cough etiquette.
- Encourage staff to change clothes before leaving the worksite and designate a location for changing clothes.

h) Environmental Cleaning

- Continue to emphasize the importance of cleaning and disinfection (refer to CDC Cleaning and Disinfecting Your Facility).
- Ensure compliance with the specific cleaning and disinfection procedures for areas where a COVID-19 case spent time (Element #10).

i) Implement medical isolation of confirmed or suspected COVID-19 cases (Element #10).

- Assess adequacy of PPE for staff working in medical isolation areas (see Element #8).
- Implement telehealth modalities, if possible.
- When there are space constraints related to medical isolation, consult with the health care provider and the Hawaii Department of Health on decisions about placement.

j) Implement quarantine of close contacts of COVID-19 cases (Element #12).

- Assess adequacy of PPE for staff working in quarantine areas (see Element #8).
- Require all inmates wear masks while in quarantine, except when contraindicated or not feasible.
- When there are space constraints related to quarantine, consult with the health care provider and the Hawaii Department of Health on decisions about placement.

k) In the event of a COVID-19 outbreak, consult with the Medical Director and the Hawaii Department of Health on the recommended viral testing strategy for inmates and staff. Prior to conducting widespread testing, determine how test results will be used to make housing and movement decisions (i.e., where to house inmates with positive test results, negative test results with known exposure, and negative test results with no known exposure).

l) Implement a system for tracking information about inmates and staff with suspected/confirmed COVID-19 (Element #14).

2. Communication

- Communicate regularly with staff, the incarcerated population, and their families. Specific methods for communicating COVID-19 information should be established. Test communication plans to disseminate critical information to inmates, staff, contractors, vendors, visitors, and volunteers.
- Communication should be understandable for non-English speaking and low literacy persons. Provide accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or have low vision. Staff should be assigned to be responsible for crafting and disseminating regular updates.
- Post signage throughout the facility to communicate the Symptoms of COVID-19 and measures of prevention such as Hand Hygiene, Social Distancing, and Mask Use. CDC Stop the Spread of Germs posters were distributed to all correctional facilities. Post signage to remind staff to Stay at Home When Sick. Communication Resources are available on the CDC website.

- As much as possible, provide COVID-19 information in person and allow opportunities for inmates and employees to ask questions (e.g., town hall format if social distancing is feasible, informal peer-to-peer education).
- Examples of key communication messages for employees (refer to COVID-19 Communication Plan for Select Non-healthcare Critical Infrastructure Employers for methods of communication, additional key messages, and communication resources):
    - Provide updates on the status of COVID-19 within the facility.
    - The importance of staying home if signs or symptoms of COVID-19 are present.
    - The importance of staying home if there is known exposure to COVID-19.
    - Reminders about good health habits to protect themselves, emphasizing cough/sneeze etiquette and hand hygiene.
    - Elements of the facility COVID-19 Pandemic Response Plan to keep employees safe, including the universal use of masks (unless contraindicated or PPE is indicated) and the importance of social distancing.
- Examples of key communication messages to inmates:
    - The importance of immediately reporting COVID-19 symptoms (and reporting if another inmate is experiencing COVID-19 symptoms in order to protect themselves). Establish procedures on how to report symptom observations.
    - Reminders about good health habits to protect themselves, emphasizing cough/sneeze etiquette, hand hygiene, and reminders to use masks as much as possible.
    - Educate that sharing drugs and drug preparation equipment can spread SARS-CoV-2 due to potential contamination of shared items and close contact between inmates.
    - Plans to support communication with family members (when personal visits are suspended or reduced).
    - Plans to keep inmates safe, including the presence of COVID-19 within the facility and the importance of social distancing.
    - The purpose of medical isolation and quarantine. Address concerns about medical isolation and explain the difference between medical isolation and disciplinary segregation.
- Contact should be made and maintained with the Medical Director and the Hawaii Department of Health to obtain guidance, especially about managing and testing inmates with COVID-19.
- Communication should also be established with local community hospitals to discuss referral mechanisms for seriously ill inmates.

3. General Prevention Measures

Throughout the duration of the COVID-19 pandemic, the following general prevention measures should be implemented to interrupt viral infection transmission (see *Table 1* below).

Table 1. General Prevention Measures
a. Promote good health habits among employees and inmates: 1) Avoid close contact with persons who are sick. 2) Avoid touching your eyes, nose, or mouth without cleaning your hands first. 3) Wash your hands often with soap and water for at least 20 seconds. 4) Cover your sneeze or cough with a tissue (or into a sleeve), then throw the tissue in the trash. 5) Avoid non-essential physical contact. No hugs, handshakes, fist bumps, or high-fives. 6) Avoid sharing eating utensils, dishes, and cups. **b. Conduct frequent environmental cleaning of "high touch" surfaces.** **c. Institute social distancing measures to prevent the spread of germs** (i.e., examine and implement methods to ensure at least 6 feet of distance between individuals, when possible). **d. Encourage the use of masks and other no-contact barriers**. **e. Employees must stay at home if they are sick.** **f. Establish facility protocols to access the COVID-19 vaccine.** **g. Influenza (flu) vaccine is recommended for persons not previously vaccinated.** **h. Follow infection prevention and control guidance when conducting screening.** **i. Utilize control strategies for aerosol generating procedures.**

a. Good Health Habits

- Good health habits should be promoted in various ways (e.g., educational videos/posters, assessing adherence to cough etiquette and hand hygiene).
- All employees and inmates should view the COVID-19 educational video, which includes measures of prevention and detailed handwashing procedures (see also Handwashing).
- The CDC Stop the Spread of Germs poster should be posted throughout the facility. The CDC website has additional helpful educational posters: CDC Posters
- Each facility should ensure that adequate supplies and facilities are available for handwashing for both inmates and employees.
- With approval of the Warden, health care workers should have access to alcohol-based hand rub.
- Provisions should be made for employees, visitors, vendors, volunteers, and new intakes to wash their hands when they enter the facility.
- To the extent possible, 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).

- In order to help minimize the risk of transmitting SARS-CoV-2 between the facility and the community, encourage staff to change clothes before leaving the worksite and designate a location for changing clothes.

b. Environmental Cleaning

- The virus that causes COVID-19 can land on surfaces. It is possible for people to become infected if they touch those surfaces and then touch their nose, mouth, or eyes. In most situations, the risk of infection from touching a surface is low. The most reliable way to prevent infection from surfaces is to regularly wash hands or use hand sanitizer. Cleaning and disinfecting (using U.S. Environmental Protection Agency (EPA)'s List N) surfaces can also reduce the risk of infection.
- Implement routine and intensified cleaning and disinfecting procedures in accordance with the CDC guidance on Cleaning and Disinfecting Your Facility Every Day and When Someone is Sick and OSHA standards.
- Cleaning with products containing soap or detergent reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces. When no people with confirmed or suspected COVID-19 are known to have been in a space, cleaning once a day is usually enough to sufficiently remove virus that may be on surfaces. Clean more frequently or disinfect (in addition to cleaning) in shared spaces if certain conditions apply that can increase the risk of infection from touching surfaces:
  - High touch surfaces,
  - Food service, Intake, Medical Unit,
  - High transmission of COVID-19 in the community,
  - Low number of people wearing masks,
  - Infrequent hand hygiene, or
  - The space is occupied by people at increased risk for severe illness from COVID-19
- If there has been a sick person or someone who tested positive for COVID-19 in the facility within the last 24 hours, then clean and disinfect the space. If more than 24 hours have passed since someone who was sick or diagnosed with COVID-19 was in the facility, then clean the space and determine if disinfection is required (review Cleaning and Disinfecting Your Facility). If more than 3 days have passed, then regular cleaning practices are indicated.
- Routinely clean and disinfect surfaces and objects that are frequently touched, especially in common areas. These may include doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, telephones, computer equipment, handrails, elevator buttons, cell bars, etc.
- One strategy is to increase the number of workline inmates who are assigned to conduct continual cleaning of common areas throughout the day.

- Staff should clean shared equipment (e.g., radios, service weapons, keys, handcuffs, computer equipment, telephones), after shared use and when the use of equipment has concluded.
- Hard (non-porous) Surfaces:
  - If surfaces are dirty, clean using a detergent or soap and water prior to disinfection.
  - Consult the EPA List N: Disinfectants for Coronavirus (COVID-19). Follow the manufacturer's instruction for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
  - If EPA-approved disinfectants are not available, diluted, unexpired household bleach can be used if appropriate for the surface. Never mix household bleach with ammonia or any other cleanser.
  - Refer to CDC guidance on How to Make 0.1% Chlorine Solution to Disinfect Surfaces in Healthcare Settings (see also illustration).
  - Alcohol solutions with at least 70% alcohol may also be used.
  - One supplemental strategy for disinfection of hard, non-porous surfaces in large and difficult to reach areas is the timely and routine use of fogging devices, which dispense products with emerging viral pathogens and human coronavirus claims for use against SARS-CoV-2 (consult the EPA Product List of Disinfectants for Use Against SARS-CoV-2 and review Safety Precautions When Using Electrostatic Sprayers, Foggers, Misters, or Vaporizers for Surface Disinfection During the COVID-19 Pandemic).
- Soft (porous) Surfaces (e.g., carpeted floor, rugs, drapes):
  - Remove visible contamination and clean with appropriate cleaner for soft surfaces.
  - If washable, launder in hottest water setting for the item and dry completely.
  - Or, use products with EPA-approved viral pathogens claims.
- Electronics:
  - Remove visible contamination, if present.
  - Follow the manufacturer's instructions for all cleaning and disinfection of 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 and other surfaces. Dry surfaces thoroughly to avoid pooling of liquids.
- CDC provides guidance on heating, ventilating, and air-conditioning (HVAC) systems to help reduce the airborne concentration of the virus that causes COVID-19 (see Guidelines for Environmental Infection Control in Health-Care Facilities and Ventilation in Buildings).

c. Social Distancing Measures

Social distancing, or physical distancing, means keeping space between all individuals (ideally at least 6 feet) regardless of symptoms and decreasing the frequency of contact between individuals. Various administrative measures should be implemented to lessen the chance of spreading the virus by reducing close contact between people. Due to differences among correctional facilities, facility administration should discuss and implement social distancing measures specific for the individual facility, as allowable by physical plant limitations, security restrictions, and operational resources. Examples of possible social distancing strategies for use at individual facilities include:

- Common Areas
  - Provide educational reminders to stay at least 6 feet from others.
  - Provide visual reminders (e.g., tape, paint), on floor surfaces every six feet in walking areas.
  - Enforce increased space between inmates in holding cells, lines, and waiting areas.
  - Remove every other chair in a waiting area.
- Recreation
  - Utilize recreation areas where inmates can spread out, if available.
  - Stagger time in recreation spaces.
  - Restrict recreation space usage to a single housing unit, where feasible.
  - Suspend close-contact sports (e.g., basketball). Encourage individual exercises (e.g., walking).
  - Clean and disinfect equipment after individual use and between group use.
- Meals
  - Stagger meal in the dining hall, if possible (one housing unit at a time; clean and disinfect between groups).
  - Rearrange seating in dining hall to increase space between inmates (e.g., remove every other chair or use only one side of table).
  - Increase meals to cell opportunities.
  - Implement a rotational system among inmates for dining at the cafeteria.
- Group Activities
  - Limit the size of group activities.
  - Increase space between individuals during group activities.
  - Reduce the number of group participants to ensure physical separation of at least 6 feet between participants.
  - If available, consider the use of alternative settings to usual group activities (e.g., outdoor recreation areas, module dayroom areas, or other areas where inmates can spread out).
  - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment. [Note: when discontinuing group activities, it is important to provide alternative forms of activity to support the mental health of inmates during the pandemic.]

- Education and Program Services
  - Convert the educational or program curriculum to self-study, if possible.
  - Consider the use of video modalities for education and other programs, if available.
  - Use no-contact barriers when meeting with inmates, if possible.
  - Limit the size of program participants to ensure physical separation of at least 6 feet between participants in the classroom.
  - Explore alternatives to in-person education.
- Housing
  - Arrange bunks so that inmates sleep head to foot.
  - If space allows, reassign bunks to provide more space between inmates (ideally 6 feet or more in all directions).
  - Minimize the number of inmates housed in the same room as much as possible.
  - Minimize mixing inmates from different housing units (e.g., workline, program attendance).
  - Conduct thorough cleaning and disinfection of living space when inmates leave.
- Health Care
  - Use no-contact barriers when meeting with inmates, if possible.
  - Use telehealth for virtual clinic visits with Providers, forensic examiners, community-based case managers, and other professional service providers, if available.
  - If available, designate a room near the intake area to evaluate new intakes with COVID-19 symptoms or exposure risk before the inmate moves to other parts of the facility.
  - If possible, designate a room near each housing unit to evaluate inmates with COVID-19 symptoms, rather than having inmates with COVID-19 symptoms walk through the facility to be evaluated in the medical unit. If designating a room near each housing unit is not feasible, consider staggering inmate sick call visits.
  - Stagger pill-lines or administer medication at modules.
  - Consider increased use of keep on person (KOP) medication orders.
- Minimize Inmate Movement
  - Avoid transferring inmates between living areas, when possible.
  - Modify work detail assignments so that each detail includes only individuals from a single housing unit. If a workline provides goods or services (e.g., food service or laundry), for other housing units under medical isolation or quarantine, ensure that deliveries are made with extreme caution (e.g., workline delivers prepared food to a set location, leaves, and then staff or workline from the housing unit pick up the delivery. Clean and disinfect all coolers, carts, and other objects involved in the delivery).
  - Depending on the degree of local community transmission, suspend work furlough and other programs that involve inmate movement in and out of the facility. When work furlough or other programs resume, implement facility protocols to cohort work furlough and other transiently housed inmates with routine quarantine measures while at the facility, if possible.

- Depending on the degree of local community transmission and potential for patient harm, adhere to the CDC Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic. Prioritize services that, if deferred, are most likely to result in patient harm. Prioritize at-risk populations who would benefit most from services (e.g., inmates with serious underlying health conditions, inmates most at-risk for complications from delayed care, or inmates without access to telehealth). When returning from outside facility appointments, implement routine quarantine measures for inmates who return to the facility, if possible.

- Re-entry
  - Ensure the facility re-entry programs include information on accessing housing, social services, mental health services, and medical care within the context of social distancing restrictions and limited community business operations related to COVID-19.
  - Where possible, encourage releasing inmates to seek housing options among their family or friends in the community to prevent crowding in other congregate settings such as homeless shelters.
  - When linking inmates to shared housing, link preferentially to accommodations with the greatest capacity for social distancing.
- Provide video or telephonic visitation, if available. When visitation resumes, use no-contact barriers and no-contact visit stations, if available.

d. Encourage the use of Masks and Other No-Contact Barriers

- Transmission of SARS-CoV-2 occurs from individuals who are symptomatic, asymptomatic (i.e., absence of symptoms), and pre-symptomatic (i.e., prior to the development of symptoms). This means COVID-19 could spread between people interacting in close proximity, even if those people are not exhibiting symptoms.
- Encourage inmates to use masks provided at no cost by the facility and launder the masks routinely. Require employees and others present at correctional facilities to use masks to the extent possible. Anyone who has trouble breathing, is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not use masks (refer to additional CDC Considerations for Wearing Masks for conditions and situations that may require adaptation).
- Educate inmates, employees, and others at correctional facilities on How to Select, Wear, and Clean Your Mask (see also Guidance for Wearing Masks, How to Wear Masks, Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19, Improve How Your Mask Protects You, Types of Masks, Facemask Do's and Don'ts, How to take off a mask, and How to Store and Wash Masks). CDC recommends masks that have two or more layers of washable, breathable, tightly woven fabric (e.g., cotton and cotton blends); completely cover the nose and mouth and secure it under the chin; fit snugly against the sides of the face and do not have gaps; and be handled only by the ear loops, cords, or head straps (not by the surface of the mask). CDC does NOT recommend masks that are made of single layer, loosely woven, hard to breath fabric (e.g., vinyl, plastic, leather). CDC does NOT recommend masks that have exhalation valves or vents for source control.

- The use of masks helps protect the wearer from getting COVID-19 and helps the wearer, who has the virus and does not know it, from transmitting it to others (see CDC Use of Masks to Help Slow the Spread of COVID-19). If everyone wears a mask in congregate settings, the risk of exposure to SARS-CoV-2 can be reduced. Clearly explain the purpose of masks: "My mask protects you, your mask protects me." Note: masks are a type of source control intended to help slow the spread of COVID-19 and are not Personal Protective Equipment (PPE). Masks are not surgical masks or respirators.
- The use of a gaiter with two layers or folding the gaiter to make two layers is an acceptable substitute for masks. Due to insufficient evidence to support the use of face shields for source control, CDC does not recommend the use of face shields as a substitute for masks.
- Utilize no-contact barriers for inmate encounters as a supplement to the use of masks, where feasible. A mask is NOT a substitute for social distancing.

e. Sick/Exposed Employees Remain Home

- COVID-19 could gain entrance to a facility via infected employees. Staff should be educated to stay home if they have COVID-19 symptoms.
- If employees develop fever, cough, shortness of breath, or other COVID-19 symptoms at work, they should be advised to immediately put on a mask, promptly inform their supervisor, leave the facility, and follow CDC recommended steps for persons who are ill with COVID-19 symptoms.
- Employees should be advised to consult their health care provider by telephone.
- If employees have been exposed, without the use of appropriate PPE, to a known COVID-19 case, adhere to the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers," currently Version #4, COVID-19 Critical Infrastructure Sector Response Planning, Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19, Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 (COVID-19), Strategies to Mitigate Healthcare Personnel Staffing Shortages, and Occupational Safety and Health Administration standards.
- In addition to physical and medical considerations, the CDC provides information for employees on How to Cope with Job Stress and Build Resilience During the COVID-19 Pandemic (see also Coping with Stress, Grief and Loss, Fatigue, and specific information for Healthcare Personnel and First Responders). Employees seeking mental health assistance are encouraged to contact their Primary Care Provider or the Employee Assistance Program (WorkLifeHawaii.org): Oahu at (808) 543-8445 or Neighbor Islands and After Hours at (800) 994-3571. Additional sources of help include:

  National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255)

  National Domestic Violence Hotline call 800-799-7233 or TTY 800-787-3224

  Disaster Distress Helpline call 800-985-5990 or text TalkWithUs to 66746

  Hawaii CARES Crisis Helpline call 808-832-3100 or 800-753-6879

f. COVID-19 Vaccination

The U.S. Food and Drug Administration (FDA) has authorized the emergency use of several unapproved vaccines to prevent COVID-19 under Emergency Use Authorization (EUA). The FDA provides regularly updated information on COVID-19 Vaccines. The CDC recommends getting a COVID-19 vaccine. The CDC reports "COVID-19 vaccination will help protect you from getting COVID-19" and "COVID-19 vaccines are safe and effective."

- Offer the COVID-19 vaccine to all inmates (existing population and new intakes). Provide education about COVID-19 vaccines and opportunities to ask questions and receive responses.
- The CDC provides the following COVID-19 vaccine information:
  - About COVID-19 Vaccines - Benefits of Getting a COVID-19 Vaccine, Key Things to Know, Frequently Asked Questions, and Vaccine Data.
  - Getting Your Vaccine - How to Find a COVID-19 Vaccine, Preparing for COVID-19 Vaccination, COVID-19 Vaccine Information for Specific Groups, and What to Expect When Getting the Vaccine.
  - Types of Vaccines Available - How COVID-19 Vaccines Work with specific information on mRNA COVID-19 Vaccines and Viral Vector COVID-19 Vaccines; and COVID-19 vaccine overview and safety for Pfizer-BioNTech, Moderna, and Johnson & Johnson's Janssen.
  - Possible Side Effects – common side effects include pain, redness and swelling on the arm the vaccine was administered; tiredness, headache, muscle pain, chills, fever, nausea (see also What to Expect after Getting a COVID-19 Vaccine).
  - Safety and Monitoring, - What to Do if You Have an Allergic Reaction After Getting A COVID-19 Vaccine, Reported Adverse Events, and Vaccine Reporting Systems.
  - Effectiveness.
  - When You've Been Fully Vaccinated - Interim Public Health Recommendations for Fully Vaccinated People [Note: the interim guidance may not apply where required by federal, state, or county laws, rules, and regulations, including workplace guidance; the interim recommendations for fully vaccinated people concerning medical isolation, quarantine, and testing may not apply to workers and residents at correctional centers and facilities].

The CDC provides COVID-19 vaccine clinical resources for healthcare workers:

- Clinical Care Considerations for COVID-19 Vaccination
  - Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States
  - Interim Considerations: Preparing for the Potential Management of Anaphylaxis after COVID-19 Vaccination

- Clinical Consideration: Myocarditis and Pericarditis after Receipt of mRNA COVID-19 Vaccines Among Adolescents and Young Adults
- Lab Tests to Collect Shortly After Severe Allergic Reaction/Anaphylaxis Following COVID-19 Vaccination
- The Advisory Committee on Immunization Practices (ACIP) has issued interim recommendations for the use of Pfizer-BioNTech, Moderna, and Janssen/Johnson & Johnson COVID-19 vaccines for the prevention of coronavirus disease 2019 (COVID-19) in the United States.

- U.S. COVID-19 Vaccine Product Information, including changes and updates; general vaccine information (i.e., dosage, age indication, schedule, and route of administration); administration overview with contraindications/precautions and directions to thaw, prepare and administer; Prevaccination Screening Form; standing orders (i.e., Pfizer-BioNTech, Moderna, Janssen); and Preparation and Administration Summary (i.e., Pfizer-BioNTech, Moderna, Janssen).
  - Pfizer-BioNTech
  - Moderna
  - Janssen
- CDC COVID-19 Vaccination Program Provider Requirements and Support , which includes requirements for vaccine administration reporting and documentation, directions for reporting adverse events to the Vaccine Adverse Event Reporting System (VAERS), instructions on How to Enroll as a COVID-19 Vaccination Provider, and Inventory Management Best Practices.
- Training and Education modules with core competencies required by professional qualification, as well as specific information on Safe and Proper Sharps Disposal During the COVID-19 Mass Vaccination Campaign.
- Vaccine Recipient Education, including various educational handouts, instructions on How to talk to patients about COVID-19 vaccination, and Answering Patients' Questions About COVID-19 Vaccine and Vaccination (see also COCA webinar on how to address patient questions and concerns about vaccines).
  - Pfizer-BioNTech
  - Moderna
  - Janssen
- COVID-19 Vaccine Breakthrough Case Investigation and Reporting. Vaccine breakthrough infection is defined as the detection of SARS-CoV-2 RNA or antigen in a respiratory specimen collected from a person ≥14 days after they have completed all recommended doses of a U.S. Food and Drug Administration (FDA)-authorized COVID-19 vaccine. Vaccine breakthrough cases are expected. No vaccine is 100% effective at preventing illness in vaccinated people. If COVID-19 infection is suspected in a person who received a complete primary series and it has been at least 14 days since the last dose:

- Collect a respiratory specimen for SARS-CoV-2 diagnostic testing
- For patients with positive respiratory specimen results:
  - Forward positive specimen to the State Laboratories Division (SLD) for whole genome sequencing analysis
  - Report the case to HDOH
  - Submit a Vaccine Adverse Event Reporting System (VAERS) report at: https://vaers.hhs.gov/reportevent.html

- Vaccine Effectiveness Research.

g. Influenza Vaccination

- During influenza season, flu vaccination remains an important measure to prevent an illness that presents similarly to COVID-19. The CDC provides Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic.
- Encourage correctional employees to obtain flu vaccination.
- Offer the seasonal influenza vaccine to all inmates (existing population and new intakes). Implement the HCD inmate influenza vaccine campaign (see Attachment 9) to encourage improved compliance through positive behavioral reinforcement.

h. Infection Prevention and Control Guidance for Screening

Protocol when conducting temperature checks:

- Perform hand hygiene, (i.e., Wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 60% alcohol).
- Put on a surgical mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face) and disposable gloves [in facilities with PPE shortage, CDC provides Strategies to Optimize the Supply of PPE and Equipment].
- Check the individual's temperature. Refer to Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for information on proper thermometer usage and factors that could impact thermometer readings.
  - Non-contact or disposable thermometers are preferred over reusable oral thermometers.
  - If performing temperature checks on multiple individuals, put on new gloves for each individual screen and thoroughly clean the thermometer between each screen.
  - 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 screen. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard PPE.
- Perform hand hygiene.

Protocol when conducting temperature checks if a physical barrier or partition is used to protect the screener rather than a PPE-based approach (During screening, the screener stands behind a physical barrier, such as a plexiglass partition, which protects the screener's face and mucous membranes from respiratory droplets that may be produced when the person being screened sneezes, coughs, or talks):

- Perform hand hygiene.
- Put on disposable gloves [in facilities with PPE shortage, CDC provides Strategies to Optimize the Supply of PPE and Equipment].
- Check the individual's temperature by reaching around the partition or through the window. The screener's face must remain behind the barrier at all times during the screening.
  - Non-contact or disposable thermometers are preferred over reusable oral thermometers.
  - If performing temperature checks on multiple individuals, put on new gloves for each individual screen and thoroughly clean the thermometer between each screen.
  - 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 screen. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard gloves.
- Perform hand hygiene.

i. Control Strategies for Aerosol Generating Procedures

- Refer to Attachment 8 for recommended control strategies during aerosol generating procedures, including SARS-CoV-2 specimen collection, emergency dental procedures, CPAP/BiPAP, pulmonary function tests/peak flow tests, nebulizer treatment, and CPR.
- Adhere to the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response and guidance from the Hawaii Board of Dentistry (Dentist FAQs file no longer found).

4. Visitors / Vendors / Volunteers

- Provide visitors, vendors, and volunteers with information to prepare them for screening. Instruct visitors to postpone their visit if they have COVID-19 symptoms. Display signage outside visiting areas explaining the COVID-19 screening process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- Implement COVID-19 screening of visitors, vendors, and volunteers in accordance with State and County requirements (Attachment 1A or Attachment 1B). Visitors, vendors, and volunteers who do not clear the screening process or who decline screening should be denied entrance to the facility.
- To the extent possible and unless contraindicated, visitors, vendors, and volunteers should be required to wear a mask or a higher medical grade mask while present at correctional facilities.

- Depending on the degree of local community transmission, consideration should be given to limiting access to the facility by visitors, volunteers, and non-essential vendors.
- Promote non-contact visits and encourage alternatives to in-person visitation. If the facility resumes in-person non-contact visits, consider staggered and scheduled visitation to enforce adequate social distancing (e.g., in visitation waiting lines, screening, and the visitation area). In-person non-contact visitation areas should be cleaned regularly after each use.
- If suspending in-person visitation in the interest of inmates' physical health and the health of the general public, facilities should explore alternative ways for inmates to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. Arrangements should be made to increase options for inmates to communicate with their families via telephone or video visitation, where possible. Consider reducing or temporarily eliminating the cost of phone calls. Consider increasing inmates' telephone privileges. Visitation is important to maintain mental health. If the facility utilizes virtual visitation, clean electronic surfaces regularly after each use.
- If suspending in-person visits, provide alternative means (e.g., telephone or video visitation), for inmates to engage with legal representatives, clergy, and other individuals whom they have a legal right to consult.

5. Employee Screening

- In locations where it is identified that there is sustained COVID-19 community transmission, employees should be screened upon arrival using the COVID-19 Employee Screening form, which asks questions about COVID-19 symptoms, COVID-19 positive results, travel, contact with a known or suspected COVID-19 individual, and temperature check, in accordance with State and County requirements (Attachment 2A or Attachment 2B).
- Facilities might choose to laminate employee screening forms (not the visitor/vendor/volunteer screening form), and have employees review the screening questions and verbally respond to them. Employees can then sign a log book that includes date, employee name, and position. The temperature should be taken and recorded by the screener in a fourth column in the log book. Employee screenings would not require documentation on an employee screening form, unless the employee responds "YES" to any question in section 1 or 2, responds "NO" to section 3, or has a temperature of 100.0°F or above. Only positive screens that would deny clearance into the facility require completion of the employee screening form. All cleared employees would only complete the log book (see example spreadsheet below).

DATE	EMPLOYEE NAME	POSITION	TEMPERATURE

- A temperature should also be taken ideally with a no-touch infrared thermometer. Refer to Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for information on proper thermometer usage and factors that could impact thermometer readings.
- Screening is generally performed by non-health care personnel.
- Positive screens require notification of the Watch Commander and the employee's immediate supervisor for civilian staff.
- All actions should adhere to the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers," currently Version #4.
- Employees who screen positive for symptoms should be sent home and advised to consult their healthcare provider.
- Employees, who are COVID-19 close contacts, should get tested, consult their healthcare provider, self-monitor for symptoms and, if feasible, self-quarantine for 14 days (see 3 Key Steps to Take While Waiting for Your COVID-19 Test Result and Contact Tracing). According to the CDC, "The best way to protect incarcerated/detained persons, staff, and visitors is to quarantine for 14 days." As an alternative to the 14-day quarantine period for identified close contacts who do not reside in a correctional facility, HDOH adopted the CDC option to shorten the quarantine period to 10 days, ONLY if the following criteria are met:
  - No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
  - Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
  - Close contacts who develop symptoms within 14 days of the last exposure should be tested for COVID-19 and self-isolate while awaiting results; **AND**
  - Close contacts are informed to strictly adhere to all recommended mitigation strategies, including:
    - Correct and consistent mask use
    - Physical distancing
    - Hand and cough hygiene
    - Avoiding crowds
    - Environmental cleaning and disinfection
    - Ensuring adequate indoor ventilation
- Employees, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine if exposed to someone with COVID-19.

- The fully vaccinated employee, who is identified as a COVID-19 close contact, does not require quarantine and may continue to report to work if no symptoms have been experienced since exposure and the employee remains asymptomatic. HDOH recommends that employers who exempt vaccinated employees from quarantine only accept written, dated records as evidence of vaccination (see Sample Letter). Employees who are unable to produce written documentation of vaccination(s) are subject to quarantine requirements. The fully vaccinated employee should get tested, consult their healthcare provider (people who have a condition or are taking medication that weaken the immune system may not be protected), self-monitor for symptoms, and strictly adhere to the mitigation strategies for close contacts detailed above. Symptomatic employees should be sent home. Note: in general, people are considered fully vaccinated two weeks after the second dose in a 2-dose series or two weeks after a single dose vaccine.
- As a last resort and only in limited circumstances when it is necessary to preserve the function of critical infrastructure workplaces (e.g., when cessation of operation of a facility may cause serious harm or danger to public health or safety), the facility Warden or Administrator, in collaboration with HDOH, may consider allowing an exposed and asymptomatic critical infrastructure worker (e.g., adult correctional officers, law enforcement officers, and healthcare workers), to continue to work following exposure to a person with suspected or confirmed COVID-19 provided the employee remain asymptomatic and has not tested positive.

  Additionally, the following risk mitigation precautions should be implemented to protect the critical infrastructure worker and others (see Returning to Work) prior to and during the work shift:

  - Pre-Screen: The employee should self-screen at home prior to arriving onsite. The employee should not attempt to enter the workplace if any of the following are present: symptoms of COVID-19; temperature equal to or higher than 100.0 °F; or are waiting for the results of a viral test.
  - Screen at the Workplace: Before the employee enters the facility, employers should conduct an on-site symptom assessment, including temperature screening, prior to each work shift.
  - Regular Monitoring: Under supervision, the employee should self-monitor and report to the supervisor the development of a temperature or other symptoms. To the extent possible, complete the self-monitoring form for asymptomatic workers with low risk exposure or the active monitoring form for asymptomatic workers with high risk exposure (see also Flowchart for management of HCWs with exposure to a person with COVID-19).
  - Wear a Mask: The employee should wear a mask (unless contraindicated) at all times while in the workplace for 14 days after the last exposure and/or in accordance with CDC and OSHA guidance and any state or local requirements.
  - Social Distance: The employee should maintain 6 feet of physical distance from others and practice social distancing as work duties permit in the workplace.
  - Disinfect and Clean Workspaces: Continue enhanced cleaning and disinfecting practices in all areas, especially frequently touched surfaces and objects, including offices, bathrooms, common areas, and shared equipment (refer to CDC Cleaning and Disinfecting Your Facility).

6. New Intake Screening

- New intakes should be provided masks (unless contraindicated) and screened for symptoms in accordance with established nursing protocols. Screening should take place in an outdoor space prior to entry, in the sally port, or at the point of entry into the facility immediately upon entry (weather, security protocols, and logistics permitting), before beginning the intake process.
- Temperature should be taken, ideally with an infrared no-touch thermometer with staff wearing PPE as described in Element #3f.
- Additional questions should be asked regarding travel history and potential exposure to COVID-19.
- New inmate arrivals should be separated from other inmates until the screening process has been completed.
- If new intakes are identified with symptoms then ***immediately place a mask (unless contraindicated) on the inmate,*** have the inmate perform hand hygiene, and place the inmate in a separate room, preferably with a toilet, while determining next steps. If no mask is immediately available, instruct the inmate to cover mouth/nose with cotton/cotton-blended shirt, towel, or pillowcase until a mask is available. Staff entering the room shall wear personal protective equipment (PPE) in accordance with guidance in Element #8.
- Identify inmates who were transferred with the symptomatic new intake for the need to quarantine (see Element #12).
- If new intakes report history of exposure to COVID-19, then they should be placed in quarantine (see Element #12).
- To the extent possible, implement routine intake quarantine (i.e., quarantine all new admissions to the facility for 14 days before housing such inmates in the general population). Inmates in routine intake quarantine should be housed separately from inmates who are quarantined due to contact with a suspected or confirmed COVID-19 case, if possible.
- Inmates, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine or routine intake quarantine.

7. Initial Management and Testing of SARS-CoV-2

- **Source control (placing a mask on a potentially infectious person) is critically important.** If an inmate is identified with COVID-19 symptoms, then *immediately place a mask on the inmate (unless contraindicated)* and have the inmate perform hand hygiene.
- Place the inmate in a separate room, preferably with a toilet and sink, while determining next steps. Contact should be minimized to the extent possible until the symptomatic inmate is wearing a mask (unless contraindicated) and staff are wearing personal protective equipment (PPE) as outlined in Element #8.

- The CDC provides an Overview of Testing for SARS-CoV-2, Testing Strategies for SARS-CoV-2, and Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities. Decisions about how to manage and test inmates for SARS-CoV-2 should be made in collaboration with the facility Provider or Medical Director and the Hawaii Department of Health. Test strategy implementation should be guided by what is feasible, practical, and acceptable, and should be tailored to the needs at each facility.
- Viral tests, including nucleic acid amplification tests (NAATs) and antigen tests are used as diagnostic tests to detect infection. The "gold standard" for clinical diagnostic detection of SARS-CoV-2 remains the real-time reverse transcription-polymerase chain reaction (RT-PCR), which are high sensitivity, high specificity NAATs for diagnosing SARS-CoV-2 infection. Antigen tests are immunoassays that detect the presence of a specific viral antigen. Because of the performance characteristics of antigen tests, use of the Antigen Testing Algorithm is recommended to determine when confirmatory NAAT testing is needed. The CDC provides Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing and Interim Guidance for Antigen Testing for SARS-CoV-2.
- Viral testing is recommended for inmates with signs or symptoms consistent with COVID-19 and all close contacts of persons with SARS-CoV-2 infection. Decisions on testing asymptomatic inmates without known or suspected SARS-CoV-2 exposure (e.g., testing in routine intake quarantine prior to rehousing in the general population, pre-release testing if released to a congregate setting or to a household with persons at increased risk for severe illness from COVID-19), should be based on an assessment of the unique situation in each facility and the testing requirements for certain pre-medical procedures (e.g., see Interim SARS-CoV-2 Testing Guidelines for Patients in Outpatient Hemodialysis Facilities), as determined by the Medical Director in consultation with the Hawaii Department of Health. The CDC does not recommend using antibody testing for diagnosing current infection (see the CDC Interim Guidelines for COVID-19 Antibody Testing). Antibody tests are used to detect past infection with SARS-CoV-2.
- Inmates infected with SARS-CoV-2 can have another viral (e.g., influenza), bacterial, or fungal infection at the same time. During widespread cocirculation of SARS-CoV-2 and influenza, the CDC recommends clinicians consider testing inmates with compatible symptoms for both viruses.
- The CDC provides considerations for jails and prisons when Performing Broad-Based Testing for SARS-CoV-2 in Congregate Correctional, Detention, and Homeless Service Settings, including needed supplies, planning, physical space, protocol for testing multiple inmates in succession, staff assignments, and post-test tasks (see also the CDC Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities). In addition to testing inmates, consider strategies for screening testing asymptomatic staff without known SARS-CoV-2 exposure for early identification of SARS-CoV-2 in the facility. The CDC provides Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, Interim Guidance for SARS-CoV-2 Testing in Non-Healthcare Workplaces, Workplace SARS-CoV-2 Testing: Consent Elements and Disclosures, and Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case is Identified. If offering testing to staff, follow the guidance from the Equal Employment Opportunity Commission. Refer to the Occupational Safety and Health Administration Revised Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19) for compliance with 29 CFR Part 1904 with respect to COVID-19 occupational illness recording requirements.

- For additional testing information, see the CDC Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing, CDC Diagnostic Tests for COVID-19, Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19), Guidance for SARS-CoV-2 Point-of-Care Testing, and How to Report COVID-19 Laboratory Data.
- Nasopharyngeal swabbing should only be performed by staff with demonstrated competency. See instructional video at: https://www.youtube.com/watch?v=DVJNWefmHjE.
- Suspend co-pays for inmates seeking medical evaluation for possible COVID-19 symptoms.

8. Personal Protective Equipment (PPE)

Table 2. Definitions of "Surgical Masks" and "Respirators"

***Surgical Masks*:** Disposable FDA-approved masks, which come in various shapes and types (e.g., flat with nose bridge and ties, duck billed, flat and pleated, pre-molded with elastic bands). If surgical masks are in short supply, use temporary alternative methods of source control, such as the use of cloth masks.

Respirators: N-95 or higher filtering, face-piece respirators that are certified by CDC/NIOSH.

- The CDC recommends the following Personal Protective Equipment (PPE) when an individual encounters a person with suspected or confirmed COVID-19.
  - **N95 Respirator**.
    - N95 respirators should be prioritized when staff anticipate contact with infectious aerosols or droplets from someone with COVID-19. Individuals working under conditions that require an N95 respirator should not use a cloth mask when an N95 is indicated.
    - Through the established respiratory protection program, ensure that staff and inmates who require respiratory protection for work responsibilities have been medically cleared, trained, and fit-tested as appropriate.
    - N95 respirators should not be worn with facial hair that interferes with the respirator seal.
    - If N95 respirators are to be used, they must be used in the context of a fit-testing program. Fit testing is specific to the brand/size of respirator to be used.
    - Perform User Seal Check prior to every use to ensure an adequate seal is achieved (see also Respirator On/Respirator Off).
  - **Surgical Mask**.
    - Worn to protect the wearer from splashes, sprays, and respiratory droplets generated by others. Note: Surgical masks are distinct from masks (i.e., cloth-type), which are not PPE but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer. Individuals working under conditions that require a surgical mask should use a surgical mask, not a cloth mask.

- A surgical mask can be layered underneath a cloth mask for improved fit and filtration. However, a surgical mask should not be layered underneath a second surgical mask. Use of a mask fitter or brace may help to improve fit.

- **Eye Protection** (goggles or disposable face shield that fully covers the front and sides of the face).
  - This does not include personal eyeglasses.
  - If reusable eye protection is used, it should be cleaned and disinfected in accordance with the manufacturer's instructions.
- **Gloves**.
  - Disposable examination gloves should be changed if torn or heavily contaminated.
- **Gown/One-Piece Coverall**.
  - If security staff are unable to wear a disposable gown or coverall due to limitations in access to the duty belt and gear, then the duty belt and gear should be disinfected after close contact with an inmate with confirmed or suspected COVID-19. Clothing should be changed as soon as possible. Clean and disinfect duty belt and gear prior to reuse.
  - If gowns/one-piece coveralls are in short supply, prioritize for aerosol-generating procedures and high contact activities that provide opportunities for transfer of pathogens to the hands and clothing of the wearer.

- Train staff and inmates, who will have contact with infectious materials, to correctly don, doff, and dispose of PPE relevant to the level of contact anticipated with individuals with confirmed and suspected COVID-19. See CDC instructions on donning (putting on) and doffing (removing) PPE: Comprehensive PPE Training Videos , Using Personal Protective Equipment (PPE), PPE Sequence Poster, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, and Protecting Healthcare Personnel. Ensure strict adherence to OSHA PPE standards.
- It is strongly emphasized that hand hygiene be performed before donning and after doffing PPE.
- Designate PPE donning/doffing stations outside all spaces where PPE will be used. PPE stations should include a dedicated trash can for disposal of used PPE, a hand washing station or access to alcohol-based hand sanitizer, and a PPE Sequence Poster for donning and doffing.
- Ensure PPE is readily available where and when needed.
- Inventory current supplies of PPE and implement plans for restocking PPE as needed (see Personal Protective Equipment (PPE) Burn Rate Calculator (Version 2)).
- Develop contingency plans for PPE shortages during the COVID-19 pandemic. The CDC notes that PPE shortages are anticipated in every category during the COVID-19 response. Refer to the CDC Strategies to Optimize the Supply of PPE and Equipment and Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages (see also N95 and Other Respirators, Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages, and Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators).

- Criteria for using various types of PPE based on the type of contact is outlined in Table 3.
- The CDC identifies PPE as one of many examples of risk factors for heat-related illness. Heat stroke, the most severe form of heat-related illness, is a life-threatening medical emergency.

  Early signs of heat stroke may include:

  - Confusion
  - Difficulty performing routine tasks or answering simple questions, like "What is today's date?" or "Where are we?"
  - Slurred speech

  Late signs of heat stroke may include:

  - Seizures
  - Loss of consciousness
  - Organ failure resulting in death

  The CDC provides guidance on how to reduce the risk for heat-related illness during the COVID-19 pandemic (see What Workers Need to Know about Heat Stress Prevention during the COVID-19 Pandemic and Employer Information for Heat Stress Prevention during the COVID-19 Pandemic).
- Other Supplies
  - Standard medical supplies and pharmaceuticals for daily clinic needs
  - Liquid or foam soap when possible; If bar soap is used, ensure that it does not irritate the skin and thereby discourage frequent hand washing; Ensure a sufficient supply of soap for each individual
  - Hand drying supplies
  - Tissues
  - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible)
  - Cleaning supplies, including EPA-registered disinfectants effective against SARS-CoV-2, the virus that causes COVID-19
  - Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

Table 3. COVID-19 Personal Protective Equipment Recommendations					
Situation	**N95 respirator**	**Surgical mask**	**Eye protection**	**Gloves**	**Gown/ coveralls**
STAFF					
Staff performing routine screening and temperature checks on: employees, visitors/vendors/volunteers, or inmates		X	X	X	
Medical Isolation: Staff providing medical care for suspected/confirmed COVID-19 cases (including testing)	X [1]		X	X	X
Medical Isolation: Correctional staff entering isolation room	X [1]		X	X	X
Staff present during aerosolizing procedure on suspected or confirmed COVID-19 case	X		X	X	X
Staff handling laundry (from a COVID-19 case or close contact)				X	X
Staff handling used food service items (from a COVID-19 case or close contact)				X	X
Staff cleaning an area (where a COVID-19 case has spent time)	*Additional PPE may be needed based on the product label.*			X	X
Transport of suspected/confirmed COVID-19	X [1]		*During transport*		
Prior to & following transport (if in close contact)	X [1]		X	X	X
Quarantine: Direct contact with asymptomatic persons (including medical care/temperature checks)	X[1]		X	X	
Quarantine: Direct contact with asymptomatic persons (but not performing temperature checks or providing medical care) or no direct contact with asymptomatic persons who are close contacts to COVID-19		*Surgical mask[1], eye protection and gloves as local supply and scope of duties allow.*			
INCARCERATED/DETAINED PERSONS					
Confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	*Use masks for source control[2]*				
Quarantine: Asymptomatic COVID-19 close contacts					
Laundry worker (handling items from COVID-19 case or close contact)				X	X
Food service worker (handling items from COVID-19 case or close contact)				X	X
Worker performing cleaning (areas where COVID-19 case has spent time)	*Additional PPE may be needed based on the product label.*			X	X

1 A NIOSH-approved N95 respirator is preferred. However, based on local situational analysis of PPE supplies, surgical masks may be 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.

2 Masks (i.e., cloth-type) are NOT PPE and may not protect the wearer. Prioritize PPE for source control among all persons who do not meet criteria for N95 or surgical masks, and to conserve surgical masks for situations that require PPE.

Adapted from: CDC. Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities (Table 1); 10/21/20. Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Min_Mod_Trans

9. Transport

Depending on the degree of local community transmission, postpone non-essential inmate transports. To the extent possible, implement routine transport quarantine (i.e., quarantine of all inmates, who enter the facility by outside transport, for 14 days before housed in the general population). Inmates in routine transport quarantine should be housed separately from inmates who are quarantined due to contact with suspected or confirmed COVID-19 case(s).

Prior to transporting inmates to outside appointments and transferring inmates between other jurisdictions and facilities, procedures should be established to ensure screening is conducted by nursing. Positive screens should remain at the sending facility until cleared by the Provider. To the extent possible, inmates transported outside the facility must wear masks (unless contraindicated). Prior to the transport, ensure that the receiving facility has capacity to properly quarantine or medically isolate the inmate upon arrival.

Refer to the CDC guidance for Emergency Medical Services on safely transporting inmates with confirmed or suspected COVID-19. If a decision is made to transport a patient with confirmed or suspected COVID-19, or a quarantined close contact, to a health care facility and the transport vehicle is not equipped with the features described in the EMS guidance, the following transport considerations should be followed at a minimum.

- Notify the receiving health care facility of the pending transport of a potentially infectious patient.
- Patient wears a mask (unless contraindicated) and performs hand hygiene.
- Transporting officer wears recommended PPE, depending on local situational analysis of PPE supplies: preferably N-95 respirator, gloves, gown, and eye protection if in close contact with inmate prior to transport. Note: when accompanying EMS in ambulance, transporting officer should use recommended PPE for aerosolizing procedures.
- Prior to transporting, all PPE (except for surgical mask or N-95) is removed and hand hygiene is performed. This is to prevent contaminating the driving compartment.
- Ventilation system should bring in as much outdoor air as possible. Set fan to high. If the vehicle has a ceiling hatch, keep it open.
- Do NOT place air on recirculation mode.
- Weather permitting, drive with the windows down.
- Following the transport, if close contact with the patient is anticipated, put on a new set of PPE. Perform hand hygiene after PPE is removed.
- After transporting a patient, air out the vehicle for one hour before using it without a mask.
- When cleaning the vehicle, wear a disposable gown and gloves. A mask and a face shield or goggles should be worn if splashes or sprays during cleaning are anticipated.
- Clean and disinfect the vehicle after the transport utilizing instructions in Element #3b.

Table 4. Definitions of "Medical Isolation" and "Quarantine"
Medical Isolation: refers to the procedure of separating someone with confirmed or suspected COVID-19 infection (i.e., those who are sick with COVID-19 symptoms and those with no symptoms), from others who are not infected.
Quarantine: refers to the procedure of separating people who might have been exposed to COVID-19 from others.

10. Medical Isolation / Cohorting (*Symptomatic Persons*)

A critical infection control measure for COVID-19 is to promptly separate inmates with confirmed or suspected COVID-19 infection (i.e., those who are sick with COVID-19 symptoms and those with no symptoms), from other inmates who are not infected. Medical isolation is a non-punitive medical intervention. To the extent possible, the conditions in medical isolation should be distinct from those in disciplinary segregation. While cohorting inmates with laboratory confirmed COVID-19 is acceptable, cohorting inmates with suspected COVID-19 is not recommended due to the high risk of transmission from infected to uninfected inmates. Inmates with laboratory confirmed COVID-19 should be housed separately from those with undiagnosed respiratory illness.

- The CDC provides guidance for housing individuals under medical isolation (refer to Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities). Facilities without sufficient space to implement effective medical isolation should coordinate with the Hawaii Department of Health to ensure that COVID-19 cases will be appropriately managed.
- To minimize the likelihood of disease transmission, inmates who are medically isolated or cohorted should wear a mask (unless contraindicated). Masks should be replaced as needed. Inmates who are cohorted with undiagnosed respiratory illness should wear a mask (unless contraindicated) to protect inmates with respiratory illnesses other than COVID-19.
- Facilities should ensure that medical isolation is operationally distinct from disciplinary segregation to the extent possible, even if the same housing spaces are used for both. To avoid being placed in punitive housing conditions, inmates may be hesitant to report COVID-19 symptoms, leading to continued transmission within shared housing spaces and, potentially, lack of health care and adverse health outcomes for infected inmates who delay reporting symptoms. For example:
    - Ensure that inmates under medical isolation receive regular visits from medical staff and have access to mental health services.
    - Make efforts to provide similar access to radio, television, reading materials, personal property, and commissary, as would be available in regular housing units, if possible.
    - Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while medically isolated, where possible.
    - Communicate regularly with medically isolated inmates about the duration and purpose of the medical isolation period.

- Medical isolation cells or rooms should be identified with the Respiratory Infection Isolation Room Precautions sign (see Attachment 5) and relevant CDC Transmission-Based Precautions sign(s) (e.g., Contact Precautions and Droplet Precautions). See Attachment 3 and Attachment 4.
- The door to the Medical Isolation Cell should always remain closed, except when staff must enter and exit the cell, or when the medically isolated inmate must enter and exit the cell for treatment or bathroom use.
- Keep the inmate's movement outside the medical isolation space to an absolute minimum.
  - Provide medical care to medically isolated inmates inside the medical isolation space, unless they need to be transferred to a healthcare facility.
  - Dedicated medical equipment (e.g., blood pressure cuffs), should be left in room (ideally) or decontaminated in accordance with manufacturer's instructions.
  - Serve meals inside the medical isolation space. Inmates in medical isolation should throw disposable food service items in regular trash in the medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling food service items should clean their hands after removing gloves.
  - Exclude the inmate from all group activities.
  - Provide inmates in medical isolation with tissues, and if permissible and available, a lined no-touch trash receptacle. Instruct inmates 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.
  - Laundry should be transported from the medical isolation area to the laundering location in a bag liner that is either disposable or can be laundered. Individuals handling laundry from COVID-19 cases should wear disposable gloves and gown, discard after each use, and perform hand hygiene. Do not shake dirty laundry (to minimize the possibility of dispersing virus through the air). Laundry from COVID-19 cases may be washed with other inmate laundry. Use the hottest appropriate water setting and dry items completely. Clean and disinfect clothes hampers in accordance with Element 3b.
  - Ideally, the Medical Isolation unit should have a dedicated bathroom attached. If not, inmates must wear a mask (unless contraindicated) to go to the bathroom outside the room. When a dedicated bathroom is not feasible, do not reduce access to restroom or shower use as a result. Clean and disinfect areas used by infected inmates frequently on an ongoing basis during medical isolation.
- If inmates with respiratory illness must be taken out of the medical isolation room, they should wear a mask (unless contraindicated) and perform hand hygiene before leaving the room.
- If an inmate who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medication, testing for COVID-19), they should be placed in a separate room. An N95 respirator (not a surgical mask), gloves, gown, and face protection should be used by staff.

- If the facility is housing inmates with confirmed COVID-19 as a cohort:
  - Only inmates with laboratory-confirmed COVID-19 should be placed under medical isolation as a cohort. Do not cohort inmates who have confirmed COVID-19 with other inmates who have suspected COVID-19, who are close contacts of individuals with confirmed or suspected COVID-19, or who have an undiagnosed respiratory infection that does meet the criteria for suspected COVID-19.
  - Use a well-ventilated room with solid walls and a solid door that closes fully, where possible.
  - To conserve PPE and reduce the risk of cross-contamination across different parts of the facility, consider using one large space for cohorted inmates with confirmed COVID-19 on medical isolation status. Depending on the degree and severity of illness among inmates, bunk beds may or may not be suitable.
- If feasible, designated security staff should be assigned to monitor medically isolated inmates in order to minimize exposures. If an inmate has laboratory-confirmed COVID-19, staff should maintain a consistent duty assignment in the same area of the facility across shifts to prevent transmission across different facility areas, where possible. Staff assigned to medical isolation posts should limit their movement to other parts of the facility as much as possible. If staff must serve multiple areas of the facility, ensure staff change PPE when leaving the medical isolation space. If PPE supplies necessitate reuse, staff should move from areas of low to high exposure risk (e.g., start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in a medical isolation unit).
- When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an inmate with COVID-19 symptoms while interviewing, escorting, or interacting in other ways. Keep interactions with inmates with COVID-19 symptoms as brief as possible.
- Admission to and Discharge from Medical Isolation must be ordered by a Provider.
  - If an inmate with suspected COVID-19 receives a positive SARS-CoV-2 test, continue medical isolation until discharged by the Provider.
  - If an inmate with suspected COVID-19 receives a negative SARS-CoV-2 test and the inmate is discharged from Medical Isolation by the Provider, the inmate may be returned to general population housing unless the inmate requires quarantine as a close contact of someone with COVID-19 or the inmate requires completion of the 14-day Routine Intake Quarantine.

Table 5. CDC Levels of Illness Severity

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging).

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥ 94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency > 30 breaths per minute, SpO2 < 94% on room air at sea level (or, for individuals with chronic hypoxemia, a decrease from baseline of > 3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) < 300 mmHg, or lung infiltrates > 50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Note: The highest level of illness severity experienced at any point in the clinical course should be used when determining the duration of transmission-based precautions.

- The CDC recommended strategy for discontinuing medical isolation and transmission-based precautions are expected to change as additional data on Duration of Isolation and Precautions for Adults with COVID-19 become available. Providers should review the CDC guidance cited above and HDOH Medical Advisories for rapidly changing updates. Except for rare situations, CDC and HDOH no longer recommend a test-based strategy for confirmed COVID-19. At this time, CDC and HDOH recommend the following symptom-based strategy for discontinuation of transmission-based precautions for confirmed COVID-19.
  - Inmates, who experienced *mild to moderate illness* and *are not severely immunocompromised*:
    - At least 10 days have passed since symptoms first appeared; **AND**
    - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
    - Symptoms (e.g., cough, shortness of breath), have improved*

      * Loss of taste and sense of smell may persist for weeks or months after recovery and need not delay the end of medical isolation.
  - Inmates, who were *asymptomatic* throughout the infection and are not *severely immunocompromised*:
    - At least 10 days have passed since the date of collection of the first positive viral diagnostic test
  - Inmates, who experienced *severe to critical illness* or who *are severely immunocompromised* (consultation with an infectious disease specialist is recommended):
    - At least 10 days and up to 20 days have passed since symptoms first appeared; **AND**
    - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
    - Symptoms (e.g., cough, shortness of breath), have improved
  - Inmates, who were *asymptomatic* throughout the infection and are *severely immunocompromised* (consultation with an infectious disease specialist is recommended):
    - At least 10 days and up to 20 days have passed since the date of collection of the first positive viral diagnostic test

    Note: Some adults with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; severely immunocompromised patients (e.g., being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, receipt of prednisone >20mg/day for more than 14 days), may produce replication-competent virus beyond 20 days and require additional testing and consultation with infectious diseases specialists and infection control experts. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise. Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions should be tailored to each patient.

- According to the CDC, the above guidance on medical isolation does not imply immunity to COVID-19.
  - People who have recovered from COVID-19 may have low levels of virus detectable for up to 3 months after diagnosis. This means that if the person, who has recovered from COVID-19, is retested within 3 months of initial infection, the person may continue to have a positive test result, even though the person may not be spreading COVID-19.
  - To date, reinfection appears to be uncommon during the initial 90 days after symptom onset of the preceding infection; however, research is ongoing (see Reinfection with COVID-19). Persons infected with related endemic human betacoronavirus appear to become susceptible again at around 90 days after onset of infection. Thus, for persons recovered from SARS-CoV-2 infection, a positive PCR during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.
  - If an inmate has a new exposure to someone with suspected or confirmed COVID-19 and:
    - Has recovered from illness due to laboratory-confirmed SARS-CoV-2 infection and has already met criteria to end isolation, and
    - Is within the first 90 days following the onset of symptoms of their initial laboratory-confirmed SARS-CoV-2 infection or within the first 90 days of their first positive SARS-CoV-2 test result if they were asymptomatic during initial infection, and
    - Has remained asymptomatic since the new exposure,

    then the inmate does not require repeat testing or quarantine for SARS-CoV-2 in the context of the new exposure.
  - If an inmate has a new exposure to a person with suspected or confirmed COVID-19 and meets the first two above criteria, but has or develops new symptoms consistent with COVID-19 within 14 days of the new exposure, consultation with a health care provider is recommended, and consultation with infectious disease or infection control experts may be necessary. If an alternative cause of the symptoms (e.g., influenza, seasonal allergy), cannot be readily identified, retesting for SARS-CoV-2 infection may be warranted. Medical isolation is recommended during the evaluation and until the inmate meets criteria for discontinuation of transmission-based precautions.
- If an inmate with suspected or confirmed COVID-19 is to be released from the facility before discharge from medical isolation, notify the Hawaii Department of Health to provide direct linkage to community resources and release planning (e.g., transport, shelter, and medical care).
- If an inmate on medical isolation status is scheduled to transfer to the Hawaii State Hospital or another correctional facility, hold the transfer until the inmate is cleared for transfer by the Medical Director.
- After an inmate with COVID-19 is discharged from medical isolation, close off the area. If possible, open outside doors and windows and use fans or HVAC 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. Ensure that persons cleaning the area wear recommended PPE for medical isolation (see Table 3). Thoroughly clean and disinfect utilizing instructions in Element #3b with an emphasis on frequently touched surfaces.

Vacuum the space, if needed, using high-efficiency particulate air (HEPA) filter and bags. While vacuuming, temporarily turn off in-room, window-mounted, or on-wall recirculation heating, ventilation, and air conditioning systems to avoid contamination of HVAC units. Do not deactivate central HVAC systems, which provide better filtration capabilities and introduce outdoor air into the areas serviced.

11. Care for the Sick

- Staff evaluating and providing care for COVID-19 cases should review the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and the National Institutes of Health Coronavirus Disease 2019 (COVID-19) Treatment Guidelines. Monitor the guidance and the CDC COVID-19 Published Science and Research websites regularly for updates to the recommendations.
- Two main processes are thought to drive the pathogenesis of COVID-19. Early in the course of the infection, the disease is primarily driven by replication of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Later in the course of infection, the disease is driven by a dysregulated immune/inflammatory response to the virus that leads to tissue damage.
- Current clinical management of COVID-19 includes Core Infection Prevention and Control Practices and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated. The U.S. Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), for the treatment of COVID-19 in certain situations. The FDA has also issued emergency use authorization (EUA) to allow healthcare providers to use certain products that are not yet approved, or that are approved for other uses, to treat patients with COVID-19 if certain legal requirements are met.
- The recipe for oral rehydration solution is shown in Table 6 below.

Table 6. Oral Rehydration Solution Recipe
1-gallon clean water
10-tablespoons of sugar
4-teaspons salt
Directions: Stir up. Do not boil. Can add sugar-free drink mix to flavor. Use within 24 hours.

- Patients should be assessed at least twice daily for signs and symptoms of shortness of breath or decompensation.
- Clinicians should be aware of the potential for some patients to rapidly deteriorate 1 week after illness onset.
- The median time to acute respiratory distress syndrome (ARDS) ranges from 8 to 12 days.
- The facility should have a plan in place to safely transfer inmates with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.

- A low threshold should be used for making the decision to transport an inmate to the hospital if the inmate develops shortness of breath.
- Inmates diagnosed with COVID-19 should be evaluated and managed in chronic care clinic until they are feeling well and without symptoms for two weeks. Inmates should be instructed to immediately notify the Medical Unit if experiencing any relapse of COVID-19 symptoms.
- The CDC is actively working to learn about the short- and long-term health effects associated with COVID-19. Although most people with COVID-19 get better within weeks of illness, some people experience Post-COVID Conditions, which include a wide range of health consequences that are present **more than four weeks** after infection with SARS-CoV-2. The CDC identifies three types of Post-COVID Conditions (see also Post-COVID Conditions: Information for Healthcare Providers):
  - **Long COVID** encompasses a range of symptoms and clinical findings that can last weeks or months after first being infected with the virus that causes COVID-19 or can appear weeks after infection. The most commonly reported persisting symptoms include:
    - Tiredness or fatigue
    - Difficulty thinking or concentrating (sometimes referred to as "brain fog")
    - Headache
    - Loss of smell or taste
    - Dizziness on standing
    - Fast-beating or pounding heart (also known as heart palpitations)
    - Chest pain
    - Difficulty breathing or shortness of breath
    - Cough
    - Joint or muscle pain
    - Depression or anxiety
    - Fever
    - Symptoms that get worse after physical or mental activities
  - **Multiorgan Effects of COVID-19** can affect most, if not all, body systems including cardiovascular, pulmonary, renal, dermatologic, neurologic, and psychiatric. Multisystem inflammatory syndrome (MIS) and autoimmune conditions can also occur after COVID-19. A wide variety of health effects can persist after the acute illness has resolved (e.g., pulmonary fibrosis, myocarditis). It is unknown how long multiorgan system effects might last and whether the effects could lead to chronic health conditions.
  - **Effects of COVID-19 Treatment or Hospitalization** include some longer-term effects that are similar to those related to hospitalization for other respiratory infections or other conditions. This category can also encompass post-intensive care syndrome (PICS), which refers to health effects that remain after a critical illness (e.g., severe weakness and post-traumatic stress disorder).

- Inmates who are released while being treated for COVID-19 should be provided education about:
  - Steps to help prevent the spread of COVID-19 if you are sick
  - Symptoms of Coronavirus (COVID-19) and emergency warning signs (e.g., trouble breathing; persistent pain or pressure in the chest; new confusion; inability to wake or stay awake; and pale, gray, or blue-colored skin, lips, or bed nails, depending on skin tone), requiring immediate medical care.

12. Quarantine (*Asymptomatic Exposed Persons*)

The purpose of quarantine is to help prevent the spread of disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. Quarantine is a medical intervention that separates inmates who might have been exposed to COVID-19 from others.

- In the context of COVID-19, a person is considered a Close Contact if the person has been within 6 feet of a confirmed COVID-19 case for a cumulative total of 15 minutes or more over a 24-hour period, starting from 48 hours before illness onset (or starting from 48 hours before the first positive test if asymptomatic) until the time the infected person meets criteria to end medical isolation; the person had direct physical contact (e.g., hugged, kissed), with a suspected or confirmed COVID-19 case; OR the person had direct contact with infectious secretions (e.g., sharing utensils, sneezed or coughed on), from a suspected or confirmed COVID-19 case.
- Refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan, Contact Tracing for COVID-19, Case Investigation and Contact Tracing in Non-healthcare Workplaces: Information for Employers, and Managing Investigations During an Outbreak for additional information on the use of Contact Tracing for the identification of Close Contacts in order to help contain disease outbreaks.
  - Contact tracing can be especially impactful when there is a small number of infected individuals in the facility or in a particular housing unit, when the infected individual had close contact with individuals from other housing units, and when the infected individual recently visited a community setting.
  - Contact tracing may be more feasible and effective in settings where inmates have limited contact with others (e.g., celled housing units), compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
  - If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage. Under such conditions, consider broad-based testing in order to identify infections and prevent further transmission.
- Viral testing is recommended for all close contacts of persons with SARS-CoV-2 infection.
  - Medically isolate those who test positive to prevent further transmission.
  - Asymptomatic close contacts testing negative should be placed under quarantine precautions for 14 days from their last exposure.
  - Re-test inmates in a quarantine cohort every 3-7 days to identify and medically isolate infected inmates early and minimize continued transmission within the cohort.

- Re-test inmates in a quarantine cohort on day 14 of the quarantine period. If all cohorted inmates test negative, quarantine precautions may be discontinued. If cohorted asymptomatic close contacts refuse SARS-CoV-2 testing on day 14, HDOH recommends extending the quarantine period to 28 days to account for transmission and incubation of the virus.

- Inmates who are close contacts of a suspected or confirmed COVID-19 case (i.e., other inmates, staff, visitors, vendors, volunteers), should be placed under quarantine for 14 days.
  - If an inmate is quarantined due to close contact with an individual who has laboratory confirmed COVID-19, but the quarantined inmate tests negative, the inmate should continue to quarantine for the full 14 days after last exposure and follow all recommendations of public health authorities. A negative COVID-19 test result could mean that the individual tested was likely not infected at the time the sample was collected or the specimen was inadequate. Persons with a negative COVID-19 test can develop infection at a later time.
  - If an inmate is quarantined due to close contact with a suspected COVID-19 individual who subsequently tests negative, the inmate may be considered for medical discharge from quarantine by the Provider. Due to the possibility of false negative results and other medical considerations involving the medically isolated inmate, only a Provider may order the discontinuation of quarantine.
  - NOTE: Inmates, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine.
- Facilities should make every effort to quarantine close contacts of an inmate with suspected or confirmed COVID-19 individually. Cohorting multiple close contacts in quarantine could result in the transmission of COVID-19 to inmates who are not infected. Cohorting should only be practiced if there are no other available options. Do not add more inmates to an existing quarantine cohort after the 14-day quarantine clock has started, if possible.
- The CDC provides guidance for housing multiple individuals under quarantine, in order of preference, (refer to Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities). If ideal quarantine housing is not available in a facility, use the next best alternative as a harm reduction approach.
  - IDEAL: 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 inmate 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 inmate 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 inmates. Note: Inmates are single-celled, but 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 to maintain at least 6 feet of space between inmates housed in the same cell.
- As a cohort, in inmates' regularly assigned housing unit, but with no movement outside the unit (if an entire housing unit has been exposed – referred to as "quarantine in place"). Employ social distancing strategies to maintain at least 6 feet of space between inmates.
- 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.

- Facilities without sufficient space to implement effective quarantine should consult with the Hawaii Department of Health (HDOH) to ensure that quarantine cases will be appropriately managed. The CDC provides Recommendations for Quarantine Duration in Correctional and Detention Facilities. In collaboration with HDOH, facilities considering a shortened quarantine duration should carefully weigh the risks of increased transmission and secondary clusters, and consider facility-specific characteristics (e.g., level of community transmission, ability to maintain social distancing, compliance with universal masking policies, ability to properly ventilate, proportion of employees and inmates at increased risk for severe illness from COVID-19, and availability of resources for broad-based testing and outbreak response), before implementing a reduced quarantine alternative. Decisions to modify quarantine duration must be ordered by the Medical Director.
- Due to the rate of turnover of inmates, higher risk of transmission, and challenges in maintaining recommended physical distancing in correctional settings, the CDC recommends fully vaccinated inmates should continue to quarantine for 14 days and test for SARS-CoV-2 following an exposure to someone with suspected or confirmed COVID-19. If there is an urgent need to mitigate critical issues (e.g., lack of space or staff to care for exposed inmates), facilities, in collaboration with HDOH, could consider waiving quarantine for a fully vaccinated inmate if the fully vaccinated inmate receives a laboratory confirmed negative PCR test result during the quarantine period. Decisions to modify quarantine duration for fully vaccinated inmates must be ordered by the Medical Director.
- The solid door (if available) to the Quarantine Room should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Room, which lists recommended personal protective equipment (PPE) (see Attachment 6).
- Facilities should maintain a system for the identification of inmates, with COVID-19, who are at increased risk for severe illness (e.g., Older Adults, People with Certain Medical Conditions, Pregnant People, People Who Use Drugs or Have Substance Use Disorder). If feasible, facilities should quarantine inmates in single cells and avoid cohorting in quarantine People Who Are at Increased Risk for Severe Illness (see also the CDC list for People with Certain Medical Conditions and Evidence used to update the list of underlying medical conditions that increase a person's risk of severe illness from COVID-19). If cohorting is unavoidable, make all possible accommodations (e.g., intensify social distancing strategies), to reduce exposure risk and adverse health outcomes for inmates at increased risk for severe illness.

- If single cells for medical isolation (of those with suspected COVID-19) and quarantine (of close contacts) are limited, CDC recommends prioritizing the available housing in rank order as follows to reduce the risk of further SARS-CoV-2 transmission and adverse health outcomes:
  - Inmates with suspected COVID-19 who are at increased risk for severe illness from COVID-19.
  - Other inmates with suspected COVID-19.
  - Quarantined close contacts of someone with COVID-19 who are themselves at increased risk for severe illness from COVID-19.
- CDC recommends monitoring inmates in quarantine at least once per day for COVID-19 symptoms and temperature. If an inmate develops symptoms for SARS-CoV-2, the inmate should be considered a suspected COVID-19 case, given a mask (if not already wearing one), and moved to medical isolation immediately (individually, and separately from those with confirmed COVID-19 and others with suspected COVID-19) and further evaluated. If the inmate is tested and receives a positive result, the inmate can then be cohorted with other inmates with confirmed COVID-19. When an inmate who is part of a quarantined cohort becomes symptomatic:
  - If the inmate is tested for SARS-CoV-2 and receives a positive result, the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - If the inmate is tested for SARS-CoV-2 and receives a negative result: the 14-day quarantine clock for this inmate and the remainder of the cohort does not need to be reset. The inmate can return from medical isolation to the quarantine cohort for the remainder of the quarantine period as the symptoms and diagnosis allow.
  - If the inmate is not tested for SARS-CoV-2, the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- Keep the inmate's movement outside the quarantine space to an absolute minimum.
  - Provide medical evaluation and care inside or near the quarantine space when possible.
  - Meals should be provided to quarantined inmates in the designated quarantine area. Disposable food service items can be placed in regular trash in the quarantine area. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling food service items should perform hand hygiene after removing gloves and gowns.
  - Exclude the inmate from all group activities.
  - Laundry should be transported from the quarantine area to the laundering location in a bag liner that is either disposable or can be laundered. Individuals handling laundry from the quarantine area should wear a mask, disposable gloves, and a gown, discard after each use, and perform hand hygiene. Do not shake dirty laundry (to minimize the possibility of dispersing virus through the air). Laundry from quarantined inmates may be washed with other inmate laundry. Use the hottest appropriate water setting and dry items completely. Clean and disinfect clothes hampers in accordance with Element 3b.

- Ideally, the quarantine area should have a dedicated bathroom attached. If not, inmates must wear a mask (unless contraindicated) to go to the bathroom outside the room. When a dedicated bathroom is not feasible, do not reduce access to restroom or shower use as a result. Clean and disinfect areas used by quarantined inmates frequently on an ongoing basis during the quarantine period.

- Restrict quarantined inmates 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.
- If a quarantined inmate leaves the quarantine space for any reason, the inmate should wear a mask (unless contraindicated) as source control.
  - Quarantined inmates housed as a cohort should wear masks at all times, except when contraindicated or not practicable.
  - Quarantined inmates housed alone should wear masks whenever another individual enters the quarantine space, except when contraindicated or not practicable.
- Staff assignments to quarantine spaces should remain as consistent as possible. Staff assigned to quarantine posts should limit their movement to other parts of the facility as much as possible. If staff must serve multiple areas of the facility, ensure staff change PPE when leaving the quarantine space. If PPE supplies necessitate reuse, staff should move from areas of low to high exposure risk to prevent cross-contamination.
- Admission to and Discharge from Quarantine must be ordered by a Provider.
  - Inmates quarantined individually may be considered for release from quarantine restrictions if they have not developed COVID-19 symptoms and have not tested positive for SARS-CoV-2 for 14 days since their last exposure to someone who tested positive.
  - Consider testing inmates who are cohorted on quarantine when identified as close contacts of someone with suspected (not tested) or confirmed COVID-19 at the end of the 14-day quarantine period, before releasing the cohort from quarantine.
- If an inmate on quarantine status (not routine quarantine) due to exposure to suspected or confirmed COVID-19 is to be released from the facility before medically discharged from quarantine, notify the Hawaii Department of Health to provide direct linkage to community resources and release planning (e.g., transport, shelter, and medical care).
- If an inmate on quarantine status is scheduled to transfer to the Hawaii State Hospital or another correctional facility, hold the transfer until the inmate is cleared for transfer by the Medical Director.
- Inmates who are released while in quarantine should be provided education about the following:
  - Self-quarantine and stay home for 14 days* after last exposure.
  - Check temperature twice a day and watch for Symptoms of COVID-19.
  - Stay away from people, especially those who are higher risk for getting very sick from COVID-19.

*As an alternative to the 14-day quarantine period for inmates being released while on quarantine status, the quarantine period may be shortened to 10 days, ONLY if the following criteria are met:

- No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
- Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
- If symptoms develop within 14 days of the last exposure, the inmate should be tested for COVID-19 and self-isolate while awaiting results; **AND**
- The inmate is informed to strictly adhere to all recommended mitigation strategies, including:
  - Correct and consistent mask use
  - Physical distancing
  - Hand and cough hygiene
  - Avoiding crowds
  - Environmental cleaning and disinfection
  - Ensuring adequate indoor ventilation

13. Surveillance for New Cases

Inmates and staff should immediately report suspected cases of COVID-19 to the medical unit. Facilities should ensure that inmates receive medical evaluation and treatment at the first signs of COVID-19 symptoms. The initial medical evaluation should determine whether a symptomatic individual is at increased risk for severe illness from COVID-19.

- Daily screening of workline inmates, who provide services within the facility (e.g., kitchen, janitorial, laundry), is recommended to prevent infection in multiple locations.
- If individuals with COVID-19 have been identified among staff or inmates (excluding the introduction of a known COVID-19 positive inmate admission to the facility) in a facility, consider implementing regular symptom screening and temperature checks in housing areas that have not yet identified infections, until no additional infections have been identified in the facility for 14 days.
- In addition to routine intake quarantine (see element #6) and routine transport quarantine (see element #9), to the extent possible, implement and customize routine quarantine procedures for inmates who leave and return to the facility for other reasons (e.g., work furlough, weekend sentence, inmate workline, pre-release). As an example, implement routine work furlough quarantine (i.e., cohorting and restricting movement within the facility of all inmates, who leave and return to the facility while participating in work furlough). Inmates in routine work furlough quarantine should be housed separately from inmates who are quarantined due to contact with a suspected or confirmed COVID-19 case and the general inmate population.

14. Data Collection, Analysis, and Reporting

Implement methods for tracking information about inmates and employees with suspected and/or confirmed COVID-19.

- COVID-19 data assists public health professionals and health care providers monitor the spread and intensity of COVID-19 in our correctional system; supports an understanding of the illness, disease severity, and associated social disruptions; and informs the public health response to COVID-19. The following information should be tracked:
  - Facility: the specific correctional facility where the inmate is housed.
  - Tested: the number of inmates who have been administered a COVID-19 viral test and received results while incarcerated.
  - Results Pending: the number of inmates who have been administered a COVID-19 viral test and are waiting for results.
  - Refused Testing: the number of symptomatic inmates who refused COVID-19 viral testing.
  - Negative: the number of inmates who have been administered a COVID-19 test and have received a negative result from a COVID-19 viral test while incarcerated.
  - Inconclusive: the number of inmates who have been administered a COVID-19 test and have received an inconclusive result from a COVID-19 viral test while incarcerated.
  - Positive: the number of inmates who have been administered a COVID-19 test and have received a positive result from a laboratory confirmed COVID-19 PCR test while incarcerated.
  - Probable: the number of inmates who have been administered a COVID-19 test and have received a positive result from a COVID-19 antigen test, but do not confirm infection by taking a PCR test, while incarcerated.
  - Pre-Incarceration Positive: the number of inmates who received a positive result from a COVID-19 viral test prior to incarceration.
  - Number of Persons in Medical Isolation: the number of inmates who received a positive result from a COVID-19 viral test and are currently infectious and the number of inmates who are presenting with symptoms of COVID-19 and have been separated, in a single cell or by cohorting, from others who are not ill in order to prevent the spread of disease.
  - Number of Persons in Quarantine: the number of inmates who are asymptomatic close contacts of individuals with suspected or known COVID-19.
  - Hospitalization: the number of inmates with laboratory confirmed COVID-19 who are currently hospitalized.
  - Recovered: the number of inmates who received a positive COVID-19 viral test, but have been successfully treated and discharged from medical isolation by the Provider in accordance with CDC guidelines.
  - Court-Ordered Release: the number of inmates who were released by court order while on medical isolation status and followed by the DOH.

- Deaths: the number of inmates who received a positive COVID-19 viral test and was under the care of a Provider for COVID-19 at the time of death. This is provisional data that does not reflect the actual cause of death, which is based on the medical examiner report and autopsy.

- The Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form is submitted to the Hawaii Department of Health when COVID-19 viral testing is requested for inmates with symptoms of COVID-19. The form includes basic inmate medical and social history information, as well as information about clinical symptoms, pre-existing medical conditions, and respiratory diagnostic test results.
- To the extent permitted by Federal and State laws, facilities and programs should maintain a database on the number of employees who have tested positive for COVID-19, the number of employees who are recovered from COVID-19, and the number of employee deaths related to COVID-19. If a staff member has a confirmed SARS-CoV-2 infection, maintain the infected employee's confidentiality as required by the Americans with Disabilities Act.

15. Continuous Quality Improvement

The purpose of Continuous Quality Improvement (CQI) programs is to improve health care by identifying problems, implementing and monitoring corrective action, and studying the effectiveness of the corrective action. Periodically and at the conclusion of an outbreak, the facility should review the implementation of the COVID-19 Pandemic Response Plan in the context of identifying what has worked well and what areas require improvement. Findings from the facility CQI committee should be reported to the Division Administration for appropriate distribution to assist all correctional facilities. Members of the facility CQI committee should include the Warden and relevant Section Administrators.

COVID-19 Pandemic Response Plan Implementation Worksheet

This MS Word® template worksheet is designed for facilities to operationalize the guidance in this COVID-19 Pandemic Response Plan. It should be adapted to the unique needs of your facility.

Date Updated:	**Completed by:**

1. Administration/Coordination

a. Identify members of the facility leadership team responsible for COVID-19 pandemic response planning and implementation, including roles and responsibilities:

b. How will facility administration regularly meet?

c. Who is responsible for monitoring COVID-19 updates from CDC and Hawaii Department of Health?

CDC Website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Hawaii Department of Health Websites:
https://health.hawaii.gov/news/covid-19-updates/
https://health.hawaii.gov/docd/advisories/novel-coronavirus-2019/
https://health.hawaii.gov/docd/for-healthcare-providers/news-updates/

2. Communication

a. The mechanisms for regular updates (paper/electronic/telephonic) will be as follows:

- **Staff:**
- **Inmates:**
- **Families of inmates:**

Review recommendations for posting signage in the facility. What signage will be posted in the facility and where will the signage be posted?

b. The following staff are responsible for communicating with stakeholders:

c. Department of Health:

Oahu (**Disease Reporting Line**): (808) 586-4586
Maui District Health Office: (808) 984-8213
Kauai District Health Office: (808) 241-3563
Big Island District Health Office (Hilo): (808) 933-0912
Big Island District Health Office (Kona): (808) 322-4877
After hours on Oahu: (808) 600-3625
After hours on neighbor islands: (800) 360-2575 (toll free)

Fax: (808) 586-4595

d. Communicate with the Hawaii Department of Health and discuss guidance on management and COVID-19 testing of persons with respiratory illness.

Document date of communication and the plans discussed:

e. Local community referral hospital:

Phone:

3. General Prevention Measures

a. Good Health Habits: How will good health habits be promoted with your staff (e.g., posters, leadership emphasizing hand hygiene, educational video, email messages to staff)?

1) **Are there facilities for employees and visitors to wash hands when entering and leaving the facility? YES NO If no, what are the plans to address this issue?**

2) **Are there facilities for inmates to wash hands at intake? YES NO**
If no, what are the plans to address this issue?

3) **Are soap dispensers or hand soap available in all employee and inmate restrooms? YES NO**
What is the plan to ensure soap dispensers are refilled regularly?

4) **What is the plan to ensure inmates have an adequate supply of soap?**

5) **Are signs for hand hygiene and respiratory etiquette visibly posted at the entry, in modules, and other high traffic areas? YES NO**

6) **Are tissues available? YES NO If so, where?**

7) **Are no-touch trash receptacles available? YES NO**
If so, where?

b. Environmental Cleaning:
Review updated CDC recommendations regarding environmental cleaning. Note: common EPA-registered household disinfectants are considered effective. (*If necessary*) purchase EPA hospital-grade disinfectants from Schedule N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2. (Recommended products are both a surface cleaner and disinfectant with a 3-minute wet time or less.) What disinfectants will the facility use?

Identify "high-touch" surfaces in the facility (e.g., doorknobs, handrails, keys, telephones):

The following plan will be implemented to increase the frequency and the extent of cleaning and disinfection of high-touch surfaces in this facility:

c. Social Distancing Measures: What administrative measures will your facility implement to increase social distancing (Review across all Sections in the facility)?

1)

2)

3)

4)

5)

6)

7)

8)

9)

In what areas of the facility do staff interact or come in close contact with one another (e.g., break rooms, locker rooms, shared offices)?

What precautions are you taking to prevent transmission between staff members in these spaces?

d. Encourage the Use of Masks and Other No-Contact Barriers:
Will the facility distribute masks to staff and inmates? YES NO

What is the facility plan for inmate encounters using no-contact barriers?

e. Employees Stay Home When Sick: Does communication with employees include the message that they should stay home when sick or under quarantine? YES NO

Sick employees should be advised to follow CDC guidance on What to do if you are Sick

If NO, what corrective action will be implemented?

f. COVID-19 Vaccination: Is there a protocol for obtaining and administering COVID-19 vaccines? YES NO

If yes, what is the procedure for obtaining COVID-19 vaccines?

If yes, what plans are there to continue offering COVID-19 vaccination to inmates who have not been vaccinated?

Have health care staff received training on how to respond to inmate questions about COVID-19 vaccines?
YES NO

g. Influenza Vaccination: Is there flu vaccine in stock? YES NO

If yes, number of doses?

If yes, what plans are there to continue offering vaccination to health care staff and inmates who have not been vaccinated?

h. Infection Prevention and Control Guidance When Screening: Have staff who conduct screening of employees, visitors, vendors, volunteers, and new intakes received education on the infection prevention and control guidance? YES NO

If no, what corrective action be taken?

i. Control Strategies for Aerosol Generating Procedures:

Did medical staff implement control strategies for aerosol generating procedures involving diagnostics, CPAP/BiPAP use, pulmonary function/peak flow tests, and nebulizer treatments?
YES NO

If NO, what corrective actions are being implemented?

Did dental staff implement control strategies for aerosol generating procedures in accordance with the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response and guidance from the Hawaii Board of Dentistry?
YES NO

If NO, what corrective actions are being implemented?

4. Visitors / Vendors / Volunteers

What changes in procedures/polices are being instituted in response to COVID-19 for:

a. Visitors:

b. Volunteers:

c. Vendors:

d. Attorneys:

What signage or methods are being used to communicate with visitors?

Is the facility prepared to conduct screening for visitors/vendors/volunteers? YES NO

If yes, who will conduct the screening?

5. Employee Screening

Do you have an infrared no-touch thermometer for employee screening? YES NO

If NO, what are your plans for acquiring an infrared no-touch thermometer?

When did your facility implement employee screening?

The following system will be utilized for employees to report illness/exposures:

The following system will be used to track employee illness/exposures:

6. New Intake Screening

It is recommended that new arrivals be isolated from rest of population until screening is performed. New intakes should be screened with temperature and questionnaire.

Where will screening occur?

Who will conduct screening?

What other screening logistics are being considered?

7. Initial Management and Testing of SARS-CoV-2

It is recommended that individuals with symptoms be immediately issued a mask and be placed in a separate room with a toilet and sink.

What separate room will be used for this purpose?

Do you have capacity in this facility to perform testing of SARS-CoV-2? YES NO
If yes, what are the plans to ensure competency in nasopharyngeal swabbing?

What are current recommendations from your Medical Director and the Hawaii Department of Health regarding COVID-19 testing?

Review CDC recommendation for collection of clinical specimens. Do you have needed supplies for testing? YES NO

If NO, what are your plans to obtain the supplies?

Planning for how the facility will modify operations when implementing broad-based testing for SARS-CoV-2.

Will specific housing units or areas be designated for inmates who test positive? YES NO

How will the facility manage those who decline testing?

If testing reveals that more inmates are positive than negative, will those who test negative be reassigned to different housing (rather than reassigning those who test positive)? YES NO

If yes, how will the facility mitigate further transmission within the facility?

How will housing areas be systematically and thoroughly cleaned and disinfected if large numbers of positive inmates are identified and housing units are rearranged?

How will the facility manage the logistics of moving large numbers of inmates into different housing arrangements (e.g., where will inmates go while the housing units are being cleaned and disinfected, and how will positive and negative inmates be separated during this time)?

8. Personal Protective Equipment

Date: **What is the current inventory of the following?**

Surgical Masks:

N-95 respirators:

Gowns (disposable):

Gowns (washable):

Eye Protection- Goggles:

Eye Protection—Disposable face shields:

What is your plan for securing and maintaining an adequate supply of PPE?

If respirators are available, but in limited supply, what activities will they be prioritized for?

What is your plan for fit-testing adult correctional officers?

What is your plan for fit-testing health care workers?

What is your plan for fit-testing inmate workline?

How does the facility plan to train adult correctional officers in donning and doffing of PPE?

Who will conduct the training?

Who will organize the training?

When will the training occur?

How does the facility plan to train Health Care Workers in donning and doffing of PPE?

How does the facility plan to train inmate workline in donning and doffing of PPE?

Review Table 3 (COVID-19 Personal Protective Equipment Recommendations) and the CDC Strategies to Optimize the Supply of PPE and Equipment. **What strategies are being implemented to optimize the supply of PPE and equipment?**

9. Transport

What is your plan for training transport staff on procedures fortransport?

10. Medical Isolation / Cohorting (*Symptomatic Inmates*)

What is your capacity for medically isolating inmates with suspected COVID-19 in single cells with a toilet?

Where will medical isolation cells for suspected COVID-19 be located?

What is your capacity for cohorting inmates in cells, quads, modules, or dorms, with toilets/sinks?

What areas of the facility have been designated for medical isolation of confirmed COVID-19 in cohorts?

What is your plan for designating and training officers assigned to medical isolation cells, quads, modules, or dorms on isolation room procedures?

Is it feasible to designate specific security staff to only monitor medically isolated inmates to minimize the potential for exposure among staff? YES NO

If YES, how will staff be selected for this duty?

Review recommendations for laundry and food service. What are your plans for educating staff and inmate workers on the laundry and food service recommendations?

Review recommendations for cleaning areas where COVID-19 cases spent time. What are your plans for training staff and inmate workers on the cleaning recommendations?

11. Care for the Sick
Do you have an adequate supply of Oxygen and medications for supportive care of a respiratory illness? **What is your facility plan for monitoring ill inmates?**
12. Quarantine (*Asymptomatic Exposed Inmates*)
What cells, quads, modules, and dorms could be used for individual quarantine? **What cells, quads, modules, and dorms could be used for group quarantine?** **How do you plan to monitor inmates under quarantine?** **What is your plan for supplying masks needed for an entire housing unit of inmates for a period of 14 days?** **What is your plan/ability to provide single cells for exposed persons who have risks for complications (e.g., over age 60 or with medical risk factors)?**

13. Surveillance for New Cases
What is the facility plan for notifying the medical unit of suspected COVID-19 cases by inmates and staff? **What is the facility procedure for daily screening of workline inmates?**
14. Data Collection, Analysis, and Reporting
Who is responsible for collecting and reporting data on employees with suspected/confirmed COVID-19? **How will the employee information be communicated to the data collector?** **Who is responsible for collecting and reporting data on inmates with suspected/confirmed COVID-19?** Daniel Kinikini, CRS, and Toni Schwartz, PIO, collect and report on data, respectively. **How will the inmate information be communicated to the data collector?** Facility nursing will report instances of COVID-19 testing, requiring medical isolation and quarantine as a Priority I Incident.
15. Continuous Quality Improvement
Who are the members of the facility CQI committee for COVID-19? **Who will be responsible for communicating the results of the reviews to the Division Administrators for appropriate distribution to other facilities?**

Attachment 1A. COVID-19 Visitor/Vendor/Volunteer Screening Tool A

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
VISITOR/VENDOR/VOLUNTEER SCREENING TOOL

SECTION A (TO BE COMPLETED BY VISITOR/VENDOR/VOLUNTEER)

Please complete the following:	
Date of Requested Entrance	
Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled off-island?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can staff take your temperature?

SECTION B (TO BE COMPLETED BY STAFF)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the visitor/vendor/volunteer 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the visitor/vendor/volunteer clear for purpose of this screening to enter the facility?

Staff Name: _____

Staff Title: _____

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Attachment 1B. COVID-19 Visitor/Vendor/Volunteer Screening Tool B

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
VISITOR/VENDOR/VOLUNTEER SCREENING TOOL

SECTION A (TO BE COMPLETED BY VISITOR/VENDOR/VOLUNTEER)

Please complete the following:	
Date of Requested Entrance	
Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled outside Hawaii?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can staff take your temperature?

SECTION B (TO BE COMPLETED BY STAFF)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the visitor/vendor/volunteer 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the visitor/vendor/volunteer clear for purpose of this screening to enter the facility?

Staff Name: _____

Staff Title: _____

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Attachment 2A. COVID-19 Employee Screening Tool A

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
EMPLOYEE SCREENING TOOL

SECTION A (TO BE COMPLETED BY EMPLOYEE)

Please complete the following:	
Date	
Employee Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled off-island?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19, while not wearing recommended PPE?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can the screener take your temperature?

SECTION B (TO BE COMPLETED BY SCREENER)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the employee 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the employee clear for purpose of this screening to enter the facility?

Screener Name: _____

Screener Title: _____

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Attachment 2B. COVID-19 Employee Screening Tool B

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
EMPLOYEE SCREENING TOOL

SECTION A (TO BE COMPLETED BY EMPLOYEE)

Please complete the following:	
Date	
Employee Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled outside Hawaii?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19, while not wearing recommended PPE?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can the screener take your temperature?

SECTION B (TO BE COMPLETED BY SCREENER)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the employee 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the employee clear for purpose of this screening to enter the facility?

Screener Name: _____

Screener Title: _____

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Attachment 3. CDC Contact Precautions Sign

Attachment 4. CDC Droplet Precautions Sign

Attachment 5. Isolation Room Precautions Sign

Respiratory Infection
Isolation Room Precautions

PRECAUCIONES de sala de aislamiento de infección respiratoria

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,
todas las peronas que entren e esta habitacion tienen que:

HAND HYGIENE

Hygiene De Las Manos

Face Mask or N-95 Respirator

Mascara Facial o Respirador N95

Gloves

Guantes

GOWN

Bata

Eye Protection

Protección para los ojos

Ensure that the door to this room remains closed <u>at all times</u>.

Asegurese de mantener la puerta de esta habitacion carrada <u>todo el tiempo</u>.

Attachment 6. Quarantine Room Precautions Sign

Quarantine Room Precautions

PRECAUCIONES de Sala de Cuarentena

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,

todas las peronas que entren e esta habitacion tienen que:

HAND HYGIENE

Hygiene De Las Manos

Face Mask

Mascara facial

Eye Protection

Protección para los ojos si contacto cercano

Gloves

Guantes

Ensure that the door to this room remains closed <u>at all times</u>.

Asegurese de mantener la puerta de esta habitacion carrada <u>todo el tiempo</u>.

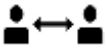
Attachment 7. COVID-19 Re-entry Information Handout

DEPARTMENT OF PUBLIC SAFETY

COVID-19 RE-ENTRY INFORMATION

COVID-19 INFO:
CALL 2-1-1
TEXT 8??-???-????
CHAT
EMAIL
hawaiicovid19.com
2-1-1

Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person-to-person. Symptoms of the disease may include fever, cough, and/or shortness of breath. Severe cases can result in hospitalization and death. Residents of Hawaii are advised to take a few simple precautions to help reduce their risk of exposure.



HOW TO PROTECT YOURSELF & OTHERS

Avoiding crowds and other people's personal space helps to curb the spread of the virus. **Social Distancing** or keeping at least six feet away from other people will also reduce your chances of catching COVID-19. Examples general prevention measures:

- Avoid handshaking, hugging, and other intimate types of greetings
- Wash your hands often with soap and water for at least 20 seconds after you have been in a public place, or after blowing your nose, coughing, or sneezing
- Avoid touching your eyes, nose, and mouth with unwashed hands
- Clean and disinfect frequently touched objects and surfaces
- Avoid groups larger than 10 people, especially in poorly ventilated spaces
- Stay at home as much as possible
- Wear a cloth face mask or equivalent face covering

SELF-QUARANTINE

People who have been exposed to the new coronavirus and who are at risk for coming down with COVID-19 should **self-quarantine**. Health experts recommend a self-quarantine period of 14 days. Two weeks provides enough time for people to know whether they will become ill and be contagious to other people. Self-quarantine involves:

- Staying at home
- Not having visitors
- Practicing social distancing with other people in your household
- Standard hygiene practice and frequent hand washing
- Not sharing things like towels and dining ware

RESOURCES AND LINKS

Below are COVID 19 hotline numbers and web links for more information:

- **Hawaii Department of Health**
  - 2-1-1
    https://www.hawaiicovid19.com/ or
    https://www.health.hawaii.gov/coronavirusdisease2019/
- **Centers for Disease Control and Prevention**
  - 1-800-232-4636
    https://www.cdc.gov/coronavirus/2019-ncov/index.html

Attachment 8. Control Strategies for Aerosol Generating Procedures

General Strategies to Reduce Risk with Aerosol Generating Procedures:

1. Examine whether the procedure is medically necessary, identify viable effective alternatives, and consider temporarily discontinuing non-essential use during the COVID-19 pandemic.
2. If aerosol generating procedures are deemed medically necessary, minimize the risk by:
    a. Limiting staff involved in the procedure
    b. Recommended PPE: N95 respirator, face shield, gloves and gown.
    c. Perform in airborne infection isolation (AII) room or single room with solid walls and doors.
    d. Thoroughly disinfect the room after use.

Procedure	Recommendations
Diagnostics (e.g., COVID-19, Influenza)	**Nasopharyngeal and oropharyngeal swabs** should be performed in a room with a door that closes. PPE: N95 respirator, gown, gloves, eye protection
Dental	**Dental Health Professionals adhere to the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response** and guidance from the Hawaii Board of Dentistry**.** PPE: N95 respirator, gown, gloves, eye protection
CPAP/BiPAP	**Providers review patients with sleep apnea on CPAP/BiPAP:** ▪ For most patients on CPAP the short-term discontinuation of CPAP is less risky than the potential for aerosolized virus spread with CPAP use during pandemic. ▪ For patients on BiPAP/CPAP with severe sleep apnea and comorbidities (such as significant cardiomyopathy with history of arrhythmias) for whom short-term discontinuation of BiPAP/CPAP is not considered safe, single cell housing (with solid door) should be sought. ▪ COVID-19 can live on surfaces so frequent cleaning of CPAP equipment being used is encouraged during the pandemic
PFTs/Peak Flow Meters	It is recommended that pulmonary function tests and peak flow measurements be postponed due to COVID-19 pandemic.
Nebulizer Treatments	**Avoid nebulizer use by converting to metered dose inhaler (MDI) if possible** ▪ Use MDI with spacer, if possible ▪ Consider increasing puffs per sitting and more frequent use, if clinically indicated ▪ Some medications are available as dry powder inhaler ▪ National supply issues have been reported for some MDIs; consult with pharmacist as needed **If must use nebulizer:** ▪ Use in single room with closed door ▪ Limit staff and staff present use N95 respirator, gown, gloves, eye protection ▪ Disinfect room and equipment after treatment
CPR	**CPR is performed in accordance with American Heart Association guidelines.** Modifications include: ▪ Limit number of people in room to essential (no more than 3) ▪ Put on appropriate PPE before entering the scene: N95 respirator, gown, gloves, eye protection ▪ Use of bag-mask ventilation over mouth-mask/face shield preferred

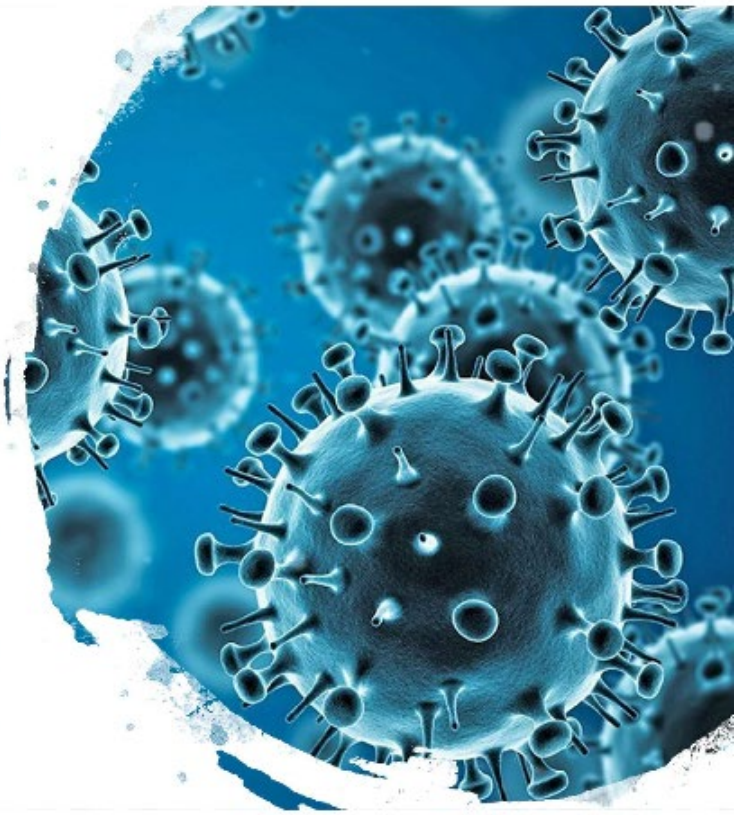
Adapted from: VitalCore Health Strategies and California Department of Corrections Division of Health Care Services Memorandum: Aerosol Generating Procedures, April 8, 2020.

Attachment 9. HCD Seasonal Influenza Campaign

Da FLU ends with "U"

Get Your Free Flu Shot Today
and
Get 1 FUTURE COPAY Credit

Copay credit can only be used for one (1) future visit.
One (1) per person per year.
Expires one (1) year from the date of your flu shot.
Non-transferrable (no trading). No cash value.



Appendix 1. CDC Definitions of Commonly Used Terms

Close contact of someone with COVID-19 – Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the person is isolated.

** Individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). Data are limited, making it difficult to precisely define "close contact;" however, 15 cumulative minutes of exposure at a distance of 6 feet or less can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity (closer distance likely increases exposure risk), the duration of exposure (longer exposure time likely increases exposure risk), whether the infected individual has symptoms (the period around onset of symptoms is associated with the highest levels of viral shedding), if the infected person was likely to generate respiratory aerosols (e.g., was coughing, singing, shouting), and other environmental factors (crowding, adequacy of ventilation, whether exposure was indoors or outdoors). If the employee has not received training on proper selection and use of respiratory PPE, such as an N95, the determination of close contact should generally be made irrespective of whether the contact was wearing respiratory PPE. At this time, differential determination of close contact for those using fabric face coverings is not recommended.*

Cohorting – The practice of isolating multiple individuals with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells. While cohorting those with confirmed COVID-19 is acceptable, cohorting individuals with suspected COVID-19 is not recommended due to high risk of transmission from infected to uninfected individuals.

Community transmission of SARS-CoV-2 – When individuals are exposed to the virus through contact with someone in their local community, rather than through travel to an affected location. When community transmission is occurring in a particular area, correctional facilities and centers are more likely to start seeing infections inside their walls.

Confirmed vs. suspected COVID-19 – A person has **confirmed COVID-19** when they have received a positive result from a COVID-19 viral test (i.e., RT-PCR) but they may or may not have symptoms. A person has **suspected COVID-19** if they show symptoms of COVID-19 but either have not been tested via a viral PCR test or are awaiting test results. If their test result is positive, suspected COVID-19 is reclassified as confirmed COVID-19.

Masks – Masks cover the nose and mouth and are intended to help prevent people who have the virus from transmitting it to others, even if they do not have symptoms. CDC recommends wearing cloth masks in public settings where social distancing measures are difficult to maintain. Masks are recommended as a simple barrier to help prevent respiratory droplets from traveling into the air and onto other people when the person wearing the mask coughs, sneezes, talks, or raises their voice. This is called **source control**. If everyone wears a mask in congregate settings, the risk of exposure to SARS-CoV-2 can be reduced. Anyone who has trouble breathing or is unconscious, incapacitated, younger than 2 years of age or otherwise unable to remove the mask without assistance should not wear a mask (for more details see How to Wear Masks). **CDC does not recommend use of masks for source control if the mask has an exhalation valve or vent).** Individuals working under conditions that require PPE should not use a cloth mask when a surgical mask or N95 respirator is indicated. Surgical masks and N95 respirators should be reserved for situations where the wearer needs PPE. Detailed recommendations for wearing a mask can be found here.

Medical isolation – Separating someone with confirmed or suspected COVID-19 infection to prevent their contact with others to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established criteria for release from isolation, in consultation with clinical providers and public health officials. 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, and should ensure that the conditions in medical isolation housing are distinct from those in disciplinary segregation.

Quarantine – The practice of separating individuals who have had close contact with someone with COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine reduces the risk of transmission if an individual is later found to have COVID-19. Quarantine for COVID-19 should last for 14 days after the exposure has ended. Ideally, each quarantined individual should be housed in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, and/or a quarantined individual receives a positive viral test result for SARS-CoV-2, the individual should be placed under medical isolation and evaluated by a healthcare professional. If symptoms do not develop during the 14-day period and the individual does not receive a positive viral test result for SARS-CoV-2, quarantine restrictions can be lifted. (NOTE: Some facilities may also choose to implement a "routine intake quarantine," in which individuals newly incarcerated/detained are housed separately or as a group for 14 days before being integrated into general housing. This type of quarantine is conducted to prevent introduction of SARS-CoV-2 from incoming individuals whose exposure status is unknown, rather than in response to a known exposure to someone infected with SARS-CoV-2.)

NOTE: According to the CDC, "The best way to protect incarcerated/detained persons, staff, and visitors is to quarantine for 14 days." As an alternative to the 14-day quarantine period for identified close contacts who do not reside in a correctional facility, HDOH adopted the CDC option to shorten the quarantine period to 10 days, ONLY if the following criteria are met:

- No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
- Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
- Close contacts who develop symptoms within 14 days of the last exposure should be tested for COVID-19 and self-isolate while awaiting results; **AND**
- Close contacts are informed to strictly adhere to all recommended mitigation strategies, including:
  - Correct and consistent mask use
  - Physical distancing
  - Hand and cough hygiene
  - Avoiding crowds
  - Environmental cleaning and disinfection
  - Ensuring adequate indoor ventilation

Social distancing – The practice of increasing the space between individuals and decreasing their frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet of physical distance 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 would be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Social distancing is vital for the prevention of respiratory diseases such as COVID-19, because people who have been infected with SARS-CoV-2 but do not have symptoms can still spread the infection. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication.

Order (1) Granting Plaintiffs' Motion For Provisional Class Certification And (2) Granting In Part And Denying In Part Plaintiffs' Motion For Preliminary Injunction And Temporary Restraining Order

Civil No. 21-00268 JAO-KJM
U.S. District Court for the District of Hawai`i

EXHIBIT "B"

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAII

ANTHONY CHATMAN, FRANCISCO ALVARADO, ZACHARY GRANADOS, TYNDALE MOBLEY, and JOSEPH DEGUAIR, individually and on behalf of all others similarly situated, Plaintiffs, vs. MAX N. OTANI, Director of State of Hawai‘i, Department of Public Safety, in his official capacity, Defendant.	CIVIL NO. 21-00268 JAO-KJM ORDER (1) GRANTING PLAINTIFFS' MOTION FOR PROVISIONAL CLASS CERTIFICATION AND (2) GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

ORDER (1) GRANTING PLAINTIFFS' MOTION FOR PROVISIONAL CLASS CERTIFICATION AND (2) GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

This putative class action concerns the alleged conditions in Hawaii's prisons and jails that have contributed to multiple COVID-19 outbreaks. Plaintiffs Anthony Chatman ("Chatman"), Francisco Alvarado ("Alvarado"), Zachary Granados ("Granados"), Tyndale Mobley ("Mobley"), and Joseph Deguair ("Deguair") (collectively, "Plaintiffs") contend that the Department of Public Safety ("DPS"), headed by Defendant Max Otani ("Defendant"), has mishandled

the pandemic and failed to implement its Pandemic Response Plan ("Response Plan") in violation of their Eighth and Fourteenth Amendment rights. Plaintiffs seek provisional class certification and request a temporary restraining order and preliminary injunction; namely, the appointment of a special master to oversee the development and implementation of Plaintiffs' proposed response plan. For the following reasons, the Court GRANTS Plaintiffs' Motion for Provisional Class Certification ("Class Certification Motion"), ECF No. 20, and GRANTS IN PART AND DENIES IN PART Plaintiffs' Motion for Preliminary Injunction and Temporary Restraining Order ("Injunction Motion"). ECF No. 6.

Defendant is ORDERED to immediately implement and *adhere* to DPS's Response Plan at all eight DPS facilities and comply with the specific conditions outlined herein.

BACKGROUND

I. Factual History[1]

Hawaii's state prisons and jails have been plagued by COVID-19 outbreaks at five of its eight facilities, resulting in the infection of more than 50% of the inmate population (1,532 inmates out of a population of approximately 3,000) and 272 DPS staff, and seven deaths. ECF No. 18 ("SAC") ¶¶ 1–2, 113–14; *see also*

[1] The facts are from the Second Amended Class Action Complaint for Injunctive Relief and Declaratory Judgment ("SAC"), unless otherwise indicated.

http://dps.hawaii.gov/blog/2020/03/17/coronavirus-covid-19-information-and-resources/ (last visited July 13, 2021).

The first outbreak occurred at Oahu Community Correctional Center ("OCCC") in August 2020, and to date, OCCC has had 452 cases of COVID-19. SAC ¶ 102.

In November 2020, Waiawa Correctional Facility ("Waiawa") experienced an outbreak, causing 90% of the inmate population to contract COVID-19. *Id.* ¶ 103. During the outbreak, dirty clothes from Waiawa were laundered at Halawa Correctional Facility ("Halawa") by inmates and staff, and Halawa staff were forced to work at Waiawa due to staff shortages there. *Id.* ¶ 104. These practices resulted in an outbreak at Halawa, where 544 inmates became infected and seven died from COVID-19. *Id.* ¶ 105.

In March 2021, an outbreak at Maui Community Correctional Center ("MCCC") resulted in 100 inmate COVID-19 infections, which represents one-third of MCCC's inmate population. *Id.* ¶ 106.

The most recent outbreak occurred at Hawai'i[2] Community Correctional Center ("HCCC"), beginning in late May 2021. *Id.* ¶ 107. Within three weeks,

[2] Plaintiffs misidentify this as Hilo Correctional Community Center. SAC ¶ 4.

two-thirds of the inmate population contracted COVID-19. *Id.* Twenty DPS staff and 228 pretrial detainees tested positive for COVID-19 during this period.[3] *Id.* ¶ 5. Plaintiffs attribute this rapid and extensive spread to the allegedly unsanitary conditions in holding areas at HCCC, most notably a room known as the "fishbowl." *Id.* The fishbowl is approximately 31.5 feet by 35.3 feet[4] and 40 to 60 pretrial detainees have been housed there, with no toilet or running water, causing detainees to urinate and sometimes defecate in the room. *Id.* ¶¶ 5–6; ECF No. 22-2 ¶ 38.

A. Plaintiffs

Plaintiffs are currently incarcerated or detained at DPS correctional facilities in Hawai‘i.

1. Anthony Chatman

Chatman has been incarcerated at Halawa since July 2019. SAC ¶ 123. While Chatman was housed in module 4A-2 in December 2020, two inmates who tested positive for COVID-19 were placed in his quad, then-designated a COVID-negative quad, and allowed to mingle with other inmates in the quad without masks. *Id.* ¶¶ 124, 127–28. Nearly all inmates in the quad tested positive for

[3] Defendant does not dispute these figures.

[4] The SAC identifies the dimensions as 30 feet by 30 feet. SAC ¶ 5.

COVID-19 shortly thereafter, including Chatman's roommate. *Id.* ¶ 129. Chatman's roommate nevertheless remained in their cell, and Chatman then contracted COVID-19. *Id.* ¶¶ 130–31. He too stayed in the cell, "sick as a dog," without receiving meaningful medical treatment. *Id.* ¶ 131. Chatman claims that upon his departure from his cell, it was not cleaned before the next occupant moved in. *Id.* ¶ 132.

Chatman filed a grievance after contracting COVID-19 and appealed each denial to exhaust his administrative remedies. *Id.* ¶¶ 133–34. Despite the COVID-19 outbreak at Halawa, Chatman has yet to see any social distancing practices — during recreation and dining, or in the common areas and cells — and reports that 60 people eat shoulder to shoulder in an approximately 400 square foot room. *Id.* ¶¶ 135–36.

2. Francisco Alvarado

Alvarado, a 52 year old inmate with lupus, was previously incarcerated at Halawa from 2019 to March 2021, and is currently incarcerated at Kulani Correctional Facility ("Kulani"). *Id.* ¶¶ 137–40. At Halawa, Alvarado was a module clerk who prepared paperwork for inmates' movement within the facility and delivered meals to cells. *Id.* ¶ 141. He witnessed inmates remaining in their cells after testing positive for COVID-19, comingling of COVID-positive inmates with asymptomatic inmates, and transfer of asymptomatic inmates into unsanitized

cells previously occupied by COVID-positive inmates. *Id.* ¶ 142. During meal deliveries, Alvarado was exposed to COVID-positive inmates, who were not forced to wear masks, through "open screen" cell doors. *Id.* ¶ 143.

When Alvarado contracted COVID-19 in December 2020, he requested medical assistance but received little to none. *Id.* ¶¶ 144, 146. His underlying medical condition caused him to sustain serious damage to his kidneys. *Id.* ¶ 145. Alvarado filed a grievance regarding the conditions that caused him to contract COVID-19 but he never received a response. *Id.* ¶¶ 146, 148–49. He was initially informed that the COVID-19 outbreak created a backlog of grievances and was instructed to file another grievance. *Id.* ¶ 150. However, between January and March 2021, he was repeatedly told that no grievance forms were available. *Id.* ¶¶ 151–53.

3. Joseph Deguair

Deguair, an asthmatic, has been incarcerated at HCCC since December 4, 2020. *Id.* ¶¶ 154–55. Before the May 2021 COVID-19 outbreak at HCCC, Deguair noticed an absence of mitigation efforts to prevent the spread of COVID-19. *Id.* ¶ 157. For example, he reports seeing symptomatic detainees housed with those who had not been tested for COVID-19, and social interaction between COVID-positive detainees and the general population during recreation time. *Id.* ¶¶ 157–59.

Due to these conditions, Deguair requested an inmate grievance form almost every day during the last two weeks of May to file a grievance. *Id.* ¶ 160. Multiple Adult Corrections Officers ("ACOs") told Deguair there were no forms and that he could not file a grievance. *Id.* ¶¶ 161–62. Since testing positive for COVID-19 on June 1, 2020, Deguair has requested a grievance form daily, only to be told none were available. *Id.* ¶¶ 163–64. ACOs told Deguair that there was nothing they could do to help him obtain a form or file a grievance. *Id.* ¶¶ 165, 167. Even when he attempted to file a grievance by phone, he was told during the call that he could not file a grievance and would have to wait. ECF No. ¶ 166.

4. Tyndale Mobley

Mobley received a COVID-19 vaccine prior to his incarceration at HCCC. *Id.* ¶¶ 168, 170. COVID-positive inmates were initially contained within the main HCCC building, though staff moved freely without masks between the main building and the unit housing Mobley. *Id.* ¶¶ 172–73. Mobley once confronted a guard who returned from the main building without a mask, and she responded that she did not want or need to wear a mask. *Id.* ¶ 174. This guard contracted COVID-19. *Id.* ¶ 174.b.

At the beginning of June 2021, two inmates with COVID-19 were housed in Mobley's cell block. *Id.* ¶ 175. Two additional COVID-positive inmates were moved into the cell block and the four infected inmates were instructed to stay on

the opposite end of the room from the non-infected inmates. *Id.* ¶ 176. Nearly all the inmates in the cell block then contracted COVID-19. *Id.* ¶ 177. Mobley and the COVID-positive inmates shared restroom facilities and he saw no efforts by staff to sanitize the facilities. *Id.* ¶¶ 178–79.

Mobley attempted to file grievances every day starting in late May or early June 2021, but the guards said they had no grievance forms and that there was no way to file a grievance. *Id.* ¶¶ 180–82, 184–85. Mobley was diagnosed with COVID-19 on June 6, 2021. *Id.* ¶ 183.

5. Zachary Granados

Granados has been incarcerated at Waiawa since August 2020. *Id.* ¶ 186. In November 2020, certain inmates housed in Waiawa's building 9 displayed COVID-19 symptoms. *Id.* ¶ 188. Upon testing positive in the medical unit, they returned to building 9, where nearly every inmate later contracted COVID-19. *Id.* ¶ 188.a–c. Around the same time, inmate kitchen workers contracted COVID-19 so Granados, along with other inmates from building 10, filled in for the COVID-positive kitchen workers. *Id.* ¶¶ 187, 189.a. The kitchen was not sanitized before the building 10 inmates stepped in, and four days later, one of those inmates tested positive for COVID-19. *Id.* ¶ 189.b–c.

Guards in building 9 wore "hazardous materials" suits because building 9 housed the COVID-positive inmates. *Id.* ¶ 190. Granados saw the guards wear these suits into building 10 to conduct head counts. *Id.* ¶ 191.

Approximately 30 COVID-positive inmates were transferred to building 10 from other buildings in mid-November 2020, after which Granados contracted COVID-19. *Id.* ¶¶ 192–93. Granados was bedridden for one week as a result. *Id.* ¶ 194.

In early December 2020, Granados filed a grievance regarding Waiawa's conditions, followed by appeals after receiving responses. *Id.* ¶¶ 195–96.

B. DPS's Management of COVID-19

In addition to the facilities housing Plaintiffs, DPS operates and manages Kauai Community Correctional Center ("KCCC"), MCCC, OCCC, and the Women's Community Correctional Center ("WCCC"). *Id.* ¶ 43. Plaintiffs allege that Defendant has mishandled and failed to manage outbreaks at its facilities notwithstanding its Response Plan, which has been in place since March 2020. *Id.* ¶ 83. In particular, Plaintiffs identify the following deficiencies: (1) housing up to 60 residents/detainees in a single room; (2) failure to provide adequate water; (3) failure to provide sanitary living conditions or proper hygiene; (4) failure to separate COVID-positive inmates; (5) failure to properly quarantine new intakes; (6) failure to communicate with DPS staff and inmates regarding proper COVID-

19 protocols; (7) failure to protect elderly and medically vulnerable inmates; (8) failure to allow adequate social distancing; (9) failure to provide personal protective equipment or enforce proper mask wearing; and (10) failure to consistently or adequately evaluate, monitor, and treat inmates with COVID-19 symptoms. *Id.* ¶¶ 92–122.

Plaintiffs propose the following classes and subclasses:

> **Post-Conviction Class**: All present and future sentenced prisoners incarcerated in a Hawai‘i prison.
>
> Post-Conviction Medical Subclass: Includes all present and future Post-Conviction Class members whose medical condition renders them especially vulnerable to COVID-19 as determined by guidelines promulgated by the CDC. *See* U.S. Centers for Disease Control and Prevention, *People Who Are At Higher Risk* (last viewed June 9, 2021) https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.
>
> **Pretrial Class**: All present and future pretrial detainees incarcerated in a Hawai‘i jail.
>
> Pretrial Medical Subclass: Includes all present and future Pretrial Class members whose medical condition renders them especially vulnerable to COVID-19 as determined by guidelines promulgated by the CDC. *See* U.S. Centers for Disease Control and Prevention, *People Who Are At Higher Risk* (last viewed June 9, 2021) https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

Id. ¶ 198.

II. Procedural History

Plaintiffs initiated this action on April 28, 2021, in the Circuit Court of the First Circuit, State of Hawai‘i. ECF No. 1-1. On June 8, 2021, Defendants and the other originally named defendants removed the action. ECF No. 1. Plaintiffs immediately filed a First Amended Class Action Complaint for Injunctive Relief and Declaratory Judgment ("FAC") and the Injunction Motion. ECF Nos. 5–6.

On June 18, 2021, Plaintiffs filed a Supplement to the Injunction Motion. ECF No. 14.

On June 22, 2021, Plaintiffs filed the SAC pursuant to a stipulation entered into by the parties and approved by Magistrate Judge Kenneth J. Mansfield. ECF Nos. 17–18. The SAC asserts three causes of action pursuant to 42 U.S.C. § 1983 and 28 U.S.C. § 2241: unconstitutional punishment in violation of the Fourteenth Amendment (Count One), unconstitutional conditions of confinement in violation of the Fourteenth Amendment (Count Two), and unconstitutional conditions of confinement in violation of the Eighth Amendment (Count Three). SAC ¶¶ 209–44. The first claim applies to the pretrial subclass, the second claim applies to the pretrial class, and the third claim applies to the post-conviction subclass. *Id.* at 53, 57, 59.

Plaintiffs request injunctive relief to require Defendant to implement the following response plan ("Proposed Response Plan"):

a. Physically distance all residents from one another and staff within DPS correctional facilities, which imposes at least six feet of distance between individuals at all times;

b. Provide all residents in DPS custody sanitary living conditions (*i.e.*, ensure regular access to a working toilet, sink, and drinking water);

c. Identify residents who may be high-risk for COVID-19 complications, in accordance with guidelines from the CDC, and prioritize these individuals for medical isolation or housing in single cells;

d. On a daily basis, thoroughly and professionally disinfect and sanitize the DPS correctional facilities;

e. Provide hygiene supplies that are not watered down, including supplies to wash hands and disinfect common areas, to inmates at all times and free of charge;

f. Implement policies and procedures requiring that common areas be disinfected between uses;

g. Provide adequate personal protection equipment and sanitizer, including but not limited to masks, to all staff members and residents (and ensure that these materials are replaced at least every third day);

h. Implement a testing procedure to identify residents who are possibly carrying COVID-19, including testing to identify asymptomatic carriers and those with one or more symptoms of COVID-19;

i. Implement a quarantine and isolation procedure that is in line with CDC guidelines for all individuals exposed to COVID-19 and new intakes to DPS correctional facilities;

j. Take particularly heightened precautions with respect to food handling and delivery, such as ensuring that people who come into contact with food are not displaying any potential

symptoms of COVID-19, have not recently been in contact with people displaying potential symptoms of COVID-19, and people who come into contact with food wear appropriate personal protective equipment at all times when in contact with food;

k. Provide regular, accurate, up-to-date educational and informational memorandum to DPS staff and inmates regarding the status of how COVID-19 is affecting the facility, including what measures employees and inmates must take in the event of an outbreak;

l. Develop comprehensive plans to educate and promote COVID-19 vaccination for all DPS residents and staff and ensure residents are provided regular access to vaccines; []

m. Prohibit DPS employees from restricting access to inmate grievance forms or from preventing the submission of grievances, and prohibit retaliation against any DPS employee or inmate for making complaints or filing grievances regarding conditions or practices in DPS facilities that promote the spread of COVID-19[; and]

n. In accordance with CDC guidelines, ensure that medical isolation of inmates with COVID-19 is distinct from punitive solitary confinement of incarcerated/detained individuals, both in name and in practice. This includes making efforts—where feasible—to provide similar access to radio, TV, reading materials, personal property, and the commissary as would be available in regular housing units.

Id. at 61–64.

Plaintiffs pray for certification of the proposed classes and subclasses, entry of judgment declaring Defendant's practices and actions violated the Constitution, entry of an order requiring Defendant to execute the Proposed Response Plan,

appointment of a special master to oversee the development and implementation of the Proposed Response Plan, and attorneys' fees and costs. *Id.* at 65.

Defendant filed his Opposition and Plaintiffs filed their Reply to the Injunction Motion on June 23 and 25, 2021, respectively. ECF Nos. 22, 26. On June 28, 2021, Defendant filed his Opposition to the Class Certification Motion. ECF No. 28. Plaintiffs filed their Reply on July 1, 2021. ECF No. 29.

The Court held a hearing on the Injunction Motion and Class Certification Motion on July 8, 2021. ECF No. 35.

LEGAL STANDARDS

I. Class Certification

Provisional class certification may be granted for the purposes of preliminary injunction proceedings. *See Al Otro Lado v. Wolf*, 952 F.3d 999, 1005 n.4 (9th Cir. 2020) (citation omitted). "Class actions are 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Olean Wholesale Grocery Coop., Inc. v. Bumble Bee Foods LLC*, 993 F.3d 774, 784 (9th Cir. 2021) (quoting *Comcast Corp. v. Behrend*, 569 U.S. 27, 33 (2013)). As such, Federal Rule of Civil Procedure ("FRCP") 23 "imposes 'stringent requirements' for class certification." *Id.* (quoting *Am. Express Co. v. Italian Colors Rest.*, 570 U.S. 228, 234 (2013)). "The party seeking class certification has the burden of affirmatively demonstrating that the class meets the

requirements of Federal Rule of Civil Procedure 23." *Mazza v. Am. Honda Motor Co.*, 666 F.3d 581, 588 (9th Cir. 2012) (citation omitted). "[T]he failure of any one of Rule 23's requirements destroys the alleged class action." *Rutledge v. Elec. Hose & Rubber Co.*, 511 F.2d 668, 673 (9th Cir. 1975) (citation omitted). A party requesting class certification must *first* satisfy FRCP 23(a)'s numerosity, commonality, typicality, and adequacy of representation requirements.[5] *See Olean*, 993 F.3d at 784 (citing *Leyva v. Medline Indus.*, 716 F.3d 510, 512 (9th Cir. 2013); Fed. R. Civ. P. 23(a)).

If all four of these prerequisites are met, Plaintiffs must then "satisfy through evidentiary proof at least one of the provisions of Rule 23(b)." *Comcast*, 569 U.S. at 33. Pertinent here, the Court can certify an FRCP 23(b)(2) class if "the party

---

[5] FRCP 23(a) provides:

> One or more members of a class may sue or be sued as representative parties on behalf of all members only if:
>
> (1) the class is so numerous that joinder of all members is impracticable;
>
> (2) there are questions of law or fact common to the class;
>
> (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
>
> (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a).

opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2).

"When considering whether to certify a class, it is imperative that district courts 'take a close look at whether common questions predominate over individual ones'" and "perform a 'rigorous analysis' to determine whether this exacting burden has been met before certifying a class." *Olean*, 993 F.3d at 784 (citations omitted). "Courts must resolve all factual and legal disputes relevant to class certification, even if doing so overlaps with the merits." *Id.* (citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 351 (2011)). However, "Rule 23 grants courts no license to engage in free-ranging merits inquiries at the certification stage." *Amgen Inc. v. Conn. Ret. Plans & Tr. Funds*, 568 U.S. 455, 466 (2013). Such inquiries "may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied." *Id.* (citations omitted).

II. Temporary Restraining Order/Preliminary Injunction

The standards governing temporary restraining orders ("TRO") and preliminary injunctions are "substantially identical." *Washington v. Trump*, 847 F.3d 1151, 1159 n.3 (9th Cir. 2017) (citation omitted); *see Kaiser Found. Health*

Plan, Inc. v. Queen's Med. Ctr., Inc., 423 F. Supp. 3d 947, 951 n.1 (D. Haw. 2019).

FRCP 65(a) allows courts to issue preliminary injunctions. "[The] purpose of a preliminary injunction . . . is to preserve the status quo and the rights of the parties until a final judgment issues in the cause." *Ramos v. Wolf*, 975 F.3d 872, 887 (9th Cir. 2020) (alterations in original) (internal quotation marks and citation omitted).

To obtain preliminary injunctive relief, a plaintiff must establish: (1) a likelihood of success on the merits, (2) a likelihood of irreparable harm in the absence of preliminary relief, (3) the balance of equities tips in favor of the plaintiff, and (4) an injunction is in the public interest. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (citations omitted). Where, as here, the government is a party, the last two factors merge. *See Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014).

Mandatory injunctions ordering affirmative action by a defendant, go "well beyond simply maintaining the status quo . . . [and are] particularly disfavored." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009) (quoting *Anderson v. United States*, 612 F.2d 1112, 1114 (9th Cir.

1979), *as amended* (1980)).[6] Mandatory injunctions, are "subject to a higher standard than prohibitory injunctions," but "are permissible when 'extreme or very serious damage will result' that is not 'capable of compensation in damages,' and the merits of the case are not 'doubtful.'" *Hernandez v. Sessions*, 872 F.3d 976, 999 (9th Cir. 2017) (citation omitted). "The court's finding of a strong likelihood that plaintiffs would succeed on the merits of their claims also evidences a conclusion that the law and facts clearly favor plaintiffs, meeting the requirement for issuance of a mandatory preliminary injunction." *Katie A., ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1157 (9th Cir. 2007) (citation omitted).

District courts should exercise caution in issuing injunctive orders and avoid becoming "enmeshed in the minutiae of prison operations." *Farmer v. Brennan*, 511 U.S. 825, 846–47 (1994) (quoting *Bell v. Wolfish*, 441 U.S. 520, 562 (1979)). Where appropriate, courts may exercise their discretion "by giving prison officials time to rectify the situation before issuing an injunction." *Id.* at 847.

DISCUSSION

I. Class Certification

Plaintiffs request provisional certification of their proposed classes and subclasses for the purposes of their requested preliminary injunctive relief and ask

[6] In contrast, a "prohibitory injunction prohibits a party from taking action and 'preserves the status quo pending a determination of the action on the merits.'" *Marlyn Nutraceuticals*, 571 F.3d at 878–79 (brackets and citations omitted).

that they be appointed as class representative and that their counsel be appointed as class counsel. ECF No. 20-1 at 7, 8. They argue that class certification is appropriate because they satisfy the requirements set forth in FRCP 23(a) and 23(b)(2). *Id.* at 13. Defendant challenges certification for lack of commonality and typicality,[7] and he also contends that certification pursuant to FRCP 23(b)(2) is inappropriate.[8] ECF No. 28 at 10, 15–16. The Court begins with FRCP 23(a)'s prerequisites.

A. FRCP 23(a)

1. Numerosity

Numerosity is satisfied if "the class is so numerous that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). This requirement mandates an "examination of the specific facts of each case and imposes no absolute

[7] Defendant does not oppose numerosity or commonality at this time but reserves the right to do so in response to any future motion for class certification. ECF No. 28 at 10 n.2.

[8] Defendant further argues that the Class Certification Motion should be denied because the Injunction Motion is tethered to the FAC and is therefore moot. ECF No. 28 at 7 n.1. But it is unclear how the mooting of the Injunction Motion would necessitate denial of the Class Certification Motion, which was filed *after* the SAC to correspond with the allegations in the SAC. ECF No. 13 ("Plaintiffs are directed to file their motion for provisional class certification after filing their second amended complaint to ensure that the request pertains to the operative pleading."); ECF No. 12. Although class certification is sought concurrently with the Injunction Motion to obtain class-wide relief, class certification can be decided independently of the present request for injunctive relief.

limitations." *Gen. Tel. Co. of the Nw. v. EEOC*, 446 U.S. 318, 330 (1980). "[A]s a general rule, classes of 20 are too small, classes of 20–40 may or may not be big enough depending on the circumstances of each case, and classes of 40 or more are numerous enough." *Handloser v. HCL Techs. Ltd.*, Case No. 19-CV-01242-LHK, 2021 WL 879802, at *5 (N.D. Cal. Mar. 9, 2021) (internal quotation marks and citation omitted).

This requirement — uncontested by Defendant — is easily satisfied, as there are nearly 3,000 residents housed at DPS facilities, *see* ECF No. 20-1 at 14, and the joinder of these class members would be impracticable. Plaintiffs have therefore satisfied the numerosity requirement.

2. Commonality

Commonality ensures that "there are questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). FRCP 23(a)(2) is permissively construed. *See Staton v. Boeing Co.*, 327 F.3d 938, 953 (9th Cir. 2003) (quoting *Hanlon v. Chrysler Corp.*, 150 F.3d 1011, 1019 (9th Cir. 1998), *overruled on other grounds by Wal-Mart*, 564 U.S. 338). It requires class members' claims to "'depend upon a common contention' and that the 'common contention, moreover, must be of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.'" *Vaquero v. Ashley Furniture Indus., Inc.*, 824 F.3d

1150, 1153 (9th Cir. 2016) (quoting *Wal-Mart*, 564 U.S. at 350). Critical to certification "is not the raising of common questions—even in droves—but rather, the capacity of a class-wide proceeding to generate common *answers* apt to drive the resolution of the litigation." *Wal-Mart*, 564 U.S. at 350 (internal quotation marks and citation omitted). "The existence of shared legal issues with divergent factual predicates is sufficient[.]" *Staton*, 327 F.3d at 953 (internal quotation marks and citation omitted). Therefore, "[s]o long as there is 'even a single common question,' a would-be class can satisfy the commonality requirement of Rule 23(a)(2)." *Parsons v. Ryan*, 754 F.3d 657, 675 (9th Cir. 2014) (some internal quotation marks and citations omitted).

Defendant challenges commonality on the basis that Plaintiffs are subject to different policies applicable at their respective facilities and that their allegations regarding a failure to implement policies will require fact-intensive inquiries.[9] ECF No. 28 at 12–14. Plaintiffs acknowledge that they have different custody

[9] To support this argument, Defendant submits declarations from the warden at each DPS facility. Ironically, the wardens' declarations reflect the adoption of nearly identical policies across facilities. ECF Nos. 28-2 to 28-9 (taking the pandemic seriously; educating inmates and staff about COVID-19, vaccinations, sanitation, and hygiene; implementing enhanced cleaning schedule, social distancing measures; suspending family and friend visitations; screening for COVID-19 upon admission; identifying housing units for quarantine and medical isolation; providing cloth masks, encouraging mask wearing for inmates, and requiring mask wearing for staff; maintaining adequate supply of PPE; testing protocols for COVID-19; and offering COVID-19 testing and vaccines at intake).

statuses and are housed at multiple facilities with differing policies. ECF No. 20-1 at 18. But they argue that commonality is nevertheless satisfied because they share a common set of facts and core questions of law: (1) they are confined at DPS correctional facilities and are therefore subject to the same policies, procedures, and customs that resulted in more than 1,500 inmates/detainees contracting COVID-19; (2) they are unable to adhere to social distancing practices, per the instruction of public health officials, due to the common conditions of confinement provided by DPS; (3) they are subject to the same conditions that actively promote the spread of COVID-19; (4) whether conditions at DPS facilities create a substantial risk that those in custody will be infected with COVID-19; (5) whether conditions at DPS facilities create a substantial risk that those infected with COVID-19 will face serious illness, long-term physical damage, or death; (6) did Defendant know, or should he have known, of this risk; and (7) is Defendant acting with deliberate indifference of this risk. *Id.* at 20–21.

Central to this lawsuit is Defendant's alleged failure to comply with its Response Plan, and the resulting harm to DPS inmates/detainees. "[N]umerous courts have concluded that the commonality requirement can be satisfied by proof of the existence of systemic policies and practices that allegedly expose inmates to a substantial risk of harm." *See Parsons*, 754 F.3d at 681 (citations omitted). The infrastructure or population variations among the DPS correctional facilities are of

no consequence where, as here, there are many questions of fact and law common to the class that are capable of class-wide resolution. *See id.* at 678 ("The putative class and subclass members thus all set forth numerous common contentions whose truth or falsity can be determined in one stroke: whether the specified statewide policies and practices to which they are all subjected by ADC expose them to a substantial risk of harm." (citation omitted)). Consequently, the Court concludes that Plaintiffs satisfy FRCP 23(a)(2).

3. Typicality

Typicality requires "the claims or defenses of the representative parties [to be] typical of the claims or defenses of the class." Fed. R. Civ. P. 23(a)(3). "The purpose of the typicality requirement is to assure that the interest of the named representative aligns with the interests of the class." *Wolin v. Jaguar Land Rover N. Am., LLC*, 617 F.3d 1168, 1175 (9th Cir. 2010) (internal quotation marks and citation omitted). Typicality is a permissive requirement so representative claims need not be substantially identical; they are "typical" as long as "they are reasonably coextensive with those of absent class members." *Just Film, Inc. v. Buono*, 847 F.3d 1108, 1116 (9th Cir. 2017) (internal quotation marks and citation omitted). "Measures of typicality include 'whether other members have the same or similar injury, whether the action is based on conduct which is not unique to the

named plaintiffs, and whether other class members have been injured by the same course of conduct.'" *Id.* (some internal quotation marks and citation omitted).

Plaintiffs argue that they satisfy this requirement because their claims are typical of the classes and subclasses they represent; they are individuals incarcerated or detained at DPS facilities who face a substantial risk of contracting COVID-19 if measures are not immediately implemented and their claims concern Defendant's alleged failure to effectuate adequate health measures in response to COVID-19. ECF No. 20-1 at 22. Defendant counters that Plaintiffs have also failed to demonstrate typicality because DPS operates multiple facilities across four islands, each managed by its own warden, with different physical configurations, housing styles, classes and types of inmates, and capacity levels. ECF No. 28 at 14. In short, Defendant contends that Plaintiffs cannot satisfy typicality because they "are not subject to the same confinement under the same allegedly unconstitutional conditions caused by the same entity." *Id.* at 15. The Court is not persuaded.

Defendant fails to apply the relevant standard. Typicality merely requires that representative claims are reasonably coextensive with absent class members' claims, which they are here. Considering the relevant measures — whether other class members have experienced the same or similar injury, whether the alleged conduct is not unique to the named plaintiffs, and whether other class members

have suffered injury as a result of the same course of conduct — Plaintiffs satisfy typicality. The unnamed class members have experienced the same or similar injuries by the same alleged course of conduct. Defendant's alleged failure to implement and follow COVID-19 procedures has resulted in outbreaks within the facilities and a substantial risk of contracting COVID-19. That is, Plaintiffs' injuries "arose 'from the same event or practice or course of conduct that gave rise to the claims of other class members and his claims were based on the same legal theory.'" *Ramirez v. TransUnion LLC*, 951 F.3d 1008, 1033 (9th Cir. 2020) (brackets and citations omitted), *rev'd on other grounds*, No. 20-297, 594 U.S. __, 141 S. Ct. 2190 (2021). Thus, Plaintiffs satisfy the typicality requirement.

4. Adequacy of Representation

FRCP 23(a)(4) requires "the representative parties [to] fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). The Court must "carefully scrutinize the adequacy of representation in all class actions." *Rutledge*, 511 F.2d at 673 (internal quotation marks and citation omitted); *see also Daly v. Harris*, 209 F.R.D. 180, 196 (D. Haw. 2002) (citing *id.*). The purpose of the adequacy of representation requirement is to ensure that absent class members are "afforded adequate representation before entry of a judgment which binds them." *Hanlon*, 150 F.3d at 1020 (citation omitted). Two inquiries determine whether representation will be fair and adequate: (1) whether "the named plaintiffs and

their counsel have any conflicts of interest with other class members" and (2) whether "the named plaintiffs and their counsel prosecute the action vigorously on behalf of the class." *Id.* (citation omitted).

Plaintiffs submit that they do not have any conflicts with the unnamed class members, they share a common interest in receiving adequate protection against COVID-19, the requested relief would benefit all class members equally, and they will vigorously prosecute the interests of the class through qualified counsel. ECF No. 20-1 at 23. Plaintiffs also argue that their counsel have extensive experience litigating complex class actions and civil rights litigation, including cases regarding unconstitutional corrections systems, and will zealously advocate on behalf of Plaintiffs and the class members. *Id.* at 23–24. In his Opposition, Defendant did not refute Plaintiffs' or counsel's ability to adequately represent the classes. The Court concludes that Plaintiffs and their counsel do not have conflicts with other class members and that they will vigorously prosecute the classes' interests, as they have to date.

Because Plaintiffs have satisfied FRCP 23(a)'s prerequisites, the Court now turns to FRCP 23(b)(2).

B. FRCP 23(b)(2)

Plaintiffs request certification of an injunctive relief class. FRCP 23(b)(2) authorizes a court to certify an injunctive relief class when "the party opposing the

class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). "[O]nly where the primary relief sought is declaratory or injunctive" is class certification appropriate under FRCP 23(b)(2). *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 986 (9th Cir. 2011) (internal quotation marks and citation omitted). "The key to the (b)(2) class is 'the indivisible nature of the injunctive or declaratory remedy warranted—the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them.'" *Wal-Mart*, 564 U.S. at 360 (citation omitted). Plaintiffs can satisfy FRCP 23(b)(2) if "class members complain of a pattern or practice that is generally applicable to the class as a whole." *Rodriguez v. Hayes*, 591 F.3d 1105, 1125 (9th Cir. 2010) (internal quotation marks and citations omitted).

Plaintiffs argue that certification of FRCP 23(b)(2) classes is appropriate because they request the same uniform relief due to DPS's failure to mitigate the spread of COVID-19 in its facilities and an injunction would accord the same relief to all class members. ECF No. 20-1 at 25. Defendant contends that the requested injunctive relief is not amenable to certification under FRCP 23(b)(2) due to the variation in the implementation between facilities of DPS's otherwise uniform

Response Plan, attributable to the facilities' configurations, security levels, and populations. ECF No. 28 at 16.

Here, Plaintiffs challenge the conditions of their confinement under the Eighth and Fourteenth Amendments and Defendant's failure to mitigate the spread of COVID-19 in DPS facilities. They seek injunctive relief requiring Defendant to implement protocols and adhere to procedures to prevent COVID-19 transmission. ECF No. 14-1 at 2–4. This relief conforms with FRCP 23(b)(2). *See Parsons*, 754 F.3d at 688–89. Contrary to Defendant's assertion that an injunctive class cannot be certified because of the differences between facilities, the class members are allegedly suffering the same or similar injury that can be alleviated for all by uniform changes in and/or adherence to DPS policies and practices statewide. *See id.* at 689 (citations omitted). Accordingly, Plaintiffs have satisfied FRCP 23(b)(2).

C. Breadth of Class Definitions

Defendant also argues that Plaintiffs' class definitions are overbroad because other cases certifying classes did not involve classes of inmates at all correctional facilities within a given state, and the classes should not include vaccinated inmates or those who recovered from COVID-19. ECF No. 28 at 16–19. These arguments are without merit.

Defendant's effort to draw a distinction based on geographic proximity or number of facilities affected is misplaced and disregards pertinent facts, such as class size and the impracticability of joinder when class members are geographically separated across counties. In fact, the cases relied upon by Defendant, *see* ECF No. 28 at 17, support certification here. *See*, *e.g.*, *Roman v. Wolf*, ED CV 20-00768 TJH (PVCx), 2020 WL 3869729, at *2, *4 (C.D. Cal. Apr. 23, 2020) (provisionally certifying class covering 1,370 detainees at Adelanto Immigration and Customs Enforcement Processing Center); *Ahlman v. Barnes*, 445 F. Supp. 3d 671, 684–85 (C.D. Cal. 2020) ("*Ahlman I*") (noting that there are 3,047 individuals incarcerated at the Orange County Jail and estimating that "both the Pre-Trial and Post-Conviction classes likely have over 1,000 individuals" and "about 1,200 inmates will be members of the Disability Subclass and at least 1,200 will be members of the Medically-Vulnerable Subclass"); *Gayle v. Meade*, __ F. Supp. 3d __, 2020 WL 3041326, at *13 (S.D. Fla. June 6, 2020) ("*Gayle I*") ("Petitioners are filing on behalf of a putative class of approximately 1400 individuals. In addition to the large number of members here, the class is also geographically dispersed across different counties in South Florida—detainees are being held in three ICE detention centers. The size and geographical diversity of the class renders joinder of all members impracticable." (citation omitted)).

Class certification in these cases did not turn on the number of facilities affected, nor did they prohibit certification of a classes implicating all facilities within a state. The number of inmates affected here is similar to classes certified by other courts, whether at one facility or multiple facilities. Moreover, the geographic separation across multiple islands, coupled with the inmates' frequent transfer between facilities, demonstrate that joinder is particularly impractical.[10] The class definitions in other cases where certification was granted were also equally as broad as Plaintiffs' proposed definitions. *See Roman v. Wolf*, 977 F.3d 935, 944 (9th Cir. 2020) ("We further hold that the district court did not err by provisionally certifying a class of all Adelanto detainees. The alleged due process violations exposed *all* Adelanto detainees to an unnecessary risk of harm, not only those who are uniquely vulnerable to COVID-19 or who are not subject to mandatory detention."); *Criswell v. Boudreaux*, No. 1:20-cv-01048-DAD-SAB, 2020 WL 5235675, at *5, *12, *15 (E.D. Cal. Sept. 2, 2020) (provisionally certifying a class of "all people who are now, or in the future will be, incarcerated in Tulare County Jails," with approximately 1,086 people then incarcerated at three facilities); *Parsons*, 754 F.3d at 678 (affirming a "class of 'all prisoners who are

[10] *See Gayle I*, 2020 WL 3041326, at *13 (identifying "geographic diversity of the class members" as one of the factors to consider in deciding "whether joinder of all members is practicable in view of the numerosity of the class").

now, or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the ADC'"").

The Court already rejected Defendant's argument that the differences between facilities precludes certification and is again unpersuaded by Defendant's contention that these differences render the class definitions unworkable. Regardless of the facilities' distinctions, *all* class members would obtain relief from the issuance of the proposed injunction. *See Parsons*, 754 F.3d at 689 ("[C]onsidering the nature and contours of the relief sought by the plaintiffs, the district court did not abuse its discretion in concluding that a single injunction and declaratory judgment could provide relief to each member of the proposed class and subclass." (footnote omitted)).

The Court also declines to exclude vaccinated inmates and those who previously contracted COVID-19 from the proposed classes and subclasses.[11] Medical and scientific data continue to evolve, with conflicting information about the length of protective immunity following COVID-19 infection and the efficacy

[11] The Response Plan treats vaccinated individuals the same as unvaccinated individuals for the purposes of quarantine following exposure to someone with suspected or confirmed COVID-19, citing the "turnover of inmates, higher risk of transmission, and challenges in maintaining recommended physical distancing in correctional settings[.]" ECF No. 22-12 at 45. This undercuts Defendant's request to exclude vaccinated inmates.

of vaccines against the new variants.[12] For the purposes of provisional class certification and preliminary injunctive relief, the Court certifies the classes proposed by Plaintiffs. If circumstances change during the course of litigation, the parties may request modification of the class definitions.

Having met FRCP 23(a)'s and 23(b)(2)'s requirements, Plaintiffs are entitled to provisional class certification.

II. TRO/Preliminary Injunction[13]

A. *Winter* Factors

The Court now turns to the *Winter* factors to determine whether Plaintiffs are entitled to a preliminary injunction. Plaintiffs urge the Court to review their requested injunction as prohibitory, not mandatory, because they are requesting maintenance of the status quo, defined by Defendant as DPS facilities

[12] To illustrate, at least one Plaintiff contracted COVID-19 post vaccination. ECF No. 26-10 ("Mobley Decl.") ¶¶ 3, 15.

[13] Defendant's supposition that the Injunction Motion was mooted by the filing of the SAC, asserted for the first time in opposition to the Class Certification Motion, ECF No. 28 at 7 n.1, is unavailing. In assessing the Injunction Motion, the Court evaluates the causes of action and relief requested in the SAC, which are substantially similar to the FAC. So Defendant's reliance on *Lacey v. Maricopa County*, 693 F.3d 896 (9th Cir. 2012) (en banc), is misdirected. Given the expedited nature of the request, judicial economy would not be served by ordering Plaintiffs to file a renewed Injunction Motion, especially when Defendant submitted his opposition *after* Plaintiffs filed the SAC and had an opportunity to challenge a preliminary injunction based on the allegations therein.

implementing the Response Plan. ECF No. 26-1 at 11–12. Insofar as Plaintiffs claim that DPS is not complying with its Response Plan, and they request the appointment of a special master to develop and implement their Proposed Response Plan, they arguably seek a mandatory injunction, *i.e.*, an order requiring Defendant to take certain action. *See Marlyn Nutraceuticals*, 571 F.3d at 879 (citation omitted). Even though DPS claims it is compliant, the problematic conditions identified by Plaintiff would not change if the status quo is merely maintained, and Plaintiffs would not obtain the relief they desire. *See Hernandez*, 872 F.3d at 999 ("Mandatory injunctions are most likely to be appropriate when 'the status quo . . . is exactly what will inflict the irreparable injury upon complainant.'" (alteration in original) (citation omitted)). Assuming without deciding that the requested injunction is mandatory, Plaintiffs meet the corresponding stringent standard for the reasons discussed below.[14] And because

[14] The Ninth Circuit recognizes that its "approach to preliminary injunctions, with separate standards for prohibitory and mandatory injunctions, is controversial," and has faced widespread criticism. *Hernandez*, 872 F.3d at 997. Other district courts in the Ninth Circuit that addressed similar requests for preliminary injunctive relief have applied the heighted mandatory injunction standard. *See*, *e.g.*, *Maney v. Brown*, Case No. 6:20-cv-00570-SB, __ F.3d __, 2021 WL 354384, at *10–16 (D. Or. Feb. 2, 2021) ("*Maney II*"); *Alcantara v. Archambeault*, No. 20cv0756 DMS (AHG), __ F.3d __, 2020 WL 2315777, at *7 n.5 (S.D. Cal. May 1, 2020); *Doe v. Barr*, Case No. 20-cv-02263-RMI, 2020 WL 1984266, at *3–6 (N.D. Cal. Apr. 27, 2020).

they satisfy this standard, they would easily meet the more lenient "sliding scale" standard also employed by the Ninth Circuit.[15]

1. Likelihood of Success on the Merits[16]

Plaintiffs contend that they are likely to succeed on their claims because the harm from COVID-19 is sufficiently serious and DPS recognizes the seriousness, but it nevertheless continues to violate its own policies. ECF No. 6-1 at 21–28. Defendant argues that Plaintiffs have not shown a likelihood of success on the merits or that there are serious questions going to the merits because he has proactively adopted and implemented measures to prevent and control the spread of COVID-19 in DPS facilities. ECF No. 22 at 29.

a. Deliberate Indifference

Plaintiffs challenge the conditions of their confinement under the Eighth and

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[15] Under the "sliding scale" approach to preliminary injunctions, "the elements of the preliminary injunction test are balanced, so that a stronger showing of one element may offset a weaker showing of another." *All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011). The issuance of a preliminary injunction may be appropriate when there are "'serious questions going to the merits' and a balance of hardships that tips sharply towards the plaintiff . . . so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Id.* at 1135.

[16] Defendant does not challenge Plaintiffs' exhaustion of administrative remedies under the Prison Litigation Reform Act ("PLRA"). *See* 42 U.S.C. § 1997e(a).

Fourteenth Amendments. "Inmates who sue prison officials for injuries suffered while in custody may do so under the Eighth Amendment's Cruel and Unusual Punishment Clause or," in the case of pretrial detainees, "under the Fourteenth Amendment's Due Process Clause." *Castro v. County of Los Angeles*, 833 F.3d 1060, 1067–68 (9th Cir. 2016) (citation omitted). The Eighth Amendment imposes duties on prison officials, "who must provide humane conditions of confinement" such as "ensur[ing] that inmates receive adequate food, clothing, shelter, and medical care" and "tak[ing] reasonable measures to guarantee the safety of the inmates[.]" *Farmer*, 511 U.S. at 832–33 (internal quotation marks and citations omitted). "[P]retrial detainees (unlike convicted prisoners) cannot be punished at all, much less 'maliciously and sadistically.'" *Kingsley v. Hendrickson*, 576 U.S. 389, 400 (2015) (citations omitted).

Both clauses require a plaintiff to "show that the prison officials acted with 'deliberate indifference.'" *Castro*, 833 F.3d at 1068. Deliberate indifference requires a showing that "prison officials were aware of a 'substantial risk of serious harm' to an inmate's health or safety" and that there was no "'reasonable' justification for the deprivation, in spite of that risk." *Thomas v. Ponder*, 611 F.3d 1144, 1150 (9th Cir. 2010) (quoting *Farmer*, 511 U.S. at 837, 844) (footnotes omitted). This requires a state of mind derived from criminal recklessness; that is, "the official must both be aware of facts from which the inference could be drawn

that a substantial risk of serious harm exists, and he must also draw the inference." *Farmer*, 511 U.S. at 837; *see also Clem v. Lomeli*, 566 F.3d 1177, 1181 (9th Cir. 2009).

To succeed on an Eighth Amendment claim, a plaintiff must "'objectively show that he was deprived of something "sufficiently serious," and 'make a subjective showing that the deprivation occurred with deliberate indifference to the inmate's health or safety.'" *Thomas*, 611 F.3d at 1150 (quoting *Foster v. Runnels*, 554 F.3d 807, 812 (9th Cir. 2009)). Establishing a Fourteenth Amendment violation is less burdensome as a plaintiff need only a show objective deliberate indifference, not subjective deliberate indifference. *See Gordon v. County of Orange*, 888 F.3d 1118, 1124–25 (9th Cir. 2018).

i. Objective Deliberate Indifference

The Ninth Circuit applies the following test in evaluating objective deliberate indifference:

> (i) the defendant made an intentional decision with respect to the conditions under which the plaintiff was confined; (ii) those conditions put the plaintiff at substantial risk of suffering serious harm; (iii) the defendant did not take reasonable available measures to abate that risk, even though a reasonable official in the circumstances would have appreciated the high degree of risk involved—making the consequences of the defendant's conduct obvious; and (iv) by not taking such measures, the defendant caused the plaintiff's injuries.

Id. at 1125. The third element requires the defendant's conduct to be objectively unreasonable, which turns on the facts and circumstances of each case. *See id.* (citation omitted). An individual is not deprived of life, liberty, or property under the Fourteenth Amendment based on a "mere lack of due care by a state official." *Id.* (internal quotation marks and citation omitted). Consequently, a plaintiff "must 'prove more than negligence but less than subjective intent—something akin to reckless disregard.'" *Id.* (footnote and citation omitted). This standard dispenses of the need to prove "subjective elements about the officer's actual awareness of the level of risk." *Id.* n.4. (citation omitted). Applying this standard, Plaintiffs have shown a strong likelihood of success on their Fourteenth Amendment claim and the objective prong of their Eighth Amendment claim.

At this point in the pandemic, the seriousness and transmissibility of COVID-19 is well established, and it has proven uniquely problematic for prisons and other detention facilities. DPS is no exception, having experienced outbreaks at more than half of its facilities and inmate COVID-19 infections exceeding 50%. If the conditions described in the declarations submitted by Plaintiffs continue, the risk of harm to all inmates is undeniable. The Court therefore focuses on whether Defendant has done or is doing enough to reasonably keep inmates healthy and safe.

The parties offer somewhat differing accounts of the conditions at DPS facilities.[17] Defendant submits declarations from each DPS facility's warden – Cramer Mahoe ("Mahoe"), Scott Harrington ("Harrington"), Sean Ornellas ("Ornellas"), Wanda Craig ("Craig"), Eric Tanaka ("Tanaka"), Deborah Taylor ("Taylor"), Francis Sequeira ("Sequeira"), and Neal Wagatsuma ("Wagatsuma"); the Deputy Director for DPS's Corrections Division – Tommy Johnson ("Johnson"); DPS's Corrections Health Care Administrator – Gavin Takenaka ("Takenaka"); and an Advanced Practice Registered Nurse and Section Health Care Administrator for HCCC – Stephanie Higa ("Higa"), that uniformly recite provisions from the Response Plan, while Plaintiffs share personal reports from inmates *and DPS staff* at different facilities. In other words, Defendant conveys what *should* happen at DPS facilities and Plaintiffs reveal what *is* occurring or has occurred at the facilities.

The wardens' declarations contain boilerplate language indicating that their facilities have adopted the same or substantially similar policies, which are also

[17] At the hearing, defense counsel argued that Plaintiffs failed to submit any declarations concerning KCCC and WCCC and that those facilities would therefore inappropriately be subject to an injunction. The Court is unconvinced. Inmates are frequently moved between facilities, so outbreaks are a system-wide concern. KCCC and WCCC should not be exempt from the injunction, as the injunction would order relief contemplated by the Response Plan, and all facilities are subject to the Response Plan.

consistent with the general DPS policies identified by Johnson, Takenaka, and Higa. *See* ECF Nos. 22-1 ("Takenaka Decl."); 22-2 ("Johnson Decl."); 22-3 ("Mahoe Decl."); 22-4 ("Harrington Decl."); 22-5 ("Ornellas Decl."); 22-6 ("Craig Decl."); 22-7 ("Tanaka Decl."); 22-8 ("Taylor Decl."); 22-9 ("Sequeira Decl."); 22-10 ("Wagatsuma Decl."); 22-11 ("Higa Decl."). But the mere existence of policies is of little value if implementation and compliance are lacking.

The declarations Plaintiffs submitted offer on-the-ground descriptions of what is actually happening at the facilities. And the reality is that the inmates have no motivation to fabricate (they are not seeking release nor money damages), while DPS staff have a *disincentive* to raise these issues concerning their employer in such a public forum. Therefore, the Court finds credible the declarations Plaintiffs submitted. This is not to say that the declarations supplied by Defendant are incredible; rather, as detailed below, the declarations Plaintiffs submitted were more compelling due to their specificity and direct perspective.

In a nutshell, Defendant defends his COVID-19 response by claiming that DPS has proactively and vigilantly addressed COVID-19, beginning with the adoption of a department-wide Response Plan on March 23, 2020 — consistent with CDC guidelines that has been updated to reflect evolving CDC guidance — and a pandemic response plan tailored to each DPS facility, based on space, unique challenges, and population and staff needs. ECF No. 22 at 14–15; Johnson Decl.

¶¶ 8–9. According to Defendant, the following measures have been implemented at DPS facilities: screening, quarantine and medical isolation, medical care, sanitation and hygiene, social distancing, personal protective equipment ("PPE"), education and information, testing, and vaccination. ECF No. 22 at 15–20.

Screening and Testing: Defendant claims that all facilities have screening procedures for inmates, staff, and visitors — new inmates are screened by medical staff for COVID-19 symptoms and risk factors while staff, visitors, volunteers, and vendors are screened for symptoms through surveys and temperature checks prior to entry. ECF No. 22 at 16; Takenaka Decl. ¶¶ 15–16; Johnson Decl. ¶¶ 13–14; Harrington Decl. ¶ 15; Ornellas Decl. ¶¶ 8–9; Craig Decl. ¶ 8; Tanaka Decl. ¶ 13; Taylor Decl. ¶ 12; Sequeira Decl. ¶ 13; Wagatsuma Decl. ¶ 12; Higa Decl. ¶ 9. At HCCC, existing inmates are also supposedly screened through self-reporting, temperature and symptom checks for those in quarantine units, medical assessments for older inmates and those with certain medical conditions, and upon departure and return to the facility. Higa Decl. ¶¶ 10–12.

Defendant also represents that COVID testing is continuously conducted at all DPS facilities and that DPS performs diagnostic and screening testing and has expanded non-exposure asymptomatic screening testing to: (1) broad-based testing; (2) new admission and day 14 routine intake quarantine testing; (3) pre-medical procedure testing; (4) pre-release testing for inmates entering community

programs; (5) pre-flight testing for inmates transferred to another facility; and (6) surveillance testing of randomly selected inmates. Takenaka Decl. ¶¶ 19–20, 25.

Plaintiffs paint a different picture, providing declarations from inmates and staff averring that not all new inmates are screened or tested for COVID-19, nor are all inmates tested before transferring to another facility. ECF No. 6-4 (Decl. of Lisa O. Jobes ("Jobes Decl.")) ¶ 6.g; ECF No. 6-6 (Decl. of Ryan Tabar ("Tabar Decl.")) ¶ 6.b; ECF No. 6-7 (Decl. of Marie Ahuna ("Ahuna Decl.")) ¶ 5.f; ECF No. 6-10 (Decl. of Isaac Nihoa ("Nihoa Decl.")) ¶ 11; ECF No. 6-13 ("Alvarado Decl. I") ¶¶ 10–11; ECF No. 6-15 (Decl. of Dustin Snedeker-Abadilla ("Snedeker-Abadilla Decl. I")) ¶ 6; ECF No. 26-7 (Decl. of William Napeahi ("Napeahi Decl.")) ¶ 9; ECF No. 26-8 (Decl. of Pokahea Lipe ("Lipe Decl.")) ¶ 6; ECF No. 26-16 (Decl. of Todd Bertilacci ("Bertilacci Decl.")) ¶ 8; ECF No. 26-17 ("Snedeker-Abadilla Decl. II") ¶¶ 7–9. Mahoe, HCCC's Warden, admits that inmates are not tested upon arrival and are placed in a holding area separated by chain-link fences — dubbed the "dog cages" — to be later screened by healthcare staff.[18] Mahoe Decl. ¶¶ 11–13.

[18] The Court is troubled by the allegation that the HCCC administration fails to inform staff when COVID-positive inmates are in close proximity. Rosete-Arellano Decl. ¶ 12 (learning from DPS guards that COVID-positive inmates were being held in the dog cages and in the hallway); Jobes Decl. ¶ 9 (learning from a detainee in the dog cages that other detainees in the dog cages had COVID-19); Nihoa Decl. ¶ 4 (learning from the inmates he was supervising that they had

(continued . . .)

Quarantine and Medical Isolation: Defendant represents that DPS employs medical and isolation strategies to contain and control COVID-19 transmission and that each facility has units designated for quarantine and medical isolation. ECF No. 22 at 16; Harrington Decl. ¶ 16; Ornellas Decl. ¶ 10; Craig Decl. ¶ 10; Tanaka Decl. ¶ 14; Taylor Decl. ¶ 13; Sequeira Decl. ¶ 14; Wagatsuma Decl. ¶ 13; Johnson Decl. ¶¶ 25–26. Defendant also offers the caveat that exceptions are sometimes necessary due to space and security concerns. Johnson Decl. ¶¶ 15, 27.

Plaintiffs describe a "quarantine" process that involves mixing multiple inmates with unknown COVID statuses in the HCCC dog cages, the fishbowl, or a visitor's room, and introducing new inmates into those spaces daily. ECF No. 6-1 at 14–15; Jobes Decl. ¶¶ 6.h–i, 7; Nihoa Decl. ¶ 13; Snedeker-Abadilla Decl. I ¶ 10; Lipe Decl. ¶ 9. This is consistent with Mahoe's admission that HCCC frequently lacks the physical space to completely quarantine new inmates for ten days and instead places them in the fishbowl, a multi-purpose room, to monitor them for COVID-19 symptoms and to separate them from the inmate population. Mahoe Decl. ¶ 16. And while all incoming inmates are purportedly screened for COVID-19 symptoms and exposure upon arrival at the facilities, *see* Takenaka

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COVID-19 and testing positive for COVID-19 a few days later). While DPS staff are not parties to this action and the Court is not factoring this into Plaintiffs' likelihood of success, the alleged lack of notification illustrates another symptom of the indifference.

Decl. ¶ 16, at the hearing, Defendant's counsel admitted that the intake process at HCCC — which precedes any testing and involves the housing of numerous inmates in confined spaces — can take several hours.

Plaintiffs also report multiple instances of DPS mixing COVID-positive and/or symptomatic inmates with COVID-negative inmates, which resulted in clusters of COVID-19 infections at different facilities. ECF No. 6-1 at 13–14; ECF No. 26-6 ("Deguair Decl.") ¶¶ 7, 9, 13; Napeahi Decl. ¶¶ 6–8, 11–12, 15–21, 25; Lipe Decl. ¶¶ 16–20, 29–30; ECF No. 26-9 ("Chatman Decl.") ¶ 6; ECF No. 26-10 ("Mobley Decl.") ¶¶ 8–11, 15–16; ECF No. 26-11 (Decl. of Tyson Olivera-Wamar ("Olivera-Wamar Decl.")) ¶¶ 7–19; ECF No. 26-12 ("Granados Decl.") ¶¶ 9–10; ECF No. 26-15 (Decl. of Nicholas Hall ("Hall Decl.")) ¶¶ 8–18; Bertilacci Decl. ¶¶ 9–10, 14–17; ECF No. 6-14 (Decl. of Jeffrey Parent ("Parent Decl.")) ¶ 13.

Living Conditions/Social Distancing: Defendant asserts that DPS has implemented social distancing strategies, adapted for each facility, including limitation of transports and movements, suspension of visitation and certain programs, restructured recreation and meals, bunk rearrangement so inmates sleep head to foot, staggered pill lines, medication administration at modules, and spaced seating in common areas.[19] ECF No. 22 at 17–18; Harrington Decl. ¶¶ 13–14;

[19] Defendant accuses Plaintiffs of failing to submit evidence showing that social distancing is supported by medical evidence, *see* ECF No. 22 at 43, while (continued . . .)

Ornellas Decl. ¶¶ 15–16; Craig Decl. ¶¶ 16–17; Tanaka Decl. ¶¶ 11–12; Taylor Decl. ¶¶ 10–11; Sequeira Decl. ¶¶ 11–12; Wagatsuma Decl. ¶¶ 10–11; Johnson Decl. ¶ 23.

Meanwhile, Plaintiffs describe eating shoulder-to-shoulder in the chow halls and indicate that inmates are regularly packed into small spaces — 40 to 60 inmates in the fishbowl, which measures 31.5 feet by 35.3 feet,[20] where they sleep on thin mats on the floor three to six inches apart; up to seven inmates in the dog cages, which measure five feet by ten feet; up to ten inmates in the visitor's room at HCCC, which is ten feet by twelve feet; 40 to 60 inmates in a 25-foot-by-35-foot room at Waiawa called the "pavilion." Jobes Decl. ¶ 8; Ahuna Decl. ¶ 5.h–i; Tabar Decl. ¶ 7.a; Parent Decl. ¶ 21; Snedeker-Abadilla Decl. I ¶¶ 8, 12. The dog cages, fishbowl, and visitor's room do not have bathrooms or running water, so inmates housed there have restricted access to restrooms and water. Because guards often deny inmates' restroom and water requests, inmates are forced to urinate on

(. . . continued)
simultaneously claiming that DPS facilities are social distancing to the extent possible, submitting declarations from Johnson and the wardens attesting that they have implemented social distancing practices, and emphasizing that an inability to social distance does not amount to deliberate indifference. *See id.* at 39.

[20] *See* Johnson Decl. ¶ 38.

themselves, on walls, or in cups. And constant toilet clogging and overflow in the adjacent restroom causes the fishbowl to smell like urine and feces.[21] Jobes Decl. ¶ 8; Tabar Decl. ¶¶ 7–8; ECF No. 6-8 (Decl. of Erin Loredo ("Loredo Decl.")) ¶¶ 10, 12–17; Snedeker-Abadilla Decl. I ¶¶ 15–17, 19–26. Inmates are unable to wash their hands in these holding areas and they are not provided with cleaning products. Snedeker-Abadilla Decl. I ¶ 30; Tabar Decl. ¶ 7.p. Staff have also observed mice and rats in the area, as well as other parts of HCCC. Rosete-Arellano Decl. ¶ 9; Loredo Decl. ¶ 19.

Mahoe represents that ACOs "do their best" to provide water to inmates in the dog cages but may not be able to readily allow restroom access depending on circumstances. Mahoe Decl. ¶ 15. He refutes allegations that inmates in the fishbowl are denied restroom access or water, stating that a water jug is filled during every meal and upon request. *Id.* ¶ 20. It is unclear if this is mere policy or actual practice because staff claims that Mahoe has not performed a walk-through of the facility since he started working at HCCC, despite DPS policy that the warden should do two daily walk-throughs to ensure compliance with protocols. Jobes Decl. ¶¶ 12–13.

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[21] These conditions are alarming, with or without COVID-19. "The Constitution 'does not mandate comfortable prisons,' but neither does it permit inhumane ones[.]" *Farmer*, 511 U.S. at 832 (citations omitted).

HCCC started moving inmates from the fishbowl to other housing units, and Johnson issued a directive that inmates may not stay overnight in the dog cages. Johnson Decl. ¶ 39; Mahoe Decl. ¶ 24. At the hearing, Plaintiffs' counsel argued that the new housing accommodations are equally unsuitable because not only are they smaller and proportionately as overcrowded as the fishbowl, they similarly have no running water or toilets.

Mask Wearing/PPE: Defendant argues that staff are always required to wear masks unless medically or operationally excepted and that PPE is provided for certain tasks like entering quarantine or isolation units, transporting inmates, and interacting with an individual with suspected or confirmed COVID-19. Defendant also supplies inmates and staff with multiple cloth masks that can be laundered. ECF No. 22 at 18; Johnson Decl. ¶¶ 17, 18, 21. According to Plaintiffs, mask wearing is inconsistent at best with minimal enforcement, if at all, and masks and PPE are not necessarily provided to staff. Ahuna Decl. ¶¶ 8–9; Rosete-Arellano Decl. ¶ 15; Loredo Decl. ¶ 8; Nihoa Decl. ¶ 4.b–c; Alvarado Decl. I ¶ 7.e, g.

Cleaning Supplies and Protocols: According to Defendant, inmates are provided with soap and towels in restrooms and cells; additional are supplied at the inmates' request, and towels are laundered twice daily. ECF No. 22 at 17; Johnson Decl. ¶ 20. Defendant also represents that the facilities maintain an enhanced

cleaning schedule for housing units; transportation vans are sanitized daily; high touch areas are cleaned and sanitized daily; common areas and housing are disinfected and cleaned daily; staff disinfects their work areas; and inmates receive cleaning supplies and gloves to clean their personal areas. ECF No. 22 at 17; Tanaka Decl. ¶ 9; Taylor Decl. ¶ 8; Sequeira Decl. ¶ 9; Wagatsuma Decl. ¶ 8; Harrington Decl. ¶ 10; Ornellas Decl. ¶ 14; Craig Decl. ¶ 15.

The declarations submitted by Plaintiffs suggest otherwise. Plaintiffs, other inmates, and staff claim that inmates do not receive cleaning supplies; hand sanitizer and wipes are unavailable in housing units; soap must be purchased with commissary money; cleaning is left to the inmates' discretion; when provided, cleaning products are watered down; and cells housing COVID-positive inmates are not cleaned before new occupants move in. Chatman Decl. ¶ 18; ECF No. 26-13 ("Alvarado Decl. II") ¶ 4.g,i–j; Snedeker-Abadilla Decl. I ¶¶ 27, 30; Parent Decl. ¶¶ 6.b–c, 15, 20.b; Ahuna Decl. ¶ 11; Loredo Decl. ¶ 9 (indicating that she was not provided with cleaning supplies for her office at HCCC).

Identification of Older and Medically Vulnerable Inmates: Defendant explains that medical staff conducts assessments within 14 days of admission, including the identification of older adults and inmates with medical conditions that put them at an increased risk of severe illness from COVID-19. Takenaka Decl. ¶ 18. Both staff and inmates indicate that no assessments occur, and inmates

with medical conditions have not been isolated or identified as high risk, which resulted in COVID-19 infections and hospitalization. Nihoa Decl. ¶ 10; Alvarado Decl. I. ¶ 8; ECF No. 6-9 (Decl. of Jason Cummings ("Cummings Decl.")) ¶¶ 7–13; *cf.* Snedeker-Abadilla Decl. I ¶¶ 10–11, 31–34 (explaining that he was held in the fishbowl for months, and was initially told it was for "quarantine" even though he was housed with 40 to 50 other males and new detainees were added daily).

The evidence before the Court demonstrates that Defendant has not taken reasonable available measures to abate the risks caused by the foregoing conditions, knowing full well — based on multiple prior outbreaks — that serious consequences and harm would result to the inmates. And Plaintiffs have suffered injuries as a result. *See Roman*, 977 F.3d at 943 ("The Government was aware of the risks these conditions posed, especially in light of high-profile outbreaks at other carceral facilities that had already occurred at the time, and yet had not remedied the conditions. Its inadequate response reflected a reckless disregard for detainee safety."). Defendant did not submit persuasive evidence contradicting the detailed accounts of Plaintiffs, inmates, and DPS staff showing a failure to implement and/or comply with the Response Plan. The declarations relied upon by Defendant offer summaries of provisions in the Response Plan without specific examples of compliance. Johnson provides some details about measures taken to address the HCCC outbreak and Mahoe responds to certain allegations concerning

the fishbowl, dog cages, PPE, cleaning supplies, communications, and social distancing during recreation time. However, they too were couched in generalities.

Policies are meaningless if they are not followed. Although Defendant attempts to characterize the failures identified by Plaintiffs as "occasional lapses in compliance by PSD staff," *see* ECF No. 22 at 33, many of the failures — such as the cramped housing of inmates in the fishbowl at HCCC or the need for inmates to urinate in cups due to a lack of access to toilets — are more than simple lapses and demonstrate objective deliberate indifference. Consequently, there is a strong likelihood that Plaintiffs will prevail on the merits of their Fourteenth Amendment claim and satisfy the objective prong of their Eighth Amendment Claim.

ii. Subjective Deliberate Indifference

This subjective standard applicable to Eighth Amendment claims requires an official to "know[] of and disregard[] an excessive risk to inmate health or safety." *Gordon*, 888 F.3d at 1125 n.4. (internal quotation marks and citation omitted). Thus, the Court must determine if Plaintiffs will be able to establish that Defendant is aware of, but is disregarding, an excessive risk to Plaintiffs' health or safety by failing to take measures to prevent or mitigate the spread of COVID-19 in DPS facilities.

Defendant cannot reasonably claim ignorance of the seriousness of COVID-19 at this stage in the pandemic, nor the consequences that could result from a

failure to take necessary steps to prevent transmission in DPS facilities. Approximately 1,575 inmates and 240 correctional staff have contracted COVID-19, and seven inmates died. *See* https://dps.hawaii.gov/blog/2020/03/17/coronavirus-covid-19-information-and-resources/ (last visited July 13, 2021). Prisoners have tested positive for COVID-19 at 17.4 times the rate in Hawai‘i overall and have died at 5.1 times the rate. *See* https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (last visited July 13, 2021). Halawa, MCCC, OCCC, Waiawa, and HCCC already experienced outbreaks and given DPS's alleged current *practices* (not policies), others are inevitable. Despite this knowledge, it appears that Defendant continues to disregard the excessive risk to inmate health and safety. The inmate populations are in constant flux and the arrival of new inmates presents an ongoing threat of exposure to new sources of infection, especially if new inmates are not properly screened, tested, or quarantined. Many of the concerning facts outlined in the preceding section support a finding of subjective deliberate indifference because they evince Defendant's knowing disregard of excessive risk to inmate health and safety. However, the recent transfer of inmates best exemplifies this disregard, and here, shows that there is a strong likelihood that Plaintiffs will establish subjective deliberate indifference.

In an effort to alleviate overcrowding at HCCC during the middle of a COVID-19 outbreak, Defendant chartered private flights to transport dozens of inmates to facilities on Oahu. Johnson Decl. ¶ 36; ECF 26-14. Notwithstanding Defendant's public statement that only inmates who were medically cleared of COVID-19 were considered for transfer, *see* ECF No. 26-14, inmates who were symptomatic and untested, or had yet to receive test results, were among those transferred. Hall Decl. ¶¶ 9–11; Bertilacci Decl. ¶ 8; Snedeker-Abadilla Decl. II ¶ 7; Napeahi Decl. ¶¶ 9, 11–12; Olivera-Wamar Decl. ¶¶ 7, 9–12, 14. Many of these inmates informed staff that they felt ill. Hall Decl. ¶ 12; Napeahi Decl. ¶ 13; Olivera-Wamar Decl. ¶¶ 8, 13. At least nine of these inmates tested positive for COVID-19 at Halawa. ECF No. 26-1 at 6. Inmates from HCCC were grouped with inmates from other facilities while they awaited their COVID-19 test results. Hall Decl. ¶¶ 14–15; Bertilacci Decl. ¶ 9; Olivera-Wamar Decl. ¶¶ 15–16; Napeahi Decl. ¶¶ 15–17. COVID-positive and COVID-negative inmates are housed in the same open-air modules, share common spaces and devices, and are able to shake hands through the bars of their cells. Olivera-Wamar Decl. ¶¶ 15, 19; Bertilacci Decl. ¶¶ 9–10, 13–17; Hall Decl. ¶ 14; Napeahi Decl. ¶¶ 20, 23, 25. One of the COVID-positive transferees has requested, but not received, medical treatment for his symptoms. Napeahi Decl. ¶ 24.

This is problematic on multiple levels. Defendant knowingly (1) transported *symptomatic* inmates from a facility *with an active COVID-19 outbreak*, (2) who *told staff* they were ill, (3) who were *infected*, (4) but whose infections were unconfirmed due to *late or no testing*, (5) *on an airplane*, (6) to a facility with no active COVID-19 cases *that previously experienced an outbreak*, and (7) then housed those inmates *with COVID-negative inmates*. There is almost no clearer an example of complete disregard for the Response Plan and abandonment of precautionary measures to prevent the spread of COVID-19 between DPS facilities and islands.

Creating and successfully implementing a workable policy to mitigate the spread of COVID-19 in a carceral setting is an unenviable task. But Defendant has had ample time to do so and the prior outbreaks should have served as cautionary tales. The Court finds that Plaintiffs have demonstrated, through the foregoing facts, that they have a strong likelihood of success on their Eighth Amendment claim.

2. Irreparable Harm

Plaintiffs argue that they will suffer irreparable harm without an injunction because DPS's failure to meet public health standards places them at risk of serious infection and death. ECF No. 6-1 at 28. Defendant counters that Plaintiffs have

not presented evidence demonstrating that a COVID-19 outbreak is imminent or, were another outbreak possible, that it is likely. ECF No. 22 at 42.

"A plaintiff seeking preliminary relief must 'demonstrate that irreparable injury is likely in the absence of an injunction.'" *California v. Azar*, 911 F.3d 558, 581 (9th Cir. 2018) (citation omitted). "At a minimum, a plaintiff seeking preliminary injunctive relief must demonstrate that it will be exposed to irreparable harm." *Caribbean Marine Servs. Co. v. Baldrige*, 844 F.2d 668, 674 (9th Cir. 1988) (citation omitted). As a prerequisite to injunctive relief, "a plaintiff must *demonstrate* immediate threatened injury"; a speculative injury is not irreparable. *Id.* (citations omitted). "Irreparable harm is . . . harm for which there is no adequate legal remedy, such as an award of damages." *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1068 (9th Cir. 2014) (citation omitted). "[A]n alleged constitutional infringement will often alone constitute irreparable harm," *Monterey Mech. Co. v. Wilson*, 125 F.3d 702, 715 (9th Cir. 1997) (internal quotation marks and citation omitted), but not if "the constitutional claim is too tenuous." *Goldie's Bookstore, Inc. v. Superior Court of Cal.*, 739 F.2d 466, 472 (9th Cir. 1984).

The Court already determined that Plaintiffs are likely to succeed on the merits and "the deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)). In addition, Plaintiffs clearly

identify the irreparable harm they will suffer if conditions at DPS facilities persist. Comingling COVID-positive inmates with non-infected inmates, unsanitary living conditions, lack of social distancing, failure to provide PPE, failure to enforce mask wearing and proper usage, insufficient COVID-19 screening and testing, and lack of adequate medical care, increase Plaintiffs' risk of contracting COVID-19 and potentially suffering serious illness or death. *See Maney v. Brown*, 464 F. Supp. 3d 1191, 1216 (D. Or. 2020) ("*Maney I*") (citations omitted). Indeed, the Hawai'i Supreme Court determined that multiple DPS facilities are overcrowded and in light of the pandemic, "they have the potential to . . . place the inmates at risk of death or serious illness." *In re Individuals in Custody of State*, No. SCPW-20-0000509, 2020 WL 5015870, at *1 (Haw. Aug. 24, 2020) ("*In re Inmates II*") (discussing MCCC, HCCC, and KCCC); *see In re Individuals in Custody of State*, No. SCPW-20-0000509, 2020 WL 4873285, at *1 (Haw. Aug. 17, 2020) ("*In re Inmates I*") (discussing OCCC). And facilities remain overcrowded. *See* https://dps.hawaii.gov/wp-content/uploads/2021/07/Pop-Reports-Weekly-2021-07-05.pdf (last visited July 13, 2021). Accordingly, Plaintiffs have established that they are likely to suffer irreparable injury.

The Court rejects Defendant's assertion that this determination requires Plaintiffs to confirm the *imminence of a COVID-19 outbreak* at a DPS facility. ECF No. 22 at 42. *See Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("We have

great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year."). Plaintiffs' concerns about harm are not speculative for the reasons explained above. As they currently exist, DPS's practices — exacerbated by the shared and confined spaces in carceral settings — are likely to cause irreparable harm because they present a considerable risk of exposure to COVID-19, with or without an outbreak. *See Maney II*, __ F.3d at __, 2021 WL 354384, at *15; *Criswell*, 2020 WL 5235675, at *23–24; *Torres v. Milusnic*, 472 F. Supp. 3d 713, 740–41 (C.D. Cal. 2020); *Zepeda Rivas v. Jennings*, 445 F. Supp. 3d 36, 40 (N.D. Cal. 2020); *Kaur v. DHS*, Case No. 2:20-cv-03172-ODW (MRWx), 2020 WL 1939386, at *3 (C.D. Cal. Apr. 22, 2020). And, in any case, "a remedy for unsafe conditions need not await a tragic event." *Helling*, 509 U.S. at 33.

Regardless of whether another outbreak is imminent, the Court is unconvinced that DPS's recent efforts in the midst of this litigation have eliminated the *ongoing* harm to Plaintiffs. On June 10, 2021 — one day after Plaintiffs filed the Injunction Motion and the same day the Court held a status conference on the matter — Johnson issued a directive that inmates are not to be placed in the dog cages overnight. Mahoe Decl. ¶ 14. Then, shortly before Defendant's opposition deadline, DPS began relocating inmates from the fishbowl

to other housing units at HCCC. *Id.* ¶ 24; Johnson Decl. ¶ 39. The timing of DPS's actions is suspect. And given Plaintiffs' counsel's allegation that DPS actually replicated these deficient housing conditions elsewhere in the facility, any improvement in conditions is debatable. Furthermore, improvements at HCCC do not remedy the many other dangers identified above that promote the spread of COVID-19 in DPS facilities. DPS's recent efforts to remediate egregious conditions — that should never have occurred in the first place — do not persuade the Court that DPS can and will successfully manage the pandemic moving forward. After all, the five severe outbreaks demonstrate otherwise. Based on DPS's record of handling of COVID-19 in its facilities, it is not unreasonable to assume that issues will persist and that future outbreaks are likely, driven in part by the inmates' inter-facility movement and constant introduction of new inmates into the facilities.

Defendant claims that DPS will be irreparably harmed if an injunction issues because the Court would assume administration over its facilities.[22] ECF No. 22 at 42 (citation omitted). Putting aside the fact that this is not the salient inquiry, the

[22] Defendant cites *Swain v. Junior*, 958 F.3d 1081, 1090 (11th Cir. 2020), for this proposition. *Swain* concerned a motion for stay pending appeal of a preliminary injunction. *See id.* at 1085. Therefore, the defendants bore the burden of establishing that they would be irreparably harmed absent a stay. *See id.* at 1088, 1090. *Swain* has no application under this factor, as the Court considers whether Plaintiffs will suffer irreparable harm in the absence of an injunction, not whether an injunction will cause Defendant to suffer irreparable harm.

Court struggles to identify any harm to DPS, let alone irreparable harm, when the injunction would merely require DPS to do not only what it *should* be doing but what it claims it *has* been doing throughout the course of the pandemic. "Self-inflicted wounds are not irreparable injury." *Al Otro Lado*, 952 F.3d at 1008 (internal quotation marks, brackets, and citations omitted). "An injunction cannot cause irreparable harm when it requires a party to do nothing more than what it maintained, under oath, it was already doing of its own volition." *Ahlman v. Barnes*, No. 20-55568, 2020 WL 3547960, at *3 (9th Cir. June 17, 2020) ("*Ahlman II*").

For these reasons, the Court finds that Plaintiffs have demonstrated that they will be irreparably harmed in the absence of an injunction.

3. Balance of Equities/Public Interest

Plaintiffs contend that the equities weigh in favor of protecting them, DPS staff, and the community from the spread of COVID-19, and that any burden to Defendant — economic or administrative — is relatively limited. ECF No. 6-1 at 30–33. Instead of addressing the applicable considerations, Defendant argues that Plaintiffs have failed to provide the necessary evidence entitling them to relief[23]

[23] Citing *Roman v. Wolf*, Defendant asserts that "an 'injunction should, to the extent possible, reflect the scientific evidence about COVID-19 presented to [a] district court' and 'should stem from medical evidence properly before the court.'" ECF No. 22 at 42–43 (alteration in original) (citing *Roman*, 977 F.3d at 946).
(continued . . .)

and that DPS already implemented the measures that Plaintiffs request. ECF No. 22 at 42–43. Defendant also argues that injunctive relief is disfavored because of federalism concerns and the policy against court interference with prison administration. *Id.* at 43–44.

In assessing whether Plaintiffs establish that the balance of equities tip in their favor, "the district court has a 'duty . . . to balance the interests of all parties and weigh the damage to each.'" *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1138 (9th Cir. 2009) (alteration in original) (citation omitted). "When the reach of an injunction is narrow, limited only to the parties, and has no impact on non-parties, the public interest will be 'at most a neutral factor in the analysis rather than one that favor[s] [granting or] denying the preliminary injunction.'" *Id.* at 1138–39 (alterations in original) (citation omitted). When an injunction's impact "reaches beyond the parties, carrying with it a potential for public consequences, the public interest will be relevant to whether the district court grants the preliminary injunction." *Id.* at 1139 (citations omitted). "'The public interest inquiry primarily

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These principles have no bearing on Plaintiffs' *entitlement* to injunctive relief. The *Roman* court affirmed the issuance of a preliminary injunction but vacated and remanded specific provisions of the injunction due to the drastic changes that occurred after its issuance. *See Roman*, 977 F.3d at 945. The above references to scientific and medical evidence were provided for the district court's consideration on remand. *Id.* at 946. They are not tied to the balancing of equities/public interest factor.

addresses impact on non-parties rather than parties.'" *League of Wilderness Defs./Blue Mountains Biodiversity Project v. Connaughton*, 752 F.3d 755, 766 (9th Cir. 2014) (citation omitted). It also requires the Court to "'consider whether there exists some critical public interest that would be injured by the grant of preliminary relief.'" *Cottrell*, 632 F.3d at 1138 (citation omitted).

Here, the equities tip sharply in Plaintiffs' favor because they face irreparable harm to their health and constitutional rights. *See Castillo v. Barr*, 449 F. Supp. 3d 915, 923 (C.D. Cal. 2020). The Court acknowledges that Defendant has a strong interest in the administration of DPS facilities, *see Woodford v. Ngo*, 548 U.S. 81, 94 (2006), and that "separation of powers concerns counsel a policy of judicial restraint." *Turner v. Safley*, 482 U.S. 78, 85 (1987); *see also* 18 U.S.C. § 3626(a)(2) ("The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the preliminary relief and shall respect the principles of comity[.]"). And "[w]here a state penal system is involved, federal courts have . . . additional reason to accord deference to the appropriate prison authorities." *Turner*, 482 U.S. at 85 (citation omitted). That said, Defendant "cannot suffer harm from an injunction that merely ends an unlawful practice . . . to avoid constitutional concerns," *Rodriguez v. Robbins*, 715 F.3d 1127, 1145 (9th Cir. 2013) (citation and footnote omitted), particularly when Defendant claims it is already complying with its Response Plan.

Additionally, "while States and prisons retain discretion in how they respond to health emergencies, federal courts do have an obligation to ensure that prisons are not deliberately indifferent in the face of danger and death." *Valentine v. Collier*, 590 U.S. __, 140 S. Ct. 1598, 1599 (2020) (statement of Sotomayor, J., joined by Ginsburg, J.); *see Brown v. Plata*, 563 U.S. 493, 511 (2011) ("Courts nevertheless must not shrink from their obligation to 'enforce the constitutional rights of all "persons," including prisoners.'" (citation omitted)). "Courts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration." *Brown*, 563 U.S. at 511.

It is noteworthy that the injunctive relief requested and ordered here simply requires DPS to comply with its own policies. Defendant will not be burdened or harmed if DPS must do what he insists it is already doing. *See Ahlman II*, 2020 WL 3547960, at *3. Moreover, this mitigates federalism concerns and allows the Court to address alleged constitutional violations without becoming too "enmeshed in the minutiae of prison operations." *Bell*, 441 U.S. at 562.

The public interest would also be served by requiring DPS to adhere to policies it formulated, which are designed to limit the spread of COVID-19, especially when non-compliance causes the violation of constitutional rights. *See Am. Beverage Ass'n v. City & County of San Francisco*, 916 F.3d 749, 758 (9th Cir. 2019) ("[I]t is always in the public interest to prevent the violation of a party's

constitutional rights." (internal quotation marks and citation omitted)). With inmate COVID-19 infections far exceeding the general rate in Hawai‘i, and multiple severe outbreaks in DPS facilities throughout the course of the pandemic, Defendant has not adequately protected the health and safety of the inmates. And the continued spread of COVID-19 in DPS facilities will impact DPS staff and other individuals who enter DPS facilities, along with their families and surrounding communities. *See In re Inmates II*, 2020 WL 5015870, at *1 (recognizing the endangerment to "the lives and well-being of staff and service providers who work [at DPS facilities], their families, and members of the community at large"). These considerations support the issuance of a preliminary injunction.

In sum, Plaintiffs have demonstrated that there is a strong likelihood of success on the merits of their claims, that they will suffer irreparable injury if relief is not granted, and that the balance of hardships and public interest weigh heavily in their favor.

B. Scope of Injunctive Relief

Plaintiffs request the same injunctive relief in the Injunction Motion that they ultimately seek in this litigation — the appointment of a special master pursuant to 18 U.S.C. § 3626(f)(1)(A) to oversee the development and

implementation of their Proposed Response Plan.[24] *Compare* SAC at 61–65 *with* ECF No. 14-1 at 2–5. It is typically improper "to grant the moving party the full relief to which he might be entitled if successful at the conclusion of a trial. This is particularly true where the relief afforded, rather than preserving the status quo, completely changes it." *Tanner Motor Livery, Ltd. v. Avis, Inc.*, 316 F.2d 804, 808–09 (9th Cir. 1963). But even if the injunction here is mandatory, it is mild because it merely requires Defendant to adhere to its Response Plan and employ practices that comport with CDC guidelines. *See Hernandez*, 872 F.3d at 999–1000.

1. Appointment of a Special Master

The PLRA authorizes the Court to appoint a special master in a civil action regarding prison conditions (1) "who shall be disinterested and objective and who will give due regard to the public safety, *to conduct hearings on the record and prepare proposed findings of fact*" (2) "*during the remedial phase of the action* only upon a finding that the remedial phase will be sufficiently complex to warrant the appointment." 18 U.S.C. § 3626(f)(1)(A)–(B) (emphases added).

[24] Plaintiffs initially requested an evaluation of whether inmates should be released to comply with CDC guidelines. ECF No. 6-1 at 34. At the time, the FAC was the operative pleading, and it also requested the same relief. ECF No. 5 at 75. The SAC does not request this relief, nor is it outlined in Plaintiffs' supplemental memorandum regarding the specific injunctive relief sought. ECF No. 14.

Because this case is not in the remedial phase, appointment of a special master under § 3626(f) is improper. *See McCormick v. Roberts*, Civil Action No. 11-3130-MLB, 2012 WL 1448274, at *2 (D. Kan. Apr. 26, 2012) (denying motion to appoint special master pursuant to § 3626(f) because the case had yet to enter the remedial phase); *Roberts v. Mahoning County*, 495 F. Supp. 2d 713, 714 (N.D. Ohio 2006) (discussing work of special master appointed after a bench trial to assist the parties with a remedial phase aimed at achieving final resolution). Plaintiffs have not presented any cases, and the Court has found none, appointing a special master pursuant to § 3626(f) at the preliminary injunction phase in a civil case regarding prison conditions.

At the hearing, Plaintiffs requested that their request be considered pursuant to FRCP 53 instead of § 3626(f). The PLRA defines a "special master" as "any person appointed by a Federal court pursuant to Rule 53 of the Federal Rules of Civil Procedure or pursuant to any inherent power of the court to exercise the powers of a master, regardless of the title or description given by the court." 18 U.S.C. § 3626(g)(8). Therefore, the Court finds that even if it were to award relief under FRCP 53, it would still be subject to the constraints of § 3626(f).

Additional reasons support denial of the request at this time. Special masters are ordinarily appointed after liability is established or a consent decree or injunction issues, to assist courts with enforcement. *See*, *e.g.*, *Brown*, 563 U.S. at

511; *Balla v. Idaho State Bd. of Corr.*, No. 1:81-cv-1165-BLW, 2011 WL 108727, at *1–2 (D. Idaho Jan. 6, 2011); *Plata v. Schwarzenegger*, 603 F.3d 1088, 1097 (9th Cir. 2010); *Hook v. Ariz. Dep't of Corr.*, 107 F.3d 1397, 1399–400 (9th Cir. 1997).

Courts have *contemplated* the appointment of a special master in cases involving ICE facilities *when a defendant failed to comply with orders*. *See*, *e.g.*, *Roman v. Wolf*, ED CV 20-00768 TJH, 2020 WL 6107069, at *2 (C.D. Cal. Oct. 15, 2020); *Fraihat v. ICE*, Case No. EDCV 19-1546 JGB (SHKx), 2020 WL 6541994, at *13 (C.D. Cal. Oct. 7, 2020). Plaintiffs cite two cases in which special masters were appointed. However, the appointments followed ICE's pattern of non-compliance and the PLRA does not apply to civil detainees.[25] *See* ECF No. 26-19; *Gayle v. Meade*, Case No. 20-21553-Civ-COOKE/GOODMAN, 2020 WL 4047334, at *2 (S.D. Fla. July 17, 2020). The final case cited by Plaintiffs is a consent order addressing class certification and appointing a special master pursuant to FRCP 53. ECF No. 26-18.

None of the circumstances in these cases are present here. Accordingly, the Court denies Plaintiffs' request to appoint a special master. This does not foreclose the possibility that a special master or another person with a similarly contemplated role may be appointed in the future, if appropriate.

[25] *See Agyeman v. INS*, 296 F.3d 871, 886 (9th Cir. 2002).

2. Limitations on Relief

The PLRA also authorizes the Court to issue a preliminary injunction in a civil action regarding prison conditions. *See* 18 U.S.C. § 3626(a)(2). "[I]njunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm." *Id.*; *see also Melendres v. Maricopa County*, 897 F.3d 1217, 1221 (9th Cir. 2018) ("We have long held that injunctive relief 'must be tailored to remedy the specific harm alleged.'" (some internal quotation marks and citation omitted)). Courts are required to "give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief."[26] 18 U.S.C. § 3626(a)(2); *see also*

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[26] Paragraph (1)(B) provides:

> The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless—
>
> > (i) Federal law requires such relief to be ordered in violation of State or local law;
> >
> > (ii) the relief is necessary to correct the violation of a Federal right; and
> >
> > (iii) no other relief will correct the violation of the Federal right.

18 U.S.C. § 3626(a)(1)(B).

Maricopa County, 897 F.3d at 1221 ("Federalism principles make tailoring particularly important where, as here, plaintiffs seek injunctive relief against a state or local government." (citation omitted)). District courts nevertheless retain "broad discretion to fashion injunctive relief" so long as the injunctive relief "is 'aimed at eliminating a condition that does not violate the Constitution or does not flow from such a violation.'" *Maricopa County*, 897 F.3d at 1221 (some internal quotation marks and citation omitted).

Preliminary injunctive relief automatically expires "90 days after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period." 18 U.S.C. § 3626(a)(2).

Although Plaintiffs' requested injunctive relief is largely appropriate, the Court has made necessary adjustments to ensure that the relief is narrowly tailored to correct the constitutional violations identified herein and is the least intrusive means to correct the harm to Plaintiffs. Based on the foregoing, the Court GRANTS the Injunction Motion and ORDERS Defendant to *fully comply* with the Response Plan,[27] focusing in particular on the following:

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[27] To be clear, the Court is referring to the State of Hawaii Department of Public Safety Pandemic Response Plan COVID-19 (May 28, 2021 Revision). ECF No. 22-12. At the hearing, Plaintiffs' counsel conceded that she does not take issue

(continued . . .)

- Section 3.a (Good Health Habits).
- Section 3.b (Environmental Cleaning).
- Section 3.c (Social Distancing Measures).
- Section 3.d (Encourage the use of Masks and Other No-Contact Barriers).
- Section 6 (New Intake Screening).
- Section 8 (Personal Protective Equipment (PPE)).
- Section 10 (Medical Isolation/Cohorting (*Symptomatic Persons*)).
- Section 12 (Quarantine (*Asymptomatic Exposed Persons*)) – with an emphasis on the provisions concerning the (1) identification of inmates who are at increased risk for severe illness and (2) single cell and available housing prioritization of inmates with increased risk of severe illness from COVID-19.
- Section 13 (Surveillance for New Cases).

Defendant is further ORDERED to:

- Provide sanitary living conditions to all inmates in DPS custody, *i.e.*, regular access to a working toilet, sink, and drinking water.
- Prohibit DPS employees from restricting access to inmate grievance forms or from preventing the submission of grievances with respect to COVID-19 issues.

(. . . continued)
with the Response Plan itself, and indeed, the Court agrees that it is a rather comprehensive plan that addresses the proper management of COVID-19 at DPS facilities.

Oversight is hereby referred to Magistrate Judge Mansfield, who is authorized to address compliance with the preliminary injunction, engage in factfinding procedures he deems appropriate, and issue certified factual findings to the undersigned. The parties are directed to attend status conferences with Magistrate Judge Mansfield once a month. One week prior to each status conference, the parties shall file a joint status report. If they are unable to do so, they shall file separate status reports. The parties are directed to contact Magistrate Judge Mansfield's chambers to schedule the first status conference during the week of July 19, 2021. The parties need not file a status report but should be prepared to discuss compliance with the injunction.

C. FRCP 65(c)

FRCP 65(c) permits a court to grant preliminary injunctive relief "only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." Fed. R. Civ. P. 65(c). While this language appears to be mandatory, "Rule 65(c) invests the district court 'with discretion as to the amount of security required, *if any*.'" *Johnson v. Couturier*, 572 F.3d 1067, 1086 (9th Cir. 2009) (some internal quotation marks and citation omitted). Based on the class composition and record before it, the Court waives the bond requirement.

CONCLUSION

In accordance with the foregoing, the Court HEREBY (1) GRANTS Plaintiffs' Motion for Provisional Class Certification, ECF No. 20, and (2) GRANTS IN PART AND DENIES IN PART Plaintiffs' Motion for Preliminary Injunction and Temporary Restraining Order. ECF No. 6.

IT IS SO ORDERED.

DATED: Honolulu, Hawai'i, July 13, 2021.

Jill A. Otake
United States District Judge