LEGAL DEPARTMENT
NATIONAL PRISON
PROJECT

April 16, 2020

BY ELECTRONIC MAIL ONLY

Rachel Love
Struck, Love, Bojanowski & Acedo, PLC
3100 West Ray Road, Suite 300
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rlove@strucklove.com

Re: ***Parsons v. Shinn***
Medical Isolation and Conditions in Max Custody

Dear Rachel:

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

PLEASE RESPOND TO
NATIONAL PRISON PROJECT
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DAVID C. FATHI
DIRECTOR
*ATTORNEY AT LAW**

**NOT ADMITTED IN DC: PRACTICE LIMITED TO FEDERAL COURTS*

I am writing to address Plaintiffs' growing concern about the use of detention units/punitive solitary confinement as a response to COVID-19 and the deteriorating conditions in the maximum custody units that house people in the isolation sub-class. In particular, we note that the recent count sheets posted on the Arizona Department of Corrections' (ADC) website indicate over-population in the detention units. For example, the counts in detention units for April 13 indicate overcrowding in numerous units:

- Morey Detention Unit at Lewis Complex has a capacity of 80 beds – it now houses 93 people
- Bachman Detention Unit at Lewis Complex has a capacity of 80 beds – it now houses 92 people
- Miles Detention Unit at Safford Complex has a capacity of 49 beds – it now houses 54 people
- Cimarron Detention Unit at Tucson Complex has a capacity of 96 beds – it now houses 119 people
- Winchester Detention Unit at Tucson Complex has a capacity of 24 beds – it now houses 26 people
- Complex Detention Unit at Tucson Complex has a capacity of 80 beds – it now houses 120 people

See ADC Institutional Capacity Committed Population, April 13, 2020, at https://corrections.az.gov/sites/default/files/DAILY_COUNT/Apr2020/04132020_count_sheet.pdf. In the past, when the detention units are overcapacity, the prisons "triple-bunk" people in cells designed for two people, such that one person has to sleep on a mat in the floor of the cramped cell. This overcrowding in the locked down detention units obviously forecloses any of the social distancing that the Centers for Disease Control (CDC) and the World Health Organization (WHO) have informed us is necessary to prevent the rampant spread of COVID-19. Please inform us of the actions Defendants are taking to mitigate this overcrowding and allow for social distancing in the detention units.

The overcrowding in the close quarters of the detention units also raises concerns that ADC may be inappropriately using punitive segregation/solitary confinement as a "response" to the COVID-19 outbreak. Using punitive segregation/solitary confinement as a direct response to COVID-19 is contrary to public health and the goals of prevention and containment. According to public health experts working in the correctional context, medical isolation and quarantine must be clearly distinct from the use of punitive segregation/solitary confinement that is common in both ADC's detention units and its maximum custody units. I attach a briefing paper on this subject from AMEND, a corrections project of the University of California San Francisco Medical Center. *See* D. Cloud, C. Ahalt, B. Williams, *The Ethical Use of Medical Isolation – Not Solitary Confinement to Reduce COVID-19 Transmission in Correctional Settings*, 4/7/20, https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf, and attached to this letter.

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These public health authorities raise three critical concerns with the use of solitary confinement in the context of attempts to minimize COVID-19 transmission: 1) using punitive segregation units for medical isolation will deter people from reporting symptoms due to fears of being placed in solitary confinement and the harsh conditions associated with such units; 2) placing people, especially vulnerable people, in solitary confinement/punitive segregation settings is known to cause mental health harms, including increased rates of self-harm and suicide; 3) preemptive lockdowns of units for indefinite amounts of time will result in a failure to detect symptomatic people due to reduced interactions with correctional and medical staff. According to public health officials, because of the detrimental effects the use of solitary has on desired COVID-19 containment strategies, "[d]uring the COVID-19 crisis, medical isolation and quarantine should be used only as medically necessary, and these procedures should result in living conditions clearly distinct from those found in solitary confinement." *Id*. at 2. These distinctions include:

- Medical isolation units are overseen by medical staff
- Individuals in medical isolation have free access to TV, music, tablet, email and reading materials
- Individuals in medical isolation have access to free daily phone calls
- Individuals in medical isolation have daily access to outdoor exercise for at least 1-2 hours
- Individuals in medical isolation have access to property and commissary
- Individuals in medical isolation have access to medical staff at least daily
- Individuals in medical isolation have access to mental health staff at least daily
- Individuals in medical isolation are removed from such isolation as soon as they are cleared by medical care staff
- Individuals in medical isolation receive daily updates from healthcare staff on why medical isolation is necessary and how long it might last

- The use of medical isolation must be transparent with the public and each patient's family
- Medically appropriate ventilation and temperature control

Id. at 3. We ask that Defendants set forth their medical isolation policy as currently practiced in ADC as a response to COVID-19, including any use of unit lockdowns. If ADC is not currently comporting with the above noted ethical guidelines for the use of medical isolation, we ask that Defendants inform counsel of measures they are taking or will take (with dates of inception) in the effort to comply with these critical measures.

Finally, we are deeply concerned with consistent reports from our clients in the maximum custody units that conditions in those units in the past two months have deteriorated substantially. In particular, people in the max custody units in multiple prisons are consistently reporting that they are being denied showers for days and even weeks at a time. Similarly, clients report that access to outdoor exercise has been severely curtailed. We are also deeply concerned that many report that paper forms, such as grievances and Health Needs Requests are not available on the units, and are not being passed out by officers. This means that individuals in the maximum custody units are having an even harder time making contact with medical staff than usual. We have also received reports that medical staff are rarely on the units so there is little opportunity to even try to yell for help. This means that those who may have symptoms of COVID-19 will find it very difficult to report such symptoms, and that appropriate and necessary medical care and prevention planning will likewise be delayed. As you know, such delay will result in an ever-wider circle of transmission both inside the facility and the community at large. Due to the serious nature of these allegations, both for compliance with the maximum custody performance measures (MCPM) under the Stipulation and the health and welfare of the class as a whole, we ask that you immediately investigate these allegations and act to correct any non-compliance with the Stipulation and other actions that will undermine the health and welfare of the Plaintiffs and the community at large.

AMERICAN CIVIL LIBERTIES UNION FOUNDATION

We thank you in advance for your swift action on these issues.

Sincerely,

Amy Fettig
Deputy Director

cc: All counsel

AMEND
CHANGING CORRECTIONAL CULTURE

The Ethical Use of Medical Isolation – *Not Solitary Confinement* – to Reduce COVID-19 Transmission in Correctional Settings

***April 7*, 2020**

David Cloud, JD, MPH, Dallas Augustine, MA, Cyrus Ahalt, MPP, & Brie Williams, MD, MS

What is covered in this brief

This brief clarifies the differences between "medical isolation," "quarantine," and "solitary confinement," and describes the services and benefits that corrections officials should provide to people who are separated for medical isolation or quarantine so that they are not subjected to punitive and traumatizing conditions of solitary confinement. It is intended to provide guidance to departments of correction, prison and jail residents, advocates, and other key stakeholders to help ensure that using medical isolation or quarantine to mitigate the spread of COVID-19 in correctional facilities follow the highest standards of medical ethics.

The distinction between "solitary confinement", "medical isolation", and "quarantine"

- **Solitary Confinement** is the practice of isolating incarcerated people from the rest of the prison population while simultaneously imposing punitive measures such as major restrictions on visitors, phone calls, recreation and outdoor time, and access to personal property.
- **Quarantine** is the practice of separating and restricting the movement of people who may have been exposed to a contagious disease until results of a laboratory test confirm whether or not they have contracted the disease. These individuals may have been exposed to COVID-19, for example, by spending prolonged time in close proximity to someone who has tested positive, or they may have early symptoms of a potential COVID-19 infection.
- **Medical Isolation** is the practice of isolating incarcerated people from the rest of the prison population when they show signs or test positive for COVID-19 in order to stem the risk of COVID-19 transmission throughout the prison.

The ease with which COVID-19 can spread in prisons and jails

The millions of people incarcerated in the U.S. are particularly vulnerable to infection, illness, and death from COVID-19, due to high rates of underlying medical conditions coupled with confinement in crowded and often unsanitary conditions with limited access to personal hygiene products. As the World Health Organization (WHO), Centers for Disease Control (CDC) and many others have emphasized, social distancing, regular handwashing, and frequently sanitizing living spaces are essential to preventing the spread of COVID-19 and "flattening the curve" (or delaying the

transmission of disease in order to distribute the need for life saving healthcare resources over time rather than all at once). **Unfortunately, it is virtually impossible to follow these directives in many correctional facilities**, where hundreds and even thousands of people are confined in overcrowded, often unsanitary conditions—and where people generally lack sufficient access to soap, sanitizer, hot water, and other materials necessary to minimize the risk of COVID-19 infection.

Many public health experts, policymakers, advocates, and community leaders have called for the swift release of as many people as possible from correctional facilities in order to mitigate the accelerated spread of the virus among incarcerated people, correctional workforces, and the larger community. Increasingly, state and local leaders are heeding this call. These actions will surely prevent infections, alleviate suffering, save lives, and help "flatten the curve" inside and outside prisons and jails. However, the number of people released to date has been relatively small. Millions of people will remain in custody as COVID-19 continues to spread. **Some of these individuals will require temporary quarantine or medical isolation to stem the transmission of COVID-19.**

The complexity of using isolation as a tactic to minimize COVID-19 transmission in jails and prisons

1. **Placing people in solitary confinement (punitive isolation) will worsen the COVID-19 crisis.** Many corrections officials lack guidance on how to humanely and effectively separate sick or contagious individuals from the general population. At times, the most feasible and only available housing units in jails and prisons for medical isolation or quarantine of sick patients are those used for punitive solitary confinement in "normal" times (single cells, solid cell doors rather than barred, removed from the main center of the prison). Use of these units for medical purposes, while often necessary, can run the risk of corrections officials falling back on regular policies and procedures governing living conditions in these units that harm the health of those exposed. (see figure for policy differences)
2. **Fear of being placed in solitary will deter people from reporting symptoms to correctional staff.** Experts and advocates are deeply concerned that incarcerated people, many of whom will go to great pains to avoid solitary confinement due to well-established mental and physical health harms associated with the experience, will not come forward when they have symptoms of COVID-19 because they do not want to be placed in such conditions. This avoidance of reporting symptoms or illness will not only accelerate the spread of infection within facilities but also increase the likelihood of prisoner deaths due to lack of treatment.
3. **Preemptive lockdowns may result in failure to detect symptomatic people and cause undue stress to residents.** Some correctional facilities are preemptively placing entire units or facilities on "lockdown" for indefinite amounts of time, meaning that people are confined to a small cell, alone or with another person nearly all the time. Meals, medications, commissary, and other goods are delivered to the cell door. Recreation, programming, educational and religious services are shut down. As a result, interactions with correctional staff and healthcare staff often become less frequent and people with symptoms may go undetected.

During the COVID-19 crisis, medical isolation and quarantine should be used only as medically necessary, and these procedures should result in living conditions clearly distinct from those found in solitary confinement (see figure)

COVID-19 presents daunting public health challenges both inside and outside correctional facilities. **Separating people who become infected is a necessary public health challenge, particularly in prisons and jails. But turning to the punitive practice of solitary confinement in response to the COVID-19 crisis will only make things worse**. Research shows that keeping people socially isolated in a closed cell without a meaningful opportunity to communicate with family, friends, and loved ones or to participate in exercise, educational, and rehabilitative programming (solitary confinement) causes immense, and often irreparable, psychological harm. Emerging evidence suggests that the COVID-19 pandemic will last for at least several more months. Moreover, some people in prison will hide symptoms to avoid being housed in such damaging conditions, even if only temporarily. To minimize the risk of worse health among incarcerated people we recommend the following:

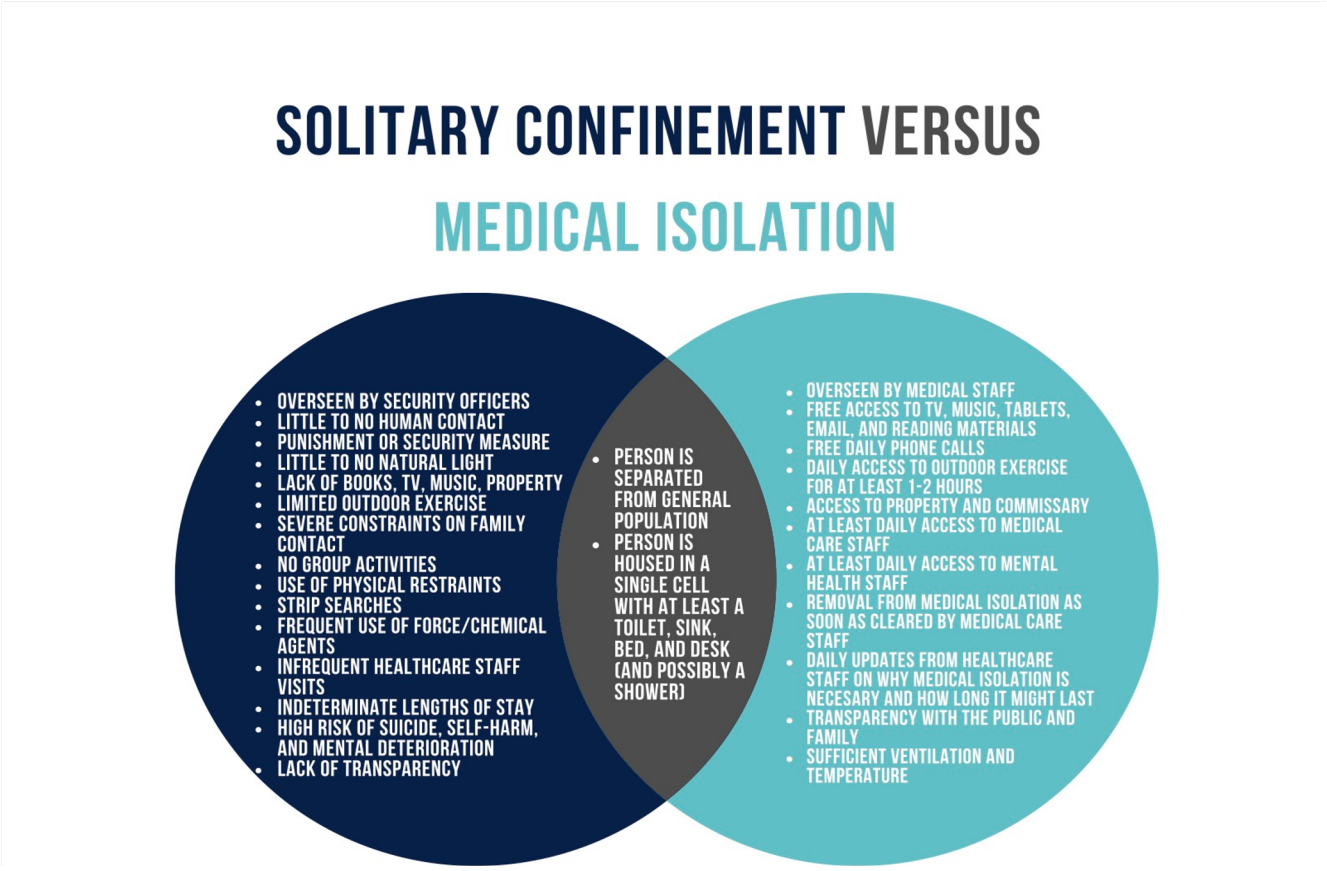
- **The purposes and practices of medical isolation and quarantine should be clearly described** to incarcerated people and their advocates, as well as to the corrections staff that oversees them.

- Corrections officials should only require people on an entire housing unit to stay in their cells ("Lockdown") **if medical professionals determine a symptomatic person resides or works on that unit or contact tracing flags a confirmed or suspected case**.

    - In this event, **time-limitations must be clearly communicated to residents and staff.** Based on current evidence, 5 days is the average time from exposure to symptom onset of COVID-19, and 97.5% of people show symptoms within 11 days. Depending on how evidence emerges in the weeks to come, unit-specific lockdowns could reasonably last 5 to 11 days, but not beyond 14 days, without new evidence of the virus entering the housing unit.

    - All decisions should be documented and communicated with health officials.

Prisons, jails, and other places of detention that are not able to comply with ethical standards of quarantine and medical isolation in the COVID-19 pandemic should urgently implement strategies to release or transfer people to locations that have the capacity to meet community standards of medical care.



Solitary Confinement is defined by the U.S. Department of Justice as:
"[A]ny type of detention that involves: (1) removal from the general inmate population, whether voluntary or involuntary; (2) placement in a locked room or cell, whether alone or with another inmate; and (3) inability to leave the room or cell for the vast majority of the day, typically 22 hours or more."

WHO and CDC define **Medical Isolation** in a correctional context as:
"Confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials…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.

The American Medical Association defines **Quarantine** as: the separation and restricted movement of people who were exposed to a contagious disease while awaiting the results of testing.

Amend COVID-19 Guidance & Tools developed by:

Brie Williams, MD, MS**;** Cyrus Ahalt, MPP; David Sears, MD; Leah Rorvig, MD, MPH; David Cloud, JD, MPH; Dallas Augustine, MA

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Amend at UCSF fundamentally transforms culture inside prisons and jails to reduce their debilitating health effects. We provide a multi-year immersive program drawing on public health-oriented correctional practices from Norway and elsewhere to inspire changes in correctional cultures and create environments that can improve the health of people living and working in American correctional facilities.

Amend is currently focused on providing resources, expertise, and support to correctional systems confronting the global COVID-19 pandemic.

For more information: https://amend.us

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