THE NATIONAL CAMPAIGN
UNLOCK THE BOX
TO END SOLITARY CONFINEMENT

September 24, 2020

Centers for Disease Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30329

ATTN: CDC Director Robert R. Redfield
Nina Witkofsky, Acting Chief of Staff
Mitch Wolfe, MD, MPH (RADM, USPHS), Chief Medical Officer
Robin M. Ikeda, MD, MPH (RADM,USPHS), Assoc. Director for Policy and Strategy

Dear Director Redfield,

We commend the CDC's recommended measures to prevent the spread of COVID-19 in correctional facilities. Nonetheless, infection and death rates continue to increase more rapidly inside adult and juvenile jails, prisons, and immigration centers than in the general population. As of August 27, the fifteen largest COVID-19 clusters in the United States were in jails or prisons.[1] There are also a concerning number of positive cases reported in juvenile facilities across the country. Public health experts have calculated the death rate in federal and state prisons to be at least three times higher than in the general population.[2]

Additionally, a June report from Unlock the Box finds that there has been a 500% increase in the use of solitary confinement in response to the outbreak of the COVID-19 pandemic – a trend that puts the lives of countless incarcerated people, corrections officers and community members at risk.[3] The report notes in extensive detail the analysis of medical experts on the risks associated with federal and state jails and prisons utilizing punitive solitary confinement instead of targeted depopulation efforts and medical isolation to contain the spread of the virus. Incarcerated people will continue to hide their symptoms out of fear of being placed in

[1] *Coronavirus in the U.S.: Latest Map and Case County*, N.Y. Times, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#clusters (last visited Aug. 27, 2020).
[2] Brendan Saloner et al., *COVID-19 Cases and Deaths in Federal and State Prisons*, JAMA (July 8, 2020), https://jamanetwork.com/journals/jama/fullarticle/2768249.
[3] Unlock the Box, Solitary Confinement is Never the Answer (2020), https://static1.squarespace.com/static/5a9446a89d5abbfa67013da7/t/5ee7c4f1860e0d57d0ce8195/1592247570889/June2020Report.pdf.

prolonged solitary confinement, a practice which the United Nations has said can amount to torture, furthering the spread inside state and federal jails and prison facilities.

The report also quotes Dr. Homer Venters, former chief medical officer for New York City Jails, who noted that lockdown units typically require more staff and greater levels of contact between corrections officers and incarcerated people "because of the need to handcuff and physically escort people to and from the shower, in and out of the cell for health care, and numerous other basic operations." For this reason, Dr. Venters has joined numerous other medical professionals in denouncing the use of solitary confinement as a response to the spread of COVID-19.

Even with unprecedented national spikes in COVID-19 infections, correctional facilities remain a reservoir for infection by comparison, threatening traditionally medically compromised residents, staff, and surrounding communities. The limited publicly available data on infection rates in correctional facilities are 40% – 80%,[4,5] strikingly higher than the general population. Further oversight and guidance from the CDC is necessary to protect front-line correctional staff, incarcerated people, and the general population.

Therefore, we, the undersigned, believe the CDC should update its current guidance for adult and juvenile correctional facilities with the following measures to both slow the high rate of COVID-19 transmission within correctional facilities and ensure effective compliance with existing guidelines.

1. Issue clear guidance to local, state and federal corrections officials, judges, and law enforcement agencies on reducing adult and juvenile jail and prison intakes and population size to reduce the spread of COVID-19. This guidance should include prioritizing releasing those who are pregnant, those age 50 and older, and persons with pre-existing medical conditions as these populations are especially vulnerable to COVID-19. Release should be prioritized for people who are within two years of finishing a sentence and people who are detained while awaiting trial. The guidance should also prioritize the use of alternative methods to detention whenever possible.[6]

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[4] Cary Aspinwall & Joseph Neff, *These Prisons Are Doing Mass Testing For COVID-19—And Finding Mass Infections*, The Marshall Project (Apr. 24, 2020), https://www.themarshallproject.org/2020/04/24/these-prisons-are-doing-mass-testing-for-covid-19-and-finding-mass-infections.

[5] Sarah Volpenhein, Marion Prison's Virus Outbreak Seeps into Public, Columbus Dispatch (Apr. 25, 2020), https://www.dispatch.com/news/20200425/marion-prisonrsquos-virus-outbreak-seeps-into-public.

[6] For an extensive discussion of ways to address the unique challenges faced by correctional facilities during COVID-19, see Brie Williams, et al., *Correctional Facilities In The Shadow Of COVID-19: Unique Challenges And Proposed Solutions*, Health Affairs (Mar. 26, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200324.784502/full/ and Benjamin A. Howell, *Protecting Decarcerated Populations In The Era of COVID-19: Priorities For Emergency Discharge Planning*, Health Affairs (Apr. 13, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200406.581615/full/.

Corrections officials, law enforcement agencies, and other relevant actors can safely de-populate their facilities by using the following criteria:

a) avoiding new custodial arrests for crimes that do not pose an unreasonable safety risk to a specific person or persons;
b) halting all new state prison sentences unless the individual has been formally charged with an offense involving the intentional use of force to cause serious bodily injury;
c) drastically limiting the use of pretrial detention;
d) eliminating incarceration as a response to non-payment of fines and fees
e) releasing all people held on probation, parole, technical violation detainers or sentences and halting incarceration for supervision violations;
f) implementing a practice of automatic release for all people serving a misdemeanor sentence;
g) commuting the sentences of imprisoned people with less than two years remaining on their sentences;
h) reviewing all felony sentences and moving for release for the elderly and those who are medically vulnerable; and
i) releasing all persons, adults, and children detained in youth and immigrant detention, including those on parole.

2. Issue public health guidelines distinguishing "solitary confinement" from "quarantine" and "medical isolation" to prevent punitive conditions for those who contract COVID-19. The purpose of quarantine and medical isolation is public health-related and *not* punitive.[7] Medical staff, and not security staff, supervise and determine the length of isolation and quarantine, and amenities and human contact are *not* more limited in isolation and quarantine than in the general population.[8] To that effect, we ask the CDC to make clear that those in quarantine and medical isolation will still be able to: make calls, have cell phone or video-based contact with loved ones, have outdoor recreation in large spaces (albeit with masks, in small groups, and with appropriate physical distancing), access the canteen, and retain other privileges available to those in the main jail/prison population. Medical staff should also give incarcerated individuals daily information about how many days they have left in quarantine or isolation. Explaining these distinctions is vital to stemming the spread of COVID-19 in correctional facilities because the use of solitary confinement for known or suspected cases of COVID-19 often dissuades people from reporting symptoms, facilitating the rapid spread through correctional populations.

3. Assemble a formal CDC working group on COVID-19 and prisons. This CDC working group should include personally affected individuals, frontline corrections staff, academics in medical fields, and should examine prison health care issues beyond just COVID-19. This crisis has demonstrated the unique vulnerability of detained people and the importance of maintaining focus on this population even after the pandemic ends.

[7] *See* David H. Cloud et al., *Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During Covid-19*, 2020 J. General Internal Med. 1 (2020).
[8] *See id.* at tbl. 2.

4. Segregate suspected and documented COVID-19 cases from the general correctional population. As stated above, medical isolation and quarantine are important measures of infection control, particularly in a correctional facility where social distancing is nearly impossible. If COVID-19 cases are detected in a facility, incarcerated individuals and correctional staff who have tested positive or come into close contact with COVID-positive individuals must be medically isolated and provided alternative housing arrangements. Decarceration will be required to free up the extra space needed for quarantine and medical isolation space.

5. Make soap and hand sanitizer freely accessible to all people incarcerated and working in correctional facilities, and make gloves mandatory for all staff. Although the CDC has already recommended that soap be freely accessible, a recent survey[9] revealed that 25% of correctional staff still do not have access to hand sanitizer on-the-job. Practices and protocols across states are inconsistent. The CDC should work closely with individual states to ensure all facilities have soap and water with a place to wash hands and/or hand sanitizer. Social distancing in correctional facilities is virtually impossible, and some facilities have poor ventilation. This makes the need for gloves, soap, and hand sanitizer vitally important for both staff and incarcerated populations.

We implore the CDC to work closely with governors, state public health officials, and state Departments of Corrections and juvenile justice agencies about the recommended measures and urge them to comply with these minimum standards. We also urge the CDC to consult with formerly and currently incarcerated people, including young people, to better understand how CDC guidance will work on the ground in prisons and jails. Unlock the Box is ready to partner with the CDC in these efforts. As an organization, we advocate for the rights of incarcerated people and aim to protect them during this dangerous pandemic. Please do not hesitate to contact us with any questions or opportunities for collaboration. We can be reached at jsandoval@unlocktheboxcampaign.org.

We look forward to hearing from you about an immediate course of action.

Sincerely,

The Unlock the Box Campaign and the undersigned,

Allard K. Lowenstein International Human Rights Clinic at Yale Law School

American Civil Liberties Union

Americans for Democratic Action (ADA)

[9] Letter from One Voice: Uniting Corrections and American Correctional Officers Intelligence Network (ACOIN) to Centers for Disease Control and Prevention, April 28, 2020

Andrew Goodman Foundation

Autistic Women and Nonbinary Network

California Coalition for Women Prisoners

California Families Against Solitary Confinement

Campaign for Alternatives to Isolated Confinement (CAIC)

Catholic Migration Services

Center for Children's Law and Policy

Church of Scientology National Affairs Office

Church World Service

Citizen Action of New York

Common Cause

Correctional Association of NY (CANY)

DC Justice Lab

Defender Impact Initiative

Defending Rights & Dissent

Disability Rights Washington

Drug Policy Alliance

End Solitary Santa Cruz County (CA)

Fair Chance Project

Family and Emergency Nurse Practitioners

Families United to End LWOP - FUEL

First Unitarian Church

Free Minds Book Club and Writing Workshop

Haitian Bridge Alliance

Health in Justice Action Lab, Northeastern University School of Law

Health Resources in Action

Human Rights Campaign

Human Rights Watch

Immigrant Legal Defense

Innocence Project

International Community Corrections Association

Justice Policy Institute

Justice Roundtable

Juvenile Law Center

Lambda Legal

Law Enforcement Action Partnership

League of Women Voters of the United States

LIFE Progressive Services Group Inc.

Louisiana Stop Solitary Coalition

Matthew Shepard Foundation

Mommieactivist and Sons

NAACP

National Association of Criminal Defense Lawyers

National Association of Counsel for Children

National Association of Social Workers

National Center for Lesbian Rights

National Center for Transgender Equality

National Council of Churches

National Employment Law Project

National Juvenile Defender Center

National Juvenile Justice Network

National Partnership for Women & Families

National Religious Campaign Against Torture

New Hampshire Public Health Association

New Sanctuary Coalition

One by 1, Inc.

Pacific Juvenile Defender Center

Pennsylvania Institutional Law Project

Physicians for Criminal Justice Reform, Inc.

Physicians for Human Rights

Prison Law Office

Project On Government Oversight

RocACTS Criminal Justice Task Force

Safer Foundation

Social Workers and Allies Against Solitary Confinement

SPLC Action Fund

Stop the Drug War

T'ruah

The Bronx Defenders

The Campaign for Youth Justice

The Florence Immigrant & Refugee Rights Project

The Leadership Conference on Civil and Human Rights

The Sentencing Project

The Wright Institute

University of New Mexico Physicians for Human Rights Chapter

University of New Mexico School of Medicine Physicians for Human Rights

Uptown People's Law Center

Washington Lawyers' Committee for Civil Rights and Urban Affairs

Wilco Justice Alliance

Individuals (signing ONLY in their individual capacity; credentials and affiliation for identification only)

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