

**Public Health Declaration to Protect Incarcerated Persons, Correctional Staff, and Wisconsin Communities from COVID-19**

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We declare as follows:

1. Amanda M. Simanek, MPH, PhD, is an Associate Professor of Epidemiology in the Joseph J. Zilber School of Public Health at University of Wisconsin-Milwaukee, where she regularly teaches courses in principles of epidemiology, social epidemiology and epidemiologic links between infectious disease and chronic disease. She is a member of the American Public Health Association and member of, as well as a designated COVID-19 expert, for the Interdisciplinary Association of Population Health Sciences. Dr. Simanek has been active in infectious disease epidemiology research since she was a graduate student in the University of Michigan School of Public Health where she completed a Master of Public Health in International Health Epidemiology and PhD in Epidemiologic Science. Her research focuses on understanding social patterning of disease, etiologic links between infectious and chronic diseases such as cardiovascular disease and depression, and novel immunologic pathways by which social conditions contribute to the development of chronic diseases across the lifecourse and across generations. She is currently funded by the National Institute for Minority Health and Health Disparities to study the association between maternal socioeconomic disadvantage, adverse birth outcomes and inflammatory response in children at birth. Dr. Simanek was also previously part of a research team that carried out a Centers for Disease Control-funded study of voluntary isolation on transmission of influenza and other respiratory illnesses among university students. She has been volunteering as an outside expert for the Wisconsin Army National Guard team planning response for the coronavirus pandemic since March 19th, 2020.
2. Lorraine Halinka Malcoe, MPH, PhD is an Associate Professor of Epidemiology and Undergraduate Program Director in the Joseph J. Zilber School of Public Health at University of Wisconsin-Milwaukee. She earned her PhD in Epidemiology and her MPH in Epidemiology and Biostatistics from the University of California at Berkeley. Her primary areas of expertise are in social epidemiology, community health, health disparities, and educational interventions. Dr. Malcoe has nearly 30 years of experience teaching epidemiologic methods and designing and directing federally-funded (e.g., NIDA, NIJ, NIEHS, CDC, CIHR [Canada]) observational and community-level intervention research impacting incarcerated, low

income, rural, urban, immigrant, African American, Native American, and Hispanic populations. Dr. Malcoe has collaborated with state-level departments of corrections, correctional institutions, community organizations, and tribal governments. Her research has informed local and national policy regarding effective re-entry strategies (New Mexico), widespread environmental exposures (the Tar Creek Superfund site in Oklahoma), and violence against American Indian women (reauthorization of the Violence Against Women's Act).

3. The SARS-nCoV-2 virus and the disease it causes (i.e., COVID-19) has become a global pandemic. The United States is now the epicenter of the outbreak with nearly 400,000 cases and 13,000 deaths reported to date.
4. COVID-19 is characterized by a flu-like illness (i.e., fever, cough, shortness of breath). While the majority of cases are self-limited and generally mild, many cases have more severe disease requiring medical intervention and support such as supplemental oxygen and positive pressure ventilation. Indeed, over the past six weeks, 20.7-31.4% of cases have been hospitalized and 4.9-11.5% have been admitted to intensive care units overall, with rates even higher among those aged 65 years and older. (1) During this same time frame, the overall case fatality rate of COVID-19 has been estimated to range from 1.8-3.4%, which is 2 to 35 times the rate of death associated with seasonal influenza infection. (1)
5. In the United States, severe complications due to COVID-19 that require intensive care unit (ICU) admission or other hospital admission are more common among the elderly and among people with one or more underlying health conditions.(2) These conditions most commonly include diabetes mellitus, chronic lung disease, and cardiovascular disease, or other recognized risk factors (e.g., smoking) for severe outcomes from respiratory infections.(2) Among laboratory-confirmed cases, those with an underlying condition had four times the rate of hospitalization without ICU admission than those with no underlying condition (27.3–29.8% vs 7.2–7.8%, respectively). Likewise, cases with an underlying condition had nearly six times the rate of ICU admission than those with no underlying condition (13.3–14.5% vs 2.2–2.4%, respectively). (2) Among cases 65 years and older with one or more underlying health conditions or risk factors, the rates of hospitalization without ICU (41.7–44.5%) and ICU admissions (20.8–22.2%) are much higher. (2)
6. The first case of COVID-19 was detected in Wisconsin on February 5<sup>th</sup>, and as of April 7<sup>th</sup>, 2020 there have been over 2,500 cases diagnosed, of which 28.9% have been hospitalized and 92 have died, with sustained community spread of the virus in numerous Wisconsin counties. (3) Mirroring national data, the hospitalization rate in Wisconsin increases with age: 19% for cases in their 40s, 26% for cases in their 50s; 38% for cases in their 60s; 52% for cases in their 70s; and 69% for cases in their 80s. (3)
7. On March 12<sup>th</sup>, 2020, Governor Evers declared a public health emergency in the State of Wisconsin. As of March 18<sup>th</sup>, 2020, all schools in Wisconsin were closed and over the next two weeks, the Governor continued to implement other social distancing measures to limit the spread of COVID-19, such as increasingly tighter restrictions on the size of public and private gatherings, closure of restaurants and bars, and the eventual issue of a "Safer at Home" order on March 24<sup>th</sup>, 2020. This "Safer at Home" order applies to the entire state and mandates that all Wisconsinites stay at home as much as possible and that non-essential businesses cease operations, with limited exceptions for minimum basic operations and working from home. All

public and private gatherings of any number of people that are not part of a single household or living unit are prohibited, with limited exceptions. (4)

8. Under the “Safer at Home” order, social distancing requirements include: 1. Maintaining social distancing of six feet between people; 2. Washing hands with soap and water for at least 20 seconds as frequently as possible or using hand sanitizer; 3. Covering coughs or sneezes (into the sleeve or elbow, not hands); 4. Regularly cleaning high-touch surfaces; 5. Not shaking hands; and 6. Following all other public health recommendations issued by the Wisconsin Department of Health Services and the Centers for Disease Control and Prevention (CDC).(3) The CDC also now recommends that individuals who leave home to obtain essential services, groceries, medications, etc., wear a cloth mask while out in public to further help prevent the spread of SARS-nCoV-2 infection. (5)
9. A primary reason for the safer-at-home order is that many of our state’s approximately 11,000 hospital beds and likely all of our state’s 2,500 ICU beds and 620 ventilators (Wisconsin Hospital Association) will likely be operating at or beyond full capacity for months, even with these social distancing measures in effect. Even with efforts to increase capacity, *it is essential during this time when our healthcare system is saturated, that every effort be made to reduce outbreaks that would only further stress our ability to care for both COVID-19 patients and all other patients who need hospital care.*
10. SARS-nCoV-2 infections are transmitted through inhalation of aerosolized droplets expelled when individuals cough or sneeze, or when individuals touch surfaces that may become contaminated when droplets land on them after someone coughs or sneezes. Individuals who are infected with SARS-nCoV-2 can take between 2-14 days to develop symptoms (6-8) yet they are still infectious up to 48 hours before showing any symptoms (9), while ***as many as 25% or more of infected individuals never become symptomatic yet still can transmit the infection to others.*** (9, 10-13) *Given this high asymptomatic rate, effective screening of prison staff who move in and out of facilities on a daily basis is not possible without frequent and rapid testing.* For these reasons, combined with the inability at present to conduct widespread testing, the combination of social distancing, hand hygiene, and proper sanitizing of frequently touched surfaces is a key mitigation strategy for this infection.
11. COVID-19 is highly contagious. We have repeatedly seen logarithmic increases in cases and deaths throughout U.S. localities since the start of the pandemic, and we are beginning to see the same pattern in prisons and jails. ***It only takes one person, for example a single asymptomatic correctional officer, to infect an entire facility*** (including incarcerated people and staff). At the Cook County jail in Illinois, the first two COVID-19 cases were identified on March 23<sup>rd</sup>. By April 1<sup>st</sup>, just nine days later, the number of confirmed cases had risen to 167. That number rose to 220 just four days later, including 14 who have been hospitalized and one who died awaiting his court date. As of April 7<sup>th</sup> there have been confirmed diagnoses of COVID-19 among 241 people incarcerated in federal prisons, *including 8 who have died*, and 73 Bureau of Prison staff. (14) The infection rate in New York jails demonstrates what can and will occur in our State prisons if action is not taken now to allow effective social distancing – in New York the infection rate has been estimated at nearly 4%, 8 times higher than the already-high New York City rate and over 9 times higher than the hardest-hit region in Italy. In Illinois state prisons, as of April 7<sup>th</sup>, 70 Department of Corrections staff have tested positive for SARS-nCoV-2 across 11 prisons, along with at least 110 persons incarcerated at seven prisons (with 187 lab

tests still pending) – of note, there is a major outbreak at Stateville Correctional Center, with at least 95 confirmed cases and two incarcerated individuals who have died from COVID-19. (15)

12. Without swift action to reduce the state prison population to allow effective social distancing, it is virtually inevitable that severe outbreaks of COVID-19 will occur throughout the State of Wisconsin prison system ***culminating in a public health disaster including many unnecessary deaths of people under the care of the Wisconsin Department of Corrections (WDOC)***. As of April 7<sup>th</sup>, 2020, **10** WDOC workers, including some medical staff, have tested positive for SARS-nCoV-2 across four facilities: the Milwaukee Secure Detention Facility (n=4), Division of Community Corrections - Milwaukee Office (n=3), Columbia Correctional Institution (n=2), and Waupun Correctional Institution (n=1). In addition, 5 cases have been diagnosed in the last week among incarcerated persons in the State: 2 at the Columbia Correctional Institution, 2 at the Oshkosh Correctional Institution, and 1 detainee in the Waukesha County Jail. (16) ***We must immediately reduce prison populations throughout Wisconsin, starting in Milwaukee where the community-wide outbreak is the most advanced - time is of the essence.***
13. Despite concerted efforts to prevent outbreaks of COVID-19 throughout the WDOC, prisons throughout Wisconsin are ripe for amplifying the spread of COVID-19 for several reasons: 1) correctional officers and other staff can easily be exposed in the community (especially those with community spread) and then transmit the virus to incarcerated persons and other staff in their workplace; 2) there is no adequate protocol for screening of asymptomatic infection in uniformed staff; 3) high population density in close confinement inhibits maintaining a 6 ft distance from others and thus social distancing is not possible to the same degree as in the general public, and 4) institutional conditions and rules common in prisons exacerbate risk - these include limited medical care infrastructure and personal protective equipment as well as delays in medical evaluation and treatment; rationed access to soap, water, and clean laundry; contraband policies that forbid the use of alcohol-based hand sanitizers and masks; inadequate ventilation; and shared toileting, showering, and eating environments. (17-20) Moreover, some WDOC correctional facilities are severely overcrowded, including the Milwaukee Secure Detention Facility and the Robert Ellsworth, both of which have been operating at over 200% capacity, and the Prairie Du Chien where in some cases there are eight people housed per cell. In sum, these conditions within Wisconsin prisons prevent implementation of the CDC's guidance on management of COVID-19 disease in correctional and detention facilities, including social distancing to prevent overcrowding during a community outbreak, separate quarantining of all new intakes for 14 days, and medical isolation. (21)
14. Space limitations within correctional institutions also pose a challenge for following Wisconsin Department of Health Services recommendations for quarantine of those with contact to a COVID-19 case (recommended duration 14 days since exposure) as well as isolation (note that this does not equate to solitary confinement, which is well known to cause psychological harm and thus could worsen recovery) of COVID-19 cases (recommended until 72 hours have passed with no fever and without the aid of fever reducing medication, and other symptoms have improved *and* at least seven days have passed since symptoms first appeared). (22)
15. Incarcerated persons in jails and prisons are not only at increased risk of COVID-19 because of the nature of the prison environment, they also have increased risk of adverse complications resulting from COVID-19 due to a higher prevalence (43.9% vs 31.0% in the general population) of underlying chronic conditions, including high blood pressure/hypertension (30.2%),

tuberculosis (6%), asthma (14.9%), diabetes (9%), cardiovascular disease (11.6%), renal disease (6.1%), hepatitis B or C (10.9%), and HIV/AIDS (1.3%). (23) As well over 19% of the WDOC prison population is 50 years or older (24), further compounding their increased risk of hospitalization and ICU admission once infected. Governor Evers pledged during his campaign for office to close the Milwaukee Secure Detention Facility (MSDF), where re-incarceration for crimeless revocations is common, and to institute reforms that would reduce Wisconsin's incarcerated population by half. The need for the Evers administration and the Courts to act on these promises is now urgent. From a public health perspective, **safe and rapid decarceration is among the most effective preventative measures that can be taken to reduce the spread of COVID-19 within jails and prisons** and reduce hospitalizations and deaths from jail- and prison-acquired COVID-19 infections. Decarceration reduces population density and allows for increased social distancing.

16. Revocations account for 40% of new admissions to Wisconsin's state prisons. Directly impacted persons and other advocates have long identified Wisconsin's supervision and revocation processes as a tool for cycling Wisconsin residents in and out of jails and prisons. MSDF was erected in 2001 to imprison people on parole/probation violations. Its mission was further expanded to detaining persons in alternatives to revocation programs, persons with "temporary lock-up" status, and incarcerated persons slated to be released within one year. Operating capacities at this facility, designed to detain under 500 people, have averaged over 1,000. Lack of access to direct sunlight, air conditioning, and outdoor recreation, 20-23 hour lockdowns and extreme heat further exacerbate MSDF's conditions of overcrowding, which force incarcerated persons into triple-bunked cells, making the risk of a COVID-19 outbreak practically imminent. Communicable disease and chronic health conditions have plagued MSDF since its opening. A total of 17 people have died while confined in MSDF, a statistic made even more alarming in the context of the COVID-19 pandemic. As stated, there are already three confirmed cases among MSDF staff. **MSDF in particular must be depopulated well below the 500 capacity for which it was designed assuming no COVID-19 pandemic.**
17. The release of detainees, especially those with increased health-related vulnerability, also protects health care surge capacity by reducing the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large.
18. There are also compelling ethical and legal obligations to decarcerate correctional institutions. Incarcerated persons have inalienable human rights conferred upon them by international treaties and covenants, including a right to adequate health care. They also have a right not to contract disease while incarcerated, particularly an infectious disease that is potentially lethal. For correctional staff, the 1970 Occupational Safety and Health Act gives workers the right to refuse to work under unsafe working conditions without reprisal.
19. To reiterate, social distancing is our primary available means to effectively control the spread of COVID-19 in correctional institutions, barring extensive testing and contact tracing, followed by isolation or quarantine. Yet, social distancing is not possible with the current number of persons in custody in jails and prisons throughout Wisconsin. Release of detainees who present a low risk of harm to the community is thus an essential public health prevention strategy allowing for increased adherence to social distancing recommendations.

20. As of April 2<sup>nd</sup>, 2020, the WDOC has committed to “releasing supervision holds on 1,148 non-violent misdemeanants throughout the state, releasing others persons in custody that qualified for Certain Earned Release,” and they identified and released “65 individuals participating in an Alternative for Revocation (ATR) at the Milwaukee Secure Detention Facility (MSDF).” (16) Of note, as of December 31<sup>st</sup>, 2018, 55% of the WDOC incarcerated population had two or fewer years left to serve.
21. Several additional populations must be prioritized for safe and rapid reduction of prison populations via compassionate release, mass clemency, medical or emergency furloughs, or other commutations of sentences: 1) persons held for non-payment of fees and fines, because of insufficient funds to pay bail, or who otherwise have not been convicted of a crime; 2) detainees in MSDF who were re-incarcerated for technical rule violations or other reasons without commission of a new crime (i.e., crimeless revocations); 3) detainees convicted of low-level offenses and those nearing release with re-entry plans or on less than 12 month deferrals; 4) parole-eligible detainees; 5) pregnant women; 6) detainees with chronic conditions or risk factors predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, renal disease, immune-compromised, heavy smokers); and 7) older detainees (50 years and older). Additionally, new incarcerations and use of pre-trial detention should be limited to the extent possible and used only in those cases where there are genuine security concerns.
22. When detainees are released, it is important to ensure that each person has family or friends who can take them in safely without jeopardizing their health. For those who do not, the WDOC and other state agencies can and should use emergency money from the federal government to help secure safe housing for them. If detainees have potentially had contact with a confirmed case in correctional staff or another detainee, they should be housed in a hotel or other similar housing for 14 days to facilitate compliance with recommended quarantine before being returned to their family’s or friend’s home.
23. In sum, as epidemiologists and public health professionals, *we urge actions to safely and rapidly reduce Wisconsin’s prison populations in order to minimize the risk of severe outbreaks of COVID-19 – and especially hospitalizations and deaths – among incarcerated persons as well as correctional staff. The time for action is now.*

Pursuant to 28 U.S.C. 1746, we declare under penalty of perjury that the foregoing is true and correct. Our views represent our best professional and scientific judgments – we are not speaking on behalf of the University of Wisconsin - Milwaukee. Executed this 7<sup>th</sup> day, April, 2020.



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