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MCI-Norfolk has been locked down for 5 weeks. During this time we have not been allowed out of our units for fresh air or exercise. This means that we have been clustered together on our tiers 24/7. Most of the time the doors to each tier are locked although our cell doors are not locked. There are several other locking units where the cell doors may (or may not--I have no direct knowledge) been locked. Each tier holds some 15 to 20 prisoners in single or double cells. Social distancing is not possible in hallways that are 6 feet wide. Those in single cells have some privacy, but with cells mostly 6 feet by 12 feet in size, with bunkbeds, the two prisoners are never far apart and cross contamination is inevitable. Further, we are brought down to the chow hall three times per day, mostly one tier at a time, to receive our food. Here it is difficult to maintain social distancing and all men need to use the same areas and equipment with no ability to clean between use. Surface cross-contamination is inevitable. No bleach is available to prisoners nor are we provided with any cleaning materials or wipes other than soap and toilet paper.

Meals have been mostly cold cuts and chips, with rare offerings of hot meals such as meatballs in tomato sauce. Even those meals are accompanied by bread, rather than rice or potato. Rare meals have offered vegetables. A welcome change is that fresh fruit is now offered, a year after having been removed from the menu. Prewashed lettuce has been the most common side dish, and even that is occasional. Currently, no one eats in the chow hall, taking their food up to the tiers. This is necessary because the crowded serving area must be cleared rapidly to serve the 68 people in our unit. The food trays and bowls are washed in the dishwasher, using "cold steriliztion" as usual in the DOC. Overall, the chow hall remains a major source of cross-contamination exposure due to inadequate cleaning and disinfecting and no ability to clean between individual touching of commonly used areas. Yet this is common ground into which prisoners from all 4 tiers need to venture three, four or five times daily.

During the first 2 to 3 weeks we were not offered masks but were given one mask each about 2 weeks ago which we are now told to wear when accessing common spaces. Of course, not all prisoners comply with this directive and there is no enforcement. Stairwells are only 4 feet wide, so social distancing is impossible as one accesses the chow hall or medline. No other protective equipment, wipes or cleaning materials are available to individual prisoners who are not allowed access to bleach or other disinfectants.

In our unit, as in many others, cells on only one of the tiers on each floor have sinks and toilets. The other tier is "dry" and all those prisoners share a single bathroom with 2 sinks, 2 toilets and 2 showers. Additionally, prisoners from the "wet" side tier also must traverse the dry tier to access the 2 showers which are available only on that side. No special cleaning

equipment, bleach, directives or supervision has been provided for cleaning and maintaining the common bathrooms to which all prisoners are exposed daily. The DOC is providing a small "hotel-sized" bar of soap and a roll of toilet paper to prisoners twice per week, rather than the usual once per week. As mentioned, bleach is prohibited.

Besides the bathroom, the chow hall is another major area ripe for cross-contamination. Here cleaning is limited mostly to 2 or 3 times per week spraying with dilute bleach solution by a roving team of 2 to 3 prisoners from other units, accompanied by an officer. However, spraying is mostly limited to the serving area, the microwaves, refrigerator and freezer. Most tables and other surfaces are not cleaned or sprayed even though many must be used communally while handling food trays or when accessing the phones which are also in the chow hall. There is no equipment or time provided to prisoners to self clean.

For the first 2 weeks the cleaning solution to use for the phones was inadequate (benzalkonium chloride). For the last 3 weeks a new solution and communal rag is offered to clean the phones. Although I have asked the Environmental Officer to identify the active ingredient(s), he does not seem to know. I have repeatedly asked for the required label to be attached to the bottle but this has not happened.

In addition to other uses, medication administration lines staffed by a nurse and officer are also held in the chow hall 2 to 3 times daily. Additionally, once per day, based on voluntary sign-ups, we are allowed 30 minute intervals for access to the 3 phones in the chow hall. This further exposes prisoners to each other and to additional staff that might eventually be infected. Currently, the only PPE used by staff accessing the units are face masks.

We are told that almost no prisoners have tested positive for Covid at MCI-Norfolk. Certainly, no one in our unit seems to have had symptoms and it is unlikely, if infection were in the unit, that no one would exhibit sufficient symptoms to be detected or reported. However, it is not clear how readily prisoners will self-report mild symptoms because, if symptomatic, we are told they will be removed from their cells (along with the cellmate if any) to be sequestered on the third floor of Segregation. There they will be tested (we are told) and only returned after resolution of symptoms and testing negative. With inevitable delays, this would isolate them for at least one week, and if positive, possibly much longer. These disincentives make it likely that many prisoners with milder symptoms may not timely report them, enhancing the likelihood of cross-infection. There has been little or no testing done here.

It is important to note that the medical department appears to be stressed beyond any capacity to function. Obviously, to date, this is not because of any infection in the institution but only because of the inadequate staffing and accommodation to servicing each unit with daily medication. Prisoners also report long delays in receiving their "keep on person" medication cards due to miscommunication and other errors. Most prisoners are experiencing interruptions, often lasting weeks, in receiving their daily medications because of confusion with ordering and delivering "keep on person" medication. This has included most oral medications, including those for thyroid, oral diabetes, hypertension, and many other conditions. Such

omissions may render prisoners more vulnerable to the ravages of Covid infection when it occurs.

Those complaining of new medical problems unrelated to Covid-19 via sick-slips are frequently ignored or their requests for evaluation seriously delayed. Patients often are not seen at all and frequently management and treatment are ordered without direct contact with the prisoner for evaluation, examination or proper history taking. Some examples include a prisoner complaining of blood in the urine who was not seen for over one week. Another prisoner who experienced a 5 day delay despite daily reporting obvious prostatitis symptoms was initially treated with antibiotic without being seen or obtaining a culture. Access to examinations, tests, cultures and blood work appears to be minimal and often delayed. Doctors and Nurse Practitioners are marginally staffed which results in inadequate and delayed responses to any intercurrent medical problems. Nevertheless, this will be the same skeleton crew of providers that will need to diagnose, assess and refer for treatment any prisoner who might exhibit symptoms or distress from Covid-19 infection. At the current rate of access to medical care, it is unlikely that timely intervention for Covid infection will be available--promoting spread and poor outcomes for anyone who eventually becomes infected.

When, as is inevitable, Covid infection finally penetrates the prisoner population at Norfolk, it is clear that the infection will spread rapidly throughout the prisoner population--likely with devastating effects since this is the oldest and longest serving prisoner population in the DOC. Furthermore, Norfolk is filled to 100% of capacity. The so-called operating capacity of 1450 has been altered by the permanent decommissioning of 150 beds, reducing the true operating capacity to the actual current population of approximately 1300. When at some point the infection penetrates the institution, prisoners will become infected and the infection will likely begin to spread throughout units even before anyone is aware. This is because it is now clear that Covid routinely transmits in the days before symptoms appear. Having been sequestered, there is no herd immunity and the close quarters virtually guarantee cross-infection.

Even the current attempt to segregate prisoners by unit is regularly invalidated by the prison policy that continues to use prisoners from multiple units in communal spaces for work. For example, all during this lockdown, prisoners from multiple units have been working side-by-side in the Laundry and Industries and some other areas. There prisoners from multiple units come into contact with each other and officers, potentially cross-contaminating each other, especially with little cleaning available. The only protective gear provided has been face masks. These prisoners then return to their regular units throughout the prison where they mingle with other isolated prisoners. With Covid's high rate of transmission and the close and crowded conditions in the prison, there appears little doubt that once infection arrives, infection will spread rapidly throughout the entire prison. In most ways, conditions here are more conducive to spread than those that have been seen in vulnerable nursing homes and facilities for the elderly. This is because of the crowded conditions and the lack of staff and means for interval cleaning in communal areas. With the large number of older prisoners and high rates of vulnerability among long incarcerated prisoners who have high rates of pre-existing conditions, outcomes will likely be equally devastating.

[I hope to provide brief weekly updates hereafter.]