INTERIM EXPERT REPORTS
OF
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Medical Report

And

M. PERRIEN, Ph.D.
Mental Health Report

IN THE MATTER OF MAYS v SACRAMENTO COUNTY
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Report on Prevention, Screening, and Management of COVID 19 at Sacramento County Jail

October 26, 2020

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Introduction

In July 2020, counsel[1] for the parties in Mays v. Sacramento requested that the medical court experts, Madeleine LaMarre MN, FNP and Michael Rowe MD, undertake an evaluation of prevention and management of COVID-19 at the Sacramento County Jail (SCJ).[2]

The evaluation focused on conditions of confinement that would contribute to or mitigate an outbreak of COVID-19 and SCJ's compliance with Centers for Disease Control and Prevention (CDC) Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities.

To prepare this report, the court experts interviewed Sacramento County Jail's (SCJ) health care and custody leadership, toured the Main Jail and Rio Cosumnes Correctional Center (Branch Jail), conducted on-site interviews with health care, custody staff, and detainees, and reviewed medical records and other documents. On October 16, 2020, the parties were provided a draft report to which they provided comments which were carefully considered prior to finalizing this report.

I thank Sandy Damiano Ph.D., Deputy Director of the Department of Health Services, Primary Health Division, and Deputy Chief Santos Ramos, Sacramento Sheriff's Office, and their staff for their assistance and cooperation in completing this review.[3]

Background

In late 2019, an unusual cluster of cases of pneumonia resulting in a number of deaths was identified in China. Subsequently, the cause of this outbreak was identified as a novel coronavirus that became known as Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). The disease it causes is known as COVID-19. As this is a new coronavirus, there is no pre-existing immunity in the population and due to its highly infectious nature, the virus has spread rapidly around the globe. On March 19, 2020 the World Health Organization (WHO) declared COVID-19 to be a worldwide pandemic. As of October 14, 2020, there have been over 38 million confirmed COVID-19 cases globally with more than 1 million deaths. In the United States, there have been more than 8 million cases and 220,000 deaths. Unfortunately, COVID-19 cases continue to occur at unacceptably high rates in the US, resulting in continued hospitalizations and deaths.

[1] Rick Heyer for Sacramento County, Margot Mendelson for the Prison Law Office, and Aaron Fischer for Disability Rights California.

[2] Since the initiation of the evaluation, Michael Rowe MD resigned as court expert. I would like to thank Dr. Rowe for his significant work and contributions to this report.

[3] I wish to acknowledge ACH staff Pamela Gandy-Rosemond RN, Nursing Director, Robert Padilla, MD, Acting Medical Director, Zoe Clauson, Administrative Services Officer, Aron Brewer, Chief, and SSO staff Lt. Paul Belli, Assistant Commander, Lt. Alex McCamy, Compliance Commander, Main Jail and Lt. Brian Amos, Assistant Commander, Lt. Mark Hatzenbuhler, Compliance Commander, Branch Jail.

Among states, California leads the nation with more than 860,000 confirmed cases and 16,700 deaths. On February 21, 2020 Sacramento County confirmed its first case of COVID-19, and as October 2, 2020, there have been approximately 24,000 cases and 458 deaths.[4] Sacramento County's COVID -19 current risk level is assessed as being Substantial.[5]

Coronavirus outbreaks have been reported in jails and prisons throughout the country. An ongoing register of COVID-19 cases in US correctional facilities shows that as of October 2, 2020 there were over 149,000 cases among detainees as well as 1,050 deaths and over 31,000 cases among staff including 58 deaths. In a May 2020 CDC report, more than half of affected facilities reported cases only among staff members.[6] This speaks to the extent to which correctional staff acquire COVID-19 infection in the community and may subsequently introduce the infection into a correctional facility.

Correctional institutions face significant challenges controlling the spread of highly infectious pathogens such as COVID-19. Factors contributing to disease transmission include crowded dormitories, shared lavatories, limited medical and isolation resources, daily entry and exit of staff members and visitors, continual introduction of newly incarcerated or detained persons, and transport of incarcerated or detained persons in multi-person vehicles for court-related, medical, or security reasons. Given these challenges, it is important that correctional institutions have operational plans in place to prevent, screen, and manage cases of COVID-19 in their institutions.

Executive Summary

This report describes the conditions of confinement that increases or mitigates the risks of COVID-19 transmission and disease outbreaks at the Sacramento County Jail (SCJ). It also describes measures Adult Correctional Health and Sacramento Sheriff's Office have taken to reduce the risk of transmission of COVID-19 at the jail.

To date, SCJ has been successful in identifying and isolating cases of COVID-19 at intake and preventing transmission within the jail. Since March 2020, staff have identified 104 of 105 COVID-19 cases through intake testing with no documented intrafacility transmission.[7] The SCJ intake screening process is an example of how a combination of quarantine and coronavirus testing has successfully identified COVID-19 cases, for which health care and custody leadership and staff are to be commended. Moreover, there are no known cases of transmission to have occurred within the jail since the onset of the pandemic.

[4] Sacramento County Department of Health Services COVID-19 Dashboard.
[5] California has established four risk levels based upon 7-day average daily cases/100,000 population and 7-day average of COVID-19 test results. Risk levels are categorized as Minimal, Moderate, Substantial and Widespread.
[6] https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm
[7] The one case not identified at intake involved an elderly patient who has been at the jail since 2018 who became ill and was transported to the hospital where he tested positive for COVID-19. A contact investigation was immediately initiated and revealed no additional cases.

There are several factors that have contributed to SCJ's success in preventing COVID-19 transmission. These include:

- Judicial intervention to reduce the population (including medically vulnerable detainees) in the Spring of 2020
- Proactive health care and custody leadership
- A cooperative relationship between health care, custody and public health
- Developing staff guidance regarding management of COVID-19 at the jail
- Leadership responsiveness to changing conditions at the jail.

However, at the same time, there are barriers and challenges that increase the risk of COVID-19 transmission and outbreaks at the jail, some that are within the control of ACH and SSO, and some that are not. The conditions at SCJ that both increase and mitigate the risk of COVID-19 disease transmission are described below.

Judicial Measures Reduced Sacramento County Jail Population in Early 2020, but the Population is Rising Again

In March 2020, SCJ's population was approximately 3,600 detainees. Due to concerns about COVID-19 disease outbreaks, two court orders were issued to release detainees from the jail including medically vulnerable detainees. In April 2020, zero cash bail was instituted for pretrial inmates with qualifying charges. The population declined to approximately 2,400 in May 2020, but has been steadily rising to the current level of 3,100 detainees, including 425 sentenced inmates awaiting transfer to CDCR. This number also includes approximately 900[8] detainees with medical conditions that place them at increased risk of severe COVID-19 disease, hospitalization and death. It is concerning that almost 30% of the jail population is at risk of severe COVID-19, however many of these detainees are not eligible for alternative sentencing.

Increasing Jail Population Impacts ACH and SSO's Capacity to Implement Public Health Measures that Prevent Transmission of COVID-19

The steadily increasing population at SCJ negatively impacts ACH and SSO's ability to implement Centers for Disease Control and Prevention (CDC) recommendations to prevent and manage COVID-19. For example, the CDC recommends that all new intakes be quarantined for 14 days upon arrival, however bed space demands as well as classification considerations only permit SSO to implement a 7-day intake quarantine. Although ACH plans to test new arrivals for coronavirus infection on day 6, this may still result in a significant number (20%) of false negative tests and lack of identification of asymptomatic cases. This is a particular concern if adequate precautions to prevent transmission are not taken during detainee arrest, booking, and placement in holding cells with other detainees, which the medical expert observed during on-site tours.

[8] This number was estimated based upon a report that noted that among the population, 1,111 had conditions increasing the risk of severe COVID-19, however some detainees had 1 to 5 different conditions associated with severe disease, and 57 detainees had 3 or more conditions.

The increasing population also adversely affects SSO's ability to enforce social distancing during daily jail activities such as booking, housing, meals, recreation, work details, etc. Lack of social distancing sets up conditions for disease transmission and may result in disease outbreaks. This is extremely significant given that approximately 30% of the population has a medical condition known to result in severe COVID-19 disease.

ACH Guidance for Prevention, Screening and Management of COVID-19

On March 2, 2020, Adult Correctional Health (ACH) published COVID-19 (Novel Coronavirus) Staff Guidance. This was prior to the March 14, 2020 publication of interim guidance for correctional facilities from the Centers for Disease Control and Prevention (CDC). ACH Guidance addresses screening, testing and quarantine of newly arriving detainees; and isolation, monitoring and treatment of COVID-19 suspects and confirmed cases. The Guidance also provides direction regarding prevention measures, universal masking and personal protective equipment. SSO works closely with ACH to follow their guidance but does not have separate COVID -19 policies and procedures.[9] SSO should develop comprehensive policies as they have different roles and responsibilities related to prevention activities.

ACH Staff Guidance did not address all areas addressed by CDC guidance and existing guidance has not been consistently enforced. For example, the medical and mental health experts observed lack of adherence to universal masking by custody, health care staff and detainees in other areas of the jail.[10] The failure of SSO to require custody staff to wear face masks was the subject of dispute between the parties in May 2020 [11], but was resolved in June 2020 by a Memorandum of Agreement that required deputies to wear masks in areas of the jail where class members are present.[12] Since then, the CDC has confirmed that COVID-19 is transmitted through aerosolization and the virus can remain suspended in the air over longer distances (usually greater than 6 feet) and time (typically hours).[13] Therefore, it is important to wear masks at all times in public spaces to prevent aerosolization of virus and not just while other staff and detainees are present. The importance of wearing masks for prevention of COVID-19 simply cannot be overstated.[14]

COVID-19 screening for staff entering the facility was not consistent with CDC guidelines. Staff screening was not performed prior to entry into the jail, but in the jail dining room where other

[9] Email correspondence from Mark Hatzenbuhler. October 23, 2020.

[10] SSO leadership reports that masking compliance among staff improved from the mental health experts site visit in August to the medical experts site visit in September, but the medical expert observed that custody staff and ACH staff did not consistently wear mask in offices.

[11] Letter from Margot Mendelson and Aaron Fischer to Rick Heyer regarding Notice of Dispute. May 27, 2020.

[12] Memorandum of Agreement. Face Coverings for Staff as Precaution Against COVID-19 Transmission in Sacramento County Jail Facilities, and Other COVID-19 Matters. June 18, 2020.

[13] https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html

[14] SSO leadership reports that the issue of staff masking has been addressed since the visits by the monitors, with near universal compliance by staff in all areas accessible to inmates. There is greater focus on modeling behavior, as suggested by monitors, and providing appropriate guidance to inmates. The monitors have not independently verified changes in masking compliance since the initial on-site visit.

staff were eating, not wearing face masks, or maintaining social distancing. An honor system was employed where arriving staff were to measure their own temperature using a paper towel to hold a thermometer. There were no alcohol wipes available to sanitize the thermometer. Staff screening was not documented so there is no verification that it is performed.[15,16] Arresting officers from other jurisdictions also were not screened prior to entering the booking area. Although these jurisdictions may have their own screening policies, no one should be permitted to enter the jail without COVID-19 screening. Visitors have temperatures taken but no symptom screening. Since reporting this finding, ACH reported that Main Jail SSO now completes screening in the lobby and that ACH will assume responsibility for staff screening in the near future, to include documentation of temperature checks and symptom screening.

Social Distancing is Not Consistently Enforced at SCJ

ACH Guidance and SSO policies do not comprehensively address social distancing and how it should be structured and enforced for all activities at the jail. In addition, medical and mental health experts observed lack of social distancing by SSO deputies, ACH and detainees. It has been established that both universal masking and social distancing are needed in combination to prevent disease transmission. SSO should incorporate monitoring and enforcement of masking and social distancing for detainees into policies and procedures and post orders. While conditions at the jail present challenges to social distancing, measures must be taken to enforce it where possible. This is true at the jail and also with court holding and transportation.

Structural Barriers Exist to Social Distancing

Structural barriers exist to implement and maintain social distancing among detainees at the jail. Main Jail is comprised of single and double cells, however, RCCC is a combination of single and double cells and open barracks with 100-120 detainees each. Beds in the barracks are not placed six feet apart and except in limited circumstances, SSO has not implemented social distancing sleeping arrangements.[17,18] SSO has implemented some strategies for social distancing such as not permitting detainees in different barrack cohorts to intermingle during meals and recreation, and reducing the size of day room groups cohorts, however SSO also reports that this is becoming increasingly difficult to implement social distancing due to the increase in jail population. As noted above, there are detainees with medical conditions that predispose them to severe COVID-19 disease housed across the jail, including in RCCC barracks. To the extent that SSO is unable to structure and enforce social distancing, it increases the risk of a COVID-19 outbreak, with possible hospitalizations and deaths.

[15] A sample Staff and Visitor COVID-19 Tracking Log is contained in the Appendix.

[16] According to the County, staff screening is conducted in a location visible on CCT and can be reviewed if necessary, however this does not permit review of COVID-19 screening results, which would be important for conducting a contact tracing investigation. For example, if a staff member had a temperature above normal, but did not meet the threshold for fever (e.g., 99.6°F.) according to the screening criteria.

[17] Conference call with Sandy Damiano, Pamela Gandy-Rosemond, Lieutenants Alex McCamy, Brian Amos, Mark Hatzenbuhler and Paul Belli.

[18] Email for Mark Hatzenbuhler. October 23, 2020. SSO has created open beds in the dormitory that houses daytime and nighttime kitchen crews because they are on separate sleeping schedules.

Quarantine and Isolation

SSO and ACH have established quarantine and medical isolation pods. However, previous ACH Guidance did not provide for definitions of quarantine and isolation, and led to confusion about whether detainees should be placed in quarantine or isolation. This resulted in persons with suspected COVID-19 being housed in the same isolation pod with someone not known or suspected to have COVID-19, presenting a risk of disease transmission. This was further complicated by incorrect terminology in the electronic health record (EHR), in which isolation was incorrectly used to apply both to patients in quarantine and isolation. On October 22, 2020, ACH revised COVID-19 Staff Guidance to provide clarification regarding definitions of quarantine and isolation, and plan to make corresponding changes in the electronic health record (EHR). Importantly, SSO has adopted ACH terminology for its housing units. Staff training is required to reeducate ACH and SSO staff to prevent errors in decisions regarding placement of detainees in quarantine and isolation.

Understanding the reality of population pressures, it remains a concern that the jail is unable to establish 14-day Intake Quarantine at the Main Jail. In addition, the public health rationale for which detainees are placed in 7-day versus 14-day quarantine is unclear. For example, in addition to new arrestees, in-custody inmates returning from the hospital are placed in 7-day quarantine, as well as Federal Bureau of Prison inmate. However, new arrestees arriving from the emergency department, in-custody inmates returning from the emergency department, and CDCR inmates are placed in 14-day quarantine.[19] There does not appear to be any difference in risk of exposure between these groups.

Monitoring Detainees in Quarantine and Isolation

With respect to monitoring detainees in 7-day quarantine, ACH Guidance initially did not require that health care staff monitor detainees on 7-day Intake Quarantine for fever and symptoms of COVID-19. ACH and SSO line staff reported that these checks were not taking place.[20] The expectation was that "Custody staff will report any new detainees in Intake Housing with signs and symptoms of COVID-19 to medical staff". This was not consistent with CDC Guidance. ACH Guidance has now been revised to include daily nurse health checks for detainees in quarantine.[21]

With respect to evaluation and monitoring of COVID-19 cases in isolation, CDC Guidance recommends medical evaluation at the first sign of symptoms. ACH Guidance initially indicated that all new COVID-19 patients would have an initial provider visit, however there was no specified time frame for this visit to take place. In addition, providers were to conduct rounds

[19] ACH Staff Guidance. October 22, 2020.
[20] The Nursing Director disputes that the COVID-19 checks were not taking place, however, line staff reported they were not occurring.
[21] A nurse health check consists of the nurse introducing themselves to the patient, performing a COVID-19 symptom screen, temperature and oxygen saturation check and patient education regarding COVID-19.

on all detainees in COVID-19 positive pods, but only required to document rounds in the medical record if the patient reported symptoms. In addition, nurses also made once daily rounds. Having providers and nurses conduct isolation rounds is a duplication of effort and not an optimal use of provider resources. ACH has changed its guidance so that medical providers will conduct an initial medical evaluation on all COVID-19 cases and suspects within 48 hours. Follow-up is expected as clinically indicated, as well as a complete a medical record review on asymptomatic patients.[22] Nurses will conduct twice daily health checks for patients in isolation.

Lack of Access to Showers in Accordance with CDC Recommendations, ACA Standards and Title 15

CDC Guidance recommends that movement of quarantined and medically isolated patients outside the unit be kept to a minimum. Some services such as meals and medical care, etc. should be provided on the unit. However, CDC also recommends that conditions of confinement are not punitive, and there is access to showers, telephone privileges, TV and reading materials. Tablets should also be considered as they can house more content to keep detainees occupied.

SSO policy is for detainees to be provided a shower before placement in quarantine and/or isolation with no additional showers until released from quarantine or isolation.[23] During on-site tours, several detainees reported to one of the medical experts that they were not provided a shower prior to placement in quarantine and not permitted a shower for the next 14 days.

Access to showers is a fundamental element of personal hygiene and human dignity. Detainees who have been homeless, have substance use disorders, or are mentally ill likely have not had adequate access to bathing prior to detention. Injection drug users are known to have increased risk of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) skin infections for which good personal hygiene reduces bacterial burden on the skin. The current policy to limit showers is not consistent with American Correctional Association (ACA) Standards to provide access to showers three times a week to detainees in restricted housing units, or with Title 15 that requires jails to provide showers at least every other day. This was subject to dispute between the parties in May 2020. SSO offered two reasons for the ban on showers: 1) the burden of disinfecting showers after use, and 2) the possibility of viral transmission associated with shower use. This is inconsistent with CDC's recommendation to continue access to showers, and demonstrates that CDC does not consider there to be a significant risk of disease transmission by providing detainees access to showers. To the contrary, CDC Guidance recommends against reducing access to showers.[24] SSO should provide access to showers while

[22] No time frame was specified for the providers to review the record of asymptomatic COVID 19 patients.
[23] Letter from Lieutenant Alex McCamy, Main Jail Division to All Main Jail Personnel. Intake Observation and Isolation Showers. June 1, 2020.
[24]https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

in quarantine and isolation consistent with CDC Guidance, ACA standards, and Title 15 state regulations.[25]

COVID-19 Disease Outbreak Preparation Should Incorporate Surveillance Testing, Including Staff

Correctional facilities, as other congregate institutions (e.g., nursing homes) must be prepared for outbreaks of COVID-19 among staff and detainees. Planning should be incorporated under the auspices of disaster planning and consider the need for mass testing, quarantine, isolation, and delivery of essential services during an outbreak. Planning should also consider surveillance and/or serial testing of staff and detainees following an outbreak.[26]

In addition, CDC has developed recommendations for surveillance staff testing in congregate settings such as nursing homes because residents are medically vulnerable. This principle applies to correctional facilities because a CDC study of COVID-19 found that at half of correctional facilities surveyed, the only cases reported were among staff.[27] Given that both nursing homes and correctional institutions house a high prevalence of medically vulnerable persons, serial staff testing should be considered in correctional institutions. CDC also recommends that if at any point, contact tracing is not practical, or if there is a concern for widespread transmission following identification of new onset SARS CoV-2 infection among detainees or staff, leadership should consider a broader based testing strategy, beyond testing only close contacts within the facility, to reduce the chances of a large outbreak.[28]

ACH Has Established an Infection Prevention Coordinator to Coordinate COVID-19 Activities

To date, ACH and SSO, in collaboration with Public Health, have successfully responded to COVID-19 cases by implementing contact tracing.[29] However, this review shows a need for improved coordination of COVID-19 prevention, screening and management operations. ACH has established an Infection Prevention Coordinator position for this purpose, which should serve to improve the coordination COVID-19 related operations and activities. ACH leadership is to be commended for moving quickly to establish such a position.

Conclusion

In summary, as influenza season approaches, it is well known that conditions which contribute to spread of influenza also contribute to transmission of Novel Coronavirus. Sacramento

[25] The County points out that the Prison Law Office (PLO) and Disability Rights Office (DRO) agreed to a compromise limiting showers during the May 2020 dispute resolution process. However, CDC guidance was updated in July and October 2020, following the completion of the Memorandum of Agreement in June 2020. Beginning in July, the revised guidance specifically states to "assign isolated individuals a dedicated bathroom when possible. When a dedicated bathroom is not feasible, *do not reduce access to restrooms or showers as a result*."

[26] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html

[27] https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm

[28] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html

[29] COVID-19 Dashboard information is shared weekly.

County's COVID-19 Risk Assessment was previously rated as Widespread and has been downgraded to Substantial, meaning that conditions for transmission are still significant. Given that 30% of the population have medical conditions that increase the risk of severe COVID-19, a disease outbreak would likely result in hospitalizations and death. Therefore, it is imperative that conditions of confinement at Sacramento County Jail are changed and mitigation measures are implemented. Key stakeholders continue their efforts to safely reduce the population of the jail, including release or transfer of medically vulnerable detainees, and to address issues regarding COVID 19 prevention, screening and management as soon as possible.

The remainder of this report focuses on details of compliance with key CDC recommendations for prevention and management of COVID-19.

Facility Description and Population Profile

The Sacramento County Jail is comprised of two adult jails, the Main Jail (MJ) and Rio Cosumnes Correctional Center (RCCC) also known as Branch Jail.

The Main Jail is a multistory building built in 1989 with an original rated capacity of 1,250 that was later increased to 2,380.[30, 31] It is the primary intake center for the jail and houses individuals of varying custody levels. Housing unit design is primarily single and double cells with solid doors. As of October 14, 2020, the population was 1,845 or 77% of rated capacity.

RCCC was originally built in 1947 and was converted to a jail in 1960, having undergone several renovations. It is the primary custody facility for detainees sentenced to County Jail from the Sacramento County Courts. An increasing percentage of the detainees are pre-sentence detainees housed at RCCC to keep the population at the Main Jail below the limit set by Federal decree. In addition, the Correctional Center houses detainees enroute to other jurisdictions, federal prisoners under a contract with the Federal Bureau of Prisons, and reciprocal prisoners from other counties. RCCC is the primary reception center for parole violators who are being held pending revocation hearings and the central transportation point for all defendants sentenced to State Prison.[32] Housing units are a combination of single and double cells as well as open barracks or dormitories. It has a current rated capacity of 1,625 detainees. As of October 14, 2020, the population was 1,352 inmate or (83%) of rated capacity.[33]

Together, the rated capacity of both jails is 4,005 detainees with a current population of 3,197, or 80% of rated capacity. Although the jails do not exceed their rated capacity, options available to custody staff for use of bed space are limited by security classifications and treatment programs (e.g., mental health).

[30] Adult Correctional Health Report. Fiscal Year 2019/2020. Sacramento County Department of Health Services. July 2020.
[31] According to SSO leadership, the rated capacity of 2,380 is never reached due to a Consent Decree limiting the population to 2,000 beds.
[32] https://www.sacsheriff.com/Pages/Organization/RCCC/RCCC.aspx
[33] Per SSO leadership, the rated capacity of the jail is 1,625 and the operating capacity is 2,385 beds.

The Sacramento Sheriff's Office (SSO) has overall responsibility for management of the jails. Adult Correctional Health (ACH), a program in the Department of Health Services (DHS), Primary Health Division, provides health care services physical/behavioral health) through county and contracted staff working in partnership with SSO.

Due to the age of the jails, they were not designed for health care, and are not compliant with the American with Disabilities Act (ADA) or Health Insurance Portability and Accountability Act (HIPAA) which were enacted at later dates. Construction of an Annex is planned to facilitate compliance with ADA and HIPAA requirements.[34]

Population Risk Profile

With respect to COVID-19, severe illness can occur in otherwise healthy individuals at any age, but predominantly occurs in older adults or those with underlying medical conditions. These conditions include chronic lung disease, asthma, cardiovascular disease, hypertension, diabetes, severe obesity, end-stage renal disease on dialysis, or liver disease such as chronic Hepatitis C infection. Any condition which compromises the ability of the immune system to fight infection including cancer, HIV/AIDS, smoking, a prior bone marrow or organ transplantation, or a requirement for any medications which weaken the immune system will increase the risk of complications and death. Having more than one of these conditions increases the risk even more significantly.[35]

Sacramento County Jail houses detainees with medical conditions that increase the risk of severe COVID-19 disease. As of mid-September 2020, SCJ housed approximately 900[36] detainees with chronic diseases such as hypertension, diabetes, asthma and chronic obstructive pulmonary disease, and HIV infection.[37] This means that approximately 30% of the population has a medical condition that increases the risk of severe COVID-19 disease.[38]

At Main Jail, detainees with serious medical and mental health conditions, and/or disabilities can be housed in inpatient medical and mental health units on 2 West; or in medical and ADA housing units on 2 East. At RCCC, there is a Medical Housing Unit and six single high security medical cells that have barred cell doors.

Other detainees with chronic diseases that result in increased risk of severe COVID-19 disease are housed throughout the jail including the RCCC Medical Housing Unit (MHU) and barracks.

[34] Adult Correctional Health Report. Fiscal Year 2019/2020. Sacramento County Department of Health Services. July 2020.
[35] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html
[36] This is an estimate based upon data that shows SCJ detainees have 1,111 chronic conditions that increase the risk for severe COVID-19.
[37] ACH reported that they do not currently have the capacity to accurately report the number of individual detainees with chronic diseases. ACH can pull data by requested diagnostic categories. Report specificity depends on the request type.
[38] According to the County, many of these inmates have been evaluated for release based on medical conditions, but were rejected due to the risk they pose to the community.

Operational Preparedness

CDC guidance for operational preparedness is intended to help facilities prepare for potential SARS CoV-2 transmission in the facility. Strategies focus on operational and communications planning, training and personnel practices.[39]

Communication and Coordination

1. **CDC Recommendation:** Develop information-sharing system with partners.
    - Identify points of contact with relevant state, local, tribal, and/or territorial health departments before SARS Co-V-2 infections develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.
    - Create and test communication plans to disseminate critical information to incarcerated persons, staff, contractors, vendors and visitors as the pandemic progresses.
    - Communicate with other correctional facilities in the same region to share information regarding disease surveillance and absenteeism patterns among staff.
    - Put plans in place with other jurisdictions to prevent individuals with confirmed and suspected COVID-19 and their contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release or to prevent overcrowding.
    - Stay informed about updates to CDC guidance via the CDC COVID-19 websites as more information becomes known.

Findings: Sacramento County Jail has information-sharing and coordination of services with public health and correctional partners. Adult Correctional Health (ACH) and Public Health (PH) are both in the Sacramento County Department of Health Services and have a close working relationship. Public health performs and prioritizes SARS CoV-2 testing for the Sacramento County Jail, provides guidance for conducting contact tracing when COVID-19 cases are identified, and provides consultation in the event of a potential outbreak. Public Health will also assist with surveillance testing if they deem it is indicated. ACH and SSO publishes COVID-19 data weekly on the SSO website.

Sacramento County Department of Personnel Services (DPS) has established an intranet page "COVID-19 Updates for County Employees" which contains a number of guidelines, including Return to Work, High Risk and Vulnerable Employees, and Paid Emergency and Family Sick

[39] CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. July 22, 2020.

Leave. DPS has dedicated staff to consult and manage "leaves" due to the myriad of balances available to staff and changes within the state.

Law Enforcement Communicable Disease Committee (LECDAC) task force communicates with medical and justice partners in the county and can convey important information to agency partners in the region. SSO leadership reports they communicate with Los Angeles Sheriff's Office on COVID-19 related issues.

With regard to preparation for COVID-19 cases, on March 2, 2020, Adult Correctional Health (ACH) published COVID-19 Staff Guidance (ACH Guidance). This was prior to publication of CDC COVID-19 guidance for correctional facilities (CDC Guidance), and prior to the first identified case of COVID-19 at the jail.

ACH Guidance focuses on identifying, isolating, treating, moving, and discharging COVID-19 suspects and cases. It also addresses other related topics including universal masking, personal protective equipment, cleaning practices, staff prevention measures, staff screening, and staff return to work, among other topics. ACH leadership has periodically revised ACH Guidance as new information has become available and/or processes have changed with the most recent revision published on October 22, 2020.[40]

At the onset of this review, ACH Guidance was incomplete and inconsistent with CDC guidance.[41] For example, there were no definitions for quarantine and isolation, and quarantine and isolation practices were incorrectly applied in the jail. This resulted in detainees with suspected COVID-19 being housed in the same units with detainees being quarantined (e.g., CDCR detainees or persons who have refused testing) increasing risk of disease transmission.[42] Intake Quarantine is limited to 7 days rather than CDC recommended 14-day quarantine due to limited jail bed space and classification issues.

ACH COVID-19 Guidance revisions, forms and email templates and other information are posted on the ACH Intranet page. Each service manager is responsible to discuss guidance documents, forms and other training in staff meetings or huddles. However, formal training records have not been kept. During medical expert on-site tours, Interviews with staff, including leadership, regarding COVID 19 procedures resulted in conflicting responses regarding policy and procedures.[43]

SSO leadership reports that Main Jail has instituted several polices and emails and publishes them for all staff. I requested SSO policies and was provided several memoranda, but was

[40] COVID-19 (Novel Coronavirus) Staff Guidance. Sacramento County Adult Correctional Health. October 22, 2020.
[41] COVID-19 (Novel Coronavirus) Staff Guidance. Sacramento County Adult Correctional Health. September 4, 2020.
[42] ACH leadership corrected these definitions on October 5, 2020.
[43] ACH leadership states that the Medical Monitor visited in the midst of changes in medical leadership and new guidance being developed, and attributes conflicting responses to the timing of the visit.

advised that SSO does not have a comprehensive policy address all aspects of COVID-19 management.[44]

Monitor Recommendations: 1) Continue to revise ACH Guidance as new information becomes available or procedures are changed. 2) SSO should develop policies and post orders that address custody procedures related to prevention and management of COVID-19. This includes areas such as structuring and enforcing social distancing, enforcing mask use among staff and detainees, etc. 3) Document staff training via Zoom and other technologies, with pre- and post-testing to assess staff knowledge. 4)Consider centralizing staff inquiries regarding policy questions (e.g. Infection Prevention Coordinator).

2. **CDC Recommendation:** Review existing influenza, all-hazards, and disaster plans, and revise for COVID-19.
    - Train staff on the facility's COVID-19 Plan
    - Ensure that separate physical locations (dedicated housing areas and bathrooms) have been identified to:
        - Isolate individuals with confirmed COVID-19 (individually or cohorted)
        - Isolate individuals with suspected COVID-19 (individually, do not cohort)
        - 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 individuals or close contacts are identified and require medical isolation or quarantine simultaneously.
    - Make a list of social distancing strategies that could be implemented as needed at different stages of transmission intensity.

Findings: 1) COVID-19 related training takes place through staff meetings and question and answer sessions but it is unclear whether systematic training has been provided to all staff, and not all training has been documented. ACH has responded that future training will be documented.

2) SSO and ACH established quarantine and medical isolation units however, initially these were not defined and applied correctly at Main Jail. This has been corrected with the most recent ACH Guidance. Due to classification issues, population increases and limited bed space at Main Jail, intake quarantine is conducted for 7 days instead of 14 days.

Quarantine units includes 7-Day intake quarantine and 14-Day quarantine for transfers, close contacts and hospital returns. With respect to ACH Guidance, the public health rationale for which detainees are placed in 7-day versus 14-day quarantine is unclear. For example, in addition to new arrestees, in custody inmates returning from the hospital are placed in 7-day quarantine, as well as Federal Bureau of Prison inmates. However, new arrestees arriving from the emergency department, in custody inmates returning from the emergency department,

[44] Email communication with Mark Hatzenbuhler. October 23, 2020.

state hospitals, and CDCR inmates are placed in 14-day quarantine. It is unclear why FBOP inmates and in custody inmates returning from the emergency department are also not placed in 14-day quarantine.

Separate 14-day medical isolation units have been established for COVID-19 cases and COVID-19 suspects, but not confirmed. According to SSO, while all efforts were made to maintain separation of isolation individuals the volume of persons entering the facility needing isolation has become high. In most, if not all cases, suspected cases are transferred to an isolation pod. Only when that pod is full, are people left in place and not allowed out of their cells unless medically or legally mandated. [45]

3) Although some social distancing measures have not been implemented, such as schedules for out of cell time, there are no policies or procedures that provide operational guidance in each of the jails to structure and enforce social distancing. ACH leadership reported that physical plant limitations do not always permit social distancing.

Monitor Recommendations: 1) Implement and document staff training regarding revised ACH Guidance for ACH and SSO staff. 2) SSO should develop comprehensive policies and procedures and post orders regarding COVID-19 related activities. 3) Establish clear guidance for structuring and enforcing among staff, detainees and visitors.

3. **CDC Recommendation:** Coordinate with local law enforcement and court officials. Identify legally acceptable alternatives to in-person court appearances, such as virtual court, as social measures to reduce the risk of SARS CoV-2 transmission.

Findings: Representatives of the Count District Attorney's Office, Public Defender, Sacramento Sheriff's Office and Adult Correctional Health, work together to promote virtual attendance of court appearances. However, according to the County, the most prevalent lack of social distancing involves court holding and transportation. It would be prohibitively cumbersome to delay court proceedings in order to maintain social distancing.

Monitor Recommendations: Continue to seek legally acceptable alternatives to in-person court appearances, such as virtual court, but explore strategies to maintain social distancing.

4. **CDC Recommendation:** Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signs throughout the facility and communicate this information verbally and on a regular basis. Sample signage and other communication materials are available on the CDC website.

Findings: COVID-19 signage is placed in booking and other areas of SCJ. However, based upon lack of adherence to masking and social distancing, it appears that efforts to educate staff and detainees requires additional focus and efforts. SSO is currently evaluating ways to increase

[45] It's unclear to me how frequently this occurs, and I will explore this further during the upcoming monitoring visit.

education and conducted staff surveys at RCCC and Main Jail. SSO is pursuing obtaining CDC videos for detainees.

Monitors Recommendations: Consider conducting surveys among ACH staff and detainees regarding barriers to COVID-19 prevention measures. In addition to CDC videos, consider utilizing COVID-19 videos for staff and detainees such as those produced by Brie Williams MD and her colleagues at UCSF. [46]

Personnel Practices

5. **CDC Recommendations:**
   - Review the sick leave policies of each employer that operates within the facility.
   - Identify duties that can be performed remotely.
   - Plan for staff absences
   - Consider offering revised duties to staff who are at increased risk for severe illness from COVID-19.
   - Make plans in advance for how to change staff duty assignments to prevent unnecessary movement between housing units during a COVID-19 outbreak

Findings: 1) Sacramento County has developed personnel policies regarding COVID-19 which are available on its Intranet Page and that address sick leave policies related to COVID-19.

2) Sacramento County Public Health has developed general guidelines for implementing safety practices for workplace outbreaks of COVID-19.[47] The guidelines address monitoring of critical infrastructure/essential employees who have been exposed to COVID-19 outside the work place, and includes minimum return to work criteria for staff that have been exposed or diagnosed with COVID-19.[48]

3) During medical expert interviews, ACH and SSO employees reported that except for their supervisor, there were no workplace resources for questions or guidance regarding COVID-19 process clarification at the jail. This may reflect that previous ACH Guidance that did not provide operational guidance regarding all aspects of CDC Guidance and that there was no single authority for COVID-19 policy information at ACH.

4) SSO leadership reports that a centralized system for monitoring employees is now in place at Main Jail and RCCC. This will be evaluated at future site visits.

Monitor Recommendations: 1) ACH has established an Infection Prevention Coordinator position to coordinate COVID-19 related and other infection prevention activities. This position

[46] http://www.amend.uc/covid
[47] The guidance is not intended for use in managing or preventing outbreaks in health care congregate living settings, or other workplaces where California Aerosol Transmissible Disease (ATD) Standards apply.
[48] Implementing Safety Practices for Workplace Outbreak of COVID-19. Sacramento County Public Health. Revised 7/15/2020.

should review CDC guidance and alert ACH and SSO leadership of CDC recommendations that have not been fully addressed or implemented. 2) Establish a centralized system for monitoring employees who are COVID-19 cases, suspects or close contacts to ensure they comply with return to work criteria.

6. **CDC Recommendations:** Offer the seasonal influenza vaccine to all detainees (existing population and new intakes) and staff throughout the influenza season. Reference the Occupation Safety and Health Administration website for recommendations regarding worker health. [49] Review CDC's guidance for businesses and employers to identify any additional strategies the facility can use within its role as an employer, or share with others.

Findings: ACH policy provides for influenza vaccination to all ACH employees. Behavioral Health employees are to receive influenza vaccination through UC Davis. ACH plans to offer influenza vaccination to detainees. According to ACH leadership, influenza clinics began the week of October 19, 2020. ACH estimates that 150 detainees can be immunized each week per facility which means that offering vaccination to all detainees would take approximately 10 weeks. If this is correct, this is too long to accomplish vaccination.

Monitor Recommendations: Influenza vaccination should be offered to all existing and newly arriving detainees and all staff who work at the jail. Coordinate with Public Health to expedite influenza vaccination for staff and detainees.

Operations, Supplies and PPE Preparations

7. **CDC Recommendations:**
   - Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies are on hand and available and have a plan to restock as needed.
   - Make contingency plans for possible PPE shortages during the COVID-19 pandemic, particularly for non-health care workers.
   - Consider relaxing restrictions on allowing alcohol-based sanitizer in the secure setting, where security concerns allow.
   - Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand-washing.
   - If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit-tested for any respiratory protection they need within the scope of their responsibilities.
   - Prepare to set up designated PPE donning and doffing stations outside all spaces where PPE will be used. These stations should include a dedicated trash can, a hand-

[49] Guidance on Preparing Workplaces for COVID-19. OSHA. 3390-03 2020. Undated.

washing station and a poster demonstrating correct PPE donning and doffing procedures.
- Review CDC and EPA guidance for cleaning and disinfecting the facility.

Findings: ACH leadership reported that PPE is obtained contracted vendors and the Medical & Health Operational Area Coordinator (MHOAC) and there have been no significant issues in obtaining PPE. ACH would rely on Public Health in the event of a large outbreak, however there is not a written COVID-19 Outbreak Response Plan to assign roles and responsibilities. There are no PPE donning or doffing stations for health care and custody staff or detainees in all locations for those who may have work assignments requiring full PPE (e.g. laundry or food service in isolation units, etc.).

Alcohol-based hand-sanitizer is available to staff but not detainees. SSO leadership reports that soap is available upon request on the housing pods. However, the mental health expert noted that in IOP, detainees shared a communal bar of soap.

Monitor Recommendations: 1) Ensure that ACH Guidance and Disaster Plan policies and procedures include routine and emergent response procedures for obtaining PPE. 20 Establish donning and doffing stations for personnel using PPE. 3) Monitor staff and inmate access to soap and ensure a free supply of soap to detainees. 4) Consider making hand sanitizer available to detainees under deputy supervision such as during transport in vehicles or work assignments when access to soap and water is not readily available.

Prevention

Correctional Institutions can prevent introduction of SARS CoV-2 and reduce transmission if it is already inside by reinforcing good hygiene practices among detainees, staff and visitors, and intensifying cleaning/disinfection practices, and implementing social distancing.

Operations

8. **CDC Recommendations:**
   - Limit transfers of detainees/detainees 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.
   - Make every possible effort to modify staff assignments to minimize movement across housing units and other areas of the facility.
   - Consider suspending work release and other programs that involve movement of detainees in and out of the facility.
   - Implement lawful alternatives to in-person court appearances.
   - Where relevant, consider suspending co-pays for incarcerated persons seeking medical care for possible COVID-19 symptom

Findings: 1) ACH Guidance indicates that inmate movement is generally restricted, and limited to necessary legal and health-related appointments, however frequent movement does occur due to changing quarantine needs 2) Previous ACH Guidance stated that "Any patient with fever or respiratory symptoms should be isolated in existing cell pending further evaluation by a nurse, and that the patient should remain with existing cellmate unless one of the individuals is high risk (elderly, chronic health conditions)." It is concerning that a cellmate would be left in the same cell with someone who was symptomatic. The Guidance is being updated to change this practice. 3) Although ACH and SSO staff report not commonly being moved from their assigned post, it is unclear how overtime assignments might result in staff working in "high to low" risk areas, such as working in a medical isolation unit and then working overtime in general population barracks. SSO leadership reports that they try to assign the same officers to isolation/quarantine to limit the spread of infection and minimize errors, however this is not always possible. 4) One of the medical experts observed nurses moving through the jail, sometimes from "high to low" risk areas. 5) Nursing leadership was not aware of the recommendation to limit work assignments and work from "low to high" risk areas, rather than the reverse. 6) Courtrooms are located within the jail and appearances take place over Zoom. SSO leadership reported that detainees are brought down to holding cells in small numbers at a time. Holding cells are cohorted by day of intake quarantine for hearings that occur within the intake quarantine period. Detainees are expected to wear masks in holding cells and SSO leadership indicates they are monitored and enforce mask use. There are no detainees from other jurisdictions in the SCJ holding areas or courtrooms. These practices will be evaluated at future site visits.

Monitor Recommendations: 1) When an inmate displays COVID-19 symptoms, health care staff should move the inmate to COVID-19 suspect isolation, and the cellmate should be removed from the room immediately and placed in close contact quarantine. 2) ACH and SSO leadership should assess operations with respect to staff assignments and seek to restrict staff from working from high to low risk areas whenever possible, and to always adhere to wearing proper PPE based upon the nature of the work assignment. 3) Continue to cohort detainees in small groups for arraignment and other court hearings. 4) SSO should monitor and enforce mask wearing.

Cleaning and Disinfecting Practices

9. **CDC Recommendations:**
    - Adhere to CDC's recommendations for cleaning and disinfection during the COVID-19 response. Monitor these recommendations for updates.
    - Several times a day, clean and disinfect surfaces and other objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, telephones, and computer equipment.

- Staff should clean shared equipment (e.g. radios, service weapons, keys, handcuffs, etc.) several times per day and when use of the equipment has concluded.
- Use household cleaners and EPA-registered disinfectants effective against SARS CoV-2 as appropriate for the surface.

Findings: 1) ACH Guidance has limited information related to cleaning and disinfection practices and does not reference any other policies and procedures for operational details. Staff reported to one of the medical experts that cleaning supplies are available in the housing units and detainees' clean common areas once daily, with ad hoc cleaning. Inmate workers wear masks and gloves. Telephones are not disinfected between use, although one pod had disinfectant available. Inmate interviews suggest little education or supervision of appropriate cleaning and disinfection techniques, including PPE. Staff cleaning of shared equipment was not observed or evaluated.

2) Medical staff have been reminded to disinfect all patient care equipment between patient use. ACH has environmental checklists for daily, weekly and monthly audits. Staff receive bloodborne pathogen training as well as infection control training every year and updated CDC information is included.

Recommendations: 1) ACH and SSO leadership should review CDC recommendations for cleaning and disinfection and incorporate them into policy and procedures and post assignments. 2) Establish supervised procedures for disinfection of high touch surfaces several times a day, throughout the jails. 30 Establish procedures and post orders for cleaning of shared equipment and monitor compliance. 4) Evaluate cleaning solutions to ensure they are EPA-registered disinfectants effective against SARS CoV-2 for the respective surfaces. 5) In COVID-19 medical isolation units, detainees' workers should wear full PPE in accordance with their duties and consistent with CDC Guidance.

Hygiene

10. CDC Recommendations:

- Encourage all staff and detainees to wear a cloth face covering as much as safely possible, to prevent transmission of SARS CoV-2 through respiratory droplets that are created when a person talks, coughs, or sneezes.
- Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting room, common areas, medical, and staff restricted areas (e.g. break rooms)
- Provide detainees and staff no cost access to soap, running water, hand-drying machines or disposable paper towels for handwashing. Also provide tissues and cloth face-masks.

Findings: 1) One of the medical experts observed that staff did not consistently wear face masks, particularly in offices with other staff. 2) SSO provides cloth masks to detainees who are able to exchange them on laundry days, however it is unclear what education regarding COVID-19 and importance of face masks is provided to detainees. 3) We did not evaluate access to hygiene items in all areas of the jail. 3) Custody reports soap is widely available, confirmed by most but not all detainees. The mental health expert reports that in an IOP unit, detainees shared a bar of soap. According to SSO leadership, it is SSO policy to keep cell doors unlocked so that detainees have access to running water and soap in their cells. 4) ACH plans to have the Infection Prevention Coordinator complete periodic inspections of compliance with face mask and access to soap and hygiene items.

Recommendations: ACH and SSO should continue to provide and monitor compliance with staff and inmate wearing of face masks. If not already done, develop a procedure for systematic and daily inspection and resupply of hygiene items throughout the facility, including access to soap and paper towels.

Testing for SARS Co-V-2

11. **CDC Recommendations:** Refer to CDC Interim Considerations for SARS CoV-2 testing in Correctional Facilities and see Intake Screening, Testing and Quarantine section below.

Prevention Practices for Staff

12. **CDC Recommendation:**
    - Remind staff to stay home if they are sick.
    - Perform verbal screening and temperature checks for all staff daily upon entry.[50]
    - Provide staff up to date information about COVID-19 and facility policies.
    - If staff develop fever at work, they should immediately put on a cloth face covering (if not already done, inform supervisor, leave work and follow-up CDC recommended steps for persons who have COVID-19 symptoms.
    - If a staff member has COVID-19, employers should notify other staff about their possible exposure, while maintaining confidentiality as required by ADA.
    - Staff identified as exposed to COVID-19 should quarantine at home unless a shortage of critical workers exists.
    - Staff with confirmed COVID-19 should inform the workplace and close contacts immediately and meet CDC requirements to end home isolation.
    - Ask staff to maintain social distancing with COVID-19 cases or suspects, consistent with security priorities.

[50] Verbal screening should include the following questions: Today or in the past 24 hours, have you had any of the following symptoms? Fever, felt feverish or had chills? Cough? Difficulty breathing? In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)? A protocol to safely check an individual's temperature include: Perform hand hygiene, put on a surgical mask, eye protection and a single pair of disposable gloves. If non-contact thermometers are used, they should be cleaned with an alcohol wipe between use.

Findings: 1) Per SSO leadership and staff interviews, employees are actively encouraged not to come to work when sick. Staff designated as essential workers who are close contacts may work if not symptomatic. Return to Work guidance is available to staff. 2) COVID-19 screening for staff entering the facility was not consistent with CDC guidelines. Staff screening was not performed prior to entry into the Main Jail, but in the dining room where other staff were eating, not wearing face masks, and social distancing was not maintained. An honor system was employed where arriving staff were to measure their own temperature using a paper towel to hold a thermometer. There were no alcohol wipes available to sanitize the thermometer. Staff screening was not documented. At RCCC, staff temperatures were taken but no symptom screening was performed. 3) In the booking area, SCJ does not perform symptom and temperature screening for arriving arresting officers. Current ACH COVID Staff Guidance requires arresting officers to wear a mask upon entry to the jail, but arresting officers were observed not wearing masks in booking areas. 4) ACH leadership reports that only two staff have reported COVID-19 infections from exposure outside of work, with no exposure to SCJ employees. 5) ACH and SSO staff limit COVID-19 case and suspects movement to decrease risk of transmission and limit the amount of time with cases/suspects consistent with their duties.

Recommendation: 1) SSO and ACH leadership should reinforce messaging about not coming to work when ill and inform staff of any changes in personnel policies. 2) and 3) SCJ health care and custody leadership should ensure that COVID 19 symptom and temperature screening is performed for all persons (county employees, contractors, arresting officers, and visitors etc.) prior to entry into the jail.[51] The results of staff screening should be documented and maintained for a designated period of time established by policy (see sample form used to record staff screening results).[52] Such documentation is evidence that screening is taking place and may assist in case of an disease outbreak and subsequent contact investigation. 4) Follow CDC recommendations for employee contact investigations. 5) ACH and SSO should review what types of PPE are appropriate depending on staff duties and ensure that PPE is readily available when needed. Even with the use of PPE, staff should employ social distancing consistent with their duties.

Prevention Practices for Detainees

13. CDC Recommendation:

- Provide cloth face coverings (unless contraindicated) and perform pre-intake symptom screening and temperature checks for all new entrants in order to identify and immediately place individuals with symptoms under medical isolation. Screening should

[51] A low-grade fever is a temperature that falls between 99.6 and 100.3 F. The CDC definition of fever for the purposes of COVID-19 screening is 100.4. F or above. Consider using criteria for low grade fever as the threshold to define fever to identify cases prior to becoming fully symptomatic. https://www.cedars-sinai.org/health-library/diseases-and-conditions/f/fever.html.
[52] A SSO memo dated April 7, 2020 states that temperatures are not to be recorded or maintained by employer. However, the failure to document temperature may interfere with conducting a contact investigation.

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, before beginning the intake process.

- Implement social distancing strategies in common areas, recreation, meals, group activities, housing, work details and medical.
- If group activities are discontinued, identify alternate forms of activity to support the mental health of the detainee.

Findings: ACH COVID-19 Staff Guidance requires arresting officers to mask arrestees, and if not done, for SSO to provide arrestees a mask. Observation of the booking process at Central Control showed that some arrestees were not wearing masks in booking, holding cells, and enroute to 7-day quarantine pods. These are opportunities for transmission to occur prior to placement in quarantine.

The Mays medical and mental health experts[53] also observed lack of compliance with use of face masks and social distancing by custody and detainees throughout the jail. This poses a serious risk of transmission of Coronavirus in the jail.

Recommendations: ACH and SSO should intensify its efforts to obtain compliance with staff and detainee face masking and social distancing (see next section) For detainees, this includes increased detainee education (verbal orientation, videos, handouts, posters in English and Spanish, inmate handbook, etc.) at the time of arrival at the jail and on an ongoing basis. Incorporate monitoring and enforcement of detainee masking in ACH and SSO policies and procedures and post orders.

14. **CDC Recommendation:** Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of symptoms), and to minimize mixing of individuals from different housing units. Enforce increased space between individuals in holding cells as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area).

Findings: 1) As referenced throughout this report, ACH and SSO policies do not comprehensively address structuring and enforcing social distancing in all areas of institutional life. SSO has developed written guidance for out of cell time and number of detainees permitted in Day rooms at a single time. However, there are a number of areas that have not been addressed. This includes common areas such as holding cells, waiting lines, recreation, meals, group activities, housing, work details and medical.

2) One of the medical experts observed holding cells that contained multiple arrestees who were not wearing masks while housed in these small spaces for unknown periods of time. New arrivals were to be placed in these holding cells as they arrived. SSO leadership reports there are no alternative spaces to hold arrestees.

[53] COVID-19 Report. Mary Perrien Ph.D.

Recommendation: 1) ACH, SSO and public health should collaborate to develop and implement policies and procedures to operationalize strategies to implement social distancing for all aspects of institutional life to the extent possible in each of the jails. 2) ACH, SSO and public health should develop a system to monitor and reinforce compliance with social distancing. 3) Monitoring should be focused on high risk areas such as holding cells where proximity and duration of exposure are significant risks for transmission.

Prevention Practices for Visitors

15. **CDC Recommendations:** If possible, discourage contact visits. Require visitors to wear cloth masks. Provide alcohol-based hand-sanitizer. Provide visitors and volunteers information to prepare them for screening. Promote non-contact visits. Consider suspending or modifying visitation program.

Findings: This area was not evaluated.

Monitor Recommendations: None at this time.

Screening

Intake Screening, Testing, and Quarantine

16. **CDC Recommendation:** Perform verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, visitors who enter correctional and detention facilities, as well as persons who are transferred to another facility or released from custody.

Findings: 1) As a component of intake screening, SCJ screens all new arrivals for COVID-19, including arrestees and transfers from other correctional facilities, including transfers between the Main Jail and RCCC. The Main Jail processes the majority of new intakes, although RCCC processes some new intakes, primarily transfers from other facilities. ACH recently amended the Coronavirus (COVID-19) Screening Tool to add 3 symptoms now associated with COVID-19 disease. 2) As noted earlier int his report, SSO practice was not consistent with CDC guidance for screening employees, including arresting officers from other agencies. As described earlier in this report, ACH and SSO have changed their screening policies to be consistent with CDC guidance. I will monitor compliance with their policies at future site visits.

Recommendations: 1) ACH and SSO leadership should monitor compliance with the revised screening procedures.

17. **CDC Recommendation:** Consider testing all newly incarcerated/detained persons before they join the rest of the population in the correctional or detention facility.[54]

Findings: ACH performs SARS CoV-2 PCR testing on all new arrivals that are still in custody on day 4 following arrival. To date, Sacramento County Jail has identified 105 COVID-19 cases, of which 104 were identified through intake testing with no known intrafacility transmission beyond intake.[55] This has been a highly successful screening program. However, testing on day 4 may produce a false negative test result if the detainee was infected just prior to arrest. A study that examined false negative test rates following exposure to the virus found that during the four days of infection prior to symptom onset, the probability of a false negative test was 100% on the day 1 to 67% on Day 4.[56] On the day of symptom onset, the false negative rate was 38%. The false negative rate decreased to 20%, 3 days after symptom onset and 8 days after infection. Thus, over time, testing on Day 4 is likely to miss cases in which detainees were infected just prior to arrest. ACH has revised its procedures to perform testing on day 6 beginning the week of October 26, 2020. Testing on day 6 is an improvement over testing on day 4 but still result in false negative test results if detainees were infected just prior to admission or during booking.

Monitor Recommendations: 1) Continue testing all new arrivals for SARS CoV-2. Consider performing rapid testing on admission to immediately identify and medically isolate infected persons and perform PCR testing prior to release from quarantine.

18. **CDC Recommendation:** If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (separately from other individuals who are quarantined due to contact with someone who has COVID-19. This practice is referred to as routine intake quarantine.

Findings: 1) At Main Jail intake quarantine is performed for 7 days for new arrestees and Bureau of Prisons detainees. New intakes or transfers are cohorted by date of arrival and are not celled together or permitted to mix with detainees with different dates of arrival.[57]

According to SSO leadership, it is not feasible to extend intake quarantine to 14 days due to bed space demands and classification considerations. Bed space demands are exacerbated by the approximately 425 sentenced detainees at SCJ awaiting transfer to CDCR.

At RCCC, Intake Quarantine is performed for 14-day days due to adequate bed space.[58] At this time, RCCC does not use dormitory space for quarantine.[59]

[54] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html
[55] https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm
[56] https://www.acpjournals.org/doi/10.7326/M20-1495
[57] COVID-19 Housing Population. ACH. 10/5/2020.
[58] In CDCR, COVID-19 outbreaks at 6 different prisons involving more than 1,000 cases at each site involved dormitory style or housing tiers with open cell fronts. https://www.cdcr.ca.gov/covid19/population-status-tracking/
[59] Per Mark Hatzenbuhler.

At Main Jail and RCCC, SSO is able to conduct 14-day quarantine for other categories of quarantine besides intake, including close contacts of COVID-19 cases, returns from hospitalizations, and transfers from CDCR and Bureau of Prisons. [60]

Monitor Recommendation: I strongly recommend that SCJ continue to explore strategies to permit 14-day quarantine of new intakes and Federal Bureau of Prison detainees.[61] However , at this time, at Main Jail, SSO does not have the bed space capacity to increase intake quarantine from 7 to 14 days.

19. **CDC Recommendation:** Facilities should make every possible effort to individually quarantine cases of confirmed COVID-19, and close contacts of individuals with confirmed or suspected COVID-19. If cohorting close contacts is absolutely necessary, be especially mindful of those who are at increased risk for severe illness from COVID-19 Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the increased risk individuals. For example, intensify social distancing strategies for the increased risk individuals.

Findings: At Main Jail, COVID-19 suspects are grouped in 14-day quarantine housing with others including transfers from other institutions and close contacts. This risks transmission of COVID-19 in these units via airborne transmission and contamination of surfaces and objects. SSO responded that detainees who are suspects and contacts are not released into the day room at the same time, however this does not adequately take into consideration the risk of airborne transmission in the units when doors are opened, as they are not respiratory isolation rooms. ACH has appropriately changed its guidance so that COVID-19 suspects are housed in isolation units and not quarantine units.

Monitor Recommendations: Do not house COVID-19 suspects in the same housing unit with close contacts due to the risk of airborne transmission.

20. **CDC Recommendation:** Quarantined individuals should be monitored for COVID-19 symptoms at least once per day (ideally twice per day), including temperature checks.

Findings: Previous ACH Staff Guidance was not consistent with CDC guidance. ACH Staff Guidance did not require that health care staff monitor detainees in intake quarantine for symptoms of COVID-19 or to perform temperature checks. The expectation was that sick call slips were available to detainees and "Custody staff will report any new detainees in Intake

[60] On October 7, 2020 At Main Jail, males in Intake Quarantine are housed on 3 East 100, 4 East 200, East 200, 600 East 100, 200 and 300 pods. Females in Intake Quarantine are housed on 7 West 300 and 7 West 400, upper tier. At RCCC Intake Quarantine housing was designated for SBF 300, SLF Ramona, Close Contact Quarantine was designated for SBF 300, SBF 100, SLF Ramona, and MHU. COVID-19 Suspect Isolation was designated for SBF 100, SLF Ramona, and MHU; and COVID-19 Case Isolation was designated for SBF 200.

[61] There have been 3 large outbreaks of COVID-19 at Federal Bureau of Prison facilities. https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm.

Housing with signs and symptoms of COVID-19 to medical staff." During the medical expert's on-site tour, both custody and nursing staff reported that no symptom and temperature surveillance was taking place in 7-Day quarantine. ACH leadership modified COVID-19 Staff Guidance to be consistent with CDC Guidance, to be effective the week of October 26, 2020. Nurses will perform daily checks in quarantine pods and twice daily checks in medical isolation pods. Health checks include a COVID-19 symptom screen, temperature and oxygen saturation checks.

Monitor Recommendations: ACH should monitor staff compliance with health checks including that nurses make appropriate referrals when patients become symptomatic or have abnormal temperatures or oxygen saturation levels.

21. **CDC Recommendation:** Keep quarantined individual's movement outside the quarantine space to an absolute minimum.
    - Provide medical evaluation and care inside or near the quarantine space when possible.
    - Serve meals inside the quarantine space.
    - Exclude the quarantined individuals from all group activities.
    - Assign the quarantined individual a dedicated bathroom when possible. When providing a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result.

Findings: ACH Staff Guidance[62] provides for general restriction on inmate movement. Patients are locked down and are not to be transported within the facility unless patient care cannot be provided at the cell. The guidance outlines instructions for the nurse when assessing patients, however it is unclear whether the assessment is specific to monitoring the patients for symptoms of COVID-19, or in the course or providing routine health care to patients in quarantine. Previous guidance stated that if a patient has signs or symptoms of COVID-19 and the door needs to be opened, the patient must wear a mask. However, due to the risk of asymptomatic transmission, the patient should always wear a mask, independent of signs or symptoms of COVID-19. The Guidance states that "If a private examination is required, it may be done in the patient's cell with custody's permission and an officer standing by."

However, any condition requiring an examination should be conducted in a clinical setting with adequate lighting, medical equipment and supplies, access to handwashing and privacy. On 10/5/2020, ACH reported that procedures have been changed, and each floor has an examination room. Patients are to be moved to examination rooms, if necessary, to perform an examination that requires privacy. The room is to be cleaned after each patient. [63]

[62] COVID-19 Staff Guidance. September 4, 2020.

[63] Cleaning should include disinfection of high touch surfaces such as countertops, exam tables, vital sign equipment, faucets, light switches, faucets, etc.

Meals are served on the unit to detainees in their cells. No group activities are permitted. By policy, access to showers is provided to detainees just prior to placement in 7 or 14-day Intake Quarantine or medical isolation and none thereafter.[64] During on-site tours, detainees in 7 and 14-day quarantine reported not having access to a shower upon admission and none thereafter.

Access to showers is a fundamental component of personal hygiene and human dignity. Detainees who have been homeless, have substance use disorders, or are mentally ill likely have not had adequate access to bathing prior to detention and injection drug users are known to have increased risk of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) skin infections. The current policy to limit showers is not consistent with American Correctional Association (ACA) Standards[65] to provide access to showers three times a week to detainees in restricted housing units, or with Title 15 that requires jails to provide showers at least every other day. This has been subject to a previous dispute between the parties. SSO offered two reasons for the ban on showers 1) the burden of disinfecting showers after use, and 2) the possibility of viral transmission associated with shower use. However, there is no evidence to support a risk of transmission of COVID-19 associated with shower use and CDC recommends against limiting showers.[66]

Monitor Recommendations: Amend ACH Staff Guidance to reflect actual practices with respect to delivery of medical care on quarantine units. SSO should provide access to showers in accordance with ACA standards and/or Title 15 requirements for detainees in quarantine and medical isolation.

Management

Medical Isolation of Suspects or Confirmed Cases

22. **CDC Recommendation:** As soon as an individual develops symptoms of COVID-19 or tests positive for SARS CoV-2, they should be given a cloth face mask (if not already wearing one and it can be worn safely), immediately placed under medical isolation in a separate environment from other individuals and medically evaluated. If the facility is housing individuals with confirmed COVID-19 as a cohort, use a well-ventilated room with solid walls and a solid door that closes fully.

[64] Letter from Lieutenant Alex McCamy, Main Jail Division to All Main Jail Personnel. Intake Observation and Isolation Showers. June 1, 2020.
[65] Performance Based Standards and Expected Practices for Adult Correctional Institutions. 5th Edition. October 2019. 5-ACI-4A-16.
[66] Letter from Margot Mendelson and Aaron Fischer to Rick Heyer. Notice of Dispute. May 27, 2020.

> Only individuals with laboratory-confirmed COVID-19 should be placed under medical isolation as a cohort. Do not cohort those with confirmed COVID-19 with those with suspected COVID-19, or with close contacts of individuals with confirmed or suspected COVID-19.

Findings: At the onset of this evaluation, at Main Jail ACH/SSO's definition of quarantine and isolation were inconsistent with CDC guidelines and implemented incorrectly. Persons who were COVID-19 suspects or close contacts of COVID 19 cases were housed in the same units as persons with confirmed COVID-19 infection. This presents a risk of COVID-19 transmission to uninfected persons.

Confusion about terminology is exacerbated by order sets in the electronic medical record (EMR) that also misapply terminology and creates confusion between quarantine and isolation. For example, the electronic medical record labels progress notes regarding release from quarantine or isolation as "Medical Isolation Notes" and "Iso Release", instead of quarantine notes or release.

ACH leadership has amended COVID-19 Population Housing definitions of quarantine and isolation and is in process of revising the electronic health record to be consistent with revised the definitions. ACH leadership states that the Infection Prevention Coordinator will periodically monitor compliance with housing placements. ACH has amended guidance definitions as follows:

- Intake Quarantine (7 days)-For all new arrivals without known exposure to COVID-19.
- Close Contact Quarantine (14 days)-For new arrivals and existing detainees with known or suspected exposure to a case
- COVID 19 Suspect Isolation (14 days)-For any detainee with symptoms of COVID-19 but not confirmed by testing (including those with symptoms but refusing testing)
- COVID-19 Case isolation (14 days)-For confirmed COVID-19 cases.

In the Main Jail, confirmed COVID-19 cases are placed in medical isolation in 1 or 2 person rooms with solid walls and a solid door, consistent with CDC recommendations. Males with COVID-19 infection are currently housed on 4E 100. Females with COVID-19 infection are housed in 2 Medical.

At RCCC, operational definitions of quarantine and isolation were accurate, and COVID-19 suspects and confirmed cases are housed separately in an isolation unit. Suspects are housed on SBF 100 and cases on SBF 200.

Monitor Recommendations: 1) Ensure that guidance documents and order sets in the electronic medical record are consistent with correct terminology. 2) Train health care and custody staff regarding correct interpretation of quarantine and isolation. 3) Monitor correct application of housing decisions regarding placement of detainees with confirmed or suspected COVID-19 to prevent inadvertent transmission of COVID 19. 4)

Clinical Care for Individuals with COVID-19

23. CDC Recommendations:

- Facilities should ensure that detainees receive medical evaluation and treatment at the first signs of COVID-19 symptoms.[67]
- Staff evaluating and providing care for individuals with confirmed or suspected COVID-19 should follow the CDC Interim Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)[68] and monitor the guidance website regularly for changes.
- Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza). However, the presence of another illness such as influenza does not rule out COVID-19.
- When evaluating and treating persons with symptoms of COVID-19 who do not speak English, use a language line or provide a trained interpreter

Findings: 1) Previous ACH Guidance stated that all new COVID-19 patients will have an initial visit with a provider, but did not specify a time frame for this to take place (i.e. <48 hours or sooner if clinically indicated). 2) Both physicians and nurses were to make rounds on the units but their roles were similar and not an optimal use of provider time.

Revised ACH guidance states that nurses will complete health checks twice daily on medical isolation units and vital signs thresholds for referral have been modified. Providers will evaluate all symptomatic COVID-19 patients within 48 hours and conduct record review on asymptomatic COVID-19 patients, but did not specify a time frame. These changes are consistent with CDC Guidance.

Monitor Recommendations: 1) I recommend that ACH Staff Guidance also be clarified to specify the time frame for medical providers to conduct record review for asymptomatic patients. 2) Nurses should carefully screen medically vulnerable COVID-19 patients with a low threshold for referral to medical providers. 3) ACH leadership should monitor nurse compliance with health checks and appropriateness of provider referrals, as well as the quality of provider evaluations.

24. CDC Recommendations: Ensure that medical isolation (and quarantine) is distinct from punitive solitary confinement of incarcerated/detained individuals, both in name and practice. For example:

- Ensure that individuals under medical isolation (and quarantine) receive regular visits from medical staff and have access to mental health services.
- Make efforts to provide similar access to radio, TV, reading materials, personal property, and commissary as would be available in individuals' regular housing units.

[67] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[68] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.
- Communicate regularly with isolated individuals about the duration and purpose of their medical isolation period.

Findings: Women with COVID-19 are housed on 2 Medical, the Medical Housing Unit (MHU). They are essentially in lockdown status and do not have access to showers, telephones or dayroom activities as men with COVID-19 that are on the housing pods. ACH advised that this was being done for lack of housing unit bed space for women. Housing asymptomatic or symptomatic COVID-19 patients in a medical unit presents a risk of transmission to other detainees unless they are placed in a room designed for respiratory isolation with an anteroom.

Monitor Recommendations: 1) Unless requiring increased medical monitoring due to symptoms, both males and female should be housed outside the main medical unit. 2) Both males and female should be provided access to health and mental health care, TV, reading materials, showers, and telephone privileges. 3) Test respiratory isolation rooms daily to ensure they are functioning properly.

25. **CDC Recommendations:** Keep the individual's movement outside the medical isolation space to an absolute minimum.[69]
    - Provide medical care to isolated individuals inside the medical isolation space, unless they need to be transferred to a health care facility.
    - Serve meals inside the medical isolation space.
    - Exclude the individual from all group activities.
    - Assign the isolated individual(s) a dedicated bathroom when possible. When a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result. Clean and disinfect areas used by infected by individuals frequently on an ongoing basis during medical isolation.

Findings: SCJ houses confirmed COVID-19 cases as a cohort where medical care was provided on the unit but is now to be provided in an exam room (excluding symptom screening and vital signs). Cohort mixing in the Day Room is permitted because all these patients have COVID-19 but movement to other parts of the institution is minimized. This is appropriate.

SCJ houses COVID-19 suspects as a cohort and medical care has been provided on the unit but in the future will be provided in an exam room (excluding symptom screening and vital signs). Cohort mixing in the Day Room of COVID-19 suspects should not be permitted because not all patients have COVID-19, but may acquire infection if exposed to other COVID-19 suspects who later are identified as a case. Meals are served on the units for both COVID-19 cases and suspects. Patients are to be provided access to showers at the time of placement in isolation, but detainees in both 7 and 14-Day quarantine reported not having a shower on admission or

[69] This CDC recommendation appears to refer to individual as opposed to cohorted COVID-19 cases. Cohorted cases can be safely allowed to mix together in the day room, eat together on the housing unit.

afterwards, and it is my understanding that patients in isolation are also not permitted access to showers for 14 days.

Monitors Recommendations: 1) Ensure that COVID-19 suspects do not mix together during isolation. 2) Provide access to showers in accordance with ACA Standards Title 15 and CDC recommendations.

26. **CDC Recommendation:** Ensure that the individual is wearing a cloth face covering if they must leave the medical isolation space for any reason.

Findings: Previous ACH Staff Guidance states that for patients in quarantine the nurse should ask the patient if they have fever, shortness of breath or cough before opening the door, and if the door needs to be opened to have the patient wear a mask. The guidance does not address that patients in quarantine with no symptoms should also be told to wear a mask when opening the cell door. For COVID-19 patients in isolation, ACH Staff guidance states that the patient must wear a mask when opening the cell door and during movement within the facility. We were not able to observe patients in isolation to determine if this CDC recommendation was met.

Monitor Recommendations: Monitor and require detainees to properly wear a face mask at all times during transport outside medical isolation.

27. **CDC Recommendation:** Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle. Instruct them to:

- Cover their mouth and nose with a tissue when they cough or sneeze
- Dispose of used tissues immediately in the lined trashed receptacle
- Wash hands immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

Findings: At SCJ, ACH Staff Guidance does not address providing COVID-19 patients or suspects with tissues and a lined trash receptacle. Actual practice shows that tissues are not provided to COVID-19 case or suspects. It was reported that detainees are to use toilet paper for this purpose and flush it down the toilet.

Monitor Recommendations: Amend ACH Staff Guidance and SSO policy to provide COVID-19 cases or suspects tissues and a lined trash receptacle, or ensure that detainees have sufficient supplies of toilet paper.

28. **CDC Recommendation:** Maintain medical isolation at least until CDC criteria for discontinuing home-based isolation have been met.

Findings: ACH provider guidance for release from isolation is consistent with, and in some cases exceeds CDC guidelines. For example, ACH states that immunocompetent COVID positive patients are released from isolation 15 days from symptom onset and 3 days from the last documented fever. CDC guidance states that for most persons, isolation and precautions can be discontinued 10 days after symptom onset and resolution of fever for at least 24 hours, without fever-reducing medications, and improvement in other symptoms.[70] For patients with severe illness and/or immunocompromised patients, both ACH and CDC Guidance recommend extending isolation up to 20 day.

Monitor Recommendations: Given bed space demands as well as work-load associated with COVID-19 monitoring, I recommend that ACH Guidance be consistent with CDC Guidance and not exceed it, except on a case-by-case basis.

Infection Control

29. CDC Recommendations:

- All individuals who have the potential for direct or indirect exposure to someone with COVID-19 or infectious materials should follow infection control practices as outlined in CDC Interim Infection and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Health care settings.
- Staff should exercise caution and wear recommended PPE when in contact with persons showing COVID-19 symptoms.
- Refer to PPE Section to determine recommended PPE for persons in contact with individuals with COVID-19, their close contact, and potentially contaminated items.
- Remind staff about the importance of limiting unnecessary movements between housing units and through multiple areas of the facility to prevent cross contamination.
- Ensure staff and inmates are trained to don and doff PPE.

Findings: This area was not fully evaluated; however, observations were made throughout this report related to use of PPE. ACH leadership reports that staff have received training on donning and doffing and reviewed CDC videos. Due to physical plant limitations, ACH does not have separate donning and doffing rooms. Staff are receiving updated information from California Department of Public Health (CDPH) and CDC at staff meetings on current COVID-19 healthcare employee practice. ACH has developed the Infection Prevention Coordinator position and custody has assigned a Lieutenant at each facility to oversee coordination of COVID-19 activities.

Monitor Recommendations: 1) ACH and SSO leadership should continue to ensure that staff and detainees are trained regarding CDC infection control guidelines and provided appropriate PPE to comply. 2) Monitor compliance with adherence to infection control principles and practices.

[70] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

Definitions

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 patient 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). Because the general public 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 – In this guidance, cohorting refers to 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. See Quarantine and Medical Isolation sections below for specific details about ways to implement cohorting as a harm reduction strategy to minimize the risk of disease spread and adverse health outcomes.

Community transmission of SARS-CoV-2 – Community transmission of SARS-CoV-2 occurs 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 detention centers are more likely to start seeing infections inside their walls. Facilities should consult with local public health departments if assistance is needed to determine how to define "local community" in the context of SARS-CoV-2 spread. However, because all states have reported cases, all facilities should be vigilant for introduction of the virus into their populations.

Confirmed vs. suspected COVID-19 – A person has confirmed COVID-19 when they have received a positive result from a COVID-19 viral test (antigen or PCR test) 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 test or are awaiting test results. If their test result is positive, suspected COVID-19 is reclassified as confirmed COVID-19.

Incarcerated/detained persons – For the purpose of this document, "incarcerated/detained persons" refers to persons held in a prison, jail, detention center, or other custodial setting. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e., detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

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 they have 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 (see Table 1). Surgical masks and N95 respirators should be reserved for situations where the wearer needs PPE.

Medical isolation – Medical isolation refers to 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 spaces are distinct from those in punitive isolation.

Quarantine – Quarantine refers to 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.)

Social distancing – Social distancing is 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 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 can be challenging to practice in correctional and detention environments; examples of potential social distancing strategies for correctional and detention facilities are detailed in the guidance below. Social distancing is vital for the prevention of respiratory diseases such as COVID-19, especially because people who have been infected with SARS-CoV-2 but do not have symptoms can still spread the infection.

Staff – In this document, "staff" refers to all public or private-sector employees (e.g., contracted healthcare or food service workers) working within a correctional facility. Except where noted, "staff" does not distinguish between healthcare, custody, and other types of staff, including private facility operators.

Symptoms – Symptoms of COVID-19 include cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, and new loss of taste or smell. This list is not exhaustive. Other less common symptoms have been reported, including nausea and vomiting. Like other respiratory infections, COVID-19 can vary in severity from mild to severe, and pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations at increased risk for severe illness are not yet fully understood. Monitor the CDC website for updates on symptoms.

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MENTAL HEALTH INTERIM EXPERT REPORT OF MARY PERRIEN, Ph.D.

IN THE MATTER OF MAYS v SACRAMENTO COUNTY
2:18-cv-02081 (E.D. Cal.)

SUBMITTED
October 26, 2020

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BRIEF OVERVIEW[1]

What follows is my interim report in the matter of the impact of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or coronavirus disease 2019 (COVID-19) on the delivery of treatment to detainees[2] of the Sacramento County Jail system (Main Jail and RCCC[3]) with mental health issues and severe mental illness. I have been asked by all parties (*Mays v County of Sacramento*) in this matter to provide an evaluation of mental health care received during this unusual time of pandemic and make any relevant recommendations. All parties have had an opportunity to review the draft version of this report and provide feedback. Whenever possible, careful consideration has been given to these comments and requests and they have been incorporated in this final report. In some areas, there may be no reconciliation possible given the timeline to finalization of the interim report and it is hoped that any further concerns or discrepancies can be addressed in the final general report.

COVID-19 in detention facilities

Detention facilities present unique challenges to the prevention and management of COVID-19. As a result of a complex interplay of factors including limited ability to social distance, congregate living, the increased incidence of people with underlying medical disorders, and challenges with integration across different departments[4], incarcerated people are especially vulnerable to contracting COVID-19. Integration is particularly challenging for the Sacramento County Jail System as there are multiple agencies who must coordinate: security staff, mental

[1] Please note, data on COVID-19 is rapidly becoming available, meaning that the accuracy of information may be dependent on when it was collected. The primary source for COVID-19 prevention and management should be the medical experts' report whereas the information specific to the mentally ill has been a focus of this report.
[2] The residents of the Sacramento County Main Jail and RCCC have a variety of legal statuses (e.g., pre-trial detainee, post-conviction sentenced offenders) and the term "detainee" shall be used to reflect all offenders rather than "inmate." Inmate is a term typically reserved for post-conviction sentenced offenders.
[3] Rio Cosumnes Correctional Center.
[4] CDC guidelines, July 2020.

health contract staff, and County health care staff are all employed by different agencies with different chains of command and no clear structure for communication established to coordinate response.

People in detention facilities are 5.5 times more likely to contract COVID-19[5]. When adjusted for age and gender differences between incarcerated people and the community population in the United States, that rate was reduced, but people remained three (3) times more likely to contract COVID-19 if incarcerated[6]. Correctional rates of COVID-19 are higher than community rates and they have been growing more rapidly than community cases[7]. Patients with psychiatric disorders are particularly vulnerable to COVID-19 due to high rates of overweight, tobacco smoking, medical comorbidities, and poor self-care[8]. For these reasons, it is necessary that jails and prisons like those in Sacramento County develop appropriate plans to address the prevention and management of COVID-19 while still providing constitutionally adequate mental health services.

Serious Mental Illness (SMI) and COVID-19

While objective data regarding any increased risk of COVID-19 for individual with serious mental illness (SMI) is sparse, there is data that suggests multiple reasons that people with SMI may be at greater risk of contracting COVID-19. As noted above, people with SMI have multiple co-morbidities placing them at greater risk of contracting COVID-19 while the cognitive impairment and socio-economic deficits experienced make them less able to successfully reduce their risk. Schizophrenia and bipolar disorder are associated with cognitive deficits, including

[5] Saloner, B. et al, COVID-19 Cases and Deaths in Federal and State Prisons, *Journal of the American Medical Association*, 324(6):602-603. doi: 10.1001/jama.2020.12528.
[6] Saloner, B. et al, 2020.
[7] Saloner, B. et al, 2020.
[8] Ongur, D. et al, Psychiatry and COVID-19, *JAMA.* 2020;324(12):1149-1150. doi:10.1001/jama.2020.14294.

impairment in problem-solving, planning, and organization.[9] This increases the difficulty they may experience in understanding the pandemic and how to protect themselves, particularly when conflicting information is repeatedly presented through various sources (e.g., radio, television).

People with SMI are known to be subjected to stigma and disenfranchisement, contributing to lower educational attainment and health literacy, on average, compared to the general community population[10]. Individuals with mental illness are some of the most isolated and marginalized in our society, leaving many without a support system that may protect them from mental decompensation and suicide. These factors contribute to challenges for caseload[11] detainees to access available information at the main jail and RCCC regarding COVID-19 and adhere to prevention protocols. Limited studies have found that people with psychosis specifically and inpatient psychiatric patients generally were less likely to adhere to prevention measures, including the willingness to be isolated and wear face masks.

In addition to being at greater risk of contracting COVID-19, SMI has been associated with poorer outcomes.[12] A recent study[13] found that individuals who had *any* prior psychiatric diagnosis were more likely to die from COVID-19. This was consistent with an earlier published study from Denmark[14] that focused on people with depression.

Psychosis was associated with viral exposure, the treatments used to treat the virus (i.e., the treatment may cause or exacerbate psychosis), and psychosocial stress related to the pandemic and prevention measures.[15] Detainees may be more likely to attempt suicide as suicide rates have

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[9] Shinn, A. MD, MPH and Viron, M. MD, Perspectives on the COVID-19 Pandemic and Individuals with Mental Illness, *Journal of Clinical Psychiatry*, 81:3, May/June 2020.
[10] Shinn, A. and Viron, M., 2020.
[11] "Caseload" as used in this report refers to detainees receiving regular mental health services (FOSS levels 1-3).
[12] Brown, E. et al, The Potential Impact of COVID-19 on Psychosis: A rapid review of contemporary epidemic and pandemic research, *Schizophrenia Research*, https://doi.org/10.1016/j.schres.2020.05.005.
[13] Li, L., et al, Association of a Prior Psychiatric Diagnosis With Mortality Among Hospitalized Patients With Coronavirus Disease 2019 (COVID-19) Infection, *JAMA Netw Open.* 2020;3(9):e2023282. doi:10.1001/jamanetworkopen.2020.23282.
[14] *Ibid.*
[15] Brown, E. et al, 2020.

been shown to rise during other pandemics,[16] placing them at heightened risk given the already-high risk setting of a jail[17]. Major Depression is noted as a significant cause of disability nationally, a leading cause of suicide, and prevalence rates have increased across all severity levels during the pandemic.[18] There is no reason to suspect that this would not be true of correctional populations. The pandemic has been traumatic for many Americans, including detainees, and may further compromise a person's mental status[19]. The stress level associated with the pandemic has been significant and overlaid upon the stress of incarceration and pending criminal cases, and it can be devastating; the pandemic and COVID-19 prevention measures inside the jails can be reasonably expected to have a substantial negative impact on the mental well-being of Sacramento County's detainees. Mental illness can increase stress levels as certain detainees may be less likely to understand the complex technical explanations for the illness. For example, people with psychosis were more likely to believe "psychotic" explanations for SARS such as that it was punishment, a sign, or indicated the end of the world[20]. They may be more willing to accept similar explanations for COVID-19 that would further increase their stress levels. SMI may also contribute to a person becoming overwhelmed by the sheer volume of information provided on prevention of COVID-19[21].

The pandemic has dramatically impacted how mental health services are provided in the community, with many providers moving to telehealth. This directly impacts release planning from the jails as it may be difficult for many releasing detainees to access telehealth services due to their disadvantaged status. In addition, services in many areas have been scaled back at the same time

[16] *Ibid.*
[17] Hayes. L., National Study of Jail Suicide: 20 Years Later, *U.S. DOJ National Institute of Corrections*, www.nicic.gov.
[18] Shim, R., Mental Health Inequities in the Context of COVID-19, *JAMA Network Open.* 2020;3(9):e2020104. doi:10.1001/jamanetworkopen.2020.20104.
[19] Shim, R., 2020.
[20] Brown et al, , https://doi.org/10.1016/j.schres.2020.05.005.
[21] Hamade, K. and Kan, X. The Impact of COVID-19 on Individuals Living with Serious Mental Illness, *Schizophrenia Research*, 2020 May 27, doi: 10.1016/j.schres.2020.05.054.

demand has increased[22]. This may cause significant delays for counseling and/or psychotropic medication refill evaluations for released detainees, creating difficulty in release planning for JPS providers and difficulty in continuity of care for detainees.

Finally, one of the primary tools for preventing the spread of COVID-19 is isolating the individual through isolation or quarantine procedures. Record review also showed repeated lockdowns in the main jail due to COVID-19 concerns. However, isolation has been known to exacerbate existing mental illness and to increase the vulnerabilities of those not yet diagnosed with SMI[23].

CENSUS INFORMATION

The census at the main jail was 1841 of 2396 beds filled as of August 25th. Forty-seven of those were individuals classified as "TSEP" or total separation which correlated with Phase I administrative segregation. There were also 35 people in segregation (correlated with Phase II of administrative segregation) at the main jail. There were 1035 detainees housed at RCCC on the same date. There were 1225 open beds at RCCC. Just nine TSEP detainees were present at RCCC, all male, and three in segregation. No female detainees were housed as maximum custody or protective custody (PC), though there were 29 maximum custody male detainees and 162 in PC.

Caseload numbers were as of August 25th unless noted otherwise. At the time of the August site visit, the total mental health caseload was as follows:

MAIN JAIL		RIO COSUMNES CORRECTIONAL CENTER	
FOSS I	33	FOSS I	0
FOSS II	256	FOSS II	69
FOSS III	634	FOSS III	299
TOTAL	923	TOTAL	368

[22] *Ibid,* and *p*ersonal observation.
[23] Hamada and Kan, 2020, doi: 10.1016/j.schres.2020.05.054.

The mental health caseload was 50% (.50136) of the jail population. At RCCC, detainees receiving mental health services was 36% (.35556).

IOP	34	JBCT (8/26/20)	46
ACUTE/2P	18	IOP (8/26/20)	21
TOTAL[24]	52	TOTAL[25]	67

Please note, some of the detainees listed in the FOSS level census overlap with the jail-based competency treatment (JBCT), intensive outpatient (IOP), and acute inpatient (acute) census numbers.

There were 17 detainees on suicide precautions with three of those housed in booking. All were listed as 2P/acute pre-admission patients awaiting a bed.

POSITIVE OBSERVATIONS

One of the most significant positive observations was the commitment to providing adequate mental health care by the mental health and Sheriff's executive teams interviewed. The team members appeared cohesive and the working relationship was positive and collegial. There was also great stability in these "branches" of the executive team. The minimum amount of time spent working in the Sacramento jail system for the security compliance lieutenant and mental health managers was 10 years. This provides for consistency for other staff and detainees as well as assists with continuity of care.

During the August site visit, this expert was told by JPS management staff that mental health services were initially ceased in March 2020 as the entire U.S. was shut down, but executive staff for the main jail and RCCC identified that detainees still needed mental health services. Consequently, services began again in approximately April or May 2020. Upon review of this report, JPS management modified their response to report that all mental health services

[24] This total reflects detainees in residential (IOP) and inpatient (acute/2P) levels of care and overlaps with the FOSS level numbers.
[25] Same as footnote 24 above.

were not shut down initially, they were just significantly curtailed. There was no documentation (e.g., COVID-19 Staff Guidance, temporary JPS policy) to reflect what was occurring in real time. It is presumed that crisis services were provided during that time based on interviews of staff and detainees at the time of the August site visit.

It was positive to note that interviewed detainees at both RCCC and the main jail were generally positive about the mental health services that they had received. They were able to specify some of the services that they found helpful as well as particular JPS staff who were responsive to their mental health needs.

As mentioned in the brief overview, relapse planning has become more complex during the pandemic. ACH and JPS have worked together to provide a larger supply of medications to sustain the released detainee until the community mental health appointment can be completed.

Detainees had also been provided with several cloth masks to wear by the jail. This appeared consistent (more than one mask provided) across detainee interviews in the Main Jail and RCCC.

AREAS OF CONCERN

Staff not Wearing Masks Consistently or Appropriately

During the site visits conducted in August, numerous healthcare[26] staff and Sacramento County Sheriff's Department deputies were observed not wearing masks or not wearing them properly (e.g., nose was not covered). This was true far more for deputies than healthcare staff observed. It should be noted that JPS indicated that they had not seen any JPS staff interacting with detainees without masks. It was unknown how often JPS mental health administrative staff spent in the treatment areas on the jail floors. What is important to remember, as caseload

[26] Healthcare includes medical and mental health staff.

detainees observe any staff not maintaining proper masking, it provides conflicting information to them as to the value of wearing masks. As stated above, their mental illness already creates challenges in understanding the nature of the pandemic and prevention measures. It is not only important that staff consistently adhere to mask mandates to reduce the spread of COVID-19, it is also important that caseload detainees see staff model appropriate behavior. Most staff interacting with detainees in our presence were wearing their masks appropriately; however, even just one staff member who does not take appropriate precautions can start or spread an outbreak. Subsequent to the site visit, the SSO have reported that staff have "near universal" mask wearing when around class members. While this supports the need to monitor and track when staff do not have masks appropriately, the process for monitoring this could not be reviewed prior to finalization of the interim report. While the SSO is commended for reported increased compliance, monitoring methods should be reviewed and assessed, whether with the medical expert or mental health expert or both.

Security staff acknowledged struggling with how to enforce the mask and social distancing mandates, particularly in addition to existing duties. While it is unfortunate that there has been national confusion regarding the value of masks and social distancing, the Center for Disease Control (CDC) guidelines are clear and should be enforced. There did not appear to have been any focused education for all detainees with mental illness and JPS staff did not appear to require adherence to preventive measures.

Detainees Rarely Wearing Masks or Social Distancing

During the site tours, rarely were detainees observed wearing their cloth masks. They acknowledged that they had masks, but the caseload detainees interviewed did not understand the need for masks or were skeptical, clearly not understanding the purpose and benefits of wearing

masks. Detainees also reported that the masks would stretch easily, making them difficult to wear and not particularly useful. This was confirmed through observation. Mental health staff were observed interviewing detainees and facilitating groups where most if not all detainees were not wearing masks. Participants in treatment groups were not socially distanced.

When interviewing detainees, they had to be reminded by this writer of the need for social distancing and masks. Two detainees opted to return for masks without any complaint, suggesting that if mental health staff adhered to COVID-19 prevention standards with detainees and local staff guidance[27], the detainees would comply with little complaint. In at least one interview group, COVID-19 and prevention behaviors had to be explained to the detainees who implied that they had not received that information previously. Defendants have reported that detainee education efforts have been undertaken, in video and written formats. However, this could not be confirmed prior to the final report deadline.

Confidentiality

One area of complaint from detainees focused on the lack of confidentiality. Detainees at both facilities reported that they did not receive confidential contacts. They reported that they were usually seen in a non-confidential space despite direction to clinical staff to use the classrooms at the main jail for private contacts and that even when in a place that could be confidential, deputies were always present. This was not due to COVID-19 restrictions, however, but was consistent with treatment pre-COVID-19. The SSO reported efforts to increase privacy for clinical contacts but did not provide specific detail. It is hoped that these efforts will be specified to the mental health expert and that the parties can review them together, in time for the general report.

[27] ACH Staff guidance (revision 8-12-20).

While one obstacle to confidential contacts was the physical plant, mental health staff were observed meeting with detainees in non-confidential areas even when there was confidential space available. For example, classrooms were frequently empty while JPS clinicians met with detainees, cell front or in the large open area outside of the unit underneath the officer's bubble. The classrooms have large windows that allow for line-of-sight monitoring without the need for a deputy to be present in that individual or group session. The need for confidential contacts is a significant issue as it is difficult to conclude a clinician has received all necessary information during a non-confidential contact given the sensitivity of the topic areas.

Treatment Provided

While it was positive that mental health recognized the need to provide services during the pandemic, many of those services were provided cell front. This was confirmed through observation during the site visits, staff and detainee interviews, and the medical records. It is important to note again that cell front contacts were not due to COVID-19 restrictions and occurred in every setting, even for suicide risk assessment and daily suicide re-assessments. This was particularly alarming as suicidal ideation is particularly challenging for many people to discuss in front of others not involved in their treatment. Mental health staff did not consistently document the location of the clinical contact or whether it was confidential despite the importance of this aspect of documentation. On a positive note, JPS has since requested updates to documentation forms so that location of contact and confidentiality can be included, tracked, and reported. The length of time for completion of this project was not provided, but will be monitored and reported on in the general report.

The IOP group schedule indicated that detainees received primarily recreation therapy though it was provided by licensed clinical social workers. There were no recreation therapists

or psychiatric technicians on staff to provide these types of services, leaving existing mental health staff to provide treatments that they may not have been familiar with while taking away time those clinicians could have used to provide clinical groups and individual contacts. Groups seen during the site tours at both facilities included detainees who were not social distancing and did not wear masks. While JPS commented regarding additional clinical treatment, that information was not provided as data per treatment group (JBCT and IOP). It appeared based on interviews at the time of the site visit that JBCT received the bulk of additional treatment, though this will be clarified for the general report.

Treatment implementation was even more problematic in the acute unit, where treatment need was greatest. Acute treatment consisted of medication management and a great deal of isolation, similar to the findings in the "*Mays*" case. While there were space challenges in the unit, acute treatment needs to include confidential therapeutic interventions beyond medication management.

There were no treatment guidelines for mental health services for those detainees in quarantine or isolation status. It was noted that entire units would get locked down for quarantine and may be on that status for more than 14 days. This removes the detainee from their regular treatment (e.g., groups) without increased monitoring by JPS staff to ensure that the detainee does not decompensate. As mentioned above, physical isolation or segregation can exacerbate existing psychiatric difficulties and can cause others who have not been identified as mentally ill to decompensate and begin showing psychiatric symptoms. As is readily known, the longer a person remains in a decompensated state, the more difficult it is, even with treatment, for that person to return to baseline functioning.

<u>Lack of Integration</u>

It appeared that there were some difficulties between the branches of the executive team and with JPS and ACH specifically, as was noted in the Consent Decree. For example, mental health reported that caseload detainees with suicidal ideation would be taken to the 2P/acute unit as would detainees with SMI in isolation or quarantine status. However, when attempting to confirm this during a call with ACH staff, they were unaware and did not believe that was happening. While there appeared to be confusion around this matter, it was reviewed several times during the site visit and the cause for confusion could not be readily identified in time for the final interim report. Luckily, the COVID-19 Staff Guidance document (10/22/20) indicated that detainees with suspected or confirmed COVID-19 will be placed in P-16 through P18 and comanaged by medical and mental health while new intakes who were suicidal would be housed on 3W in single cells. This was significant clarification from prior reports from both ACH and JPS and was seen as a positive step forward and necessary integration.

Another example of the need for further coordination also involved the 2P/acute unit. While policy clearly stated that only caseload detainees should be housed there, there was a safety cell designated for use by security for separation of the detainee. The use of this area was clarified, as stated above, by the ACH Staff Guidance document, revised 10/22/20. It was unclear whether this was the best location for those individuals, confirmation of coordination across all three branches (SSO, ACH, JPS) shall be confirmed prior to the final report.

An issue identified with 2P that could not be clarified until after the draft interim report involved nursing rounds. While there was mention that the visibility into the cell from the nurses' station was problematic, the nurses should be making regular rounds on the unit so that they regularly check on patients housed there. The 2P/acute unit schedule did not indicate that nursing rounds were expected. JPS later reported that nursing rounds were expected every 15 or

30 minutes. This appeared supported by the medical records but will be confirmed for the general report.

When discussing treatment, particularly for those who require enhanced treatment such as IOP or acute programs, assessments of adequacy typically involve reviewing out-of-cell scheduled structured activity and unstructured activity. The acute schedule did not indicate any out-of-cell structured clinical activity, listing only doctor's rounds which may or may not involve out-of-cell contacts. Detainees in the acute program were offered showers, dayroom, and/or telephone, but the schedule was not specific enough to determine if every detainee would be offered that activity during that time. People in an acute level of care require more than doctor's rounds to stabilize and additional structured clinical activity would be expected for that setting. While both male and female IOP detainees were offered dayroom, the schedule did not indicate if everyone would be offered dayroom when scheduled. It should be noted that there have been times when clinical contacts and dayroom have not been offered due to staffing shortages because of COVID-19-related absences. The same was reported in segregation due to staffing shortages.

Showers for Isolated and Quarantined detainees

At the time of the site visit (August 25th and 26th), detainees on isolation or quarantine status were provided only one shower at the beginning of their stay requiring them to go seven to 14 days or more without showering. While scientific evidence of the impact of showering on mental health is sparse, a decrease in hygiene habits has long been associated with a deteriorating mental status and SMI. When people are depressed or psychotic, they may neglect their personal hygiene and the severity of neglect increases with the severity of the illness.

Each individual enters the jail setting with their own standards of personal hygiene. For example, a detainee with Obsessive-Compulsive Disorder (OCD) would likely engage in frequent handwashing, showering, and other hygiene behaviors. It would be extremely anxiety-provoking to restrict these activities, particularly if not necessary. It is not necessary that showers be eliminated to prevent the spread of COVID-19, quite the opposite in fact. There have been many journal articles and even the CDC guidelines stress the need to maintain high levels of personal hygiene.

Once admitted to the jail setting, the detainee is forced to conform to the jail's standards regarding shower schedules and access to appropriate supplies for handwashing and cell cleaning. This adjustment is exacerbated by the initial intake quarantine, despite the value of that quarantine. Mental health could provide treatment to help manage the resulting stress and anxiety. While JPS staff reported providing such services, this was an assertion without data to support it. It is hoped that this can be clarified by the time of the general report. Without care provided regularly to class members in isolation and quarantine, those protocols may inadvertently be reinforcing behaviors associated with mental status decompensation. Some detainees indicated that they had requested cleaning supplies for their cells but had not received the requested supplies. They knew that they would have to return the supplies and were not asking for unusual products. It should be noted that the SSO indicated they had received no complaints regarding cleaning products and had received no kites regarding this matter. That may have been because there were no such complaints previously, these were only recent complaints or that the detainees did not trust the grievance system. There was no information available that would suggest that the detainees did not trust the grievance system. It did seem that

at least some of them preferred to use an informal resolution model, having told unit officers and hoping for remedy.

It was also reported that detainees in the men's IOP and OPP have a bar of soap in their housing unit that a detainee can use to then wash his hands. Guidelines strongly recommend not using communal bar soap as COVID-19 could be passed that way. There was also no access to hand sanitizer for the detainees, though many correctional systems/facilities across the nation have loosened those restrictions during the pandemic. The SSO reported that there was no practice or indication that detainees actually shared that bar of soap. However, two inmate workers informed this expert of the use of the communal bar, were able to provide extensive detail about how it was utilized, and other detainees agreed with the report. At minimum, this would be an area for further investigation, particularly whenever unit rounds are completed. On a positive note, the SSO also indicated that they may consider provision of hand sanitizer when its use can be appropriately monitored.

Psychotropic Medications

Detainees in the main jail did complain about not receiving medications timely. Specifically, morning meds would be administered early in the morning, around breakfast time, but evening meds were being provided as late as midnight or 0200 hours, forcing detainees to wait up or be woken from their sleep lest they miss critical psychiatric medications. This was most problematic for those in IOP or sheltered (living in IOP unit) OPP. This problem was confirmed with staff who reported several attempts to resolve the problem. Staff had suggested that medication administration nurses start on the 3rd floor where the IOP is housed and then go to the other housing areas if there was not sufficient staff to administer medications simultaneously and timely.

RECOMMENDATIONS

These recommendations are focused primarily on delivering adequate care during the pandemic. While the pandemic has had an impact on all detainees, certain characteristics of SMI can make it more difficult for caseload detainees to understand the nature of the COVID-19 pandemic, understand how to minimize their risk of COVID-19, and to comply with related COVID-19 management practices (e.g., quarantine). The mixed messages provided by different entities regarding COVID-19 and its prevention and management further increase the probability of confusion on the part of detainees with SMI and lower their compliance levels with prevention efforts. They may experience some of the management practices as punitive, such as removing them from their housing even if they have not tested positive or being "locked down" when an entire unit is placed on quarantine.

The following recommendations are outlined as actions that *should* occur to address existing obstacles to adherence with treatment expectations in accordance with the Consent Decree, particularly while working to prevent and manage COVID-19 transmission, as well as other noted areas for improvement such as medication administration which may or may not have been impacted by the COVID-19 Staff Guidelines.

1. Frequent communication with caseload detainees is critical. While defendants noted a patient education program in development and referred to the ACH COVID-19 Guidelines, those guidelines did not address this item though they should.

This pending communication program should include education regarding current guidelines and prevention practices, and it should not be solely ACH staffs' responsibility. Mental health staff need to regularly communicate with caseload detainees to ensure that the detainees' understand the status of the pandemic and the processes to keep them safe within the jails.

1a. Mental health staff should reserve a portion of each clinical contact, individual or group, to allow caseload detainees to ask questions regarding COVID-19 and how they can reduce risk. It should not be dependent upon the detainee to bring this topic up. Providers should all be well educated in COVID-19 precautions and jail policies so that they when they address the topic, they will only provide accurate information. Further, defendants stated that these training and education occurrences would be documented. While this is important and laudable, that should be articulated through a temporary policy or COVID-19 updated Staff Guidelines to ensure consistency across providers and in compliance with the Consent Decree (policies and procedures).

1b. While this may seem obvious, staff should be reminded that their personal opinions of the prevention and management measures are off-limits. While defendants reported that staff are aware that they should not share personal opinions regarding prevention and management measures, that was not located in the COVID-19 Staff Guidelines or in a specific policy (consistent with the Consent Decree). This underscores the importance of policies that are shared by all entities, SSO, ACH, and JPS.

If a staff member thinks that masks do not mitigate the spread, this should not be discussed with detainees. Detainees should only be provided with factual information provided by the CDC or similar authoritative sources. To achieve this, all staff must be briefed on current protocols and the rationale behind them. It is not enough to rely on staff to review updated guidelines. They must be provided an opportunity to ask questions or clarify. This could be handled through daily all-staff meetings or huddles. This will be particularly important if there is any change to existing protocols. Caseload detainees will ask deputies these questions and deputies must be provided the resources they need to successfully answer detainees' questions. That is a reasonable expectation since everyone must know the COVID-19 Staff Guidelines.

2. Frequent communication between security, mental health, and medical staff is also critical to ensuring that all staff understand current procedures. Mental health executive staff should be present when plans related to the prevention and management of COVID-19 are being discussed and mental health should have a voice in those plans to make sure that the operations will not interfere with the provision of mental health care. The Consent Decree references the development of an organizational structure that incorporates the SSO, JPS, and ACH. The development of this clear structure and organizational reporting lines as well as appropriate integration of all departments will prevent further confusion and provide all staff with a clear mechanism for addressing how these different entities will work together.

2b. It is recommended that the jails utilize a shift briefing or huddle during each shift to share relevant information across all disciplines. While JPS reported having daily huddles or rounds that include custody for acute, IOP, and the JBCT, there was no documentation of those huddles/rounds provided to support their occurrence. This will be further explored as part of the general report.

These shift briefings should include all staff working during that shift, as able. Only people who cannot leave their posts or are handling an emergency would not be present; all staff would be allowed to ask questions. This should be incorporated into a regular policy since this procedure is expected to outlive the pandemic.

2c. It is recommended that regular management meetings be held with security, mental health and medical executives present in accordance with the Consent Decree. The development or modification of COVID-19 operational plans and policies should be developed in this context. This has reportedly already occurred based on the SSO, but no documents were provided to support the actual integration of operations and policies.

3. Utilize COVID-19 procedures in the existing incentive system for caseload detainees.

3a. It is recommended that the current incentive program be examined and revised to reinforce safe behaviors. This expert is happy to assist JPS in identifying appropriate incentives should that be requested. Until then, an example of an incentive such as a detainee not requiring a reminder during a group therapy session to stay socially distanced will be followed by an incentive such as earning points or verbal recognition. JPS have been receptive to these suggestions and this expert looks forward to reviewing those efforts for the general report. This incentive system would be part of a progressive behavioral privileging program in accordance with the Consent Decree.

4. COVID-19 policies must be adhered to before they can be expected to be successful.

4a. It is recommended that detainees be reminded to wash their hands and wear their masks when they are being called out for a group or clinical appointment. Participation in a group treatment setting should only occur if the detainees have their masks properly worn. This can be reinforced through the incentive or progressive behavioral privileges as outlined in the Consent Decree. It is recommended that mental health staff be prepared to ask a detainee to return to their cell/dorm if they do not adhere to guidelines. This is a natural and logical consequence for those who choose to not comply when reminded. It should not be used to withhold treatment from acutely psychotic individuals.

5. Group treatment should consider social distancing guidelines. While JPS has said that they would review group schedules to determine feasibility, there actually is no option if JPS is going to remain compliant with COVID-19 Staff Guidelines (10/22/20) and CDC current guidelines. They must provide treatment consistent with those guidelines. While smaller groups will have to

be addressed through increased treatment availability or additional space identified to allow for more simultaneous groups.

5a. It is recommended that maximum group size be determined for each group treatment area. This should be clearly posted the way the Fire Inspector occupancy numbers are posted. It may be necessary to reduce groups to only six participants. This will likely require the scheduling of more group activity. There is a need to provide indicated treatment that adheres to COVID-19 standards. If it cannot be achieved with current staffing and space, then there needs to be development of an interim plan that clearly addresses how adequate treatment will be provided until the new facility is built or other time.

6. Group treatment opportunities should be increased. JPS has committed to reviewing their staffing and treatment schedules to determine the feasibility of this. However, since there are treatment standards in the Consent Decree, JPS must work fervently to meet the Consent Decree standards while adhering to COVID-19 prevention guidelines.

6a. This is an incredibly stressful time for all people and made even more distressing to detainees by their incarceration and extremely limited control over their environment. Mental health management should review existing treatment schedules to maximize treatment opportunities, both group and individual. This may be achieved by utilizing housing unit space for unstructured and structured activities that are less likely to require discussion of sensitive topics (e.g., art therapy, music appreciation). It may require current space used for other purposes and scheduling mental health treatment in those areas during specific times of the day.

7. Mental health staff monitoring should increase for detainees on isolation or quarantine status.

7a. It is recommended that during shift briefings/huddles, those detainees on isolation or quarantine status be reviewed by all staff (SSO, ACH, JPS) to discuss current challenges, expectations, and goals for the detainees.

7b. It is recommended that mental health staff conduct daily rounds, at minimum, for detainees on isolation or quarantine status. It is important to note that JPS has stated that they are unlikely to meet this recommendation because of staffing limitations. They also note that they continue to see detainees as expected (e.g., monthly, more than monthly). However, detainees on isolation and quarantine status should not be held on that status, per COVID-19 Staff Guidelines (10/22/20) more than 7 or 14 days. Therefore, during an extremely stressful time for detainees, based on the research identified at the beginning of this report, mental health should be regularly monitoring the mental status of those caseload detainees. With limited staffing, until full staffing is realized, staff may have to prioritize tasks and document what has been completed at the end of each shift with reasons for any tasks not completed also listed. Medical will not be assessing those patients for mental decompensation as they have their own medical monitoring to complete. It is insufficient to rely on medical staff referrals of detainees who require additional mental health evaluation or treatment based on the available Guidelines.

These mental health rounds should be documented in the medical record. The focus of rounds would include assessing for decompensation, reducing detainees' anxiety through discussion and answering detainees' questions, and visual observation of the detainee to document any changes to appearance or lack of adherence to policy guidelines. For example, the clinician would make sure that the detainee has a mask and understands when and how to use the mask properly.

8. Confidentiality must be prioritized.

8a. JPS staff should be re-educated regarding resources (e.g., classroom) and expectations for confidential contacts in accordance with the importance of patient privacy as outlined within the Consent Decree. This was to be discussed "asap" with staff per JPS, but no documentation was provided to support that it had occurred.

8b. JPS staff should be re-educated on the necessity of noting their location and whether a contact was confidential in their progress notes, again in accordance with the Consent Decree. JPS noted above that this would be done but provided no target dates or document supporting that it had occurred.

8c. Other confidential space must be creatively sought, and all of these efforts should be documented. Please note that during the site visit security and JPS staff reported ongoing efforts at the main jail to find such space. They were strongly encouraged to document those efforts and meetings. SSO has indicated that they have shared this recommendation and plan to begin to document those activities. This will be reviewed as this documentation is made available.

9. Medication administration should not require a detainee to be awake at an unreasonable time. In accordance with the Consent Decree, medication should be administered as prescribed. It is presumed that psychiatric staff assign particular administration schedules for psychotropic medication to ensure that there is stability in blood levels of that medication and that it is administered as the physician determines necessary.

9a. Because security staff noted that there had been a solution previously identified that had been and was expected to again be successful, there should be a policy that includes the solution that is adhered to, with progressive discipline utilized if staff fail to do so due to their own actions. It is understood that there may occasionally be exceptions due to unforeseen emergencies. These exceptions should be clearly documented.

10. Detainees on isolation or quarantine status should have access to the same privileges and property as deemed allowed by COVID-19 management strategies. Any exceptions should be documented and justified, in accordance with the Consent Decree.

10a. The comprehensive management team should review and modify current policy on shower limitations in an effort to increase access to showers for both physical and mental health reasons for class members. Meetings held to review and modify shower policy for those on isolation and quarantine should be documented as to the content of those meetings. Modifying current policy to be consistent with what is provided in other jails (e.g., Santa Barbara County Jail) would be beneficial for detainees and staff.

10b. The jails should ensure that detainees stop using communal soap. Each detainee should receive an individual bar of soap and dispensers be used in communal areas in accordance with policy. The SSO has indicated that they provide detainees with individual soap. It is hoped that this is verified and documented during unit rounds or some other method of regularly reviewing that detainees have access to individual soap and are not using under any circumstances communal soap. If there is not such documentation now, it is recommended that such reviews be documented.

10c. The executive team should examine the feasibility of hand sanitizer for detainees and the safe provision of such while noting the security concerns of unsupervised access. SSO has indicated that they would consider the practicality of providing hand sanitizer.

11. The executive management team should review unit schedules and develop updated unit schedules that include scheduled structured and unstructured activities so that all staff working on those units (security, mental health, medical) will be aware of the unit's activities and the expectations for each staff member. These schedules should allow for someone to review the

schedule and determine the expected amount of time spent out of cell. Per JPS, these schedules can be revised, but this should be completed jointly between JPS and SSO so that all staff know what is expected of them individually.

12. Mental health management staff should review release planning procedures and ensure that release planning is occurring early enough during the pandemic. It should be consistent with what has been outlined in the Consent Decree (page 27 of 63, section 3). This may require a staff memorandum or policy change in light of pandemic conditions.

13. As mental health staff continue to work on increasing clinical activities, they should be encouraged to prioritize clinically-focused treatment groups over movement groups whenever possible.

CONCLUSIONS

There have been positive actions inside the Sacramento County Jail system as a result of the efforts of all staff, security, JPS staff, and ACH staff. However, there remain significant deficiencies. Most of these deficiencies are not the result of the pandemic and reflect long-standing areas of opportunity for staff to improve. These will be more fully addressed in the first major monitoring report. However, it was noted that detainees with mental illness would benefit from COVID-19 specific actions as outlined above. It was with great pleasure that this expert noted genuine commitment and concern by all staff met with during the site visit and communicated with via telephone. While 2020 has been a chaotic year, mental health and security leadership have not allowed the chaos to interfere with their focus on improving mental health services. They were incredibly receptive to feedback during the site visit and committed to improvement.

Signed by Mary Perrien, Ph.D. and DATED this 26th day of October 2020.