Dianthe Martinez-Brooks et al v. D. Easter, Warden

No. 3:20-cv-569 (MPS)

Homer Venters

FCI Danbury Inspection Report

I. Background

1. I am a physician, internist, and epidemiologist with over a decade of experience in providing, improving, and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers as part of my public health fellowship where I conducted analyses of physical and mental health policies and procedures for persons detained by the U.S. Department of Homeland Security and evaluated individual asylum applications for torture survivors. This work included and resulted in collaboration with U.S. Immigration and Customs Enforcement ("ICE") on numerous individual cases of medical release, the formulation of health-related policies, as well as testimony before the U.S. Congress regarding mortality inside ICE detention facilities.

2. After my fellowship training, I became the Deputy Medical Director of the Correctional Health Services of New York City. This position included both direct care to persons held in NYC's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral, and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services including physical and mental health, addiction, quality improvement, re-entry, and morbidity and mortality

reviews as well as all training and oversight of physicians, nurses, and pharmacy staff. In these roles, I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time I provided numerous datasets and other forms of cooperation for the U.S. Department of Justice investigation into brutality in the NYC jail system, and worked with my team to support their critical efforts. Many of the data systems that I implemented in the NYC jails were identified and reported in the U.S. Attorney's Office for the Southern District of New York's substantiation of the health consequences of a pattern and practices of brutality regarding adolescent detainees.[1]

3. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacted almost 1/3 of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection, and several other smaller outbreaks.

4. In March 2017, I left the Correctional Health Services of New York City to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges, and law enforcement staff on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers. I subsequently worked with the nonprofit Community Oriented Correctional Health Services (COCHS) in promoting evidence-based health services for people with justice involvement. I have also worked as an independent correctional health expert since 2017. In my roles as a correctional health physician I have conducted over 50 facility inspections, three of which have been specific for assessing the adequacy of COVID-19 response. My CV with a list of cases I have testified in, and my compensation rate is attached hereto as **Appendix A**.

[1] *See* Report on CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island, U.S. Dep't of Justice (Aug. 4, 2014), https://www.justice.gov/sites/default/files/usao-sdny/legacy/2015/03/25/SDNY%20Rikers%20Report.pdf.

II. Methodology

5. The purpose of this report is to focus on the adequacy of the FCI Danbury's response to COVID-19 with focus on infection control and other public health measures currently being implemented to prevent serious illness and death among staff and detained people.

6. In order to prepare this report, I visited the various facilities of FCI Danbury on May 27, 2020 and physically inspected the facility including the main FCI campus, the female Federal Prison Camp (FPC) and the female Federal Satellite Low (FSL).

7. In FCI, I toured and examined the entry and screening area, health services unit, the intake area, the SHU, D unit, I unit, M unit, and A unit.

8. In FSL I toured and examined the entry area, the dorm, common room, food service area, visitation room, classrooms, and isolation room.

9. In FPC I toured and examined the entry area, B dorm and the medical clinic.

10. My interactions with detained people included in most cases asking the following questions, with follow-up as appropriate:

a. Have you been around anyone you thought had COVID-19?

b. What has this facility done to prepare for COVID-19?

c. Have you been asked any questions about COVID-19 by health staff?

d. How have you reported concerns about your health (including COVID-19) in this facility?

e. Who wears masks and gloves in this facility and how do they get this equipment?

f. Who cleans inside cells in this facility and how and how often do they get cleaning supplies?

g. Who cleans outside cells in this facility and how and how often do they get cleaning supplies?

11. I have conducted this assessment and review of information with the following questions in mind:

a. Do current practices in the FCI Danbury adequately detect the number and severity of COVID-19 cases among staff and prisoners and respond in a manner consistent with CDC guidelines and other established clinical standards of care?

b. Do current practices in the FCI Danbury adequately slow the spread of COVID-19 through the facility and between people, both staff and prisoners, in a manner consistent with CDC guidelines and other clinical standards of care?

c. Do current practices in the FCI Danbury adequately identify and protect high-risk prisoners from serious illness and death from COVID-19?

12. In addition to my inspection of the facility, I was able to review the following records and information:

a. Declarations from 28 incarcerated or recently released people;[2]

b. FCI Danbury/BOP policies and procedures relating to COVID-19;

c. Photographs taken during the facility inspection;

d. The deposition transcripts of the following FCI Danbury staff: HSA [redacted], Health Services Administrator for FCI Danbury; Diane Easter, Warden, FCI Danbury

e. The Complaint and Exhibits filed in this case, the Motion for Temporary Restraining Order and Exhibits, the Second Supplemental Memorandum of Law in Support of the Temporary Restraining Order and Exhibits.

f. The government's interrogatory responses

g. Documents USA 003129-5637 (prisoner medical records); 007547-8439 (temperature check logs); 005898-005974 (Danbury memos and policies re

[2] I have reviewed the declarations of the following people who are detained at, or were recently released from, the FCI Danbury; [redacted]

COVID-19); 005975-006115 (Danbury memos and policies re COVID-19); 008400-8447 (health services activity logs); 008457-8806 (health services activity logs); 008807-8811 (administrative remedy request re COVID-19); 00812-59 (Health Services Activities Reports); 008867-68 (Coronavirus Phase Seven Action Plan); 008893-94 ([redacted]); 008920-30 (CST memos); 008955 (Emails re COVID screening, testing, staffing); 008956 (COVID 19 local plan); 009231-9444 (sick call slips); 9445 (testing by units spreadsheet); 009446-47 (testing information).

13. The information I have gathered from the above referenced documents, in conjunction with the results of my physical site visit, are sufficient for me to come to the conclusions drawn below with a high degree of confidence.

III. Assessment of the COVID-19 Response in FCI Danbury

A. Visual Observations from the Inspection

14. The inspection of the various parts of the three facilities in FCI Danbury lasted approximately 4.5 hours and consisted of observations and photography of various housing units, as well as interviews of inmates both cell-side and in open areas. All interviews were conducted in the presence of at least one representative of the Respondent, including in many cases MCC staff. I spoke with 11 detained people.[3]

15. Visual observations from FCI started with the entry and health services area. Observations included the tape markings on the floor outside the health services unit, which were presented as guides for how far apart people should stand while in medication or pill line. The markings appeared 2 or 3 feet apart. Four clinical examination rooms were also

[3] I spoke with the following FCI Danbury detainees; [redacted]

observed in the health services unit and the only no touch waste receptacle appeared to be a biohazard container. The testing area was also inspected and FCI staff explained that all inmates would be tested by 5/29/20 and that the primary testing modality being utilized was a Quest test. Staff explained that the Abbott ID Now test has been utilized initially and that all of those samples were being confirmed/rerun with the Quest test and that they had a roster of which tests were still pending confirmation. Staff also explained that no staff testing is done, only inmate/patient testing. Contact tracing was explained to be under the purview of the infectious disease coordinator, but the specifics of how people who conduct contact tracing are trained or how the adequacy of their work is reviewed was not assessed or presented in the context of CDC guidelines.[4]

16. The intake area at FCI, also referred to as 'R and D' comprised of two cell areas, a body scanner and an office identified as the location for medical encounters (including screenings, COVID-19 temperature and symptoms checks and testing) for people arriving and leaving the facility. Women are brought into this unit from the Camp to quarantine before being released. The fridge in the office designated for clinical encounters was being used for staff food storage (photo). The office designated for medical encounters housed several file cabinets, some other office storage, and two chairs. No medical equipment, examination table or other evidence of health encounters was present in this room.

17. The SHU area at FCI was being used as a punitive segregation or solitary confinement as well as a COVID-19 quarantine area for women from FSL. Staff reported that this unit had been recently approved as use for housing of women. This unit comprised of open bar stock, no doors (photo), with one bunk per cell. The upper tier was being used for solitary confinement/punitive segregation and the lower for medical isolation. No PPE cart was present at the entry to the unit and no hand sanitizer was present at the entry or on the unit.

[4] https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf

No clinical examination space existed on this unit. The practice of having people under quarantine for COVID-19 in the same housing area as people who are being punished via solitary confinement, with open passage of air from one cell to another is completely inconsistent with basic infection control and CDC guidelines. In CDC guidelines for COVID-19 response in detention settings quarantine specifically mention "solid wall and doors" for separation of quarantined individuals from others who are not in quarantine.[5] Basic infection control also identified any quarantine as requiring physical separation of one group of individual from another. Put simply by the CDC "Quarantine is used to **keep someone who might have been *exposed* to COVID-19 away from others**."[6] At the time of my inspection, the women on the top tier were in open cells, as were the women on the bottom tier, and I was able to hear conversations with all of them due to the open bars in all cells. There is clearly free flow of air throughout the unit. Having women placed into open bar cells for punishment in the same unit where women are held for COVID-19 quarantine essentially exposes the first group to COVID-19 as part of their punishment, a practice that is unethical and breaches both basic correctional and infection control standards.[7] At the time, staff indicated that there were no women placed into this unit who were suspected of having COVID-19 but since my inspection I have reviewed a declaration from a prisoner who reports placement of someone suspected of having COVID-19 onto this same unit. Another prisoner reports that, in the last few days and after close contact with a woman from Camp who tested positive, she was moved to R&D and then to SHU. She observed other women on the lower tier of SHU, which is supposed to be for women in quarantine, who she knows to be in SHU for disciplinary reasons not quarantine.[8] If true,

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

[6] https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine-isolation html

[redacted]

[8] [redacted].

this would sabotage the very idea of quarantine, expose all people in the unit to COVID-19 and create significant risk not only for them but the communities they are leaving this unit to return to.

18. D unit was the next housing area observed, comprised of bunk beds approximately 3-4 ft. apart. Most people wore masks, but not all and social distancing was not observed or possible in the close confines of the bunks or bathrooms. Several people yelled out comments communicating that the unit had only recently been cleaned or that sick call appointments take months to occur. Several large fans were blowing on the unit. Staff reported that the entire unit had been tested for COVID-19 the day before, and that no person had been identified as being a potential COVID-19 case for several weeks. Staff also reported that daily temperature checks were conducted by non-medical staff in this and other units. Officers on this unit were unsure who would clean and collect the belongings of a person who is suspected of having COVID-19. Review of declarations by detained people indicates that no cleaning was conducted when a person was identified as having COVID-19.[9] No PPE cart was present at the entry to the unit and no hand sanitizer was present at the entry or on the unit. The bathrooms had filled soap dispensers. No clinical examination space existed on this unit.

19. The next unit observed and inspected was I unit. This two-tier unit was comprised of cells with solid doors and was described by staff as a unit for people with intellectual or developmental disabilities. Most, but not all, people wore masks, and social distancing was not observed or possible in the close confines of the unit. There were tables in the center of the unit with computers towards the back of the room, phones at the front, and bathrooms off the front of the room. A bottle of cleaning solution was present near the computers. No cleaning solution was visible near the phones. No paper towels or means

[9] [redacted]

to wipe down the surfaces was present at either area. No PPE cart was present at the entry to the unit and no hand sanitizer was present at the entry or on the unit. The bathrooms had filled soap dispensers. No clinical examination space existed on this unit.[10]

20. The next unit observed and inspected was M unit. This two-tier unit was comprised of cells with solid doors and was described by staff as now being utilized for quarantine. A PPE cart was located outside the unit with 10-12individual clear plastic bags, each with one gown, n95 mask, gloves, and reusable face shields were also available. There was some confusion among staff as to whether this level of PPE was needed for this unit but is was ultimately decided to put on full PPE. I observed the temperature checks taking place on this unit while we were there, which appeared to take approximately 20 seconds, and involved confirming a person's name and taking their temperature. A sink and trash can were present at the entry to the tiers for hand washing and disposal of PPE. No hand sanitizer was present at the entry or on the unit. No clinical examination space existed on this unit.

21. The next unit observed and inspected was A unit. This two-tier unit was comprised of cells with solid doors and was described by staff as identical to M unit, but was being utilized for medical isolation. At the time of our visit, no people were being held on the bottom tier. A PPE cart was located outside the unit with 10-12 individual clear plastic bags, each with one gown, n95 mask, gloves, and reusable face shields were also available. The medical isolation patients were in the top tier, which I observed. Staff reported that at some point, quarantine patients were housed below on the bottom tier, and isolation patients on the top.[11] If true, the housing of quarantine patients in the same housing area as medical isolation would represent a failure of basic infection control practices. Because the same

[10] [redacted] (lack of ventilation in I Unit).

[11] This is confirmed by the record. [redacted]

staff would work on both parts of the unit, this practice would potentially expose the quarantine patients to COVID-19 form the already diagnosed or symptomatic patients in the isolation cells. In addition, when new cases or symptoms emerged among people in the quarantine cells, it would be impossible to know whether these cases of COVID-19 originated from the original quarantine exposure or a transmission inside the housing area, thus foiling the original intent of quarantine.

22. The next area observed and inspected was the FSL. We started with the dormitory which was a very large, open building (11,924 sq ft) that had 100-200 office cubicles with bunk beds in each of them. The size and open floor and ceiling of this building are consistent with standard 10,000 square foot buildings used commonly for construction and warehouses, with some additional dedicated space for bathrooms and the common room. Most but not all detainees were observed wearing masks, few were engaging in social distancing, which was not possible given the layout of the office cubicles. A computer room and phone area were observed, neither of which would allow for social distancing. No cleaning solution or paper towels were observed near the phones or computers. No clinical examination space existed on this unit. Tables with attached seats were present near the entry to this unit (photo), with many people seated directly next to each other. There was no hand sanitizer present at the entry or on the unit.

23. The next area observed and inspected was the dining hall. Staff expressed differing opinions about whether this dining hall had had been utilized for medical isolation, quarantine or both. After discussion, it was related to us that the area had been utilized for both purposes at different times.[12] The room was a standard cafeteria style dining hall with a food service counters and kitchen on one side and a large open area on the other. No PPE

[12] This is confirmed in the government's interrogatory responses at p 2-3.

or hand sanitizer or hand washing stations were present in this room. No clinical examination space existed on this unit.

24. The next area we observed was a visitation room, which we observed from the outside. This appeared to be a medium sized room with chairs and several office cubicles and a portable commode inside. Staff relayed that this area had been used for isolation.

25. The next area observed was a series of rooms referred to as classrooms that were reported to have been used for quarantine. One classroom had steel bed frames on their sides, and staff reported that some women used those beds during quarantine and others simply brought their mattresses from their original housing areas and placed them on the floor. We were shown a bathroom in the hallway of these rooms.

26. The next area observed was an isolation cell in the same hallway as the classrooms, being utilized for medical isolation. This cell was not negative pressure, per staff.

27. The next area observed and inspected was the Camp. I was able to walk through Dorm B, which consisted of a very tight series of office-type cubicles with bunks, spaced with barely room to pass in between, in a layout that seemed designed for classrooms or office space. There was no evidence of or ability to engage in any social distancing in this unit. Most of the women had masks on. No common areas were seen on this housing area and bathrooms were not observed.

28. The next area observed was the medical clinic in the camp. Clinic staff indicated that patients would wait outside the door to the clinic to receive medications, lined up on the stairs leading up to the door. The clinic itself comprised of two examination areas and one office area. No PPE carts were observed anywhere in the Camp area, and no hand sanitizer dispensers were observed.

IV. Detection of and Response to COVID-19 Cases

29. Screening

FCI Danbury relies on a screening system that fails to identify new cases of COVID-19. Most notably, it is clear from speaking with FCI Danbury staff and detained people alike, that the approach utilized involved having non-medical staff measuring temperature, and not asking about and recording symptoms of COVID-19.[13] This is a material failing because many people experience days of COVID-19 symptoms before their temperature becomes elevated, and some may even become gravely ill without an increased temperature being appreciated. This appears to have happened in the case of Mr. [redacted] who experienced liver pains, trouble breathing, loss of sense of taste, but who did not have a fever and was told that he could not go to medical unless his temperature was more than 100 degrees. He ultimately was isolated and tested positive for COVID-19 after being sick for almost two weeks.[14] This lack of attention to symptoms of COVID-19 appears to involve all aspects of FCI Danbury operations. For example, Ms. [redacted], who was in a quarantine unit, awaiting release to the community, reported that nobody ever asked her about symptoms of COVID-19 in her unit. This is especially worrisome since this unit exists to ensure that people leaving FCI Danbury do not have COVID-19. In addition, even the taking of temperatures appears sporadic. Ms. [redacted] reported that temperatures were taken several days in a row then not taken for 2 or 3 days. Ms. [redacted] also reported very inconsistent temperature taking in the camp, with no symptom screening.

The lack of screening for symptoms of COVID-19 is especially concerning given clear CDC guidance on the need to initiate testing based on the presence of symptoms in

[13] [redacted]

[14] [redacted]

congregate settings, including prisons. CDC guidance lists people who are at high priority for testing, including "Residents in long-term care facilities or other congregate living settings, including prisons and shelters, **with** symptoms."[15] FCI Danbury has taken an important first step in testing all detained people, although confirmatory testing is still pending for some.[16] However, the Health Services Administrator reports no plan to test the entire institution again.[17] And there will be a need to conduct more testing for many months and the CDC and even the BOP's own policies regarding COVID-19 identify the need to incorporate patient symptoms as triggers of testing. Given the systematic lack of asking detainees about COVID-19 symptoms at FCI Danbury, this will pose a real threat to adequate identification of new cases. In addition, more than one person reports that some aspects of testing are conducted by correctional staff, who do not appear to correctly utilize the testing swabs.[18] This practice represents a core challenge to the ability of testing to identify COVID-19 cases and slow the spread of the virus throughout the facilities.

Another concern regarding the current screening practices involves the use of the infrared thermometers. I have reviewed temperature data representing 17,517 temperature readings. Normal human body temperature range between 97-99 degrees Fahrenheit, with a less common distribution of temperatures above and below this range. Data from FCI Danbury revealed that temperatures recorded by staff fall far lower than the ranges reported in medical and scientific literature. For example, while most (83%) of the temperatures did fall in the 97-99 range, roughly 60 temperatures were recorded as being less than 95 degrees. This represents clinical hypothermia and is not only rare, but very worrisome if

[15] https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

[16] FCI Danbury initially utilized the Abbott ID Now test, which the FDA has reported as having high false-negative rates. The facility is re-testing all of the samples originally run on the Abbott test via another method and reported during the tour that they have a roster of pending and completed confirmatory tests.

[17] See HSA Deposition p 83-84.

[18] [redacted].

true. By comparison, only one temperature reading appeared to be more than 100.4, the clinical cutoff for fever. Because the range of normal human body temperatures extends both above and below the 97-99 range, one would expect to observe a much higher number of elevated temperature readings than was found.[19] Taken together these data raise concerns that there may be a systematic reduction in temperature readings with these devices, which is very concerning given that the temperature of 100.4 appears to be virtually the only metric that FCI Danbury is utilizing to find new potential COVID-19 cases. Prisoner reports bear out this concern. Ms. [redacted] states that her temperature was taken using one of these thermometers shortly before she was taken to the hospital. Her temperature at the facility registered 97. At the hospital less than an hour later it registered 102.[20]

a. Sick Call

It is clear that people detained at FCI Danbury face widespread barriers in receiving care through the sick call system. Among the people I spoke with, the lack of any timely response to sick call requests, for both COVID-19 related and other medical concerns was reported. The lack of timely responses to COVID-19 related symptoms is particularly concerning. Even when patients directly reported symptoms of COVID-19 to FCI Danbury staff, it appears that their reports often go ignored. This was true at all three facilities.

In the men's facility, Mr. [redacted] stated that he reported his COVID-19 symptoms multiple times to staff soon after he started to feel ill on March 20th. His complaints went unaddressed until his counselor personally escorted him to medical on the 29th or 30th of March, where he was tested and placed into medical isolation. Mr.

[19] https://www.scientificamerican.com/article/normal-body-temperature-is-surprisingly-less-than-98-6/ and

[20] [redacted].

[redacted] reports that he experienced a fever, trouble breathing, and loss of taste in mid-March. When he reported his symptoms to an officer on duty he was told to see medical staff in the morning. Medical staff told him he had a cold and to drink water and rest. Mr. [redacted] reports that over the course of a few days he sought medical care but was not seen. He was told he could not see medical unless his temperature was above 100 degrees, which it was not. Finally, after almost two weeks of being ill, and after coughing up blood he was taken to medical and then placed in isolation and tested for COVID-19. He ended up going to the hospital. He tested positive for COVID-19.[21] Mr. [redacted] reports that he told staff he was coughing, felt weak, his body hurt and he was tired, but he was turned away from medical before there was no staff there on that day of the week. He was able to see medical a couple of days later because he went there without waiting for sick call and begged a prisoner who worked there to help him have a doctor see him.[22]

The women from FSL reported similar concerns. Ms. [redacted] stated that she reported COVID-19 symptoms in sick call slips multiple times in March without any response from health staff. Ms. [redacted] reported that she submitted three separate sick call requests to the health staff who gave out medications in her housing area but was never called to be seen, despite the fact that all three forms reported COVID-19 symptoms. She was ultimately hospitalized for a heart condition after she went to the clinic herself. On March 22nd or 23rd, she and others in the FSL began to directly tell health staff of their COVID-19 symptoms, with no response. She reported her symptoms of body aches, fever, chills and headache to health staff when they came through the housing area, but to no avail. She reports laying in her bed for approximately one week with COVID-19 symptoms, but because her

[21] [redacted]

[22] [redacted].

temperature wasn't elevated staff did not take her seriously. She was only seen because she went to the clinic and asked to be seen by the physician, approximately one week after her initial request, and she was sent to the hospital. Ms. [redacted] also reported that her COVID-19 symptoms were ignored by the health staff who came to their medical unit. Ms. [redacted] reported similarly being ignored when she reported COVID-19 symptoms to health staff, and was even told after her temperature was found to be 101.7 that she probably has a nonspecific respiratory infection, without any physical examination or medical assessment. Ultimately, she was only seen when she went to pill line days later and refused to leave until she was seen. She was placed into the suicide watch cell and tested for COVID-19, which was positive.[23]

This lack of response to symptoms is extremely concerning, because it represents willful disregard not only to the potential clinical worsening of individual patients but the ongoing transmission to other detainees and staff. This lack of responsiveness to symptoms reported by patients not only increases the risk that COVID-19 will spread unabated, but also that people facing life-threatening emergencies unrelated to COVID-19 will die because their concerns go unaddressed.

Interviewees and declarants consistently describe problems and delays in accessing medical care more generally at the facility. Ms. [redacted] reported that she had submitted a paper sick call request in February for a medical problem that included pain and still had not received a response. Ms. [redacted] reported that is takes weeks to be seen by medical staff. On the day of our visit, she reported that she had put in a sick call request for bleeding from her ear eight days earlier, for what she worried

[23] See also [redacted] Declaration par 20 (sick in February with fever, chills, cough, chest pain; submitted sick call; not seen for six weeks).

was a perforated eardrum, and still had not been seen. Ms. [redacted] reports that she put in two sick call requests for vomiting, diarrhea, stomach ache and body pain, and was not seen for two weeks.[24] Sick call was also reported to be slow or unresponsive at the Camp, where Ms. [redacted] reported that there is a 4-6 week wait for sick call and that the provider, a nurse practitioner, had just returned from being away for 10 days during which sick call was not conducted. Ms. [redacted] from the camp also reported that sick call (whether paper or electronic) takes weeks for any response, if one comes. Medical staff are unavailable on the weekend.[25] Prisoners report days or weeks-long delays in seeing a doctor.[26]

i. The testimony of the Health Services Administrator revealed that prior to June 1, 2020, FCI Danbury has been purposefully destroying the paper sick call requests submitted by patients.[27] This represents a gross deficiency in the standard of care. The National Commission on Correctional Health Care, which accredits some BOP facilities, addresses the retention and documentation of sick call requests in the following manner: "Without documentation of these steps, it is not possible to evaluate the responsiveness of your sick-call system, and if you are seeking accreditation, to determine if you are in compliance. Request slips are usually filed in the health records and begin the documentation trail. If you do not file the slips in the record, a log may be kept to monitor the stages of the response. The log needs to include the request date, date and result of triage, date of the sick-call visit if required, etc."

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[24] [redacted]

[25] [redacted]

[26] See, e.g., [redacted].

[27] See HSA [redacted] Deposition p 21-29.

The NCCH further identifies that "you should have documentation of compliance, either through the health records or through logs spanning three years."[28] This correctional standard of retaining sick call records is not limited to facilities that receive NCCHC accreditation. For example, in the New York City jail system (in which most facilities are not NCCHC accredited), retention of sick call information is mandated for three years as a matter of local law via the NYC Board of Correction Standards.[29]

The failure of FCI Danbury to retain these records creates multiple predictable problems in prisoner health care and COVID-19 response. Because it is not clear from the records that have been retained when sick call requests were submitted or what was written as the concern of patients, is it then impossible to monitor whether the facility responses were either timely or adequate. In general, any symptom or medical complaint by a patient should be responded to with a face to face encounter within 24 hours and my experience in correctional health is that the timeliness and adequacy of responding to sick call requests is a basic metric that is measured on a monthly basis and reviewed along with other correctional quality assurance metrics. During an outbreak, sick call requests become even more vital documents as they serve to allow for daily review of symptoms of the outbreak that can a) lead to expedited assessment of individual patients and b) provide aggregable data that is used to track the spread of the outbreak throughout the facility.

[28] https://mail.google.com/mail/u/0/?tab=wm&ogbl#inbox/FMfcgxwHNDCtkrkKqHjGPZnvXGkNfjGd

[29] http://library.amlegal.com/nxt/gateway.dll/New%20York/rules/title40boardofcorrection/chapter3healthcareminimumstandards?f=templates$fn=default.htm$3.0$vid=amlegal newyork_ny$anc=JD_T40C003

I have reviewed sick call slips that have not been destroyed, and there are indications from these slips of significant delays in care, even for those reporting symptoms consistent with COVID-19. For example, on May 15, 2020, Mr. [redacted] wrote on his slip: "I have been suffer lack of breath between three to four weeks" and checked off "I am felling short of breath" on his form. Yet the form indicates he was not seen until June 1, 2020. [redacted]

30. **Extreme medical staffing shortages.**

FCI Danbury has a severe shortage of medical staff available to see patients for sick call. Currently, there are only two physicians (Dr. [redacted] and Dr. [redacted]) and one part-time nurse (Ms. [redacted]) who are available for sick call appointments. Dr. [redacted] as medical director, has administrative responsibilities on top of seeing patients (his specialty is ob-gyn). None of these clinicians are at the facility on the weekend or after 4pm on weekdays. On the weekends, there are two EMT-paramedics present at the facility. (FCI Danbury employs a total of three EMT-Paramedics). There are no medical staff at the facility overnight on any day of the week.[30]

[redacted] It is unclear from the materials I have

[30] Interrogatory Response 6; HSA [redacted] Dep. 84.

[31] USA005897 (April 9 email).

[32] USA005897 (April 21 email).

reviewed what their responsibilities were during that time and they have all now concluded their temporary service at the facility in any event.[33]

Health Services Administrator HSA has acknowledged that FCI Danbury has had a "staff shortage for quite some time," which pre-dated the COVID-19 outbreak at the facility. She elaborated: "We have been short midlevel practitioners prior to this occurring. We've also had our nurse out on military leave, as you've seen. We also have some vacancies for a nurse or paramedic positions."[34] These shortages pre-dated COVID-19 and have continued.

These levels of staffing pose crucial risk for the health and welfare of prisoners, and force security staff to make crucial decisions about triaging emergencies overnight. In addition, this short staffing creates a situation in which the small amount of clinical time dedicated to sick call and chronic care only respond to the most emergent cases, leaving people with serious health problems to decompensate further. I have overseen medical care in 13 different correctional facilities, ranging in size from 800 to 2,400 and including women, men, pre-trial and sentenced people. I believe that the staffing levels described above represent less than half of what is needed during normal operations, and that the current levels are even more insufficient. In particular, the type of COVID-19 screening that is required at FCI Danbury relies on nursing staff to conduct. Additional staff are also required to ensure daily review of sick call and other medical requests and integrate all symptoms of COVID-19 (whether received from sick call, screening or other sources) into a facility database that tracks the outbreak. In addition, there is a need for more primary care physician staffing to supplement the lack of access to specialty care. My experience

[33] HSA Dep. 94-95.

[34] (HSA 105-108).

during widespread outbreaks and after large natural disasters is that incarcerated patients may be cut off from specialty care they absolutely need to diagnose or treat life-threatening illness. Primary care physicians are required to triage and manage these complex patients and neither nursing staff, nor mid-level providers are adequate to manage these crucial decisions. If telehealth can be implemented to supplement some of the specialty care, then mid-level providers can provide an important role. It is also important to recognize that the effects on health of these staffing shortages will become apparent in the coming weeks. The time course for chronic diseases to worsen, and undiagnosed disease to manifest in emergencies usually occurs over 2-3 months, and I fear that many patients who needed treatment in March, April and May will experience serious consequences in June and July.

31. **Patient education.**

The CDC identified education of patients in congregate settings as a critical element of identification of new cases. Multiple people I spoke with, including those who has been in medical isolation, quarantine and other specialized units, reported never receiving any basic education on the symptoms of COVID-19 to be aware of. In addition, in the one setting where a "town Hall" was reported, the message to prisoners from the facility staff was to "stop rabble rousing" regarding access to testing and care for COVID-19.[35]

32. **Inadequate medical isolation.**

a. **Use of punitive segregation or inappropriate settings for isolation.** One feature of the inadequacy of medical isolation at FCI Danbury is the reliance on punitive segregation as the primary response to COVID-19. The practice of locking people into cells with little no outside contact, meaningful medical care, and loss of privileges represents a stark disincentive to reporting COVID-19 symptoms.

[35] [redacted]

Medical isolation is not solitary confinement but the practices of MCI Danbury have essentially placed almost all the punitive experiences reserved for people who receive disciplinary infractions onto people who report COVID-19 symptoms or are found to have COVID-19.

Several prisoners reported fear of being placed in medical isolation or quarantine. Ms. [redacted] relayed that she was terrified to go into medical isolation because she didn't want to be left alone in one of the facility's suicide rooms.[36] While she was in that room she had no access to running water.[37] Ms. [redacted] reports being locked in a cell 24 hours a day and being cuffed to go to the shower while she was in SHU for quarantine.[38] Mr. [redacted] reports that the isolation room floors were dirty and that the soiled clothes of the person in the room before him were still in his cell.[39] Similarly, Mr. [redacted] reports a filthy isolation unit with broken tiles and dirt on the shower floor.[40] Ms. [redacted] stated this explicitly to me, that people are afraid to report their symptoms lest they be isolated without care or outside contact. Ms. [redacted] reported the same: "they [women at FSL] don't want to go to quarantine and be stuck in a cell or stuck in a classroom or be cuffed to go to shower."[41] Mr. [redacted] describes being sick for a week in April with fever, headaches, and lost sense of taste and smell, but not reporting symptoms because "I saw people who are sick being dragged to a quarantine unit where they're only allowed to shower once a week and they can't use the phone and aren't allowed outside at all to get

36 [redacted]

37 [redacted]

38 [redacted]

39 [redacted].

40 [redacted].

41 [redacted]

fresh air."[42] Similarly, Mr. [redacted] reports, "I did not put in a request to see medical because, like others, I fear the treatment in quarantine."[43]

Some of the women in FSL were placed into completely inappropriate settings for medical isolation, including classrooms and dining halls. Ms. [redacted] reported spending multiple days in the unheated library, sleeping on top of desks, when she returned from the hospital. She had no access to a bathroom without ringing a bell for correctional staff to come unlock her room. Medical staff did not check on her when she was in the library.[44] A number of women were isolated in the facility's visiting room.

The first woman to test positive to the Camp, a woman with documented heart conditions, has reported being placed in an isolation room that is 59 degrees, with a frosted window that does not open, with the lights on overnight, without regular access to phone or email, and without medical consultation for at least 48 hours.[45]

b. **Deficiencies in medical care in isolation.** Another inadequacy with medical isolation is the deficiencies of medical attention or care for COVID positive prisoners in isolation. Prisoners I spoke with who had experienced medical isolation reported little to no medical assessment or care while confined to their cell for 24 hours per day. Mr. [redacted] reported spending the first four days in his cell, with no access to shower or phone, and with no clinical assessments aside from daily temperature checks.[46] Ms. [redacted] reports that medical staff didn't interact with

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42 [redacted]

43 [redacted].

44 [redacted]

45 [redacted].

46 [redacted] (no record of medical consultation between 4/1 and 4/6.

the women in isolation when she was housed in the visiting room other than to distribute pills and take her temperature when she asked for it.[47] Ms. [redacted] reported that during her time in medical isolation, no health staff ever listened to her lungs with a stethoscope. She also reports that despite her positive COVID-19 test, she was returned to her original housing unit after less than a week in medical isolation. Ms. [redacted] also reports that no health staffer ever listened to her lungs during her 20 days in the library and time afterwards in the SHU, despite reporting shortness of breath.[48] Mr. [redacted] reports being left in an isolation unit for over a day without medical attention and without staff even realizing that he was in there or checking on him. He reports: "I was scared to go to sleep. I started crying in the cell. I'm a fairly tough guy but I started feeling like I was going to die in that cell alone."[49] He also describes being treated while he was in isolation, "like I did something wrong."[50]

Review of medical records reveals that when Mr. [redacted], a patient with a history of asthma, went to his chronic care visit, health staff identified symptoms of upper respiratory tract infection as well as the fact that many people in his housing area were coughing. His medical records note "Suspect for COVID-19 Coronavirus illness" and that "unable to do test for Covid-out of testing supplies". He was placed into medical isolation but there is only one record of any clinical assessment in the following week.

Those prisoners in isolation with COVID-19 are not seen by a doctor or nurse on the weekend, as the only medical staff at the facility on the weekends are EMT-

[47] [redacted]

[48] Ms. [redacted] reports the same during her stay in isolation. [redacted]

[49] [redacted] (no record of medical assessment 4/1-4/6.

[50] [redacted]

paramedics. Even during weekdays, COVID-19 patients are not consistently examined each day. Of the medical records I reviewed, it appeared that of the 90 prisoners whose records clearly reflected a positive COVID-19 test and placement in isolation, 62% of them were not seen by medical staff for at least one weekday while in isolation. More than half were not seen on at least two consecutive weekdays in isolation. The medical records of Mr. [redacted] indicate that despite being placed into medical isolation, and despite having documented seizure disorder, he was not assessed by clinical staff for a several day period during his isolation from 4/1/20-4/6/20. Other patients whose medical records reveal periods of no documented medical assessment include Mr. [redacted] (three days between assessments), Ms. [redacted] (five days between assessments), [redacted] (five days between assessments).

c. **Lack of follow-up care.** In addition some prisoners who tested positive report lack of follow-up care for continuing symptoms. For example, Mr. [redacted] reports that he had to wait several weeks for follow up care after reporting liver and kidney pains and trouble urinating, as well as a swollen foot. He reports submitting numerous sick call requests as well as a grievance before seeing a doctor. He only saw the doctor because she was on the unit to see someone else.[51] Mr. [redacted] reports complaining of chest pain after he was returned to his unit from isolation. Several sick call slips he submitted were not responded to.[52]

d. **Inadequate segregation of positive prisoners**. Multiple other prisoners report instances where there was inadequate efforts to segregate suspected positive and negative prisoners during testing. For example, men in the L-unit at FCI were left

[51] [redacted]

[52] [redacted].

in the unit after testing was done. One man who thought he was being put into quarantine before going home shook everyone's hands. He turned out to test positive.[53] In another instance men were left on the unit even after they were determined to be positive.[54] In the I Unit, Mr. [redacted] reports moving into a cell only to be informed that the person who occupied the cell immediately before him had tested positive for COVID-19 and that the cell had not been cleaned or disinfected. He and his cellmate cleaned the cell themselves without protective equipment to do so.[55]

33. **Testing.**

FCI Danbury staff, records and prisoner declarations reveal that despite an important step of testing all prisoners, important gaps remain in the approach to testing. One critical weakness is the adequacy of contact tracing and the testing of known contacts when new cases occur. This approach to testing is critical for responding to new cases of COVID-19 and has been identified as a core strategy by the CDC. CDC guidelines for congregate care settings, including nursing homes and prisons, identify that contact tracing is critical to slowing the spread of COVID-19 and the testing people with even mild symptoms is important. CDC guidelines further identify that to slow the spread of COVID-19 in nursing homes, new cases should result in testing of either the entire facility, or in cases where testing supplies are limited, all close contacts of the new case.[56] This latter approach was presented to me by facility staff as the approach being taken at FCI Danbury, however it appears that either the contact tracing or linkage to testing is incomplete. Multiple declarations from prisoners indicate that after at least one new COVID-19 case was

[53] [redacted]

[54] [redacted]

[55] [redacted]

[56] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

identified in the FSL dorm on May 7th, other residents of the same housing area were not tested. I understand that all the units at FCI Danbury were tested at the end of May by Quest tests. In the men's unit, positive cases were found in the E, F, G, H, I, J, Z, and SHU units. Everyone in a unit was tested on the same day. Because the tests results took multiple days to receive, everyone in the unit was exposed to the positive cases while awaiting the test results. At the time of the inspection, there had been no positive case in the Camp. On May 28, the Camp women were tested. On June 3, a woman was removed from the Camp based on a positive test. Two dorm-mates were also removed and put into the SHU, along with women being quarantined for home confinement.

34. **Slowing the Spread of COVID-19**

a. **Lack of social distancing.** Mr. [redacted] reported that social distancing was not possible in his unit, especially in the double cell bunks. The lack of social distancing is especially concerning in pill or medication lines. Ms. [redacted] and [redacted] also reported that there is no social distancing in the pill line of FSL.[57] Similarly, Ms. [redacted] and Ms. [redacted] at the camp both reported no social distancing in the pill line outside the clinic. Ms. [redacted] also reported that people from multiple housing areas report to pill line at the same time and they stand close enough that they are touching each day in pill line.

b. **Lack of adequate cleaning and disinfection.** The CDC makes clear that when a suspected COVID-19 case is identified, careful attention to cleaning and disinfecting areas where they spend time must occur. The CDC detention guidelines have a dedicated section for this critical work, which starts with the introduction "**Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as**

[57] [redacted]

well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19."[58] Mr. [redacted] reports that when he returned to his housing area after medical isolation, his personal effects and bed were as he had left them, that no effort had been made to clean or disinfect the area he had spent 9 or 10 days in while he developed symptoms of COVID-19 and was unable to receive care. Mr. [redacted] reports that the cell of a man who tested positive was not cleaned before the man's cellmate was placed back into the cell after testing.[59] Ms. [redacted] reports a lack of cleaning of bedding and other property of people with COVID-19. Even when some cleaning does occur it is because a Bunkie is asked to or volunteers to do so, often without any PPE.[60]

Other concerns regarding cleaning and infection control are apparent at FCI Danbury. While the soap dispensers were observed to be full during our inspection of FCI Danbury, multiple prisoners report that was not a normal occurrence and that soap dispensers are often empty and soap unavailable. [61] Hand sanitizer is reported to be similarly unavailable.[62] In addition, prisoners report lack of paper towels to dry their hands in the bathrooms.[63] Prisoners also report that the facility was cleaned thoroughly before our visit, and that such a cleaning was not otherwise regular.[64] Commonly used areas and objects are not cleaned regularly. There was no cleaning solution visible by the computers and phones in FSL, and the cleaning

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

[59] [redacted]

[60] [redacted].

[61] [redacted]

[62] [redacted].

[63] [redacted]

[64] [redacted]

bottle observed in the cell block in the men's unit had no paper towels or towels nearby for application. Prisoners report that phones and computers are not cleaned between every use.[65]

c. **Lack of wearing masks.** Multiple detained people reported that facility staff had made a special effort to get everyone to wear a mask for the inspection, but that this is not the normal state of affairs. Ms. [redacted] stated that most people wear the masks "as a chin strap" most of the time. Ms. [redacted] reported that the attention to wearing of gloves, masks, cleaning of floors and posting of signs in her unit had occurred in the run-up to the facility inspection. She also expressed fear of retaliation for speaking about her observations. Records document complaints from staff that masks aren't available[66] and that staff and prisoners have been disciplined for not wearing masks.[67]

35. **Protecting High-Risk Detainees**

There does not appear to be any effort to identify and protect high-risk inmates from COVID-19 in the FCI-Danbury facilities. These efforts would generally involve maintaining a roster of all people who meet CDC criteria for being at high-risk of serious illness or death from COVID-19, and then cohorting these people in specialized housing areas that have higher levels of infection control, staff training and also allow for more reliable delivery of health care and medications. Such a plan is envisioned in the BOP 2012 pandemic flu plan.

a. **Identification of medically vulnerable.** [redacted]

[65] [redacted].

[66] [redacted].

[67] [redacted].

[redacted]

HSA indicated at her deposition that she asked FCI Danbury physicians to review the list and identify the "true risk factors."[70] It appears that she made this request on May 7, 2020, as an email from HSA to Drs [redacted] Nurse [redacted] says: "please look at this list and let me know if you think any inmate meets criteria for Medical Exemption Release. Focus on the 3s and 2s."[71]

HSA says that the doctors sent back names of around 20 people that they thought were higher risk and would do better outside the institution, and she forwarded these names to the Warden.[72] HSA says she did not do anything else with the April 1 list.[73] The April 1 list included Mr. Gentile, who died of COVID-19 related complications on April 9. The April 1 list indicated that Mr. Gentile was a 59-year-old enrolled in the facilities cardiac chronic care clinic.[74]

[68] USA006103.

[69] USA008860-8865; HSA Dep. 41.

[70] HSA Dep. 47-49.

[71] USA 008953.

[72] HSA Dep. 58, 69.

[73] HSA Dep. 50.

[74] USA008860-8865, HSA Dep. 64:8-19.

FCI Danbury did not develop a plan to provide special protection to the medically vulnerable at the institution. The plan for the medically vulnerable was the same plan they applied to everyone else, which HSA describes as screening and sick call.[75]

b. **Attempt at cohorting.** I am aware of only one attempt—an inadequate one that has already been discontinued—to cohort medically vulnerable inmates at FCI Danbury during the COVID-19 crisis. Inmates in the E Unit were moved to 10-man rooms within the unit called "bus stops."[76] The men in the bus stops had to share the bathrooms and showers with the other men in E Unit.[77] FCI Danbury abandoned this approach, apparently because there was mingling with other men in the unit.[78] My understanding is that there has been an explicit decision *not* to create designated areas for medically vulnerable inmates at FCI Danbury.[79]

Among the inmates that we spoke with who meet CDC criteria for being high-risk, none of them had been placed into specialized units for increased surveillance or protection from COVID-19 and none of them was receiving any additional screening for COVID-19 symptoms. In fact, none of them was receiving any symptom screening. In addition, the reports by numerous detainees of lack of social distancing in the pill lines of the various FCI Danbury facilities creates a special risk for the very people who are high-risk because they are the ones most likely to be going to pill lines.

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[75] HSA 66-67.

[76] HSA Dep. 55.

[77] HSA Dep. 56.

[78] HSA Dep. 56.

[79] HSA Dep. 57-58.

c. **Response to COVID symptoms for high-risk patients.** Review of medical records indicates that FCI Danbury health staff have been slow to respond to COVID-19 symptoms among high risk patients. Mr. [redacted], who has asthma, reported his COVID-19 symptoms via sick call and during his encounter with a paramedic, he reported increased use of his asthma inhaler. He is the type of patient that should be screened at least once per day for COVID-19 symptoms and also housed in a high-risk settings with increased infection control precautions and staff training. Instead, his COVID-19 symptoms of shortness of breath and 'mild cold symptoms' were treated as a viral cold. He returned four days later, was seen by a physicians who documented that "Pt reports hx of asthma and has been feeling sick for 5 days. Pt states that he isolated himself and stayed in his room because he was feeling sick." Mr. [redacted] was sent to the hospital with respiratory and cardiac symptoms of COVID-19 and tested positive for COVID-19.

d. **Lack of adequate care for chronic health problems.** It is also my assessment that a lack of access to adequate care for chronic health problems at FCI Danbury will create additional risk of serious illness or death from COVID-19. The CDC has made clear in addition to the chronic disease risk factors for COVID-19 severity, there is additional risk created when those conditions are poorly controlled. This is exactly the circumstance that is created by lack of access to chronic and specialty care at FCI Danbury. For example, Ms. [redacted] reports that she has been unable to receive specialty care for her Crohn's disease for several months despite reporting abdominal pain, rectal bleeding and inability to eat. She reports being told by the facility physician that she doesn't currently have access to specialty care.

e. I have reviewed the pending consultation requests for FCI Danbury and find that many of the specialty encounters are still pending after months of waiting.[80] Notably, there are a total of 340 pending requests from physicians or APRNs for specialty consultations or outside procedures for prisoners at FCI Danbury. In particular:

   i. 69 requests are "pending institution clinical director action"; 27 of these have been categorized by the doctor or APRN as "urgent" requests and 3 are in the category "emergent"

   ii. 1 request is pending "UR Committee Action"

   iii. 144 are pending "consult" occurring; 56 are urgent and 1 emergent

   iv. 127 are pending "scheduling"; 32 are urgent and 8 are "emergent"

   This circumstance is extremely dangerous as chronic health problems that are treatable go undiagnosed or untreated, increasing the risk of preventable morbidity and mortality.

f. Ms. [redacted] and Ms. [redacted] also report two instances which raise concerns that lack of access to care for non-COVID-19 problems may have led to emergency hospitalizations. They both report one instance in late May when a women developed a rash that spread covered her entire body and caused her eyes to swell shut and that over three days health staff ignored her worsening condition, giving Benadryl and steroid shots without removing her to an infirmary or the hospital. She was ultimately sent to the hospital and had not returned several weeks later when Ms. [redacted] and Ms. [redacted] gave their declarations.[81] A second case reported by Ms. [redacted] involved a woman developing a "mini-stroke" which

[80] USA 005227

[81] [redacted]

involved acute arm numbness, that was treated by health staff with a sling for her arm for a day until she was finally transferred to the hospital.

g. **Lack of air-conditioning a concern for high-risk individuals.** I am also concerned about the lack of any air-conditioned units in FCI Danbury[82], especially for high risk patients who have health issues that make them heat sensitive. Patients with chronic heart or lung problems, with serious mental illness, and people prescribed medications that impair heat regulation or promote dehydration, including certain antipsychotics, medications for hypertension, diabetes, cancer, antibiotics and others are "heat sensitive" and require air conditioning in warm settings. These patients will be doubly vulnerable in high-heat conditions should they become infected with COVID-19. As subsequent waves of COVID-19 arrive in the summer months, it is especially important to have this group, which largely approximates the high-risk COVID-19 cohort, identified, subject to active surveillance of signs and symptoms of COVID-19 and protected from excessive heat.

36. **Case of** [redacted]

The deficiencies identified above represent multiple systemic carriers to prevention, identification and response to COVID-19 in FCI Danbury. But the case of one patient, [redacted], and the people around, her reveal how interconnected these failures are in amplifying the spread and severity of COVID-19 in FCI Danbury. Ms. [redacted] timeline of events starts on April 24, when she became ill in the evening. No medical staff are present in the facility to respond to requests for assistance. She spent several hours in the bathroom toilet stall vomiting and retching, with several of the women in her housing area

[82] See, e.g., [redacted] (no air conditioning and temperatures can run over 100 degrees).

intermittently helping her. Some of them were also vomited on, they were not wearing masks or gloves. Late that evening or early in the morning of the 25th, a Lieutenant calls EMS and she is transported to the hospital, where she is quickly intubated for respiratory protection, and tests positive for COVID-19. The next morning, other women are told to clean the bathroom floor where she was vomiting for several hours, without gloves. That day, some of the people in the housing area are tested, but not all of the women who were in close contact with Ms. [redacted]. Of 40 women who were tested, approximately 10 were positive and moved to be housed in a visiting room while the 30 who were negative were moved to the dining hall. At least one of the women in the dining hall would be subsequently hospitalized with COVID-19. I also spoke with several women who identified and reported their own COVID-19 symptoms in Ms. [redacted] housing area in the weeks before she became ill. Their reports appear to have gone largely ignored, initiating the spread of the virus throughout the large, densely packed FSL, and ultimately, to Ms. [redacted] and others. [83]

V. Recommendations

FCI Danbury should implement the following recommendations:

Institute daily symptom screening of all detained people, along with temperature checks. This screening would utilize a standardized tool that records the presence or absence of the CDC verified symptoms of COVID-19. Screenings would be scanned or otherwise entered into each person's medical record and any positive symptoms or signs would not only trigger clinical assessment, but would also be entered into a facility tracking database of COVID-19 symptoms;

[83] See [redacted]

Implement same-day review of every sick-call slip and electronic submission by a nurse, midlevel provider or physician that will (i) trigger immediate (same day or next morning) assessment for COVID-19 and (ii) provide data that creates a facility wide symptom tracking dashboard that health care staff will use. FCI Danbury and BOP generally should stop the practice of destroying sick call requests and retain them as part of medical records;

All patients who are suspected or confirmed to have COVID-19 should receive a standardized clinical evaluation at least daily by nursing or physician staff in a clinical setting and not cell-side;

Identify, cohort and regularly test all prisoners who possess risk factors for serious illness or death from COVID-19;

All quarantine units should follow CDC guidelines for management of COVID-19 including the use of appropriate PPE, cleaning of common surfaces, and exclude individuals not suspected to or confirmed to have COVID-19; including twice daily sign and symptom surveillance in addition to temperature check;

Test patients who possess more than one sign and/or symptom of COVID-19;

Test staff who possess (i) risk factors for serious illness or death from COVID-19; or (ii) more than one sign and/or symptom of COVID-19[84];

Use of medical professionals, not security staff for symptom screenings as well as COVID-19 testing;

[84] The CDC recommends re-testing an entire facility when a new case occurs in a nursing home. This approach may prove most expedient for FCI Danbury but the approach outlined in these recommendations represent a minimum of what is needed.

Increase medical staffing levels to allow for timely access to nursing sick call and physician evaluation seven days per week.

Lower census in housing areas to allow for social distancing.

Implement social distancing in medication lines and other congregate movement and activities.

Complete confirmatory testing of COVID-19 samples originally run with Abbott ID Now tests.

Facilitate release of medically vulnerable individuals who do not represent a danger to the community.

My assessment of the COVID-19 response at FCI Danbury is based on the information available to me and I reserve the right to supplement this assessment based on additional information.

Dated: June 6th, 2020
Port Washington, New York