AMEND
CHANGING CORRECTIONAL CULTURE

Berkeley Public Health

A CalPROTECT Report

COVID-19 Outbreak: California Medical Facility

January 19, 2021

The current outbreak occurring at California Medical Facility and State Prison located in Vacaville, California ("CMF") reflects how, despite leadership having proactively implemented effective strategies for outbreak prevention, surveillance, and response to the best of their abilities (namely, contact tracing, wastewater sampling, monoclonal antibody treatment, timely quarantine and isolation, prioritized rapid testing for exposure with 2-3 day PCR testing turnaround, early adoption of face masks, sufficient PPE stock, and early vaccinations), CMF was unable to thwart a rapidly spreading outbreak due to space limitations and the great number and variety of bed types required for their medically vulnerable population.[1] At the same time, a reportedly large number of residents at CMF have been eligible for parole for years (sometimes decades) but have not been reviewed for accelerated release. Instead, in a county with 2 available ICU beds as we entered a holiday weekend, these patients were housed inside a superspreading environment where risks from infection are far higher due to medical vulnerabilities. This document provides suggested guidance on immediate actions needed to address the current situation at CMF. Although this memo outlines the urgent needs at CMF, it is our belief that the single clear and emergent recommendation to review patients for accelerated release is an urgent need at *all* California prisons.

Background

CMF began experiencing a rapidly growing COVID-19 outbreak on November 28, 2020 that reached a local peak on December 31st with 351 active cases among its resident population. At the request of the Federal Receivership, for the purposes of investigating ongoing transmission of SARS-CoV-2, members (*) of our CalPROTECT team from AMEND at UCSF and UC Berkeley visited CMF on January 14 and 15, 2021. At the time of our visit, CMF held 1,985 residents (84.1% of the facility's 2,361 design capacity). We found the healthcare and custodial staff to be exceptionally organized, receptive to our visit, and open to discussing with us what they have done and what could have been done differently over the course of the past 10

[1] At CMF, ~45% of inmates are age 50+ and almost half are deemed to be medically "High Risk", compared to the average CDCR facility which has ~27% aged 50+ and ~17% high risk individuals.

months.[2] In this urgent memo, we present our single emergency recommendation and an outline of additional recommendations that we will elaborate upon in our upcoming supplemental report.

Emergency Recommendation (Immediate Action Required):

A coordinated, multidisciplinary partnership of experts (correctional healthcare, custody and legal representation) should immediately: (1) review patients for accelerated release, starting with those patients who have the highest COVID risk scores of 14 or greater and working through the cases in a systematic fashion; and (2) justify and document each release refusal for people with high COVID risk scores.

We arrive at this recommendation based on the following information and knowledge:

After visiting CMF and speaking at length with custody leadership and staff, healthcare leadership and staff, and prison residents, it is our conclusion that the custodial and healthcare leadership at CMF appear to have done everything in their power to follow the most up-to-date public health guidelines (as developed by CCHCS and nationally) in response to the pandemic. In addition, medical leadership has gone above and beyond the standard guidelines by proactively pursuing and engaging in wastewater testing with a local university as a means of outbreak surveillance, aggressively using rapid testing to identify and quarantine possible cases of COVID-19 before it is able to spread throughout a housing unit, and implementing early adoption of monoclonal antibody treatment. Unfortunately, despite the census being at a much lower level than before the pandemic,[3] CMF still houses extremely high-risk patients in dense, congregate living quarters with little to no ability to maintain physical distance from one another. These dense living quarters seem to remain the single largest barrier to outbreak prevention and control at CMF. We urgently recommend that custodial leadership work with healthcare leadership and medical staff to thoughtfully evaluate each eligible resident for accelerated release, with the goal of releasing the most vulnerable patients.

While at CMF, we were told that many patients (including those with very high COVID risk scores) are past, or within several months of, parole eligibility. Some patients have been granted parole already and now are awaiting final parole approval from the executive branch before they can be released.

Indeed, deaths have already occurred among patients on the threshold of release. It is our understanding that among the 7 patients who have died from the current COVID-19 outbreak at CMF, the average COVID risk score was 8.8 (lowest score 5, with a score of more than 4 considered high risk). Among these patients, two had been eligible for parole for many years

[2] In the first 9 months since the beginning of the COVID-19 pandemic, custody and medical leadership at CMF had effectively managed to maintain the total number of active COVID-19 cases among residents at one or zero, with the active case count only increasing to 5, though reported to us as likely false positives, before returning to zero in July.
[3] As of January 13, 2021, the facility is currently operating at 84.1% architectural design capacity (=2,361), reduced from 104.7% in March. The facility currently has 3,021 staff.

(since 2001 and 2006), while one received a three-year denial in 2018 and would have been eligible for reconsideration this year. We were told that these patients had not been reviewed for accelerated release since the outbreak began in March 2020.

We were also told that there are large numbers of high-risk, uninfected patients who have been eligible for parole for decades and whose cases have not been reviewed. Still other patients who are at very high risk of poor health outcomes (including mortality) if infected with COVID-19 appear to meet the criteria that were specifically developed to enable accelerated release during the pandemic, but their suitability for early release does not appear to have been assessed for release either.

If this information is accurate, it is incomprehensible that such evaluations for accelerated release have not transpired in the context of this pandemic. It is our understanding that a memo was circulated in July 2020 (referred to several times during our visit as the *"July 10 Memo from the PLO"*), which stated that all people at high risk of poor health outcomes from COVID-19 would receive a thorough and accelerated evaluation for early release. In the middle of a massive outbreak, maintaining dense congregate housing of highly vulnerable patients who are eligible for permanent or temporary release violates any reasonable human rights standard and is, in itself, an unnecessary health risk to the staff and other residents who must remain incarcerated.

We do not have information to independently verify the assertion that people have not received review of their suitability for early release despite policies and procedures dictating that they should be. However, if this assertion is true, it is of high enough medical concern that we recommend the Office of the Federal Receiver request an urgent status update from CDCR and/or plaintiff's legal counsel on the degree to which each patient at CMF who is at high risk of poor outcomes from COVID-19 has been evaluated for their suitability for release during the pandemic, starting with those with the highest COVID-19 risk scores (14 or higher, then 13 or higher, and so on).

The difficulties with sufficient space are particularly challenging at CMF due to the vast variety of medical, mental health, and individual health needs that are present in the population. These difficulties, during the rapid spread phase of the outbreak, have in some cases forced high-risk patients into unsuitably risky housing. For example, it is our understanding that 700 people at CMF have a mobility disorder, most of whom require a low bunk and housing with limited or no stairs. Such housing requirements greatly limit the isolation and quarantine spaces that can be used to house them if exposed or infected to COVID-19. Further, of these 700 patients, approximately 200 require wheelchairs, and 80 of those with wheelchairs require a wheelchair accessible cell. Additional health-related concerns arise when attempting to appropriately house people safely after exposure or infection, including their need for professional mental health oversight, safe housing given risk of victimization, sufficient light (for the visually impaired), and more. Ultimately, in such cases, even the highest standard of care, effort, knowledge and concern cannot create space that simply does not exist.

As a medical facility, CMF houses many patients who require 24-hour nursing care and/or hospice-level care. We cannot conceive of a reason why such medically fragile patients who have been already recommended for parole or who are nearing release or parole need to serve additional prison time *right now* when the consequences can easily be, as witnessed in the past month, death. Even if the justice system determines that those eligible must return to complete their sentences following the pandemic, continuing to incarcerate these patients in superspreading conditions in the middle of such a serious outbreak is dangerous for them and those around them.

We heard the story of one man who died recently of COVID-19. He had multiple medical conditions, a COVID risk score of 13, and his first parole eligibility date was in 2001. He told medical staff, rightly, that if he were to be infected with COVID-19 he would not live through it. Another patient, eligible for parole in the 1980s, has had no rule violation charges in over 2 decades, has family that is ready to house him, and was recently hospitalized with COVID-19 alongside associated cardiovascular decompensation and damage. Examples of patients such as these, with extremely high likelihood of poor outcomes if infected with COVID-19, are plentiful. We also met individuals who were within weeks of their release date, were newly infected with COVID-19, and who had high-risk medical conditions. Such persons, if they survive, will experience the added difficulty of being released back to the community with active or recently recovered from COVID-19.

There is a very important secondary benefit to releasing the most vulnerable and those who pose minimal risk -- and that is that it will open up lower-risk housing for residents who cannot be released.

It is unconscionable that any high-risk residents are being housed in large dorms in a facility with an out-of-control outbreak. Even as early as June 2020, it was understood that dorms pose an almost insurmountable risk of exposure. These earlier findings have been confirmed once more by the rapid spread of cases in the dorms at CMF, with 20-30 patients testing positive on the same day as the first case was detected in one instance. The largest dorm at CMF that houses susceptible residents neighbors a large dorm and temporary tents housing infected inmates. It did not surprise us to have one of the residents in that dorm say that "it appeared as though the Governor was deliberately trying to infect as many inmates as possible -- and if not, why were they doing what they were doing?" Any number of releases would enable reduction of the density of the most dangerous units. A sufficient number of releases would enable all high-risk residents to be housed in safer housing, though still not safe by any reasonable community standard.

We bring this forward as our sole emergency recommendation for CMF, because it is the only immediate action that can substantially mitigate risk and reduce the impact of the current outbreak. There is no technological fix left. Without swift releases, at this rate, the epidemic will extinguish itself by infecting most of the people who remain susceptible, at the further expense

of burdening the local hospital capacity and resources already at its limits, and at the cost of additional lives. On the last day of our visit, the prison reported 53 new cases. The additional recommendations we will make are primarily intended to help reduce risk at other institutions and to help CMF reduce risk to future infectious pathogens.

In sum: We predicted (as did others) many months ago that it is not possible to protect residents in most California prisons at current levels of occupancy. The experience at CMF sadly proves this point. Despite world-class efforts to minimize risk of infection, the prison is unable to contain an explosive outbreak. The only reasonable response is to temporarily or permanently release men with multiple medical problems at very high risk of severe disease and death from SARS-CoV-2 infection who are eligible for release or do not pose a clear security risk. Any other response is not only unreasonable, it is unethical, it is not representative of the values we aspire to as a state or a nation, and it violates international norms, treaties and standards to which we as a country not only subscribe, but frequently seek to enforce in other countries.

Additional Recommendations

To be elaborated upon in our upcoming supplemental report

1. There are urgent opportunities for knowledge sharing about what CMF has done well across the CDCR system.

   CMF has experienced a relatively low mortality rate in spite of its high risk community and rapid spread, likely due to early use of dexamethasone and monoclonal antibodies. Of the 26 patients currently hospitalized, only one had received bamlanizamab and none of the deceased patients received it, raising the real possibility that use of monoclonal antibodies is resulting in significantly better outcomes at CMF than might be expected. CMF medical leadership has also instituted a comprehensive and detailed approach to contact tracing. This is likely in part an explanation for how they were able to fend off a massive outbreak for so long in comparison to many other facilities in California. Other institutions could gain a great deal from learning about the measures that medical and custodial leadership has taken at CMF to prevent and control outbreaks of COVID-19. If a platform for the regular exchange of such valuable knowledge does not yet exist across CDCR facilities, we recommend that the office of the Receiver and CCHCS consider enacting a regular information-sharing opportunity immediately.

2. Need for a coordinated communication response

   Despite strong coordination and communication among leadership, and praise for communication during the first nine months of the pandemic, a lack of effective communication during the current outbreak was described by nursing, custody, and incarcerated individuals, leading to reduced morale and a high degree of mistrust. This mistrust may have immediate effects on mental health, staff burnout, and vaccine

uptake, in addition to longer-term issues including employee retention. To improve communication in the midst of a massive outbreak, increase vaccine uptake, and rebuild trust, we suggest considering: (i) the creation of more tools in central CDCR offices that can be used by institutions to inform residents and staff about critical issues (e.g. "this is what a monoclonal antibody is", "this is what 'resolved' means", "this is why we move people for quarantine", etc.), and (ii) the use of partner organizations (academic, community-based, public health) to hold a series of town halls that give residents and staff the opportunity to ask questions about COVID-19 and vaccine safety to external medical and public health professionals.

3. Understand and Address Lingering Environmental Health Risks

    a. Open doors and/or windows to increase ventilation rate: In C Dorm, the ratio of carbon dioxide to outside air was very high. We detected CO_2 levels of up to 2412 ppm in a subsection of the dorm that was being occupied by 12 people during our observation, but has capacity for 20. The observed level in that segment of the dorm is over 2.5 times that of ASHRAE's 1,000 ppm maximum for general indoor air quality. The estimated per person ventilation rate is 0.3 L/s*p which is orders of magnitude below the World Health Organization's recommendation of 80 L/s*person for healthcare facilities housing infected individuals. It is urgent to increase air exchange in C dorm to prevent aerosolized transmission of the virus. One immediate mechanism for doing so is by opening the two doors to the building (and providing the security support in order to do so) and getting a thorough review of the exhaust system to ensure that it is fully unobstructed. We will provide additional observations regarding other housing units in the upcoming supplemental report.

    b. Install lids on top of toilets: In C Dorm, no solid door separates toilet facilities and the rest of the dorm, making virus aerosolized from fecal matter a possible source of exposure and transmission. Lids should be placed on toilets and toilets should be flushed with lids down in order to prevent fecal aerosols from spreading within the bathroom and general living spaces, especially in dorms where ventilation is poor.

    c. Clean rooms in between transfers if not yet being done: We received mixed reports about whether or not comprehensive cleaning was occurring between transfers. Given the possibility that aerosol particles remain airborne for prolonged periods, we recommend that a comprehensive cleaning regimen is introduced to cells and dorms that are being vacated by people who are infected or of uncertain infection status. An infected resident producing infected fomites, droplets and aerosols in an enclosed space can render enough virus to cause infections in people who come into the space soon after the infectious person leaves. We saw a case where a confirmed positive individual was moved out of a single cell unit, but we observed no disinfection practices after he was

moved. A comprehensive disinfection protocol should be implemented including adequate time between move-outs and transfers, aeration, and surface disinfection.

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Amend at UCSF is a health-focused correctional culture change program led by experts in medicine, infectious diseases, public health, and correctional health and policy that is providing correctional leaders, policymakers, and advocates the evidence-based tools they need to protect the health and dignity of those who live and work in jails and prisons during the COVID-19 pandemic.

CalPROTECT is an initiative of Amend at UCSF that brings together a multidisciplinary team of academics and health professionals at the University of California, San Francisco and the University of California, Berkeley with expertise in clinical medicine, public health, epidemiology, health economics, infectious disease, health systems, geriatrics, and palliative care. Our work aims to document and assess capacity in California state prisons to respond to COVID-19 and provide recommendations that prioritize the dignity, health, and wellbeing of currently incarcerated people, staff, and surrounding communities.

The University of California, Berkeley School of Public Health is working on the leading edge of research, educating the public, and mobilizing to serve California's most vulnerable populations during the COVID-19 pandemic.

For more information:
https://amend.us/calprotect/