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October 26, 2021

VIA EMAIL AND ECF

Hon. Noel. L. Hillman
United States District Judge
U.S. District Court for the District of New Jersey
Mitchell H. Cohen Courthouse and Federal Building
One John F. Gerry Plaza
401 Cooper Street
Camden, NJ 08101

Re: Brown, et. al v. Warren, et al, 20-cv-7907 (NLH)
Third Initial Report and Recommendation

Dear Judge Hillman:

Pursuant to the Court's Consent Order For Appointment of a Special Master (ECF. No. 126) , attached please find the Third Initial Report and Recommendation.

Please do not hesitate to contact me if you have any questions or concerns.

Respectfully submitted,

Porzio, Bromberg & Newman, P.C.

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WJH
Attachment

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

RAYMOND LAMAR BROWN, JOHN CLARK, DESMOND ROGERS, TODD FORD, JR., AND CARLOS SOLER, individually and on behalf of others similarly situated,	:	Hon. Noel L. Hillman
Plaintiffs	:	Case No. 1:20-cv-7907-NLH-KMW
v.	:	
CHARLES, WARREN, in his Official capacity as Warden, Cumberland County Dep't. of Corrections and CUMBERLAND COUNTY NEW JERSEY,	:	
Defendants.	:	

THIRD INITIAL REPORT AND RECOMMENDATION OF THE SPECIAL MASTER

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INTRODUCTION AND PROCEDURAL HISTORY

On May 13, 2021, the Court entered a "Consent Order for the Appointment of a Federal Rule 53 Master and Other Relief."[1] This Consent Order required appointment of a Master pursuant to Fed. R. Civ. P. 53.[2] Under this rule, the appointing order must state, among other things, "the master's duties, including investigation or enforcement duties, and any limits on the master's authority under Rule 53(c)."[3] In accordance with this provision of the rule the Consent Order provided:

> Within forty-five (45) days from the appointment of the Master, the Master shall file a report to the parties and Court containing findings and recommendations ("Initial Report") regarding the adequacy of COVID-19 protections and procedures at the Cumberland County Jail. Subject to further agreement of the parties as may be Ordered by the Court, the Master shall consider and file its Initial Report about COVID-19 testing, COVID-19 contact tracing of all Jail inmates and staff, quarantining and isolation practices, including ventilation of designated isolation and quarantine areas, the availability and sufficiency of hand sanitizer, masks and other personal protective equipment, and cleaning supplies, social distancing measures and recreation, and any other issues related to COVID-19 affecting the inmate population, as such may be identified by the Master.[4]

The Court appointed me as the Special Master in accordance with the Consent Order and the Rule by Orders dated May 17 and May 21, 2021.[5] As part of the execution of my duties as Special Master, the

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[1] See, ECF No. 126.
[2] *Id.*, at ¶ 3, page 4.
[3] Fed. R. Civ. P. 53(b)(2)(A).
[4] ECF No. 126, at ¶ 6, pages 4-5.
[5] ECF Nos. 131 and 139.

Court approved my retention of experts to assist me in gathering facts and advise me on medical and health policy issues.[6] To that end, I retained Porzio Compliance Services LLC and Konsu Health LLC. These experts included trained investigators, a corrections expert, a physician, and health administration and policy experts. This Report and Recommendation is the collective and collaborative result of the observations, investigation and research of the entire team.

To date, there has been one announced inspection (June 3, 2021) and four unannounced inspections (July 8, 2021, August 18, 2021, September 13, 2021 and October 21, 2021).

The First Partial Interim Report and Recommendation was issued on June 15, 2021, and the Second Partial Interim Report and Recommendation on August 4, 2021.[7] On August 6, 2021, the Court entered an Order adopting the recommendations contained in the Second Report and Recommendation, and on September 7, 2021, the Court entered a Supplemental Order clarifying the August 6, 2021 Order.[8]

Due to the complexity of the issues involved, the rapidly changing nature of the threat COVID-19 poses at the Cumberland County Jail, and the increased duties and responsibilities with which the Court charged me, the Court granted extensions of time to file this

[6] ECF Nos. 132 and 139.
[7] ECF Nos. 146 and 156.
[8] ECF Nos. 159 and 183.

Initial Report and Recommendation on July 2, 2021, August 18, 2021, and October 1, 2021.[9]

The First Partial Interim Report and Recommendation was intended to address a primary concern of the Court and to lay the groundwork for future recommendations. In sum, this report and recommendation: 1) provided a legal analysis that dispelled a misconception concerning the applicability and exceptions to the Health Insurance Portability and Accountability Act[10] (hereinafter "HIPAA"); 2) recommended that the Cumberland County Jail (hereinafter "CCJ") institute a wristband system to denote those inmates who had COVID-19 and those were quarantined after suspected exposure; and 3) recommended that the CCJ establish a separate operational policy relating to COVID-19.[11]

The Second Partial Interim Report and Recommendation was submitted on an emergent basis when it was determined that CCJ was utilizing the cleaning agent "Simple Green All Purpose Cleaner" as a disinfectant when, in fact, it is not intended for use against viral and bacterial agents. The recommendations were to immediately cease the use of Simple Green All Purpose Cleaner as a disinfectant, replace it with a true disinfectant solution, and to establish a meaningful procedure under which inmates were assured access to

[9] ECF Nos. 152, 168 (oral request granted in Court proceedings), and 224.
[10] Pub. L. 104-191, 110 Stat. 1936 (August 21, 1996).
[11] ECF No. 146.

adequate cleaning supplies.[12] This report and recommendation was submitted on an emergent basis because of the looming threat of the Delta variant of SARS-CoV-2, the virus that causes COVID-19. At the time, there were no positive cases of COVID-19 at CCJ, but it was warned:

> When the Delta variant takes hold in CCJ – and it appears that it is only a matter of time – CCJ will be faced with many of the same health, safety and quarantine issues that challenged it at the height of the pandemic.[13]

That time is now. On August 30, 2021, there were two reported cases of COVID-19 at CCJ, and by Friday September 3, 2021, nine inmates had confirmed cases of COVID-19. On September 13, 2021, additional positive cases were reported.

Although it appears that CCJ has, on its own and in response to the recommendations provided by the Special Master, made some progress, it is still apparent that much still needs to be done. It must be made clear that it is ***not*** the purpose of these Reports and Recommendations to find fault or cast blame. Rather, the express charge by the District Court to the Special Master is to observe, report on those observations, and to make recommendations to improve the health, safety and welfare of all those who reside in and work at CCJ. Accordingly, the analysis must begin with the District Court's charge to the Special Master.

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[12] ECF No. 156.
[13] *Id.* at page 16.

ANALYSIS

A. The Charge of the U.S. District Court

Pursuant to the Court's Order, the Special Master is to advise the Court on the adequacy of COVID-19 protections and procedures at CCJ, specifically:

1. COVID-19 testing;
2. COVID-19 contact tracing of all Jail inmates and staff;
3. Quarantining and isolation practices;
4. Ventilation of designated isolation and quarantine areas;
5. Availability and sufficiency of hand sanitizer, masks and other personal protective equipment;
6. Availability of cleaning supplies;
7. Social distancing measures;
8. Recreation; and,
9. Any other issues related to COVID-19 affecting the inmate population, as such may be identified by the Master.[14]

The First and Second Partial Initial Reports and Recommendations addressed numbers 3, 5 and 6 above. This Third Report and Recommendation will address the remaining issues, but it appears that the overall root cause of the problems at CCJ remains the same: a lack of communication and accountability that is exacerbated by the distrust and concern over the future of continued operations of the Jail. Any policy and procedure relating to the operation of a

[14] ECF No. 126, at ¶ 6, pages 4-5.

correctional facility requires individuals to implement it, whether it be the administration, the supervisors, the line correctional officers, or the contractors. If the policy is not clear and effectively communicated, it will fail. If it does not clearly indicate who is responsible for carrying out the policy or procedure, it will fail. And if the individuals charged with the responsibility fail or refuse to implement the policy or procedure without consequence, it will fail. Our investigation, interviews and inspections reveal that all three circumstances are present here. Sadly, this is the issue that must be addressed first, because any policy or procedure that is employed will be doomed to failure if the constituent parties continue to act in the manner in which they have in the past.

B. The Proposed Closing of the Jail, The Injunction and its Impact on the Implementation of Effective Policies and Procedures.

On August 28, 2018, the Cumberland County Commissioners authorized the construction of, and issuance of up to $65 million in bonds for, a new corrections facility.[15] On June 23, 2020, the County Commissioner's minutes indicated that the new Jail's "footings and foundation have been put in and the project . . .

[15]file:///U:/Downloads/2018-08-28%20Board%20of%20County%20Commissioners%20-%20Full%20Minutes-1432.pdf

would be complete by June 2021."[16] The Cumberland County Improvement Authority was in charge of the construction project, and its March 30, 2020 minutes reflect that the "Jail site work phase is complete and punch list items have been addressed."[17] The construction of the new corrections facility appeared to be well underway, yet on July 22, 2020, the minutes of the Cumberland County Improvement Authority reflect that "Ms. Barber thanked Mr. Velazquez and the Board for their help with the County's decision to put the County Jail project on hold."[18]

This was the first official indication that Cumberland County was considering abandoning its partially-completed new jail. The next came on September 22, 2021, when the Cumberland County Board of Commissioners passed Resolution 2020-556, which authorized the Cumberland County Administrator to commence layoffs of up to 115 employees at CCJ, and Resolution 2020-546, which authorized an agreement to house female inmates at Salem County Jail.[19] The following month, on October 9, 2021, the Commissioners passed Resolutions 2020-560 and 2020-561, which authorized agreements to

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16 http://cumberland.iqm2.com/Citizens/FileOpen.aspx?Type=15&ID=1520&Inline=True

17 https://theauthoritynj.com/wp-content/uploads/2021/03/March-30-2020-Minutes.pdf

18 https://theauthoritynj.com/wp-content/uploads/2021/03/July-22-2020-Minutes.pdf

19 http://cumberland.iqm2.com/Citizens/FileOpen.aspx?Type=15&ID=1529&Inline=True

house inmates at Atlantic County and Burling County Jails, respectively.[20]

This came as a surprise to many in Cumberland County, and particularly to the employees of CCJ, many of whom belong to one of two unions, the Fraternal Order of Police (the "FOP") and the Policemen's Benevolent Association (the "PBA"). The FOP represents the supervisors who work at CCJ, while the PBA represents the line corrections officers. The latter are the most in danger of losing their jobs as a result of the closure.

The employees were not the only ones who were distressed about the closing of the jail: the county's public defenders were concerned about the greater distances they and family members would have to travel in order to meet with the inmates. In November 2020, the public defenders subsequently filed a lawsuit in the Superior Court of New Jersey seeking to enjoin Cumberland County from closing the jail, and they obtained a preliminary injunction prohibiting CCJ from transferring any inmate.[21] On July 30, 2021, the Superior Court granted Cumberland County's motion for summary judgment, but it permitted the injunction to remain in place pending the plaintiff's application for a stay pending appeal. The Appellate Division upheld the trial Court, but it also permitted the plaintiffs to seek a stay

[20] http://cumberland.iqm2.com/Citizens/FileOpen.aspx?Type=15&ID=1530&Inline=True

[21] *Krakora, et al, v. County of Cumberland, et al.,* Case No. CAM-L-3500-20.

pending a petition for Certification to the New Jersey Supreme Court.[22] On August 12, 2021, New Jersey Supreme Court Justice Fabiana Pierre-Louis granted a stay of the order dissolving the injunction pending an appeal to the Court.[23] On September 20, 2021, the Supreme Court denied Certification and lifted the injunction against CCJ.[24]

This lawsuit, and the injunction that prevented any transfer of inmates, has had both direct and indirect impacts upon the CCJ's handling of the COVID-19 pandemic. Directly, CCJ was unable to transfer prisoners, particularly those in housed in close conditions which facilitated the rapid transmission of this highly infectious disease. Indirectly, the impact upon staffing, already at low levels, required correctional officers to work longer shifts and more overtime to guard the increasing number of inmates at the facility. As a result, we determined that the inmates were systematically denied access to recreation and the law library because CCJ claimed that there were insufficient staff and correctional officers to permit these offerings, which are required under New Jersey law.

To add to this difficulty, we found that groups necessary to the success of the operation simply did not communicate regularly,

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[22] *Krakora, et al, v. County of Cumberland, et al.,* Case No. A-3521-20 (August 10, 2021).
[23] *Krakora, et al, v. County of Cumberland, et al.,* Supreme Court Docket Nos. S-84/85-20 (August 12, 2021).
[24] *Krakora, et al, v. County of Cumberland, et al.,* Supreme Court Docket No. 086138, Docket entries C-106, M-31 and M-32 (filed September 23, 2021).

if at all. There were no regularly scheduled and structured meetings between CCJ's administration and its medical provider, CFG Health Systems, LLC. When meetings did occur, they were often informal, with no clear assignment of responsibility for basic important tasks, such as, for example, contact tracing. The PBA union representing the line officers had no direct communications with CCJ administration, largely due to a fundamental sense of distrust between the parties. Much of this is related to the prospect that many of the PBA's members were at risk of losing their jobs, as well as a perceived indifference by CCJ to the PBA's members' health and safety while they were required to work 12-hour shifts, and overtime, even if they believed that they had been exposed to COVID-19.

To be sure, the PBA members were informed of policies and procedures through the supervisors, who read them at roll call, posted them in the hallway and on an electronic database. Despite these many methods of communication, they are still not enough. The line corrections officers are integral to the success of any policy, and particularly any policy relating to combatting COVID-19. To fail to include them in the development and the plans for implementation of a policy for which they are accountable is a mistake. Conversely, the apparent refusal of the PBA to make good faith efforts to work or communicate with CCJ's administration is similarly ill-advised.

It is therefore our initial recommendation that:

- Any COVID-19 policy or procedure that is developed and implemented be done so in a collaborative manner. This means having regular, structured meetings – with minutes – with the constituent groups that are required to implement the COVID-19 policies. These groups would then be required to communicate to their respective groups, e.g., PBA members or CFG personnel, what their responsibilities are in addition to any other methods of communication from CCJ's administration.

C. Recommendations Relating to Health, Prevention and Management

Having addressed the need for need for collaborative inclusion in the development and the plans for implementation of any COVID-19 policy, we now turn to what must be addressed in that policy and the recommendations of how CCJ can better meet the challenges of COVID-19. The starting point necessarily must focus on the immediate health, safety and welfare of the inmates and staff at CCJ.

1. Overview - COVID-19 and Correctional Institutions

a. Background of COVID-19

COVID-19 is a disease caused by the SARS-CoV-2 virus discovered in Wuhan, China in 2019. The virus is mainly spread through exposure to respiratory droplets carrying the virus when an infected person coughs, sneezes, or speaks. The symptoms of COVID-19 typically appear 2-14 days post exposure (mean = 6 days) and include fever, chills, cough, and loss of taste/smell. Up to 40% of infected individuals[25] experience no symptoms (asymptomatic) however are still

[25] Center for Disease Control and Prevention: https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

on average 75% as infections as those with symptomatic infections[26][27][28]. Though disproportionately causing severe illness in the elderly, individuals of any age can experience severe illness - especially in the presence of underlying chronic conditions. Finally, testing for COVID-19 most frequently involves PCR or Antigen testing. Both tests detect viral fragments within the test sample for an individual and thus can miss positive cases in settings where an individual has not developed enough viral load to trigger a positive test (see Figure 1).

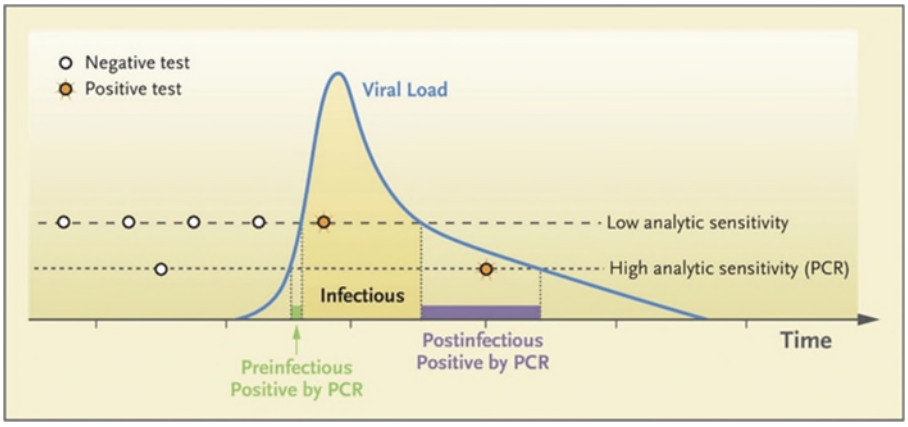

Figure 1

[26] Mc Evoy D, McAloon CG, Collins AB, et al. *The relative infectiousness of asymptomatic SARS-CoV-2 infected persons compared with symptomatic individuals: a rapid scoping review.* medRxiv. Preprint published online August 1, 2020. doi:10.1101/2020.07.30.20165084

[27] Lee S, Kim T, Lee E, et al. *Clinical course and molecular viral shedding among asymptomatic and symptomatic patients with SARS-CoV-2 infection in a community treatment center in the Republic of Korea.* JAMA Intern Med. 2020. doi:10.1001/jamainternmed.2020.38

[28] Chaw L, Koh WC, Jamaludin SA, Naing L, Alikhan MF, Wong J., *Analysis of SARS-CoV-2 transmission in different settings*, Brunei. Emerg Infect Dis. 2020;26(11):2598-2606. doi:10.3201/eid2611.20226362

Early in the coronavirus pandemic, there was scientific debate over the efficacy of respiratory droplet transmission versus surface transmission (fomite transmission). We now understand that SARS-CoV-2 is principally transmitted through exposure to infected respiratory droplets. Though it is possible for individuals to be infected through contact with contaminated surfaces, the overall risk is believed to be low. There are numerous factors that affect the efficiency of surface transmission of SARS-CoV-2. Thus, given the number of factors that materially affect surface transmission, the relative risk of transmission via this mechanism is low compared to direct contact, droplet transmission, or airborne transmission[29]. There are very few case reports of surface transmission of SARS-CoV-2, and, of the available case reports, the transmission has been between people touching surfaces an infected person has recently coughed or sneezed on, and then directly touching the mouth, nose, or eyes.[30] Good hand hygiene is, therefore, a strong barrier to

[29] E. A. Meyerowitz, A. Richterman, R. T. Gandhi and P. E. Sax, "Transmission of SARS-CoV-2: a review of viral, host, and environmental factors," Annals of Internal Medicine, 2020.
G. Kampf, Y. Brüggemann, H. Kaba, J. Steinmann, S. Pfaender, S. Scheithauer and E. Steinmann, "Potential sources, modes of transmission and effectiveness of prevention measures against SARS-CoV-2," Journal of Hospital Infection, 2020.
[30] S. Bae, H. Shin, H. Koo, S. Lee, J. Yang and Y. D, "Asymptomatic transmission of SARS-CoV-2 on evacuation flight," Emerg Infect Dis, vol. 26, no. 11, pp. 2705-2708, 2020.
J. Cai, W. Sun, J. Huang, M. Gamber, J. Wu and G. He, "Indirect virus transmission in cluster of COVID-19 cases, Wenzhou, China, 2020.," Emerging infectious diseases, vol. 26, no. 6, p. 1343, 2020.
…Continued

surface transmission and has been shown to be associated with lower infection risk.[31]

b. COVID-19 and Correctional Institutions

Preventing the introduction and subsequent transmission of COVID-19 within correctional institutions presents unique challenges given the following factors:

- Inmates spend the vast majority of their days in communal environments, increasing the potential for viral transmission between individuals;
- There is a high risk of viral introduction due to numerous entry points within corrections facilities - including officers and other staff, new or returning inmates, and visitors;
- Adequate isolation facilities are typically lacking, particularly once a virus has begun to spread within an inmate population;

C. Xie, H. Zhao, K. Li, Z. Zhang, X. Lu, H. Peng, D. Wang, J. Chen, X. Zhang, D. Wu, Y. Gu, J. Yuan, L. Zhang and J. Lu, "The evidence of indirect transmission of SARS-CoV-2 reported in Guangzhou, China," BMC Public Health, vol. 20, no. 1, p. 1202, 2020.

[31] Early in the Coronavirus pandemic, there was scientific debate over the importance of respiratory droplet transmission versus surface transmission (fomite transmission). We now understand that SARS-CoV-2 is principally transmitted through exposure to infected respiratory droplets. Though it is possible for individuals to be infected through contact with contaminated surfaces, the overall risk is believed to be low. There are numerous factors that affect the efficiency of surface transmission of SARS-CoV-2. Thus, given the number of factors that materially affect surface transmission the relative risk of transmission via this mechanism is low compared to direct contact, droplet transmission, or airborne transmission. There are very few case reports of surface transmission of SARS-CoV-2 and, of the available case reports, the transmission has been between people touching surfaces an infected person has recently coughed or sneezed on, and then directly touching the mouth, nose, or eyes. Good hand hygiene is, therefore, a strong barrier to surface transmission and has been shown to be associated with lower infection risk.

- Staffing levels typically have little flexibility, meaning the addition of further operational tasks impacts the effective functioning of employees;

- Correctional institutions are typically multi-employer settings necessitating the coordination of both government and private employers or entities;

- Health literacy within inmate populations is often below average; and

- The dynamic between corrections officers, medical staff, and inmates creates disincentives for the reporting of viral symptoms due to co-pay requirements, potential retaliation, and/or worry of medically mandated isolation.

To account for such challenges, correctional institutions should develop a multi-pronged approach that can adapt to changing national guidance and evolving situations on the ground. In keeping with guidance issued by the CDC, institutions should address (at a minimum) topics such as: Operational and communication guidelines, enhanced cleaning practices, social distancing strategies, infection control, personal protective equipment (PPE), screening practices, isolation and quarantine plans, and evaluation and testing protocols.[32]

As corrections institutions present complex settings for the prevention and containment of viral diseases, our expectation is that plans associated with the topics outlined above are codified.

[32] Centers for Disease Control and Prevention: "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities"- https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

The development of formal documentation allows for future changes to be implemented in a clear and planned way, which is particularly important when national/local guidance rapidly changes.

Last, guidelines within correctional institutions should balance the risk of viral introduction and transmission, and the mental health, quality of life, and operational realities of a correctional institution. The psychological effect of repeated lengthy quarantine periods, reduced programming and visitation should not be underestimated.

c. Placing COVID-19 in Context (August 2021)

There are currently five major observations to acknowledge when placing the current phase of the COVID-19 pandemic in context:

- Despite a decline in COVID-19 cases between December 2020 and June 2021, there has been a rapid increase in case rates through July and August 2021[33], driven in a large part by the arrival of the Delta Variant on US shores.[34]

- COVID-19 vaccines have proved effective against current viral variants - including the Delta Variant.[35]

- Despite the wide availability of vaccines, there has been hesitancy amongst both correctional institution staff and inmates to receive vaccinations.[36]

[33] Centers for Disease Control and Prevention, COVID Tracker: https://covid.cdc.gov/covid-data-tracker/#trends_dailycases
[34] http://www.cnn.com/TRANSCRIPTS/2108/05/sitroom.02.html
[35] http://www.cnn.com/TRANSCRIPTS/2108/05/sitroom.02.html
[36] Centers for Disease Control and Prevention: "Considerations for Modifying COVID-19 Prevention Measures in Correctional and Detention Facilities"https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/correction-detention/COVID-Corrections-considerations-for-loosening-restrictions-Webinar.pdf

- The Delta Variant is unlikely to be the last SARS-CoV-2 variant of concern: to date there have been numerous SARS-CoV-2 variants identified. Some variants are classed as "Variants of Interest" and others - including the Delta Variant - are classed as "Variants of Concern" based on their potential health impact.[37]

- Despite the high effectiveness of vaccines, there is an emerging trend of vaccine breakthrough infections.[38]

2. Overview of the Investigation by the Special Master's Team

We have reviewed hearing transcripts spanning over 2,000 pages, conducted interviews with inmates, medical staff, maintenance staff, corrections officers, and county health officials, and have additionally conducted both announced and unannounced inspections of the jail. To provide a framework through which we might adequately examine the protections and procedures at CCJ, we have utilized the structure detailed by the CDC in their guidance to correctional and detention facilities[39] which is organized into 3 sections: Operational Procedures, Prevention Strategies, and Management of COVID-19.

- **Operational Procedures:** Communication plans, training, staffing, and people-flow conducive to CCJ's implementation of the best prevention strategies against SARS-CoV-2 introduction into the inmate population and

[37] World Health Organization: "Tracking SARS-CoV-2 Variants" https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/
[38] Centers for Disease Control and Prevention: "COVID-19 Vaccine Breakthrough Case Investigation and Reporting" https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html
[39] Centers for Disease Control and Prevention: "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

reduce potential transmission in the eventuality that a positive case is identified.

- **Prevention Strategies:** Reinforcement strategies for good hygiene, cleaning practices, symptom screening, testing programs, and social distancing.

- **Management of COVID-19:** CCJ management of individuals with confirmed or suspected COVID-19 to prevent transmission, including isolation and quarantine practices, testing procedures, contact tracing, restriction of movement, and cleaning practices.

Within these 3 categories, we examined areas where alterations can be made based on local infection rates and/or changes in national guidance. The areas that we have examined include:

Operational Policies

- Reporting structure and accountability - clear lines of communication and delineation of roles and responsibilities to enable early action;

- Record keeping - good version control regarding policies and procedures to enable easy retrospective review;

- Mandated quarantine practices - mandated quarantine at intake, before transfer and release; and

- Staffing assignments.

Prevention Strategies

- Infection control practices - Hand washing, cleaning, and disinfection;

- Health Education;

- Diagnostic testing - staff, inmate, and visitor testing to prevent the introduction of SARS-CoV-2, and identify outbreaks early;

- Symptom screening - staff, inmate, and visitor symptom screening mask use;

- Social distancing and people flow;
- Environmental - building management and ventilation; and
- Vaccination – ensuring education and availability of COVID-19 vaccinations for inmates and staff.

Management Strategies

- Isolation and quarantine practices (inmates) - know how isolation and quarantine practices will be implemented and scaled in the event of an outbreak, and to prevent transmission and reduce risk of future outbreaks.

Our goal in developing this report and recommendation is to explore CCJ's COVID-19 response and determine how to increase the effectiveness of COVID-19 control within the jail. Some topics may seem minor in isolation, but creating as many layers of defense against COVID-19 as possible enables a "Swiss Cheese Model" that creates effective pandemic defense (See Figure 2).

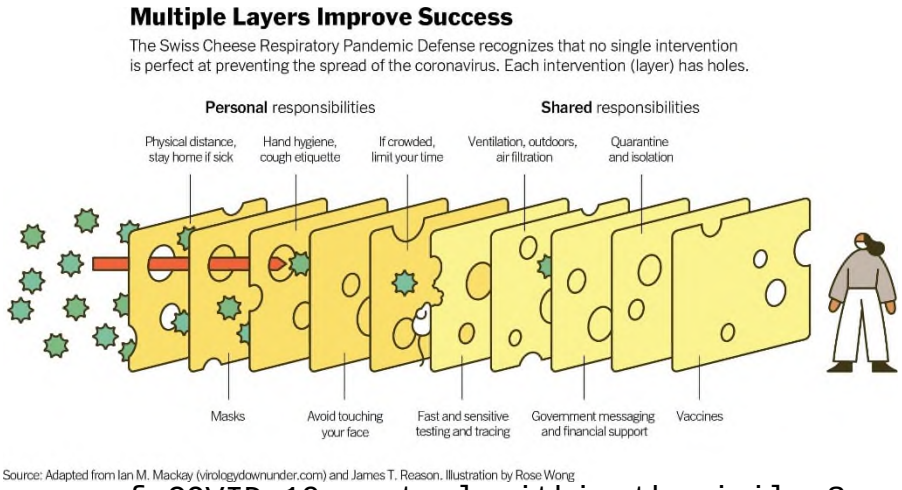

Figure 2: Source: New York Times, *The Swiss Cheese Model of Pandemic Defense*, Illustration by Rose Won.

3. Detailed Findings

a. Operational Policies: Reporting Structure and Accountability

i. Health Services Administrator ("HSA")

To maintain health and safety for inmates at CCJ, both the Custody Division and the contracted medical provider (CFG Health Systems, LLC (CFG)) are required to effectively coordinate services under direction of the Warden. The role of coordinating the two groups falls on the HSA - a CFG employee - whose responsibilities include oversight of all healthcare meetings (health staff, medical/custody (MAC), continuous quality improvement (CQI) activities, credentialing of health staff, and the maintenance of peer review documentation for all health staff.

The HSA role is critical as they coordinate between stakeholders CCJ Custody Division and CFG, communicate guidelines, share data, and manage staff and services. The position is integral to the efficient running of CCJ medical operations and is the accountable party for documenting and sharing policies, procedures, and protocols. It is our belief that the HSA role is not one that can effectively be performed alongside full-time clinical responsibilities.

(1) Current Status:

Initial interview with Evelyn Olsen, the acting HSA, did not provide a clear indication of roles and responsibilities between CCJ, CFG, and the medical staff. While Ms. Olsen holds the title of

HSA, the breadth of her overall day-to-day responsibilities, which include clinical and administrative roles, limits her ability to fully fulfill the role of HSA. On October 22, 2021, we learned that Ms. Olsen resigned at least a week prior, i.e., October 15, 2021. To our knowledge, she has not been replaced, and CCJ is without an HSA.

Furthermore, even when Ms. Olsen was the HSA, a report conducted by Richard R. Clark, MD, CCHP-P titled "Review of Cumberland County Jail NJ Health Care System" conducted in June of 2021 confirmed that Ms. Olsen was overstretched. She may not have had the bandwidth to fulfill the role as she is already overseeing the medical team and performing clinical duties.

(2) Recommendations:

- CCJ should recruit an HSA focused solely on, and accountable solely for, the administrative responsibilities of medical care;
- This position includes the responsibilities for documenting, maintaining, and communicating policies, procedures, and protocols. It should also include coordination between Custody and CFG, data sharing, and managing staff and services;
- Specific weekly time requirements should be determined by CFG and custody: a part-time (20hr/week) position may be reasonable, but CCJ should seriously consider a full-time position.

ii. Operational Policies: Record Keeping:

CCJ has generally done an adequate job of drafting guidelines.[40] However, a system of documentation, constant review, and updates has not been observed by our team through our review of available records as being implemented. In addition, policies, procedures, and protocols related to COVID-19 were not observed to be documented, tracked, reviewed, or shared throughout and across the organization. Each stakeholder our team spoke to perceives themselves as an advisor, passing ownership of COVID-19 related policy onto the next party. As a result, clinical guidelines are discussed but not formally documented, tracked or reviewed. As such, it is incredibly difficult to determine whether policies are fully defined, socialized, or followed at CCJ.

(1) Current Status:

Interviews with former Medical Director Dr. Alan Dias and Dr. James Neal, the acting Medical Director of CCJ and Corporate Medical Director of CFG, confirmed a shuffling of ownership, with each entity taking on the role of "advisor." Conversations with the Warden indicated that he does not take ownership for the medical policies related to COVID-19 and that he relies on the medical team. However, interviews with Dr. Dias, Dr. Neal, and Megan Sheppard, Health Officer at Cumberland County Department of Health, indicate that the

[40] *See* Document Response to Special Master 001350 (Kristina Smith email); Document Response to Special Master 001371 (Warden's Memo).

warden has final say over all COVID-19 policies and procedures at CCJ. COVID-19 policies and best practices have been, and are currently discussed, during meetings between CCJ Medical, CFG, and the county health department. However, meeting minutes are not documented and kept.

A COVID-19 Directive policy (policy number: 11.13) has recently been developed which is a good start but needs to be fleshed out with titles indicating all the different working areas of the policy that may require alteration as the COVID-19 situation changes.

We were also distressed to see that inmate requests for health visits were made on the same form as administrative requests and grievances and placed into an open box on the unit correction officer's desk. This was done even though there appeared to be a lock-box in each housing area dedicated to health visit requests. There was no ability of an inmate to document the fact that a health visit request was made, and quite often the "Action Taken" portion of the request form was not filled in by CFG.

(2) Recommendations:

- All meetings between CCJ, CFG and the county health department must be documented, with meetings minutes circulated and signed off on by each attending party;
- The COVID Directive policy (policy number: 11.13) should be further developed to include all working areas that may be altered to mitigate the risk that COVID-19 presents to CCJ;
- The COVID Directive policy should be used to ground COVID-19 meetings between CCJ, CJF, and the County Health Department;

- Any specific policy items that may need to change based on new COVID-19 information should be altered within the master COVID Directive policy and the relevant changes circulated amongst CCJ staff via both emails and as a formal memo;

- Training should be organized and offered to staff, with additional training as policies, procedures, and protocols evolve;

- Training should be logged to ensure all staff acknowledges and understand their responsibilities in adhering to guidelines; and

- Policies, procedures, and protocols should cover all topics described below.

- CCJ should create a separate form for health visit requests and questions, which should be placed in the medical lock box in each unit. The forms should allow for carbon copies, of if not available, a copy of the request should be made and immediately returned to the inmate.

- Twice each day, these requests should be collected by a representative of the medical staff.

- Medical staff should note the "Action Taken" on each form after the inmate visits the health facility or the inmate's question is answered.

iii. Operational Policies: Mandated Quarantine Practices

While writing this report, the Special Master's team has been liaising and working with the CCJ corrections and medical team regarding the development of written policies regarding topics such as intake quarantine, isolation, and general population quarantine practices. Per these conversations, effective August 1, 2021, Cumberland County Department of Corrections implemented the COVID

Directive policy (policy number: 11.13) that set out the procedures to be followed within CCJ to maintain a safe environment during the COVID-19 pandemic.

(1) Current Status:

There are three scenarios in which inmates at CCJ are currently mandated to enter quarantine/isolation: (1) Post intake; (2) Following a recent close exposure to a COVID-19 positive individual; and (3) testing positive for COVID-19. Each scenario is slightly different, and CCJ has specific processes in place for each.

> **Observed Post Intake Procedures:** Following the intake process, arrestees are escorted to the intake quarantine area, currently D-Pod. Inmates occupy cells either individually or with one other inmate who entered CCJ on the same day. After 5 days of mandated quarantine, inmates undergo a COVID-19 antigen test, which if negative enables custody to escort the inmate into general population.
>
> **Observed Procedures for a Close Exposure to a COVID-19 Positive Individual:** If a visitor, staff member, or inmate is found to be positive for COVID-19, inmates who are known to have had a close exposure to the diseased individual are escorted to a quarantine area and quarantined for 10 days. After 10 days of mandated quarantine, inmates undergo a COVID-19 antigen test, which if negative enables custody to escort the inmate back into general population.
>
> **Observed Procedures for Individuals Who Test Positive for COVID-19:** If an inmate tests positive for COVID-19 they are immediately escorted to an isolation area where they are held in solitary conditions and isolated for 10 days. After 10 days of mandated isolation, inmates undergo a COVID-19 antigen test, which if negative, enables custody to escort the inmate back into general population.

During our interview with Evelyn Olsen (Director of Nursing and acting HSA) on June 22, 2021, we questioned why 5 days was chosen as the quarantine period for post-intake. Ms. Olsen did not know why

this timeframe was chosen or who had made the final decision about implementing this policy. Given the importance of quarantine practices in detecting COVID-19 infections prior to an inmate joining the general jail population where containment becomes more difficult, it is surprising that no written discussion or reasoning exists supporting the use of a 5-day quarantine period. There is some research[41] that indicates that under ideal conditions, the optimal time to test an individual during a 14-day quarantine that begins 1-day post-infection is on day 6 of quarantine. With quarantine starting later than 1-day post-infection, the optimal day of testing decreases linearly. For all short quarantine periods, testing on exit was optimal under those circumstances (see Figure 3).

[41] Wells, C.R., Townsend, J.P., Pandey, A. et al. Optimal COVID-19 quarantine and testing strategies. Nat Commun 12, 356 (2021). https://doi.org/10.1038/s41467-020-20742-8.

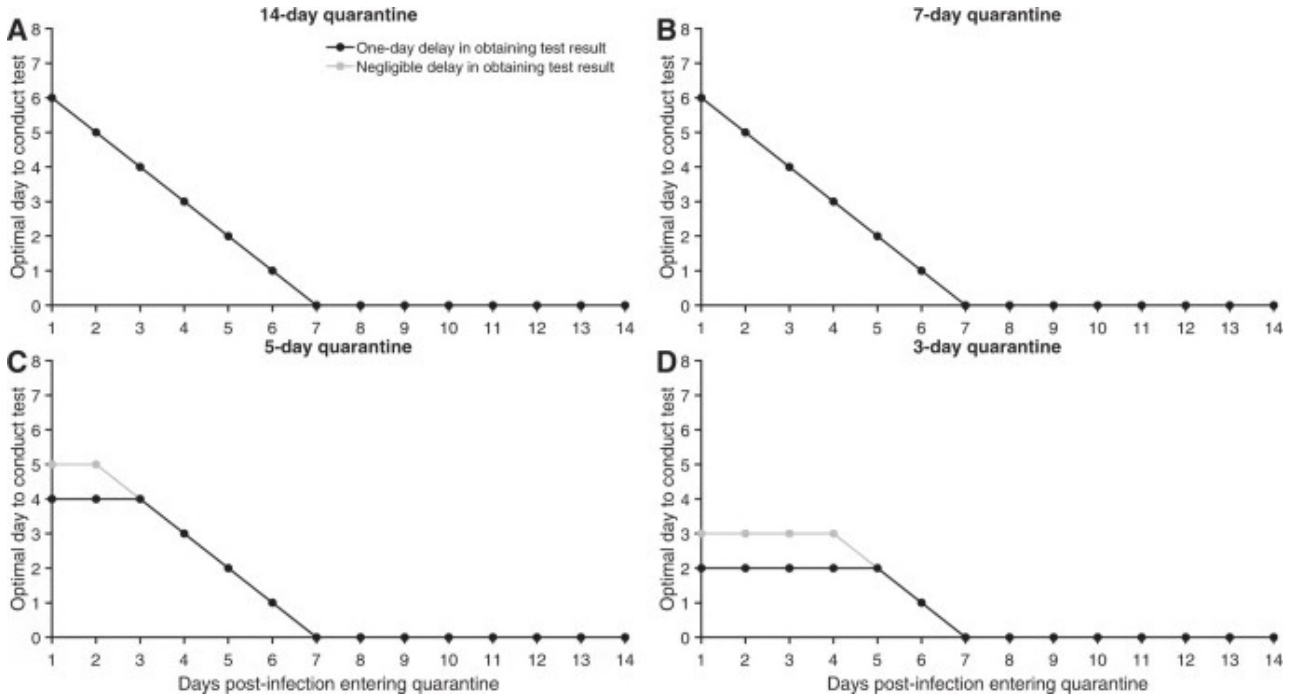

Figure 3: For a case whose date of exposure has been identified as occurring 1–14 days prior to quarantine, the optimal day to conduct the RT-PCR test with a 1-day delay (black) and with a negligible delay (gray) in obtaining test results (assuming perfect self-isolation of symptomatic infections) 30.8% asymptomatic infections, an incubation period of 8.29 days, and a quarantine lasting (A) 14 days, (B) 7 days, (C) 5 days, and (D) 3 days.

The CDC recommends a quarantine period of 14 days for contacts of persons with SARS-CoV-2 infection. However, based on local circumstances and resources, the following options are acceptable alternatives:

- A 10-day quarantine if no testing is utilized and if no symptoms have been reported during the quarantine period. (*Residual transmission risk post quarantine is ~1% with an upper limit of ~10% (see Figure 4, Figure 5, and Table 1).)*

- A 7-day quarantine when diagnostic testing is used on day 7 and no symptoms have been reported during the quarantine period and the day 7 test is negative. The COVID-19 test may be collected and tested within 48 hours before the

time of planned quarantine discontinuation, however quarantine should not be discontinued earlier than day 7. (*Residual transmission risk post quarantine is estimated to be ~5% with an upper limit of ~12% (see Figure 4, Figure 5, and Table 1).)*

- The CDC does add that in both alternative quarantine cases, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met.

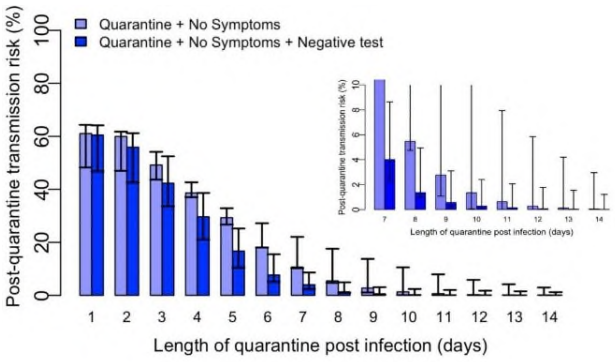

Figure 4
Modeled estimates of post-quarantine transmission risk against quarantine duration: Light blue bars = daily post-quarantine transmission risk if there is no clinical evidence of COVID-19 based on daily symptom monitoring. Dark blue bars = post- quarantine transmission risk with the addition of a negative RT- PCR result from a specimen collected 24-48 hours prior.
Source: CDC

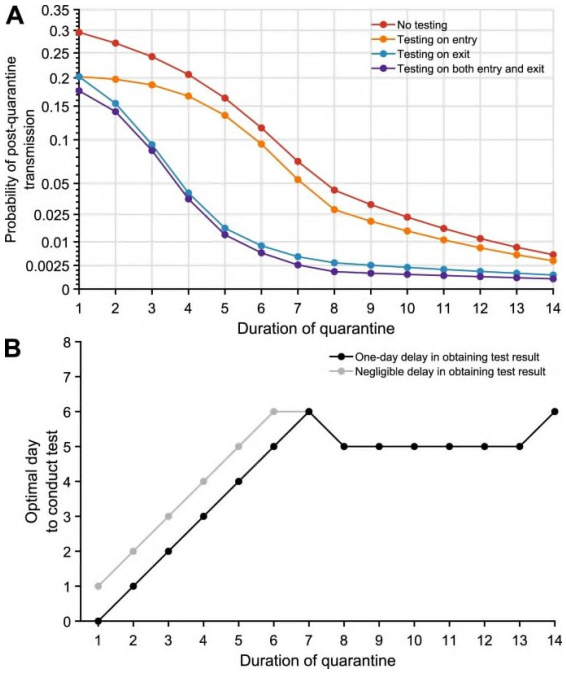

Figure 5
The impact of testing on the post-quarantine transmission for travel quarantine: The probability of post-quarantine transmission and optimal day to conduct the test when an infected individual enters quarantine uniformly within the incubation or asymptomatic period, for no testing and three testing strategies, and durations of quarantine from 1 to 14 days, with an incubation period of 8.29 days, 30.8% asymptomatic infections and perfect self- isolation of symptomatic infections. A Curves for the probability of post-quarantine transmission (one or more post-quarantine infections) without testing (red), with testing upon entry to quarantine (orange), on exit from quarantine (blue), and on both entry to and exit from quarantine (purple), incorporating with all testing strategies a one-day delay in sample collection to results, such that testing on exit occurred the day before the end of quarantine. B The optimal day to test during quarantine with a 1-day delay (black) and a negligible delay (gray) in obtaining test results.

Planned day after which quarantine is completed and can be discontinued	Residual post-quarantine transmission risk (%) with and without diagnostic testing of a specimen within 48 hours before time of planned discontinuation of quarantine					
	No testing		RT-PCR testing		Antigen testing	
	Median	Range	Median	Range	Median	Range
7	10.7	10.3-22.1	4.0	2.3-8.6	5.5	3.1-11.9
10	1.4	0.1-10.6	0.3	0.0-2.4	1.1	0.1-9.5
14	0.1	0.0-3.0	0.0	0.0-1.2	0.1	0.0-2.9

Table 1: Estimated residual post-quarantine transmission risk with and without a negative diagnostic test of a specimen collected within 48 hours prior to discontinuation of quarantine on the indicated day for a person monitored daily for symptoms and who has remained asymptomatic until quarantine is discontinued as well as through Day 14. Published data were applied to model residual post-quarantine transmission risk using RT-PCR[42][43]; for antigen testing, a diagnostic sensitivity of 70% was applied.
Source: CDC

(2) Recommendations:

- There has been discussion within CCJ about the flexibility of the 5-day quarantine period, particularly to enable the creation of jail space in the event of a major outbreak. As the mean incubation period of SARS-CoV-2 is ~5.5 days and the optimal testing time 1-day post-infection is 6 days, *our recommendation is that the 5-day quarantine period be increased to 6 days at a minimum*. However, given this deviation from the CDC's official guidance, we believe that CCJ should engage the Cumberland County Department of Health in navigating this decision given the unique circumstances the jail faces.

[42] Kucirka LM, Lauer SA, Laeyendecker O, Boon D, Lessler J., *Variation in False-Negative Rate of Reverse Transcriptase Polymerase Chain Reaction-Based SARS-CoV-2 Tests by Time Since Exposure*. Annals of internal medicine. 2020.10.7326/m20-1495.

[43] Clifford S, Quilty BJ, Russell TW, et al. Strategies to reduce the risk of SARS-CoV-2 reintroduction from international travellers. medRxiv. 2020.10.1101/2020.07.24.20161281; . https://doi.org/10.1101/2020.07.24.20161281external

- Given the data published by the CDC and other groups on post-quarantine transmission risk, there is scope for close exposure quarantine inmates to have their quarantine duration reduced from 10 days to 7 days. However, due to the increased risk of transmission, we caution CCJ not to blindly introduce this time reduction. It could however be considered as a tolerable risk to take to create jail space for the safety of all inmates in the event of a major outbreak.

- The COVID Directive policy (policy number: 11.13) should include an area to discuss a hierarchy of quarantine practices that are to be followed based on conditions on the ground. For example, the use of single cells, double cells, and inmates mixed within the same pod is an important consideration that should be included in the policy. Per CDC guidance, CCJ could consider not requiring fully vaccinated inmates who do not display signs or symptoms of COVID-19 to quarantine following the intake process.

iv. Mental health and other issues relating to quarantining:

It is important for any corrections institution to oversee and help inmates maintain their mental health. CCJ - like most correctional facilities - has limited space to house inmates, making quarantine and isolation difficult as numbers of cases rise. Inmates who test positive for COVID-19 are confined to single cells in a manner similar to that of solitary confinement. This creates a negative incentive for inmates to undergo routine testing or report COVID-19 symptoms, which impacts both the inmate and the inmates around them.

(1) Current Status:

The impact on inmates can be seen through comments made by inmate Raymond Lamar Brown:

> ...have people coughing and we tell them to go to medical and they say no because they're going to take them into lockup. That's the part that's scary because... you're like, yo, that's a sign of COVID, you need to go get checked out. They're like, you crazy, like, if I go now, I got to go to lockup. And what if I don't got it, it's like I'm sitting in the hole for five to ten days and I don't even have it.[44]

Mr. Brown echoed comments made at his trial during our interview on June 22, 2021: "Inmates won't say anything if they are sick, as being sick equals loss of privileges, phone, shower, cleaning, and recreation."

If inmates avoid testing or underreport COVID-19 symptoms, there is both an impact on the individual as they potentially suffer from COVID-19 with no medical attention, and the inmates around them who feel unprotected due to the potential for SARS-CoV-2 transmission amongst the inmate population.

(2) Recommendations:

- CCJ should ensure that medical isolation is not seen as solitary confinement.
- CCJ should provide similar or increased access to items that would normally be available to inmates in their regular unit. For example, increased access to TV, reading materials, telephone, and commissary.
- CCJ should also create an additional schedule to maintain more regular communication between officers and isolated individuals and finally, allow more regular visits from medical staff and mental health services to individuals who are in isolation.

[44] Hearing Transcript, at pages 324:3 – 325:9 (April 21, 2021).

v. Operational Policies: In-Person Visitation Procedures.

Allowing visitors into CCJ to visit inmates presents a number of challenges in light of COVID-19. The largest concern is the potential introduction of COVID-19 into the jail population via close contact between an inmate and visitor. The use of symptom and exposure screening questions, temperature checks, and mandated negative COVID-19 test results prior to admission is not a perfect barrier and creates logistical challenges. It therefore is understandable that in-person visitation was discontinued soon after the public health emergency was announced and has yet to be reinstated.

However, the discontinuation of prison visits are likely to create adverse effects on the mental well-being of inmates[45] and reinstating visitation rights as soon as possible - even under heavy restrictions- would be wise. The New Jersey Department of Corrections (NJDOC) maintains an up-to-date guideline on inmate visitation procedures[46] related to COVID-19 with the last revision occurring on June 14, 2021. This guideline covers a number of essential topics, including amount and length of appropriate

[45] Johnson L, Gutridge K, Parkes J, et al, "Scoping review of mental health in prisons through the COVID-19 pandemic "
[46] NJ Department of Corrections: Guidance on Visitation Procedures https://njdoc.gov/pdf/OffenderPublications/210423_OutdoorVisitBinder.pdf

visitation, scheduling, social distancing recommendations and other protective measures.

(1) Recommendations:

- CCJ should utilize the resources provided by the New Jersey Department of Corrections.
- CCJ should include a requirement in its COVID Directive policy to check the NJDOC guidelines prior to the regular COVID-19 meetings to determine whether there has been any update to NJDOC guidelines that require urgent implementation.

vi. Operational Policies: Staffing Assignments

During our interviews with medical staff and in our document review, it is apparent that CCJ is experiencing significant medical staffing shortages that are impacting the delivery of high-quality medical care. This finding was also noted by Richard F Clarke MD CCHP-P in his Review of Cumberland County Jail NJ Health Care System report (see Appendix D) in which he states "...there are significant staffing shortages in nursing and leadership (HSA, medical director, Mental Health director, and dentist."[47] As a consequence of these staffing shortages, the Director of Nursing (DON) acts as both the 4th day nurse and the HSA, and the CFG Medical Director is currently working in a part time capacity as the acting CCJ Medical Director.

[47] Dr. Clarke's July 13, 2021 Report, conducted pursuant to an agreement with the U.S. Department of Justice to address an alarming number of inmate suicides at the Jail, presents an alarming picture of the health care system at CCJ. We incorporate by reference all of the findings and recommendations in his report.

(1) Current Status:

CCJ is currently lacking individuals to fill the following roles:

- Director of Nursing (DON)
- Health Staff Administrator (HSA)
- Medical Director (MD) - CFG Medical Director presently acting MD;
- Mental Health Director (MHD) - Regional Mental Health Director presently acting as MHD Mental Health Clinician;
- Dentist; and
- 3 Nursing positions (RN/LPN) – DON presently acts as the 4th Day nurse.

The current lack of staffing has led to medical staff working egregious hours with staff nurses regularly working 65 hours per week and the DON working up to 80 hours per week as well as taking calls 24/7. This situation understandably leads to knock-on effects in adequacy of documentation, contact tracing, and reporting. Additionally, the lack of nursing staff has resulted in extended wait times for inmates in need of medical care. The staffing of clinic shifts at CCJ include one Registered Nurse (RN) and one Licensed Practical Nurse (LPN) where the LPN makes rounds of the jail and conducts routine tasks whilst the RN sees inmates in clinic. This bifurcation of roles results in a potential

bottleneck when multiple inmates require care - as might occur during a COVID-19 outbreak.

There are a number of factors that exacerbate the hiring of health staff that are not under the direct control of CCJ, including a shortage of available candidates (aggravated during the pandemic), more competitive wage offerings at other health care venues, and the intrinsic challenges of hiring people to work in a correctional institution. These factors are worsened by the current inability to assure job security for applicants due to Cumberland County's plan to revamp the County Jail to a Reception, Transportation and Release center which remains stalled in the legal process. Potential applicants understandably are looking for more job stability than CCJ can currently provide. In relation to current staff, the potential job insecurity contributes to an unstable working environment that is not amenable to staff retention in the long term.

(2) Recommendations:

- Between an absent director, an overstretched DON, and insufficiently staffing infirmary, medical staffing needs to be addressed as a critical issue. As COVID numbers have begun to rise again - as evidenced by the presence of positive cases as of September 1, 2021 - it is necessary to have adequate clinical resourcing and supervision to respond to increased medical needs. This includes:
    - Formal on-call coverage (not assigned to the DON) Additional RN during peak daytime hours; and

- Dedicated medical director responsible for reviewing, approving and enforcing protocols Continued effort to fill currently vacant medical staffing roles.

vii. Custody Staffing Assignments:

(1) Status:

At present, custody staffing assignments are not performed in an intentional manner. The personal preference of more seasoned officers drives the allocation of custody assignments - via a bidding system - and other factors such as vaccination status or a cohort/containment system are not included in the decision-making process. Further, due to staffing shortages, officers are required to cover multiple units and therefore regularly transition between units - often during the same shift. This constant movement between units is treated in a casual manner and as a result, the exposure of custody staff to different inmate populations within CCJ is not well controlled or documented. In fact, the current set-up created an increased risk of infection due to multiple separate exposure points officers experience whilst working within the jail. The downstream problem this creates is the inability to effectively contact trace in the event of one or more positive COVID-19 case at CCJ.

To compensate for the staffing shortages, CCJ has implemented 12-hour work shifts instead of 8-hour work shifts. As the staffing shortages have become worse, there has been increased overtime for

already tired and overworked personnel. This has had two effects: first, the health and immunity of corrections officers may be compromised; and second, corrections officers who have already worked a 12-hour shift may be less willing to take on further overtime assignments, thereby exacerbating the personnel shortage.

The situation outlined above is worrying on a number of fronts, especially with regard to officer and inmate safety. The exposure risk of offices should be reduced and staffing assignments should be more deliberate and take into account factors that feed into the creation of a safe environment within the jail.

(2) Recommendations:

- A more structured method of staffing assignments should be created to assign officers to units/pods in a more deliberate way.
- Assignments should be allocated to minimize cross-contamination based on vaccination status and risk.
- Only vaccinated officers/officers with antibodies should be assigned to quarantine/isolation units. Officers with underlying conditions should be discouraged from taking posts in quarantine/isolation units.
- Officers should log their assignments if/when they are required to float between pods to facilitate contact tracing.
- CCJ should move to three 8-hour shifts rather than two 12-hour shifts.

b. Prevention Strategies: Infection Control Practices

i. Cleaning Supplies and Facilities

(1) Current Status:

Since the Court's August 6, 2021 Order, the inmates have had increased and more consistent access to more effective sanitation solutions and supplies, such as clean mop-heads and rags. Additionally, since the Court's August 6, 2021 Order, CCJ has discontinued use of Simple Green Original Solution and has replaced it with Simple Green D-Pro 5, which is intended to be used as a disinfectant. CCJ, however, continues to use Non-Acidic Bathroom Cleaner ("NABC"). NABC is intended for use primarily in disinfecting bathrooms and should not be used for non-porous surfaces (e.g., grout, cement). Although it is effective against COVID-19, its continued use long term may cause problems as it is caustic and will cause erosion and thus increase the risk of unsanitary conditions.

Despite the increased access to cleaning supplies, there appears to be no set and consistent cleaning schedule as there were no posted guidelines for cleaning in the individual men's units. By contrast, the women's facilities encourage a regular cleaning schedule resulting in more sanitary conditions. This was due to the proactive nature of corrections officers in the unit.

With respect to air filtration, CCJ maintains a single 20-ton unit AC for A & C pods and two 20-ton AC units for B & D pods (one for each side). Filters are changed once each month, and CCJ utilizes an AAF Perfect Pleat filter, Brookaire. It has a Merv 8 classification, which captures an average of 84.9% of particles with a size of 3 to 10 microns. The problem is that the average size of the COVID-19 virus is 0.125 microns.[48] CCJ conducts air quality testing every quarter.

(2) Recommendations:

- If personnel cannot be staffed to clean common spaces, a cleaning company should be contracted to provide cleaning services weekly, or inmates should be placed on a regular cleaning schedule. This works in women's areas and can be applied to men's units as well with the use of a schedule/shift system.

- CCJ should consider replacing NABC with another disinfectant solution such as 3-M. Although NABC is an effective disinfectant, its use over time on porous surfaces will cause them to erode and decay.[49]

- Depending upon the capacity of the CCJ's HVAC units, all filtration should be replaced with HEPA filters. The COVID-19 virus average size is 0.125 microns, which is within the filtration specs of a HEPA filter.[50] [51]

- CCJ should maintain a fixed replacement schedule for the HEPA air filters.

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[48] https://www.epa.gov/indoor-air-quality-iaq/what-hepa-filter-1.

[49] https://www.3m.com/3M/en_US/commercial-cleaning-us/safer-disinfectants-for-the-healthcare-environment/coronavirus-outbreak/

[50] https://www.researchgate.net/publication/226318339_Experimental_study_of_nanoparticle_penetration_through_commercial_filter_media

[51] https://www.epa.gov/coronavirus/air-cleaners-hvac-filters-and-coronavirus-covid-19

- CCJ should keep testing air quality quarterly.

ii. Prevention Strategies: Health Education

During both scheduled and unscheduled interviews with inmates our team has found that the health literacy of the CCJ inmate population is low, especially in relation to COVID-19. The primary source of information from which inmates acquire health education is the news they watch on the television and through conversations with other inmates. Inmates interviewed expressed dismay at the fact they rarely have the opportunity to speak to medical staff. Inmate comments from our team's scheduled interviews include "We've received no information on the vaccination, only what we see on the news..." (Carlos Solar, June 22, 2021), "We have no education about the vaccination - we can't get it..." (John Clark, June 22, 2021), and "Nurses don't regularly round so sometimes people lie about symptoms just to get the attention of nursing staff..." (Raymond Lamar Brown, June 22, 2021).

It is a cause for concern that during our conversations with inmates we also heard a number of common conspiracy theories including that COVID-19 vaccinations magnetizing people; that COVID-19 vaccinations are being used to track people; and, that the vaccines contain unknown substances. Inmates also voiced concerns at the fact that many officers are unvaccinated and thus why should they receive the COVID-19 vaccine. We also learned

that one CFG nurse complained that a correctional officer actively discouraged inmates to receive a COVID-19 while the nurse was attempting to educate inmates on its safety and efficacy.

(1) Current Status:

Due to medical team staffing shortages the inmates have very little access to medical staff to answer general health-related questions. There is no regularly scheduled time during which the medical team is specifically available, or regular rounds where COVID-19 topics could be discussed. Furthermore, from our document review, there is also a general lack of inmate-friendly health educational materials, such as documents related to testing or vaccinations.

It is our belief that CCJ should make an effort to schedule regular sessions for all inmates and officers to receive up-to-date information about COVID-19 - particularly testing and vaccinations.

In developing an understanding of the flow of inmates into and throughout CCJ, we noted a point in time when a concerted push of health education could potentially deliver some positive effects. During the intake process inmates undergo a medical appointment after which they are then transferred to an intake quarantine area where they are held for 5 days prior to being tested. If they yield a negative COVID-19 test result they are released into the general population. This intake process flow is

highly conducive to the education and delivery of COVID-19 vaccinations to CCJ inmates. Intake arrestees have a dedicated one-on-one appointment with a health provider where the appointment is not related to any acute health need. This provides an ideal time to question arrestees on their vaccination status and if they are unvaccinated, educate them on the vaccines being offered at CCJ.

Vaccines are designed to illicit an immune response that mimics that of being infected by SARS-CoV-2 which leads to COVID-19-like symptoms post vaccination (typically more pronounced after the second dose for mRNA vaccines). If arrestees accept a vaccination at the time of intake, any symptoms they might experience will arise whilst still in quarantine where: (1) they will be with other inmates who may have been vaccinated during intake; and (2) they will be within the safe space of a single or double cell.

There is evidence within the public health field that many individuals who do not take up vaccinations have similar reasons for doing so and a large majority have common questions that act as the sole barrier to vaccination[52]. From our interactions with

[52] Stockwell MS, Hofstetter AM, DuRivage N, Barrett A, Fernandez N, Vargas CY, Camargo S., Text message reminders for second dose of influenza vaccine: a randomized controlled trial. Pediatrics. 2015 Jan;135(1):e83-91. doi: 10.1542/peds.2014-2475. PMID: 25548329; PMCID: PMC4279072.

the inmates at CCJ our assessment is that this statement is most likely also true for this population and good health education would go a long way to alleviate many fears and provide an understanding of the basic mechanism of both COVID-19 testing and vaccinations. As the inmates and corrections officers all interact within the same space it would be wise for CCJ to make a point of extending health education to include officers as well as inmates.

Improving the flow of credible, scientific information and reducing/eliminating misinformation among the inmate population is one of the more easily implemented, least expensive and overall productive activities in the effort to control COVID-19 within CCJ. These activities have long lasting benefits beyond the confines of CCJ into the homes and communities of the inmates, officers and staff.

(2) Recommendations:

- CCJ should include a video (in the appropriate languages) during intake from an official source to provide credible and complete education to inmates. Additionally, one-on-one vaccination education /consultations should also be made available following intake of new inmates to address:
    - Specific questions and concerns (ie. allergies, preexisting medical conditions, etc.)
    - Other important points, including:
        - Public/family/community responsibility;
        - Lower risk of serious illness while in jail;

- Reduced risk of privileges being revoked if inmate contracts COVID-19; and,

- Explanation of the incentives - if any - currently being provided in association with receiving a COVID-19 vaccination.

- CCJ should maintain an adequate inventory of vaccinations on hand to allow for immediate administration once an inmate consents.

- CCJ can explore the option of introducing an incentive for inmates who choose to accept the vaccination against COVID-19. For example, the allocation of $10 concession credit.

- High quality and easily understandable health education materials on vaccination and testing should be available for all inmates throughout the jail.

- Health education documents should be distributed amongst the CCJ staff with a record of receipt made.

- CCJ should explore the option of introducing an incentive for corrections officers who choose to accept vaccination against COVID-19.[53]

- CCJ should provide up-to-date information about COVID-19 to inmates on a regular basis. Focus should be on allowing the opportunities for questions. Inmates should be updated on:

  - Symptoms of COVID-19 and its health risks;

  - Reminders to report COVID-19 symptoms at the first sign of illness;

  - Address concerns related to reporting symptoms (e.g., being sent to isolation), explain that symptoms should be reported immediately to protect

[53] New Jersey Department of Corrections has added a number of incentives for inmates, including 10 days off their sentences if inmates get 2 doses and $10 commissary credit after the first shot: https://www.nj.com/news/2021/09/prisoners-offered-incentives-including-time-off-their- sentence-to-get-covid-19-vaccine.html.

all inmates and staff, and reiterate the differences between medical isolation and solitary confinement; and

- Reminders to wear masks at all times.

iii. Prevention Strategies: Diagnostic Testing

During the onset of the pandemic, CCJ was conducting broad based testing with PCR tests. While PCR testing is the gold standard, cost and delayed turnaround times resulted in a switch over to the use of rapid antigen tests. While antigen tests are likely to catch a symptomatic cases, they are half as effective in catching asymptomatic cases.[54]

This is quite alarming considering the testing that had been previously done at CCJ using PCR tests found that 88% of those that tested positive were actually asymptomatic. As a result, it is likely that positive cases are being missed on a regular basis. Antigen tests are more effective when used in a serial testing methodology, in which two tests are administered 24-48 hours apart, and should only be used that way, especially with asymptomatic patients.

(1) Current Status:

Inmates are currently quarantined for 10 days upon arrival in D Pod. On day 5 of quarantine, they receive a rapid antigen test. If the rapid test is positive, a confirmatory PCR test is not

[54] https://www.cdc.gov/mmwr/volumes/69/wr/mm695152a3.htm.

always completed. Nonetheless, if the rapid test is positive, the inmates are assigned to A Pod. Corrections officers flow between C & D pod units.

Testing at the beginning of the pandemic was PCR only, and revealed that about 88% of positive cases were from asymptomatic patients. When there was a second outbreak in August 2021 due to the Delta variant, testing revealed that the vast majority of the inmates were also asymptomatic. This is important because Antigen tests are less likely to pick up asymptomatic cases, making them highly inappropriate for this environment as a standalone test.

(2) Recommendations:

CCJ currently utilizes antigen tests to test its inmate population. We recommend that CCJ move to using PCR tests given their increased sensitivity at detecting COVID-19 disease, particularly in asymptomatic individuals. We are conscious that cost, availability and turn-around times of PCR tests can be challenging and emphasize that the use of PCR testing for individuals at the end of their intake quarantine period should be prioritized to reduce the risk of introduction of COVID-19 into the general population. Inmates who are fully vaccinated should still be tested for SARS-CoV-2 following exposure to suspected or confirmed COVID-19 or if they develop any signs or symptoms of COVID-19. In the alternative, serial rapid tests – that is rapid tests conducted on consecutive days, should be considered.

(a) Recommended Process:

Intake testing: Day 1:

- Antibody test to identify who has been exposed/vaccinated Antigen testing to identify active infection.

On Exit

- PCR test on exit to validate all inmates entering are COVID free (including asymptomatic).

Baseline testing

- Full inmate and officer snapshot (during the winter, flu testing should be bundled with COVID test - ideally 3-plex test).
    - Round 1: Antibody test to identify who has been exposed/vaccinated (repeat every 1-2 months) - this should include inmates and officers.
    - Round 2: If no antibodies, PCR test to confirm active presence of infection.
    - Alternative to PCR test - CCJ can use a serial testing approach to reduce costs. Serial testing means an antigen test is administered at day 1 and a second is administered 24-48 hours later. Two negative tests clear the patient from COVID- 19.
    - Confirmed exposure: Testing following a confirmed positive, and contact tracing protocol should be done by PCR - at 5-7 days post confirmed exposure (quarantine in d-pod in a single cell until testing).
    - Officers should be tested weekly on-site.

(b) Problems with inmates refusing to test because of the fear of being quarantined

Recommendation(s):

- Provide education to inmates around quarantine timeline and procedure.
- Offer inmates in quarantine/isolation special privileges such as commissary credits to minimize hesitation towards to testing.

iv. Prevention Strategies: Symptom & Exposure Screening

Part of the effective prevention of SARS-CoV-2 transmission within a facility is enacting a clear and standardized symptom and exposure screening strategies. These strategies consist of checking temperatures and other symptoms as well as ascertaining if the individual has been in a high-risk situation or environment. While, symptom and exposure screening is not the most highly effective method of preventing contagion within a facility, it is worthwhile when used as part of a larger comprehensive COVID-19 prevention program.

(1) Current Status:

CCJ currently employs temperature screening for all visitors and staff. This occurs in the main entrance lobby adjacent to the security desk. Here the attending security officer instructs all visitors to stand in front a thermal camera prior gaining access to any other part of the jail. Visitors and staff that present with a temperature under 99.5 are allowed access to the jail.

Temperature checking is the only screening tactic currently in force. There are no other screening mythologies in use. Verbal or written symptom screening does not occur.

(2) Recommendation(s):

It is recommended that CCJ adopt a broader symptom and exposure protocol, including:

- Prior to each shift, CCJ is encouraged to conduct daily health checks, such as temperature screenings, visual symptom checking, self-assessment checklists, and/or health questionnaires, consistent with CDC guidance.

- Staff and visitors should be prohibited from entering the jail if they display a fever. The U.S. Centers for Disease Control and Prevention (CDC) lists fever as one criterion for screening for COVID-19 and considers a person to have a fever if their temperature registers 100.4 or higher -- meaning it would be almost 2 degrees above what's considered an average “normal” temperature of 98.6 degrees.

- Enact a verbal symptom and exposure screening questionnaire. These questionnaires are widely available and provided on the CDC's website.[55] The questions include:

    - *Today or in the past 24 hours, have you had any of the following symptoms: Fever, felt feverish, or had chills, Cough?*

    - *Have you experienced 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)?*[56]

[55] https://www.cdc.gov/coronavirus/2019-ncov/index.html.
[56]https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Definitions.

- CCJ should provide a mechanism for self-monitoring and reporting symptoms if they occur during a shift and have a plan in place to deal with one or more officers displaying COVID-19 like symptoms.

v. Prevention Strategies: Mask Use

The COVID-19 pandemic has shone a light on the need for mask use to prevent respiratory disease transmission. There are three primary mask types used by individuals: (1) N95/KN95; (2) surgical masks (typically 3-ply); and (3) cloth masks. As new and more contagious variants of COVID-19 emerge such as the Delta variant, understanding the pros and cons of each type of mask is important in driving decisions at CCJ about which types of masks to allow and when and where to mandate certain masks over others.

N95/KN95 Masks:

N95/KN95 masks are considered the gold-standard mask to protect the wearer from particles or liquids contaminating the face. The FDA, CDC, and National Institute for Occupational Safety and Health (NIOSH) regulate N95 masks. Both N95 and KN95 masks are designed to filter out and capture 95% of particles 0.1-0.3 microns and do so by fitting tightly against the wearer's face and the use of special material filters within the mask itself.[57]

[57] MacIntyre C.R., Chughtai A.A., *Rahman B. The efficacy of medical masks and respirators against respiratory infection in healthcare workers*. Influenza Other Respi Viruses. 2017;11(6):511–517. doi: 10.1111/irv.12474.
Tcharkhtchi A., Abbasnezhad N., Zarbini Seydani M., Zirak N., Farzaneh S., Shirinbayan M., *An overview of filtration efficiency*
…Continued

Due to the tightness of fit required for N95/KN95s to work, many types require "fit testing" to select the correct size and over extended use (>8 hours) often become uncomfortable to wear. Finally, N95/KN95 masks offer very good protection for both the wearer and those around them.

Surgical Masks:

Surgical masks are fluid resistant disposable masks that are not close fitting and are designed to offer protection from larger respiratory droplets. Surgical masks have been shown to be very effective at filtering expelled respiratory droplets associated with the transmission of SARS-CoV-2 and offer a good alternative to N95/KN95 masks in that they are efficacious yet comfortable to wear over extended periods of time. In one meta-analysis surgical masks were found to be equally effective as N95 masks in preventing influenza-like illness and confirmed influenza among healthcare workers.[58] Surgical masks are able to filter 60%–80 % of particles as small as 0.3 µm.[59]

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through the masks: mechanisms of the aerosols penetration. Bioact Mater. 2021;6(1):106–122. doi: 10.1016/j.bioactmat.2020.08.002. MacIntyre C.R., Chughtai A.A. *Facemasks for the prevention of infection in healthcare and community settings*. BMJ. 2015;350 doi: 10.1136/bmj.h694.

[58] Long Y., Hu T., Liu L. *Effectiveness of N95 respirators versus surgical masks against influenza: a systematic review and meta-analysis*. J Evid Base Med. 2020;13(2):93–101. doi: 10.1111/jebm.12381.

[59] https://blogs.cdc.gov/niosh-science-blog/2009/10/14/n95/

Cloth Masks:

Research has shown that all kinds of masks are at least partially beneficial at protecting the wearer against aerosols however cloth masks in general are variable in their efficacy and suffer from the disadvantage that they are generally worn over multiple days and weeks rather than being disposed or washed when they become used and/or soiled. Compared to N95/KN95 and surgical masks, cloth masks are 0% efficient at filtering particles 0.3 microns. Compared to 3-ply masks, cloth masks are less efficacious at filtering small particles and droplets.

(1) Current Status - CCJ Staff:

It was noted by the Special Master's team that officers at CCJ all wore cloth masks during our visits, many of which appeared to be in need of either washing or disposal. Officers were found to be wearing masks throughout the facility and masks were all worn correctly, covering both the nose and mouth.

(2) Recommendation(s) - CCJ Staff:

- All staff should be required to wear at least a 3-ply surgical masks whilst physically present at CCJ and provided replacements at regular intervals.
- Given the rise of breakthrough infections in vaccinated individuals, our recommendation is that CCJ staff who are fully vaccinated (second dose of an mRNA vaccine more than 14 days ago) continue to wear masks throughout the facility.
- It is our recommendation that officers who operate within high-risk COVID-19 areas (isolation and quarantine areas) should wear N95/KN95 masks that are

appropriately fit tested for the mask they will be wearing.

- There should be regular spot checks to confirm correct use of masks throughout the facility.

(3) Current Status - Inmates:

During our visits to CCJ we noted that mask use amongst inmates was variable. Within the pods, mask wearing was generally good which was in stark contrast to the dormitories where mask wearing was almost non-existent. All inmates are offered and can request 3-ply surgical masks if needed. During on-site inspections we found boxes of masks in all units.

(4) Recommendation(s) - Inmates:

- All inmates should continue to be provided with 3-ply surgical masks and given replacements at regular intervals.

- Due to the rise of breakthrough infections in vaccinated individuals, our recommendation is that inmates who are fully vaccinated (14 days after the second dose of an mRNA vaccine or first dose of a single-dose vaccine) continue to wear masks throughout the facility.

- There should be regular spot checks to confirm the wearing of and correct use of masks.

vi. Prevention Strategies: Social Distancing and People Flow

Social distancing measures are one of the most effective protections against the spread of SARS-CoV-2. In fact, physical distancing of greater than 3.25 ft (1 meter) is more effective than even face mask use in preventing the spread of respiratory

disease[60]. Despite the high effectiveness of physical distancing, during our multiple visits to CCJ we found that social distancing was not routinely followed or enforced.

(1) Current Status:

During our first on-site visit to CCJ on June 3, 2021, it was noted that social distancing markers were visible in certain areas of the jail. They appeared new and so our working assumption is that they were placed not long before our arrival. The social distancing markers we observed were in appropriate areas of the jail where inmates might routinely congregate. We also observed, however, a notable lack of social distancing in some areas where inmates routinely congregate for extended periods of time, such as the bench outside the medical facility where inmates wait to be seen by a member of medical staff.

Additionally, there are some areas where social distancing is essentially impossible, such as the dormitory areas and the maximum security blocks. Combined with the pervasive lack of mask use, these areas are the perfect breeding ground for COVID-19 infections. Indeed, the August 2021 outbreak of COVID-19 at CCJ

[60] Chu DK, Akl EA, Duda S, Solo K, Yaacoub S, Schünemann HJ; COVID-19 Systematic Urgent Review Group Effort (SURGE) study authors. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. Lancet. 2020 Jun 27;395(10242):1973-1987. doi: 10.1016/S0140-6736(20)31142-9. Epub 2020 Jun 1. PMID: 32497510; PMCID: PMC7263814.

principally occurred in the men's dormitory areas. By contrast, the pod areas – where social distancing was possible – had a very low infection rate during this same period. With the lifting of the injunction prohibiting CCJ from transferring inmates, CCJ should consider immediately transferring inmates housed in these areas first if the Cumberland County Commissioners decide to proceed with closing the jail.

Further, inmates are not currently receiving regular recreational time, so enforcing social distancing in this setting hasn't yet been tackled by CCJ. CCJ should implement written guidance on how to oversee inmates once recreational activities recommence.

(2) Recommendations:

- The floor plan and inmate flow throughout CCJ should be reexamined with all areas where inmates congregate having social distancing markers added.
- Bench outside of the medical facility should have markers on the floor to indicate 6 ft. of social distancing.
- CCJ staff and inmates should be educated on the importance of social distancing at reducing the risk of viral spread throughout the jail.
- The size of group activities and congregations should be limited in the number of individuals.
- Arrange inmates to sleep head to foot within the dorm and cell bunkbeds to increase the distance between their faces.

- If Cumberland County decides to proceed with closing CCJ, then inmates housed in the dormitory and the maximum security block areas should be prioritized for immediate transfer.

vii. Prevention Strategies: Vaccination

As of September 20, 2021, there are three approved and authorized vaccines in the United States: (1) Pfizer-BioNTech; (2) Moderna; and (3) Johnson & Johnson/Janssen.

Pfizer-BioNTech and Moderna (mRNA vaccines):

The Pfizer-BioNTech and Moderna vaccines are both mRNA vaccines that contain material from the SARS-CoV-2 virus that provide instructions to human cells on how to make harmless proteins that are unique to the virus. After these harmless proteins have been created and copied the human body recognizes that the protein is foreign (i.e., should not normally be present in a human cell) and therefore mounts an immune response that remembers the proteins and how to fight the SARS-CoV-2 virus in the case of future infection. These vaccines require two doses (3-4 weeks apart), and an individual who receives these vaccines is only considered fully vaccinated 14 days after their second dose.

Johnson & Johnson/Janssen (vector vaccine):

The Johnson & Johnson/Janssen vaccine is a vector vaccine that contains a version of the adenovirus virus (a common virus that causes the common cold) that has been altered to include harmless genetic material from the SARS-CoV-2 virus. Once the

adenovirus has entered a human cell, harmless proteins are created that are unique to the SARS-CoV-2 virus which the human body recognizes a foreign (i.e., should not normally be present in a human cell) and therefore mounts an immune response that remembers the proteins and how to fight the SARS-CoV-2 virus in the case of future infection. This vaccine requires a single doses, and an individual is considered fully vaccinated 14 days after their dose. On October 20, 2021, however, the FDA recommended that any individual 18 years of age or older who has received the Johnson & Johnson vaccine receive a booster shot ***of any type*** (i.e., Johnson & Johnson, Moderna or Pfizer) between two and six months after the first dose.[61]

The CDC does not recommend one vaccine over another however two points should be considered regarding vaccines and their use in a correctional institution setting.

- mRNA vaccines (Pfizer-BioNTech and Moderna) require two doses to be administered to an individual before they are considered to have received a complete vaccination - important given inmates may be released or transferred prior to receiving their second and final dose; and

- The SARS-CoV-2 Delta (B.1.617.2) variant is now the most common viral variant in the United States and research suggests that COVID-19 vaccines are slightly less effective against this variant as compared to the original strain. Early research suggests that against the Delta variant:

[61] https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-additional-actions-use-booster-dose-covid-19-vaccines.

- The Pfizer-BioNTech vaccine after full vaccination is 88% effective at preventing symptomatic disease and 96% effective at preventing severe disease;
- The Moderna vaccine shows after one dose, 72% efficacy against symptomatic disease and 96% effective at preventing severe disease[62]; and
- The Johnson & Johnson/Janssen vaccine is 85% effective at preventing severe disease with a single does, but increases substantially with a booster shot of any kind.[63],[64]

As discussed in the health education section, our interviews with inmates and both scheduled and unscheduled visits to CCJ have shown that the health literacy of the inmates at CCJ is low, especially in relation to COVID-19. More specifically, much of the misinformation we heard from inmates involved COVID-19 vaccinations where views such as "vaccinations magnetize..." or "the vaccines contain penicillin" were expressed.

The topic of health education for the general inmate population has been discussed in the Health Education section of this report, however, we believe that there is an opportunity for

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[62] Lopez Bernal J, Andrews N, Gower C, Gallagher E, Simmons R, Thelwall S, Stowe J, Tessier E, Groves N, Dabrera G, Myers R, Campbell CNJ, Amirthalingam G, Edmunds M, Zambon M, Brown KE, Hopkins S, Chand M, Ramsay M. Effectiveness of Covid-19 Vaccines against the B.1.617.2

[63] Robert L. Atmar, et al., Heterologous SARS-CoV-2 Booster Vacccinations – Preliminary Report, medRxiv preprint (October 15, 2021), https://www.medrxiv.org/content/10.1101/2021.10.10.21264827v2.

[64] https://www.jnj.com/positive-new-data-for-johnson-johnson-single-shot-covid-19-vaccine-on-activity-against-delta-variant-and-long-lasting-durability-of-response

CCJ to engage the intake population in a healthy vaccination conversation to increase uptake on entry into CCJ which would ultimately work to increase the vaccination rates across the jail.

(1) Current Status:

Upon arrival at CCJ, transporting offices and arrestees wear masks if not already doing so. They have their temperature taken after which they are allowed into the institution. If accepted into the facility, arrestees undergo the intake process during which there is a medical assessment. During the medical assessment inmates are asked a number of COVID-19 symptom and exposure questions which acts as an initial screening tool to identify potential COVID-19 infections and allow for early and appropriate transfer to a local hospital to determine if he/she has COVID-19 or any other condition that may not allow for incarceration.

During the medical assessment, new intakes are asked their vaccination status however further education and administration of any vaccines during intake is not performed. Following the intake process, all new inmates are placed in quarantine for a minimum of five days, and as per the Special Master's first Partial Interim Report and Recommendation, Inmates will receive different color wristbands related to their quarantine status.

It should be noted that it is widely recognized that screening is an imperfect barrier to viral spread[65]. Under best-case assumptions, it is estimated that symptom and exposure screening will miss more than 50% of infected individuals - primarily due to undetectable disease from lack of symptoms and/or lack of awareness of exposure risk[66]. We should therefore be aware that only up to 50% of COVID-19 positive arrestees will be detected through symptom and exposure screening alone. Screening offers limited protection, underscoring the need for other measures to limit introduction of COVID-19 into CCJ.

The intake process is key in educating new inmates about COVID-19 vaccination and, if appropriate, be a moment for the administration of a vaccine. This additional step could be crucial in building stronger inmate health and COVID-19 related understanding amongst the population, a feature that testimony during CCJ employee and inmate interviews and inmate discussions during on-site visits has been highlighted as lacking.

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[65] Quilty BJ, Clifford S, Flasche S, Eggo RM; CMMID nCoV working group. Effectiveness of airport screening at detecting travellers infected with novel coronavirus (2019-nCoV). Euro Surveill. 2020 Feb;25(5):2000080. doi: 10.2807/1560-7917.ES.2020.25.5.2000080. Erratum in: Euro Surveill. 2020 Feb;25(6): PMID: 32046816; PMCID: PMC7014668.

[66] Gostic, K., Gomez, A. C., Mummah, R. O., Kucharski, A. J., & Lloyd-Smith, J. O. (2020). Estimated effectiveness of symptom and risk screening to prevent the spread of COVID-19. eLife, 9, e55570. https://doi.org/10.7554/eLife.55570

Dr. Richard F. Clarke, CCHP-P, noted in his report titled "Review of Cumberland County Jail NJ Health Care System" (Conducted June 2021, Submitted July 13, 2021) that medical staff interviews confirmed that reduced staffing caused health screenings to not occur prior to intake, thus allowing inmates into the jail without having seen a medical team member. This could be disastrous, and we believe that reducing the possible entry of COVID-19 into CCJ should be prioritized by the jail and medical staff.

By increasing the number of vaccines given during the intake process, CCJ will align the development of symptoms post vaccination with the 5-day mandated quarantine period for all new intakes. The hope is that if vaccine uptake is high, other inmates within the quarantine unit will act as a support mechanism through the course of an inmate experiencing vaccine associated symptoms. This will reduce the risk of an individual experiencing stigma from the general inmate population or perpetuating false information such as vaccinations causing COVID-19 as they might otherwise have done if they had received the vaccine whilst in general population and returned only to suffer COVID-19-like symptoms - which are expected symptoms given the aim of the vaccine is to cause the human body to mount a similar immune response to that experienced during COVID-19 disease.

(2) Recommendation(s):

- During the intake process, the medical team should emphasize COVID-19 vaccination information and administration. Inmates should be offered J&J as a single dose, or Moderna, as the most effective against the Delta variant. It should be noted that the storage and handling limitations of both the Moderna and the Pfizer vaccines

- The medical team should emphasize the provision of vaccination and COVID-19 related medical advice across the inmate population.

- The medical team should educate and engage the corrections staff in COVID-19 health information and help turn them into partners in educating the inmate population.

- Effective supporting materials should be present at intake medicals and arrestees should be given as much detail as is appropriate for them to make an informed decision about receiving a COVID-19 vaccine.

viii. Prevention Strategies: Booster Shots

On Wednesday, August 18, 2021 the U.S. Department of Health and Human Services (HHS) released a statement from their public health and medical experts announcing the Administration's plan for COVID-19 booster shots. The Administration stated that a plan has been developed to offer booster shots in the Fall of 2021, subject to the FDA conducting an independent evaluation and determining booster shots safe and effective for use, and the CDC's Advisory Committee on Immunization Practices (ACIP) issuing booster dose recommendations.

On October 20, 2021, the U.S. Food and Drug Administration approved the expansion of COVID-19 booster vaccines as follows:

- The use of a single booster dose of the Moderna COVID-19 Vaccine that may be administered at least 6 months after completion of the primary series to individuals:
    - 65 years of age and older;
    - 18 through 64 years of age at high risk of severe COVID-19; or
    - 18 through 64 years of age with frequent institutional or occupational exposure to SARS-CoV-2.
- The use of a single booster dose of the Janssen (Johnson and Johnson) COVID-19 Vaccine may be administered at least 2 months after completion of the single-dose primary regimen to individuals 18 years of age and older.
- The use of each of the available COVID-19 vaccines as a heterologous (or "mix and match") booster dose in eligible individuals following completion of primary vaccination with a different available COVID-19 vaccine.
- To clarify that a single booster dose of the Pfizer-BioNTech COVID-19 Vaccine may be administered at least 6 months after completion of the primary series to individuals 18 through 64 years of age with frequent institutional or occupational exposure to SARS-CoV-2.[67]

(1) Current Status:

The medical team at CCJ utilizes an electronic health record (CorEMR) (EHR) to record medical records for jail inmates. Vaccination status is recorded within this system, however it is not currently configured to notify the medical team that an inmate

[67] https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-additional-actions-use-booster-dose-covid-19-vaccines.

is due a booster shot. There is also no other system currently in place outside of the EHR system that serves to provide a reminder to CCJ medical staff that an inmate is due for a booster shot.

(2) Recommendations:

- Given the nature of the corrections institution setting, it would be advisable for CCJ to liaise closely with the Cumberland County Department of Health specifically around the allocation of booster shots now that their use has been authorized.

- Because corrections officers and staff have both an institutional and occupational setting that routinely expose them to COVID-19, CCJ should strongly encourage, if not require, all corrections officers and staff to obtain booster shots.

- CCJ should settle on a system for notifying medical staff of inmates due for a booster shot enabling administration as soon as possible.

- There should be an education program created to teach inmates and staff the reasons for booster shots and how/why they work.

- If applicable, during the intake medical exam, new inmates that have previously been vaccinated arriving at the jail should be given the opportunity to receive a booster shot.

a. Management Strategies

i. Management Strategies: Isolation and Quarantine Practices (Current Inmates)

During the course of writing this report the Special Master's team has been liaising and working with the CCJ corrections and medical team regarding the development of written policies including intake quarantine, isolation and general population

quarantine practices. Per these conversations, effective August 1, 2021, Cumberland County Department of Corrections implemented a COVID Directive policy (policy number: 11.13) that set out the current procedures to be followed to maintain a safe environment within the setting of the COVID-19 pandemic.

(1) Current Status (Policies):

The current expected procedures associated with a suspected COVID-19 exposure as detailed by the Cumberland County Department of Corrections COVID Directive policy (policy number: 11.13) include 6 elements that can be enacted as deemed appropriate. A summary of the protocol is as follows:

- Quarantining of the jail unit in which the exposure occurred with all inmates confined to their cells. The notification of the jail medical team who will commence a testing protocol that involves testing all individuals in the unit - both inmates and staff.

- Inmates who present to staff with one or more COVID-19 like symptoms will trigger the enforcement of the quarantine protocol (point 1).

- Any inmates who test positive on population testing will be provided a red wristband and immediately quarantined at a minimum away from COVID-19 negative inmates.

- The jail medical maintain jurisdiction over decisions related to clearing the unit post quarantine or a continued quarantine period based on the clinical picture across the unit.

- The unit in question will be cleaned and disinfected.

- Staff with close contact to any COVID-19 positive inmates will completed an in-house contact trace form.

We do not believe it is necessary for a policy such as this to contain detailed information regarding how inmates should be housed. However, given the finite space available that is inherent with a jail facility, we do think it prudent for the CCJ COVID policy to detail a mechanism for how it will deal with a potential outbreak. These details could be presented in two ways with our preference being the latter:

- A detailed hierarchy of inmate placement procedures (for example, COVID-19 suspected cases and COVID-19 positive cases should be allocated to single cells, however if necessary, maintaining COVID-19 suspected cases in single cells should take precedence over COVID-19 positive individuals who can be placed two to a cell.); and/or

- An indication of the communication pathways and individuals to be contacted in the event that a re-arrangement of inmates is necessary and their roles and responsibilities in the decision making process.

During the course of writing this report, CCJ suffered an outbreak of COVID-19 and the Special Master's team was immediately brought into the loop to help the Warden work through placing COVID-19 positive and COVID-19 suspected cases effectively. This process of collaboration we believe was both efficient and effective, and so long as there is a good written record of what has been discussed and decided, this process should be both accountable and flexible.

(2) Recommendations:

Within the current exposure management procedures, there is no timeline development of exposure, and thus further infection detection likelihood is not calculated. As stated previously, the mean incubation period of SARS-CoV-2 is about 5.5 days, and the sensitivity and specificity of both PCR and Antigen tests are low during the initial days of infection (see Figure 6). In the event of an individual having a known exposure to a COVID-19 positive individual, the required quarantine period should be at least 6 days from the time of exposure – as discussed previously – after which a PCR test should be performed. The same is true for other individuals in the unit. Therefore, we recommend:

- In the event of an individual having a known exposure to a COVID-19 positive individual, the required quarantine period should be at least 5 days from the time of exposure after which a PCR test should be performed. The same is true for other individuals in the unit. The exact length of the quarantine period should factor in advice from the Cumberland County Department of Health.

- CCJ should include within its COVID-19 Directive policy a section regarding communication pathways and individuals to involve in the event of a COVID-19 outbreak within the jail. Roles and responsibilities should be detailed with a clear chain of command and accountability.

- CCJ could, if necessary, based on urgency, follow the latest CDC guidance that states that fully vaccinated inmates who do not display signs or symptoms of COVID-19 are not required to quarantine following exposure to suspected or confirmed COVID-19.

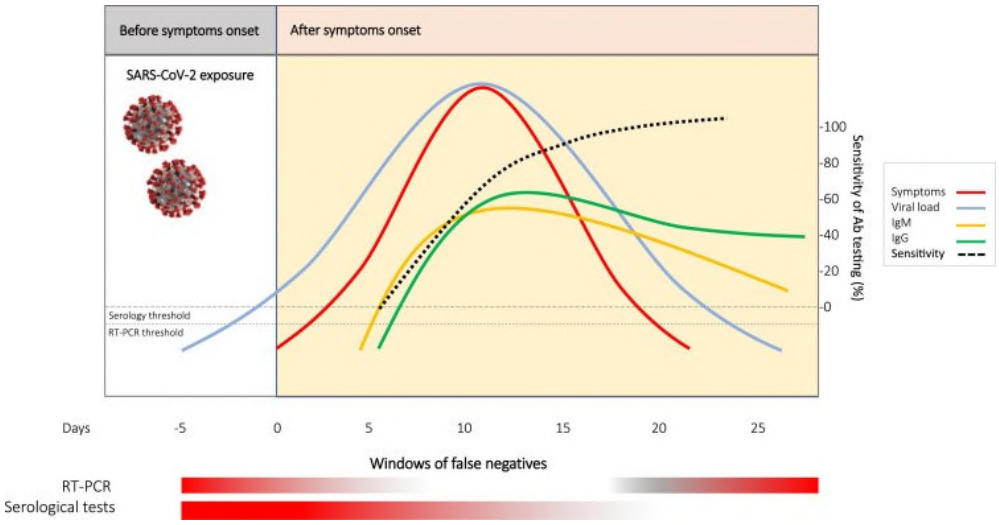

Figure 6

The time relationship between viral load, symptoms and positivity on diagnostic tests. The onset of symptoms (day 0) is usually 5 days after infection (day –5). At this early stage corresponding to the window or asymptomatic period, the viral load could be below the RT-PCR threshold and the test may give false-negative results. The same is true at the end of the disease, when the patient is recovering. Seroconversion may usually be detectable between 5–7 days and 14 days after the onset of symptoms; therefore, in the first phase of the disease, the serological tests are more likely to give false-negative results. The dotted black line in the graph illustrates the sensitivity of the chemiluminescent assay as derived from the data sheet of a commercial test (Abbott Diagnostics, USA). Ig, immunoglobulin; RT- PCR, reverse transcription-PCR; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

ii. Procedures for Inmates Testing Positive

(1) Current Status:

Our understanding of the procedures followed by CCJ regarding the handling of COVID-19 positive individuals comes primarily from our interviews with medical staff - most notably Kristina Smith (RN) and Doreen Cocchran (LPN). To our understanding there is no

written policy, or even reference to the CDC's guidance on the treatment of COVID-19 positive inmates in a corrections setting which we believe could provide an easy-to-use manual for CCJ medical and corrections staff to follow.

If an inmate is found to be positive for COVID-19 a member of the medical staff alerts the Director of Nursing who notifies via email Jail Custody and the Cumberland County Department of Health. Custody then escort the positive inmate to the CCJ COVID-19 isolation area where they are held for 10 days. No confirmatory PCR test is performed and inmates do not receive subsequent testing.

(2) Recommendations:

A number of procedures should be followed when an inmate tests positive. These procedures are designed to reduce the risk of onward spread of the SARS-CoV-2 virus. We recommend that CCJ add to their COVID Directive policy a section for the actions expected to occur in the event of a positive test result. These actions should include topics include at a minimum:

- Informing the inmate as soon as feasibly possible that they have tested positive for COVID-19.
- Informing the unit officer as soon as feasibly possible that they have an inmate who has tested positive for COVID-19.
- A mask if not already being worn by the inmate should be provided and properly worn covering both their nose and the mouth.

- The inmate should be segregated as soon as possible from general population, even whilst awaiting transfer to the CCJ isolation area.

- The inmate should be given a confirmatory PCR test.

- The inmate should be transferred to the CCJ isolation area as soon as feasibly possible and medically evaluated within the isolation area (reducing movement within the facility).

- The inmate should have a red wrist band provided by the CCJ medical team with the expectation that it will be worn until the end of their isolation period.

- The isolation period for inmates positive for COVID-19 should be in line with current CDC guidance, which as of September 15, 2021 is to isolate for 10 days after the onset of symptoms or a positive COVID-19 test result.

iii. Management Strategies: Case Investigation and Contact Tracing

Preventing the transmission of COVID-19 within correctional institutions is particularly important given the concentration of individuals within these facilities and the likelihood that many inmates may be vulnerable to severe infection due to poor health profiles. The confined setting in which inmates live encourages person-to-person viral spread, increasing the basic reproduction number (R0) leading to the potential for rapid spread amongst the population. Case investigation and contact tracing are vital to the effective containment and source identification of SARS-CoV-2 infection within an inmate population. Both case investigation and contact tracing go hand-in-hand as case investigation is focused

on supporting the diseased individual and identifying the primary source of infection.

Contact tracing is the act of contacting any exposed individuals to warn them of their potential exposure and to prevent forward transmission by way of quarantining. The aim of contact tracing is to quickly identify secondary COVID-19 cases that may arise via the transmission of the SARS-CoV-2 virus from known positive individuals. This allows active intervention to take place to reduce further onward transmission. If sufficient resources exist, contact tracing has the potential to bring COVID-19 outbreaks to a close quickly. However, the resources required - particularly for large outbreaks - are significant and the effectiveness of contact tracing rapidly diminishes as resources become stretched. It should therefore be noted that in some circumstances, forgoing contact tracing and case investigation in favor of larger local "lockdowns" may be necessary.

(1) Current Status:

CCJ does not currently employ any standardized case investigation or contact tracing processes for either inmates or staff. From our interviews with CCJ staff we understand that despite both groups interacting within the jail the responsibility for inmate tracing is separate to officer tracing. This therefore results in information gaps and inadequate case investigation and contact tracing. Given the duty of care CCJ has to its employees

and inmates, effective case investigation and contact tracing is vital.

(2) Recommendations:

CCJ should produce and implement a Contact Management Plan that includes the procedures for both contact tracing and contact investigation. Below we have detailed a template that CCJ might follow to quickly enact a plan that meets the minimum requirements necessary to provide a safer environment for inmates and staff.

(a) Contact Management Team (CMT)

- CCJ should create a Contact Management Team (CMT) that consists of at least two individuals. The purpose of this team is to oversee and manage the contact tracing and case investigation processes at the jail. In the event of a major COVID-19 outbreak, CCJ should have staff available who have been trained in COVID-19 contact management to increase the team size and thus provide increased bandwidth.

- CMT team members will need to develop the expertise required to investigate movements of inmates and staff throughout the jail, and thus highlight any potential contacts of positive COVID-19 cases. Contact Management Team members (including the individual ultimately responsible for the team) should therefore at a minimum meet the following criteria:

    - Have experience using the CCTV system within the jail.
    - Be comfortable using IT systems, including the use of Microsoft Word and Microsoft Excel.

    - CCJ should as soon as feasibly possible name a person within the jail who's responsibility it is to oversee the Contact Management Team (CMT).

(b) Training

- CMT members should all receive training on the principles of contact management ***prior*** to engagement in contact management activities.

- The CDC in association with the Association of State and Territorial Health Officials (ASTHO) have developed an introductory online course for entry-level COVID-19 case investigators and contact tracers, and Johns Hopkins has a well-regarded COVID-19 Contact Tracing course freely available. CCJ might consider these training modules (or appropriate alternatives) to help CMT members learn and understand the principles of effective contact management.

- The Cumberland County Department of Health (CC DoH) should also be engaged by CCJ in educating CMT members in the art of contact management. The CC DoH has much experience in contact management given its role in overseeing these activities within the general public.

- Any contact management training should at a minimum cover the following:

    - o An overview of COVID-19 disease and the modes of transmission of the SARS-CoV-2 virus.

    - o A thorough description of the contact tracing and contact investigation processes.

    - o An introduction to the interview scripts/questions required as part of contact management.

(*c*) *Contact Tracing Process*

Contact tracing should be conducted for all individuals who are confirmed to have COVID-19 and those who are highly probable cases of COVID-19 (See Figure 7). These definitions are true for both inmates and staff.

> ***Confirmed Case:*** An individual with COVID-19 confirmed via PCR or antigen testing
>
> ***Highly Probable Case*:** An individual with either (1) a cough and fever of >100.4F; and/or (2) shortness of breath

Figure 7

The CDC defines individuals who are considered a close contact of someone positive for COVID-19 as those who have been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period. Individual exposures are added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). For a more expanded model that introduces casual contacts, please see Figure 9. The process of contact tracing can be seen in Figure 8.

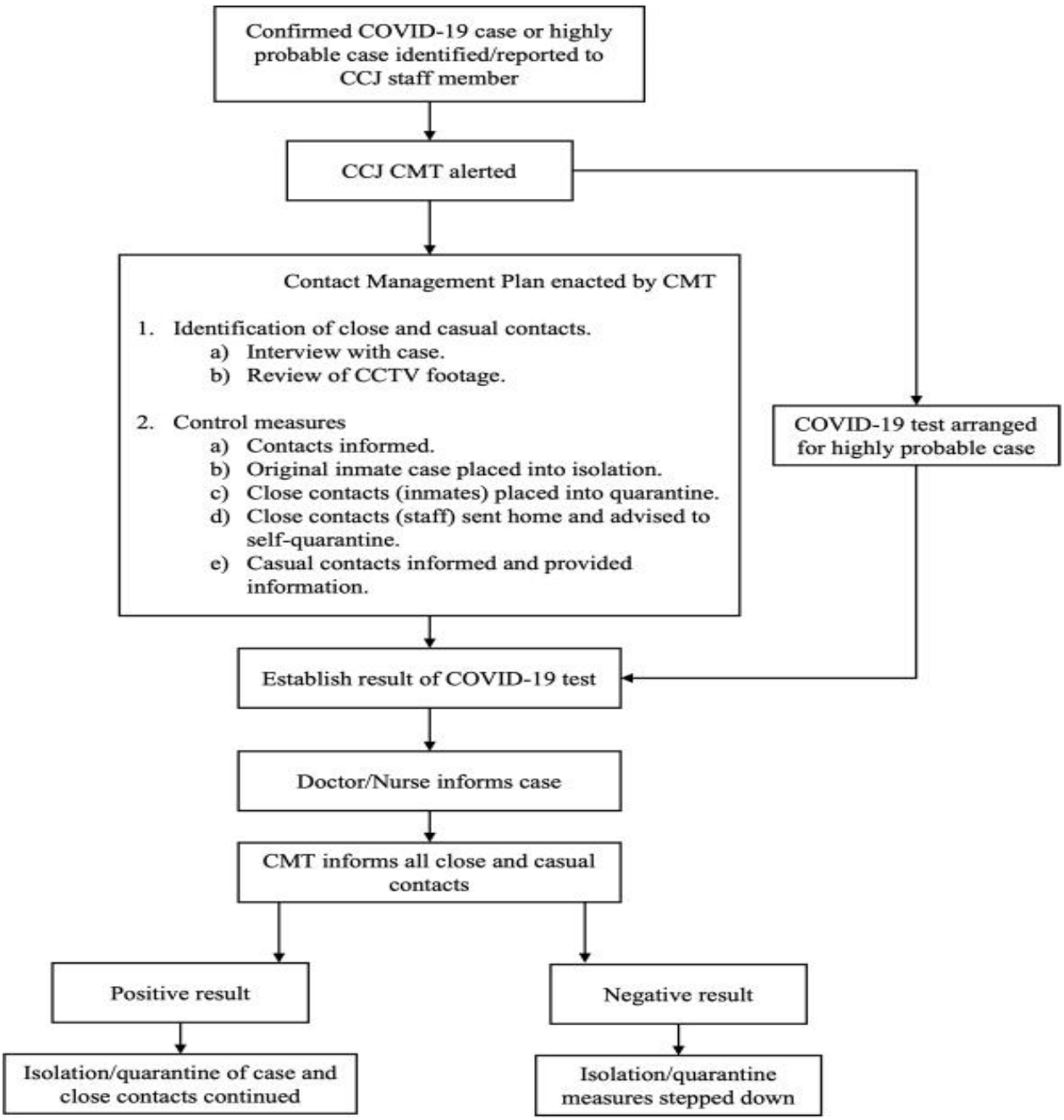

Figure 8 (Overview of the contact tracing process).

- Once a positive case has been identified or an individual is highlighted as a highly probable case of COVID-19, the CMT is notified as soon as feasibly possible.

- Upon notification a member of the CMT must interview individual in question to detail all close and casual contacts during the prior 48 hours (See Figure 9).

> **Contact tracing includes contact from 48 hours prior to symptom onset**
>
> **Close contact:**
>
> - Any person who has shared a space with for longer than 2 hours with a case.
>
> - Any person who has had face-to face contact with a case for a total of 15 minutes over the period of a day.
>
> - Any person who has not worn appropriate PPE or had a breach of PPE when dealing with a case.

Figure 9 (Expanded definitions of close and casual contacts within the jail setting)

- The key information to collect during a case interview include (See Appendix C for template contact tracing sheet):
    - Full name, Date of birth, and demographic information;
    - Health information including the following:
        - Symptoms (fever, cough, shortness of breath, diarrhea/GI, headache, muscle aches, chills, sore throat, vomiting, abdominal pain, nasal congestion, loss of smell, loss of taste, malaise, fatigue, other with description);
        - Date when symptoms began; and
        - Known close contact(s) in the preceding 48 hours.
    - Contact elicitation[68] to identify close contacts who might potentially have been exposed to the virus:

[68] "Contact elicitation" is a term of art. The "contact elicitation window" is the timeframe when the individual was infectious and not under isolation. *See,* https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/investigating-covid-19-

…Continued

- Determine start/end of contact elicitation window (previous 48 hours).

- Determine whom they have had close and casual contact with in the last 48 hours, and the dates and times of each contact they have had.

- A member of the CMT should also review any CCTV footage from within the jail which contains footage of the case during the preceding 48 hours. This process is used to identify any additional contacts the individual may have been in close or casual contact with.

(d) Other Resources

- To support the contact tracing and case identification program at CCJ, the jail should fully support the program from a population announcement and education perspective. Information leaflets about COVID-19 and contact management should be used, as well as posters on display around the jail (See Appendix D for template leaflets and posters).

- Scripts should be created that implement advice from the Cumberland County Department of Health for each step of the contact management process. At a minimum the following scripts will be required:

  - Initial case interview (See Appendix C);

  - Contact discussions (See Appendix E); and

  - Follow-up conversation following the results of the case COVID-19 test.

(e) Key Considerations for CCJ (adapted from the CDC)

- Since COVID-19 can be spread prior to symptoms occur, or when no symptoms are present, case investigation and contact tracing activities must be swift and thorough.

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case.html#:~:text=Building%20on%20that%20information%2C%20the,contacts%20should%20also%20be%20elicited.

- Despite it having been 18-months since the WHO declared the COVID-19 outbreak a pandemic, the complete clinical picture of COVID-19 is still not completely known. As more is understood of the disease, institutions such as CCJ may need to change practices based on the latest recommendations regarding testing priorities and the window period (when the patient was infectious and not under isolation) in which contacts should be elicited.

- Given the risk for contacted individuals to potentially be infected with SARS-CoV-2, CCJ should be sure to have clear guidance around staff safety during close encounters during the contact tracing/case investigation process.

- Particularly during large outbreaks, CCJ may need to prioritize case investigation and contact tracing based on areas such as the vulnerability of different populations.

- The engagement of the inmate population is required to allow for more effective case investigation and contact tracing within the jail.

- Due to the pressing nature of the COVID-19 pandemic and the potential risk to CCJ, the jail may need to hire and train extra staff to enable effective contact tracing and case investigation.

- CCJ might consider the use of digital contact tracing tools to help with case investigation and contact tracing activities.

- If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage. Under such conditions, CCJ should consider broad-based testing in order to identify infections and prevent further transmission.

- The CDC has developed a checklist to help guide institutions in developing a case investigation and contact tracing plan for COVID-19. We suggest CCJ to utilize this checklist in not only initially developing their contact tracing and case investigation plan, but also to regularly audit the program to highlight any areas where alterations may be needed.

4. Future Challenges of the Delta and Other Variants

The SARS-CoV-2 Delta (B.1.617.2) variant is now the most common viral variant in the United States and possess significant risks to inmates and staff at corrections institutions. The Delta variant causes an increased number of infections and is more contagious than early forms of SARS-CoV-2. There is some evidence to suggest that the Delta variant may cause more severe illness than prior variants - particularly in unvaccinated individuals. Vaccinated individuals may still catch SARS-CoV-2 - known as breakthrough infections - and can spread the virus to others. It should be noted however that vaccinated individuals appear to be contagious for a shorter period of time when compared to unvaccinated individuals.

Given what we know about the Delta variant, the effectiveness of vaccines against the variant, and the current uptake of vaccines within the incarcerated population, the "Swiss Cheese" approach we have discussed and highlighted throughout this document becomes all the more important. Layered prevention strategies, which includes mask use, social distancing, appropriate environmental protections (e.g., good ventilation), and others are important in preventing the introduction and subsequent transmission of the Delta variant within an institution such as CCJ.

The specific risks posed by the Delta variant when compared to the original SARS-CoV-2 strain (Alpha variant) do not differ,

however, given the increased transmissibility and disease severity the application and consistency of general COVID-19 protections are all the more necessary.

The final point to mention is the fact that the emergence of the Delta variant, and the associated risks it brings, the COVID-19 pandemic is yet to come to a conclusion, and CCJ should not see COVID-19 as a short term situation. Rather, CCJ must create policies and procedures that can be utilized over a long-term period. Already there is concern about a "Delta Plus" variant, and as the disease continues to mutate, there is strong reason to believe that we will be dealing with the challenges of COVID-19 well into the future.

D. Recommendations Relating to Inmate Services and Supervision

1. Current Status:

Two of the areas that the Court requested we examine were inmate access to recreation and the law library. Partly due to COVID-19 and mostly due to extreme staffing shortages, the inmates appear to not have received either during the pandemic, and to this day. On the many occasions that we have been at the facility on announced and unannounced inspections, the lights of the law library have been dark and the door closed. CCJ readily admits that it has not consistently provided recreation since the onset of the pandemic, and indeed, we CCJ admitted that there has been

no recreation since, at least, the Court's appointment of the Special Master.

These denials are in clear violation of the regulations that govern county correctional facilities. For instance, N.J.A.C. 10A:31-26.4 states that "Inmates ***shall*** be given the opportunity to participate in a minimum of one hour of physical exercise and recreation each day outside the living unit." (Emphasis added). Similarly, N.J.A.C. 10A:31-26.5 states that "Library services ***shall*** be made available to inmates daily, excluding weekends and holidays or during emergency incidents." (Emphasis added). It is worth emphasizing that besides a regulatory requirement, permitting inmates meaningful access to a law library is a constitutional right under the Fourteenth Amendment's Due Process Clause.[69]

CCJ's excuse for clear violations of New Jersey regulations is a critical staffing shortage. Indeed, we observed during inspections that there were critical posts unmanned, and the CCJ admitted that there were many occasions when a handful of correctional officers were responsible for supervising over 250 inmates. Particularly frustrating is the fact that the New Jersey Department of Corrections – the New Jersey State agency responsible

[69] *Bounds v. Smith*, 430 U.S. 817, 822 and 828 (1977) (Due Process may be satisfied "by providing prisoners with adequate law libraries or adequate assistance from persons trained in the law.").

for oversight of county correctional institutions[70] – appears to be indifferent to the crisis at CCJ. By way of example, inspectors from the N.J. Department of Corrections reviewed the facility on April 16, 19, 20, 21 and 22, 2021.[71] There were present at the facility for ***five days during a highly publicized trial in which the deficiencies of CCJ were brought to light***. Rather than inspecting the current conditions and problems at CCJ in 2021 – which were readily apparent – ***the inspectors evaluated and focused CCJ's performance in 2019***, two years prior![72]

The inspectors found minor non-compliance issues, but access recreation and the law library were not among them. Despite the fact that inmates had not received recreation time in over a year, the inspectors from the New Jersey Department of Corrections found CCJ in full compliance with providing inmates "the opportunity to participate in a minimum of one hour of physical exercise and recreation each day outside the living unit."[73] Similarly, while it was clear during our inspections that inmates did not have access to the law library, the inspectors found that CCJ was in full compliance of providing "access to the Inmate Law Library on

[70] N.J.S.A. 30:1B-10.
[71] Document Response to Special Master, at 001120 (May 6, 2021 Letter from N.J. Department of Corrections).
[72] Document Response to Special Master, at 001121-001262.
[73] *Id.*, at 001255.

a schedule which permits as many inmates as possible to use the library. . . ."[74]

The Court repeatedly inquired whether CCJ could obtain some assistance and relief from the New Jersey Department of Corrections. To this end, and at the Court's specific instruction, we contacted the New Jersey Governor's Office, which arranged for a September 16, 2021 video conference involving the Governor's Counsel's Office, the Commissioner and staff of the New Jersey Department of Corrections, counsel to Cumberland County, and the Special Master. During this meeting, the New Jersey Department of Corrections made several recommendations to alleviate the severe staffing shortage, but these were limited suggestions like shifting the work-schedule from 12-hour shifts to 8-hour shifts (which we recommend), recruiting officers from neighboring county facilities, and re-hiring retired officers. Although these are worthy of consideration, there was no offer of manpower assistance, as the Department of Corrections appears to be suffering from a similar workforce deficiency.

Most striking, however, was the apparent abdication of oversight responsibility of CCJ by the New Jersey Department of Corrections. When it was noted that the 2021 inspection focused on the conditions in 2019 rather than addressing the clear lapses

[74] *Id.*, at 001209.

currently existing at CCJ, there was no response. When it was noted that the Department of Corrections had a procedure by which it could order CCJ to not accept new inmates given its inability to operate in compliance with the regulations,[75] the reply was that the issue would be researched and a response was forthcoming. Since that September 16, 2021 meeting, there has been no response.

If not to comply with the law, access to recreation and a law library are necessary for the physical and mental health of the inmates. If CCJ cannot provide sufficient supervision to accomplish these required offerings, then it should reduce its inmate population to a point where CCJ can come into compliance with the law. This recommendation comports with another recommendation contained within the "Social Distancing" section whereby it was recommended that CCJ consider transferring inmates housed in the dormitories and the maximum security blocks where social distancing is virtually impossible.

2. Recommendations:

- CCJ must immediately provide Inmates the opportunity to participate in a minimum of one hour of physical exercise and recreation each day outside the living unit.
- CCJ must immediately make Library services available to inmates daily, excluding weekends and holidays or during emergency incidents.

- If CCJ cannot provide these required opportunities to inmates due to staffing shortages, then CCJ must reduce the inmate population to such a degree that there is adequate staff to immediately provide them.

[75] N.J.S.A. 30:8-57; N.J.S.A. 30:1-16.

E. Discussion: Ability to Execute

We question whether the critical paths outlined and recommendations made herein can be achieved or if they are beyond the capabilities of the current leadership. As such, we believe a stage gated process improvement plan should be followed, starting with critical items and tactical fixes that can demonstrate the team's ability and interest in addressing a broader, more involved, improvement plan. The Special Master team remains available to the Court and the parties to prioritize recommendations and work with CCJ in implementation.

CONCLUSION

This has been a very long and complex assignment where the circumstances, and the scope of the Court's charge, constantly changed. We believe that, with the right leadership, CCJ can make the necessary changes to make the conditions better at the Jail for all who work and reside there. We thank the Court and the parties for their trust, confidence, and assistance.

Respectfully submitted,

PORZIO, BROMBERG & NEWMAN, P.C.

Dated: October 26, 2021 By: 

WILLIAM J. HUGHES, JR.
Special Master

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

RAYMOND LAMAR BROWN, JOHN CLARK, DESMOND ROGERS, TODD FORD, JR., AND CARLOS SOLER, individually and on behalf of others similarly situated,	:	Hon. Noel L. Hillman
Plaintiffs	:	Case No. 1:20-cv-7907-NLH-KMW
v.	:	
CHARLES, WARREN, in his Official capacity as Warden, Cumberland County Dep't. of Corrections and CUMBERLAND COUNTY NEW JERSEY,	:	
Defendants.	:	

APPENDIX TO THE THIRD INITIAL REPORT AND RECOMMENDATION OF THE SPECIAL MASTER

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APPENDIX A

FULL LIST OF RECOMMENDATIONS

RECOMMENDATIONS

B. The Proposed Closing of the Jail, The Injunction and its Impact on the Implementation of Effective Policies and Procedures.

- Any COVID-19 policy or procedure that is developed and implemented be done so in a collaborative manner. This means having regular, structured meetings – with minutes – with the constituent groups that are required to implement the COVID-19 policies. These groups would then be required to communicate to their respective groups, e.g. PBA members or CFG personnel, what their responsibilities are in addition to any other methods of communication from CCJ's administration.

C. Recommendations Relating to Health, Prevention and Management

3. Detailed Findings

a. Operational Policies: Reporting Structure and Accountability

i. Health Services Administrator ("HSA")

- CCJ should recruit an HSA focused solely on, and accountable solely for, the administrative responsibilities of medical care;

- This position includes the responsibilities for documenting, maintaining, and communicating policies, procedures, and protocols. It should also include coordination between Custody and CFG, data sharing, and managing staff and services;

- Specific weekly time requirements should be determined by CFG and custody: a part-time (20hr/week) position may be reasonable, but CCJ should seriously consider a full-time position.

ii. Operational Policies: Record Keeping:

- All meetings between CCJ, CFG and the county health department must be documented, with meetings minutes circulated and signed off on by each attending party;

- The COVID Directive policy (policy number: 11.13) should be further developed to include all working areas that may be altered to mitigate the risk that COVID-19 presents to CCJ;

- The COVID Directive policy should be used to ground COVID-19 meetings between CCJ, CJF, and the County Health Department;

- Any specific policy items that may need to change based on new COVID-19 information should be altered within the master COVID Directive policy and the relevant changes circulated amongst CCJ staff via both emails and as a formal memo;

- Training should be organized and offered to staff, with additional training as policies, procedures, and protocols evolve;

- Training should be logged to ensure all staff acknowledges and understand their responsibilities in adhering to guidelines; and

- Policies, procedures, and protocols should cover all topics described below.

- CCJ should create a separate form for health visit requests and questions, which should be placed in the medical lock box in each unit. The forms should allow for carbon copies, of if not available, a copy of the request should be made and immediately returned to the inmate.

- Twice each day, these requests should be collected by a representative of the medical staff.

- Medical staff should note the "Action Taken" on each form after the inmate visits the health facility or the inmate's question is answered.

iii. Operational Policies: Mandated Quarantine Practices

- There has been discussion about the flexibility of the 5-day quarantine period, particularly to enable the creation of jail space in the event of a major outbreak.

As the mean incubation period of SARS-CoV-2 is ~5.5 days and the optimal testing time 1-day post-infection is 6 days, *our recommendation is that the 5-day quarantine period be increased to 6 days at a minimum*. However, given this deviation from the CDC's official guidance, we believe that CCJ should engage the Cumberland County Department of Health in navigating this decision given the unique circumstances the jail faces.

- Given the data published by the CDC and other groups on post-quarantine transmission risk, there is scope for close exposure quarantine inmates to have their quarantine duration reduced from 10 days to 7 days. However, we caution CCJ not to blindly introduce this time reduction due to the increased risk of transmission but advise them to create jail space in the event of a major outbreak. This could be considered as a tolerable risk to take for the safety of all inmates.

- The COVID Directive policy (policy number: 11.13) should include an area to discuss a hierarchy of quarantine practices that are to be followed based on conditions on the ground. For example, the use of single cells, double cells, and inmates mixed within the same pod is an important consideration that should be included in the policy. Per CDC guidance, CCJ could consider not requiring fully vaccinated inmates who do not display signs or symptoms of COVID-19 to quarantine following the intake process.

iv. Mental health and other issues relating to quarantining:

- CCJ should ensure that medical isolation is not seen as solitary confinement.

- CCJ should provide similar or increased access to items that would normally be available to inmates in their regular unit. For example increased access to TV, reading materials, telephone, and commissary.

- CCJ should also create an additional schedule to maintain more regular communication between officers and isolated individuals and finally, allow more regular visits from medical staff and mental health services to individuals who are in isolation.

v. Operational Policies: In-Person Visitation Procedures.

- CCJ should utilize the resources provided by the New Jersey Department of Corrections.

- CCJ should include a requirement in its COVID Directive policy to check the NJDOC guidelines prior to the regular COVID-19 meetings to determine whether there has been any update to NJDOC guidelines that require urgent implementation.

vi. Operational Policies: Staffing Assignments

- Between an absent director, an overstretched DON, and insufficiently staffing infirmary, medical staffing needs to be addressed as a critical issue. As COVID numbers have begun to rise again - as evidenced by the presence of positive cases as of September 1, 2021 - it is necessary to have adequate clinical resourcing and supervision to respond to increased medical needs. This includes:

  - Formal on-call coverage (not assigned to the DON) Additional RN during peak daytime hours; and

  - Dedicated medical director responsible for reviewing, approving and enforcing protocols Continued effort to fill currently vacant medical staffing roles.

vii. Custody Staffing Assignments:

- A more structured method of staffing assignments should be created to assign officers to units/pods in a more deliberate way.

- Assignments should be allocated to minimize cross-contamination based on vaccination status and risk.

- Only vaccinated officers/officers with antibodies should be assigned to quarantine/isolation units Officers with underlying conditions should be discouraged from taking posts in quarantine/isolation units.

- Officers should log their assignments if/when they are required to float between pods to facilitate contact tracing.

- CCJ should move to three 8-hour shifts rather than two 12-hour shifts.

b. Prevention Strategies: Infection Control Practices

i. Cleaning Supplies and Facilities

- If personnel cannot be staffed to clean common spaces, a cleaning company should be contracted to provide cleaning services weekly, or inmates should be placed on a regular cleaning schedule. This works in women's areas and can be applied to men's units as well with the use of a schedule/shift system.

- CCJ should consider replacing NABC with another disinfectant solution such as 3-M. Although NABC is an effective disinfectant, its use over time on porous surfaces will cause them to erode and decay.[1]

- Depending upon the capacity of the CCJ's HVAC units, all filtration should be replaced with HEPA filters. The COVID-19 virus average size is 0.125 microns, which is within the filtration specs of a HEPA filter.[2] [3]

- CCJ should maintain a fixed replacement schedule for the HEPA air filters.

- CCJ should keep testing air quality quarterly.

ii. Prevention Strategies: Health Education

- CCJ should include a video (in the appropriate languages) during intake from an official source to provide credible and complete education to inmates. Additionally, one-on-

[1] https://www.3m.com/3M/en_US/commercial-cleaning-us/safer-disinfectants-for-the-healthcare-environment/coronavirus-outbreak/
[2] https://www.researchgate.net/publication/226318339_Experimental_study_of_nanoparticle_penetration_through_commercial_filter_media
[3] https://www.epa.gov/coronavirus/air-cleaners-hvac-filters-and-coronavirus-covid-19

one vaccination education /consultations should also be made available following intake of new inmates to address:

- Specific questions and concerns (ie. allergies, preexisting medical conditions, etc.) Other important points, including:
  - Public/family/community responsibility;
  - Lower risk of serious illness while in jail;
  - Reduced risk of privileges being revoked if inmate contracts COVID-19; and,
  - Explanation of the incentives - if any - currently being provided in association with receiving a COVID-19 vaccination.

- CCJ should maintain an adequate inventory of vaccinations on hand to allow for immediate administration once an inmate consents.
- CCJ can explore the option of introducing an incentive for inmates who choose to accept the vaccination against COVID-19. For example, the allocation of $10 concession credit.
- High quality and easily understandable health education materials on vaccination and testing should be available for all inmates throughout the jail.
- Health education documents should be distributed amongst the CCJ staff with a record of receipt made.
- CCJ should explore the option of introducing an incentive for corrections officers who choose to accept vaccination against COVID-19.[4]
- CCJ should provide up-to-date information about COVID-19 to inmates on a regular basis. Focus should be on

[4] New Jersey DOC have added a number of incentives including 10 days off their sentence if they get 2 doses and $10 commissary credit after the first shot: https://www.nj.com/news/2021/09/prisoners-offered-incentives-including-time-off-their- sentence-to-get-covid-19-vaccine.html.

allowing the opportunities for questions. Inmates should be updated on:

- Symptoms of COVID-19 and its health risks;
- Reminders to report COVID-19 symptoms at the first sign of illness;
- Address concerns related to reporting symptoms (e.g., being sent to isolation), explain that symptoms should be reported immediately to protect all inmates and staff, and reiterate the differences between medical isolation and solitary confinement; and
- Reminders to wear masks at all times.

iii. Prevention Strategies: Diagnostic Testing

CCJ currently utilizes antigen tests to test its inmate population. We recommend that CCJ move to using PCR tests given their increased sensitivity at detecting COVID-19 disease, particularly in asymptomatic individuals. We are conscious that cost, availability and turn-around times of PCR tests can be challenging and emphasize that the use of PCR testing for individuals at the end of their intake quarantine period should be prioritized to reduce the risk of introduction of COVID-19 into the general population. Inmates who are fully vaccinated should still be tested for SARS-CoV-2 following exposure to suspected or confirmed COVID-19 or if they develop any signs or symptoms of COVID-19. In the alternative, serial rapid tests – that is rapid tests conducted on consecutive days, should be considered.

(a) Recommended Process:

Intake testing: Day 1:

- Antibody test to identify who has been exposed/vaccinated Antigen testing to identify active infection.

Day 5

- PCR test at day 5 to validate all inmates entering are COVID free (including asymptomatic).

Baseline testing

- Full inmate and officer snapshot (during the winter, flu testing should be bundled with COVID test - ideally 3-plex test).
    - Round 1: Antibody test to identify who has been exposed/vaccinated (repeat every 1-2 months) - this should include inmates and officers.
    - Round 2: If no antibodies, PCR test to confirm active presence of infection.
    - Alternative to PCR test - CCJ can use a serial testing approach to reduce costs. Serial testing means an antigen test is administered at day 1 and a second is administered 24-48 hours later. Two negative tests clear the patient from COVID- 19.
    - Confirmed exposure: Testing following a confirmed positive, and contact tracing protocol should be done by PCR - at 5-7 days post confirmed exposure (quarantine in d-pod in a single cell until testing).
    - Officers should be tested weekly on-site.

(b) Problems with inmates refusing to test because of the fear of being quarantined

- Provide education to inmates around quarantine timeline and procedure.

- Offer inmates in quarantine/isolation special privileges such as commissary credits to minimize hesitation towards to testing.

iv. Prevention Strategies: Symptom & Exposure Screening

- Prior to each shift, CCJ is encouraged to conduct daily health checks, such as temperature screenings, visual symptom checking, self-assessment checklists, and/or health questionnaires, consistent with CDC guidance.

- Staff and visitors should be prohibited from entering the jail if they display a fever. The U.S. Centers for Disease Control and Prevention (CDC) lists fever as one criterion for screening for COVID-19 and considers a person to have a fever if their temperature registers 100.4 or higher -- meaning it would be almost 2 degrees above what's considered an average "normal" temperature of 98.6 degrees.

- Enact a verbal symptom and exposure screening questionnaire. These questionnaires are widely available and provided on the CDC's website.[5] The questions include:

  - *Today or in the past 24 hours, have you had any of the following symptoms: Fever, felt feverish, or had chills, Cough?*

  - *Have you experienced 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)?*[6]

- CCJ should provide a mechanism for self-monitoring and reporting symptoms if they occur during a shift and have a plan in place to deal with one or more officers displaying COVID-19 like symptoms.

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

v. Prevention Strategies: Mask Use

(2) Recommendation(s) - CCJ Staff:

- All staff should be required to wear at least a 3-ply surgical masks whilst physically present at CCJ and provided replacements at regular intervals.

- Given the rise of breakthrough infections in vaccinated individuals, our recommendation is that CCJ staff who are fully vaccinated (second dose of an mRNA vaccine more than 14 days ago) continue to wear masks throughout the facility.

- It is our recommendation that officers who operate within high-risk COVID-19 areas (isolation and quarantine areas) should wear N95/KN95 masks that are appropriately fit tested for the mask they will be wearing.

- There should be regular spot checks to confirm correct use of masks throughout the facility.

(4) Recommendation(s) - Inmates:

- All inmates should continue to be provided with 3-ply surgical masks and given replacements at regular intervals.

- Due to the rise of breakthrough infections in vaccinated individuals, our recommendation is that inmates who are fully vaccinated (14 days after the second dose of an mRNA vaccine or first dose of a single-dose vaccine) continue to wear masks throughout the facility.

- There should be regular spot checks to confirm the wearing of and correct use of masks.

vi. Prevention Strategies: Social Distancing and People Flow

- The floor plan and inmate flow throughout CCJ should be reexamined with all areas where inmates congregate having social distancing markers added.

- Bench outside of the medical facility should have markers on the floor to indicate 6 ft. of social distancing.

- CCJ staff and inmates should be educated on the importance of social distancing at reducing the risk of viral spread throughout the jail.

- The size of group activities and congregations should be limited in the number of individuals.

- Arrange inmates to sleep head to foot within the dorm and cell bunkbeds to increase the distance between their faces.

- If Cumberland County decides to proceed with closing CCJ, then inmates housed in the dormitory and the maximum security block areas should be prioritized for immediate transfer.

vii. Prevention Strategies: Vaccination

- During the intake process, the medical team should emphasize COVID-19 vaccination information and administration. Inmates should be offered J&J as a single dose, or Moderna, as the most effective against the Delta variant. It should be noted that the storage and handling limitations of both the Moderna and the Pfizer vaccines.

- The medical team should emphasize the provision of vaccination and COVID-19 related medical advice across the inmate population.

- The medical team should educate and engage the corrections staff in COVID-19 health information and help turn them into partners in educating the inmate population.

- Effective supporting materials should be present at intake medicals and arrestees should be given as much detail as is appropriate for them to make an informed decision about receiving a COVID-19 vaccine.

viii. Prevention Strategies: Booster Shots

- Given the nature of the corrections institution setting, it would be advisable for CCJ to liaise closely with the Cumberland County Department of Health specifically

around the allocation of booster shots now that their use has been authorized.

- Because corrections officers and staff have both an institutional and occupational setting that routinely expose them to COVID-19, CCJ should strongly encourage, if not require, all corrections officers and staff to obtain booster shots.

- CCJ should settle on a system for notifying medical staff of inmates due for a booster shot enabling administration as soon as possible.

- There should be an education program created to teach inmates and staff the reasons for booster shots and how/why they work.

- If applicable, during the intake medical exam, new inmates that have previously been vaccinated arriving at the jail should be given the opportunity to receive a booster shot.

b. Management Strategies

i. Management Strategies: Isolation and Quarantine Practices (Current Inmates)

- In the event of an individual having a known exposure to a COVID-19 positive individual, the required quarantine period should be at least 5 days from the time of exposure after which a PCR test should be performed. The same is true for other individuals in the unit.

- CCJ should include within its COVID-19 Directive policy a section regarding communication pathways and individuals to involve in the event of a COVID-19 outbreak within the jail. Roles and responsibilities should be detailed with a clear chain of command and accountability.

- CCJ could, if necessary based on urgency, follow the latest CDC guidance that states that fully vaccinated inmates who do not display signs or symptoms of COVID-19 are not required to quarantine following exposure to suspected or confirmed COVID-19.

ii. Procedures for Inmates Testing Positive

- Informing the inmate as soon as feasibly possible that they have tested positive for COVID-19.
- Informing the unit officer as soon as feasibly possible that they have an inmate who has tested positive for COVID-19.
- A mask if not already being worn by the inmate should be provided and properly worn covering both their nose and the mouth.
- The inmate should be segregated as soon as possible from general population, even whilst awaiting transfer to the CCJ isolation area.
- The inmate should be given a confirmatory PCR test.
- The inmate should be transferred to the CCJ isolation area as soon as feasibly possible and medically evaluated within the isolation area (reducing movement within the facility).
- The inmate should have a red wrist band provided by the CCJ medical team with the expectation that it will be worn until the end of their isolation period.
- The isolation period for inmates positive for COVID-19 should be in line with current CDC guidance, which as of September 15, 2021 is to isolate for 10 days after the onset of symptoms or a positive COVID-19 test result.

iii. Management Strategies: Case Investigation and Contact Tracing

(a) Contact Management Team (CMT)

- CCJ should create a Contact Management Team (CMT) that consists of at least two individuals. The purpose of this team is to oversee and manage the contact tracing and case investigation processes at the jail. In the event of a major COVID-19 outbreak, CCJ should have staff available who have been trained in COVID-19 contact management to increase the team size and thus provide increased bandwidth.

- CMT team members will need to develop the expertise required to investigate movements of inmates and staff throughout the jail, and thus highlight any potential contacts of positive COVID-19 cases. Contact Management Team members (including the individual ultimately responsible for the team) should therefore at a minimum meet the following criteria:

  o Have experience using the CCTV system within the jail.

  o Be comfortable using IT systems, including the use of Microsoft Word and Microsoft Excel.

  o CCJ should as soon as feasibly possible name a person within the jail who's responsibility it is to oversee the Contact Management Team (CMT).

(b) Training

- CMT members should all receive training on the principles of contact management ***prior*** to engagement in contact management activities.

- The CDC in association with the Association of State and Territorial Health Officials (ASTHO) have developed an introductory online course for entry-level COVID-19 case investigators and contact tracers, and Johns Hopkins has a well-regarded COVID-19 Contact Tracing course freely available. CCJ might consider these training modules (or appropriate alternatives) to help CMT members learn and understand the principles of effective contact management.

- The Cumberland County Department of Health (CC DoH) should also be engaged by CCJ in educating CMT members in the art of contact management. The CC DoH has much experience in contact management given its role in overseeing these activities within the general public.

- Any contact management training should at a minimum cover the following:

  o An overview of COVID-19 disease and the modes of transmission of the SARS-CoV-2 virus.

- o A thorough description of the contact tracing and contact investigation processes.

- o An introduction to the interview scripts/questions required as part of contact management.

(c) Contact Tracing Process

- Once a positive case has been identified or an individual is highlighted as a highly probable case of COVID-19, the CMT is notified as soon as feasibly possible.

- Upon notification a member of the CMT must interview individual in question to detail all close and casual contacts during the prior 48 hours (See Figure 9).

- Once a positive case has been identified or an individual is highlighted as a highly probable case of COVID-19, the CMT is notified as soon as feasibly possible.

- Upon notification a member of the CMT must interview individual in question to detail all close and casual contacts during the prior 48 hours (See Figure 9).

(c) Other Resources

- To support the contact tracing and case identification program at CCJ, the jail should fully support the program from a population announcement and education perspective. Information leaflets about COVID-19 and contact management should be used, as well as posters on display around the jail (See Appendix D for template leaflets and posters).

- Scripts should be created that implement advice from the Cumberland County Department of Health for each step of the contact management process. At a minimum the following scripts will be required:

  - o Initial case interview (See Appendix C);

  - o Contact discussions (See Appendix E); and

  - o Follow-up conversation following the results of the case COVID-19 test.

(d) Key Considerations for CCJ (adapted from the CDC)

- Since COVID-19 can be spread prior to symptoms occur, or when no symptoms are present, case investigation and contact tracing activities must be swift and thorough.

- Despite it having been 18-months since the WHO declared the COVID-19 outbreak a pandemic, the complete clinical picture of COVID-19 is still not completely known. As more is understood of the disease, institutions such as CCJ may need to change practices based on the latest recommendations regarding testing priorities and the window period (when the patient was infectious and not under isolation) in which contacts should be elicited.

- Given the risk for contacted individuals to potentially be infected with SARS-CoV-2, CCJ should be sure to have clear guidance around staff safety during close encounters during the contact tracing/case investigation process.

- Particularly during large outbreaks, CCJ may need to prioritize case investigation and contact tracing based on areas such as the vulnerability of different populations.

- The engagement of the inmate population is required to allow for more effective case investigation and contact tracing within the jail.

- Due to the pressing nature of the COVID-19 pandemic and the potential risk to CCJ, the jail may need to hire and train extra staff to enable effective contact tracing and case investigation.

- CCJ might consider the use of digital contact tracing tools to help with case investigation and contact tracing activities.

- If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage. Under such conditions, CCJ should consider broad-based testing in order to identify infections and prevent further transmission.

- The CDC has developed a checklist to help guide institutions in developing a case investigation and contact tracing plan for COVID-19. We suggest CCJ to utilize this checklist in not only initially developing their contact tracing and case investigation plan, but also to regularly audit the program to highlight any areas where alterations may be needed.

D. Recommendations Relating to Inmate Services and Supervision

- CCJ must immediately provide Inmates the opportunity to participate in a minimum of one hour of physical exercise and recreation each day outside the living unit.

- CCJ must immediately make Library services available to inmates daily, excluding weekends and holidays or during emergency incidents.

- If CCJ cannot provide these required opportunities to inmates due to staffing shortages, then CCJ must reduce the inmate population to such a degree that there is adequate staff to immediately provide them.

APPENDIX B

JULY 13, 2021 REPORT ON CUMBERLAND COUNTY JAIL NJ HEALTH CARE SYSTEM, RICHARD F CLARKE MD CCHP-P.

REVIEW OF CUMBERLAND COUNTY JAIL NJ

HEALTH CARE SYSTEM

RICHARD F CLARKE MD CCHP-P

CONDUCTED JUNE 2021

REPORT SUBMITTED JULY 13, 2021

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INTRODUCTION and OVERVIEW B-1

Pursuant to contract agreement between The County of Cumberland (NJ) and Richard F. Clarke MD, CCHP-P an initial correctional health care consultation reviewing the health care system at Cumberland County Jail in Bridgeton NJ, was conducted both off site and onsite during September 2020.

Planned follow up consultations were postponed pending Cumberland County addressing issues on a tighter time frame for the DOJ and Cumberland County administration continuing to process its ongoing plans to convert the Cumberland County Jail to a Reception, Transportation, and Release Center. The final implementation of this program has been delayed as various legal issues and roadblocks are addressed and resolved.

It was recommended the consultation by this reviewer of the Cumberland County Jail heath care system be recommenced in spring 2021. The consultation was rescheduled and included onsite assessment on June 01-03, 2021 and offsite chart reviews through June 2021.

This review builds off of the September 2020 consultation report and utilizes the same format intentionally to maintain consistency in reporting on the health care jail system over time.

Additionally, this review specifically emphasizes the effects on the Cumberland County Jail health care system, especially regarding staffing, caused by the current inability to ascertain a definitive time schedule to transition the Jail to a Reception, Transportation, and Release Center.

This review again encompassed aspects of health care provided at Cumberland County Jail in all areas, including nursing, medical, mental health, dental, and preventative health care.

Particular emphasis was placed on staffing issues during this survey.

This consultation consisted of:

1. Three (3) days on site conducting multiple interviews with onsite health staff, CFG regional staff, custody, jail administration, and county administration, reviewing multiple administrative health care records, touring the health care clinic and suicide watch unit B, analyzing suicide prevention policies for both custody and health staff, reviewing suicide monitoring logs and training records with the Custody Training Officer, conducting an extensive review of mental health care with county administration, jail Warden, Regional CFG Director, and Acting Mental Health Director, and conducting a final interview with Warden Warren and Attorney Carr on the long term health care implications of understaffing (custody and health staff) at Cumberland County Jail.
2. Fifteen (15) in depth patient chart reviews completed off site following the onsite visit.
3. Offsite interview with HSA prior to onsite visit reviewing health care procedures.

All encounters included active discussion identifying positive procedures to be continued and recommendations for improving on procedures and areas of health care needing corrective action or ongoing studies.

Interviews and discussions were conducted with county administration staff, jail administration staff, CFG regional staff, health staff for all areas of health care, custody officers, and inmates addressing all areas of health care.

This included:

Warden Charles Warren

Captain Joynes (Operations Director)

Administrative Asst. Ms. Renee Whilden

Attorney John Carr

County Administrator Kim Wood

Assistant County Administrator Jody Hirata

CFG Director Ms. Denise Rahaman

DON and Acting HSA Evelyn Olson RN

Day Nurse Brenda Granato LPN

Day Nurse Nina Johnson LPN

Day Nurse Darlene Cochran

Medical NP Ms. April Munson

Acting MH Director and CFG MH Director Dr. Dennis Sandrock

Psychiatrist Dr. Rudge (phone)

Psychiatry NP "Mac" Henry (phone)

Psychiatry NP Diane DeBlanc (phone)

Dentist Dr. Hughes (phone)

Contract phlebotomist

Training Custody Officer Shane Zanes

Four custody officers (1 health clinic, 1 escort, 2 on suicide monitoring)

Five inmates (4 male, 1 female)

Warden Warren stated Cumberland County Jail now has a capacity of 300 inmates. The ADP at the time of the onsite survey was 274 (ADP September 2020 was 277).

This consultation evaluated present health care management and performance at the current site. Assessments and recommendations are based on present operating circumstances.

CFG is still the onsite health care vendor responsible for staffing and medication services. Offsite medical services are provided directly by Cumberland County through AmeriHealth Insurance Company. Laboratory services and MAT counseling are separately contracted for by the County.

COR remains the current EMR health record.

Although not accredited by NCCHC, the CFG health care staff model their health care system to be in compliance with NCCHC accreditation standards. This consultation again applied these standards as a minimum for maintaining an effective correctional health care system.

Maintaining continuity of care is the baseline goal for all health care areas (medical, mental health, dental, nursing). Continuity of care is defined as providing care for each active health care issue that is timely, properly evaluated, appropriately managed diagnostically and therapeutically, and continued until that health care issue is resolved or patient is discharged from care.

Individual components of the health care system are evaluated in the following sections of this report. The components are maintained from the September 2020 report to facilitate uniformity in assessment. Recommendations are identified in each relevant area and collated in a summary section.

ACCESS TO CARE C-1

The Cumberland County Jail health care system does not structurally restrict access to care.

However, maintaining access to care is currently compromised by staffing reductions, especially in nursing and custody staff.

1. Processes are in place from intake through discharge to maintain appropriate clinical care. As noted above, however, maintaining those processes is variable due to decreased staffing.
2. Utilization reviews are routinely completed within 24-48 hours, and no decline of treatment has occurred recently.
3. Medications both at intake and during patient's incarceration are provided as ordered.
4. Consults in all specialties and medical hospital care are accessible.
5. Offsite MH inpatient care is very difficult to obtain for administrative and logistical reasons that require county administration input to further address.
6. Ambulance service is timely.
7. Copays of variable amounts are required for sick call and medications. Dental services incur another copay.
   Nursing staff documented charges are only supposed to apply to a first provider (including dental) sick call for the same problem.
   Nursing interview also documented provider has to initiate charges at each visit or no copay is charged.
   Nursing interview also documents no copay is charged for MH medications; all other medications incur a copay charge.
   Inmate interview documents payment for sick call follow up visits is variable.
   Inmate interview also documents inmates share creams and OTC meds to avoid charges.

DISCUSSION/RECOMMENDATION 1 (ACCESS TO CARE/COPAY)

One component of the copay policy is a $5.00 charge for all prescription medications, including a $5.00 charge every 90 days for chronic care prescription medications. The cost to the patient of ongoing multiple medications is significantly more than a single prescription ordered for an acute condition, thereby increasing the possibility those long term medications might be refused due to the cost of the medications. Any such refusals imply health care could be compromised due to imposed costs. Though such refusals were not evident on this review, it is recommended that chronic care be monitored for patient refusals of recommended medications due to cost. If significant numbers of these refusals are identified, consideration should be given to terminating the chronic care medication copay. Providers and nurses should be instructed in documenting these refusals, obtaining appropriately completed refusal forms, and notifying HSA of the refusals.

8. Lab and diagnostic testing and follow up is not structured.
   There is no tracking if tests are done. (e.g., Chart review documented ordered ultrasound not done).
   Lab and diagnostic reports are left in an open file for providers to access. Providers may be signing off on other providers tests with no direct cross communication between providers. This unstructured process was documented on clinic tour.

NOTE: Consult reports are also dropped into this open file for ad hoc review by the next provider.
Chart documentation was sparse to absent regarding provider interventions for abnormal labs. (e.g., a signature on a positive RPR with a note only on the lab report ordering Bicillin. No chart note entered).

9. Inmate access to lab results is often not documented. No process for notifying patients of normal results is in place. Notification of abnormal results is variable.
Inmate interviews confirm they are not receiving lab results in any structured fashion.

DISCUSSION/RECOMMENDATION 2 (ACCESS TO CARE/LAB AND DIAGNOSTIC TESTING PROCESS)
This is one of the few areas in the health care system where a structured process is absent.
All ordered testing should be tracked for completion.
Reports (lab, diagnostic, and consult) should go to ordering provider through a structured process.
Interventions should be documented in an appropriate chart note.
Lab and diagnostic results should be reported in some form (written notification and/or patient visit) to each patient for each test.
Chronic care forms have a default notification that patient will be called back for abnormal lab results. This procedure can result in an abnormal lab result being missed but the patient believing results were normal because he/she was not called back.

10. Backlogs
    a. Medical reported no backlogs as of June 01, 2021. However, provider and inmate interviews document that timeliness of medical visits was variable prior to May 2021
    b. Mental health reports no backlogs.
    c. Dental reported backlogs in annual cleanings and recent backlogs in treatments due to equipment malfunction which was being addressed.
    d. MAT monthly visits for initial evaluations and monthly counseling were reported backlogged. Cumberland is presently engaged with outside treatment centers to come onsite (post Covid) for MAT counseling.
11. Instances of access to care being restricted specifically because of reduced staffing include:
    a. Staff interviews confirm that intake can be delayed when new inmates have to be brought by custody into the jail before receiving a full health intake screening in booking. Inmates are in population without active health issues being identified or staff available to transport inmates to medical for intake screenings.
    b. Custody interviews confirm that custody staff levels cannot support three level one suicide watches.
    c. Chart reviews document numerous provider health assessments not completed within 14 days.
    d. Interviews document staff nurses working untenable hours (65 hour weeks, routinely onsite six (6) days a week.

e. The DON is also the acting HSA and working as the fourth day nurse. Responsibilities are keeping her on site a similarly untenable 80 hours a week.
f. Per acting MH director, groups are unsafe without availability of custody officers.
g. MH staff interview noted MH sick calls being more frequently delayed in recent months.
h. Another MH staff interview described a "helter-skelter" feel to provision of care due to thinner staffing (both custody and nursing) as well as present staff being "spread too thin".
i. Medical provider interview documented sick call clinic has been understaffed at times with no nurse present in the clinic with the provider.
j. Dentist documented less efficient dental operations in 2021 due to both custody and nursing staff shortage.
k. Warden Warren interview documents drop in custody staffing from 32 to 10 on day shift, and from 24 to less than 10 on nights. As a consequence, intake is unstaffed until new inmates arrive which requires moving a custody officer from his or her post. Similarly, custody officers are now sometimes covering two (2) posts rather than one (1). Also, staff interviews document "No movement" restrictions are increasing, particularly on weekends.

DISCUSSION/RECOMMENDATION 3- (ACCESS TO CARE/ STAFFING) PRIORITY

Addressing reduced staffing for both custody and health care requires engagement of all County components (administration, custody, health care vendor) because of issues outside the health care system effecting hiring in all areas. The need for this larger engagement was addressed with Warden Charles Warren and Attorney Carr as the main topic of the exit interview. Multiple areas already being addressed at the county administrative level were discussed. Resolving the legal issues that are presently delaying implementation of long range plans is required to stabilize hiring and retention.

As discussed under "STAFFING" section there are many factors contributing to the staffing shortage. However, if all other factors were corrected, the staffing shortage cannot be corrected while the job insecurity created by the present inability to implement future plans for Cumberland County Jail definitively persists.

HEALTH CARE MANAGEMENT

D-1

Health care provided by CFG continues to be based on NCCHC standards for correctional health care administration. This NCCHC model identifies a HSA (Health Services Administrator) who oversees all aspects of the health care system for Cumberland County. The model also identifies a Medical Director (responsible MD) who oversees maintenance of appropriate clinical care.

At Cumberland County Jail, nursing care is managed day to day by a Director of Nursing (DON); provider care for all health areas (medical, mental health and dental) is overseen by the Medical Director (who also directly manages medical care) and is assisted in other direct care by a Mental Health Director and a contracted dentist; and custody liaison with health care is primarily done in the jail by Captain Joynes and administratively with acting HSA Olson by Warden Warren.

This structure is designed so problems identified by front line health staff and custody can be addressed through a chain of leadership to the appropriate level for assessing the issue, developing corrective actions, and implementing these actions until issues are corrected.

Nursing is on site 24/7 and provides the basis for all healthcare on site, coordinating all aspects of health care with providers either directly on site or on call.

1. HSA

   Evelyn Olson is the current acting HSA since April 2021. Her health care background is in nursing, particularly emergency nursing. HSA responsibilities include oversight of all health care meetings (health staff, medical/custody (MAC), and the continuous quality improvement (CQI)) program for addressing health care issues of concern. She is responsible for maintaining credentials and peer review logs for all health staff.

   Ms. Olson is also the Director of Nursing (her primary position). Because of nursing staff shortage, she is also required to perform clinical staff nurse responsibilities. These multiple roles assure her engagement with all staff routinely in the health clinic. She maintains 24 hour availability and frequently covers nursing duties.

   These multiple roles have resulted in Ms. Olson's presence onsite up to 80 hours a week encumbered with the duties of up to three health care positions.

   Ms. Olson's dedication, enthusiasm, and strong clinical skills in nursing were evidenced throughout my onsite visit and in preparatory conversations.

   As noted below, her enormous workload has also resulted in gaps in administrative functions being competed.

2. Medical Director

   There is currently no onsite medical director. Dr. Neal, who is the CFG Medical Director is the current Acting Medical Director. He is onsite only one day a week. On call all other times, he also has ongoing regional responsibilities for other CFG sites.

   Medical Director administrative responsibilities include:

   Review of site health care policies and procedures.

Attending MAC (medical/custody) and CQI (continuous quality improvement) meetings,
Participation in any mortality reviews.
Auditing nurse practitioner medical care.
Maintaining oversight of clinical care for all areas (medical, mental health, and dental), primarily through his attendance at the MAC/CQI meetings.

Dr. Neal also has direct patient care responsibilities.

Dr. Neal, as noted, has only limited onsite presence. The majority of that time is spent doing primary patient care. This precludes regular onsite involvement in onsite administrative duties, particularly health care meetings and CQI.

3. Director of Nursing (DON)
As noted above, Evelyn Olson is the full time DON in addition to multiple other health care assignments. Due to staffing shortage Ms. Olson's oversight of the nursing department is very hands on. She is often working directly with her nursing staff. She often trouble shoots to resolve more complicated and/or urgent clinical cases. Her current overloaded schedule does result in her working directly with all three shifts. Ms. Olson's clinical skills during an emergency were in evidence during the onsite survey.

4. Mental Health Director
Mental health has now incorporated a Mental Health Director into the mental health staffing. The current acting MH Director is Dr. Sandrock who is also the Director of Mental Health for all CFG. As acting MH Director, he maintains an active clinical practice, including monitoring suicide watches when on site. He is available for care of acute cases via telemetry. He oversees the clinical practice of the 2 psychiatric NPs. He also has completed a training session in suicide prevention for the entire custody staff. During this survey Dr. Sandrock was directly involved in extensive review of MH policy and procedures with administration.

5. Dental Care
Dental care is overseen by Dr. Hughes who is onsite one day a week for 8 hours. He has a dental assistant. Both extractions and restorations are available, although prioritization of cases results in a preponderance of extractions. However, Dr. Hughes is resigning in June and dental care will then be provided by per diem dentists.

6. Custody "liaison"
Although not a formalized position, custody liaison is accomplished by the Warden and acting HSA addressing administrative issues effecting custody and health care, and Captain Joynes coordinating health care/custody issues (e.g., overseeing suicide watches) within the jail. Onsite tour with Captain Joynes demonstrated his engagement with this function.

STAFFING E-1

1.	HEALTH STAFF ADMINISTRATOR	FULL TIME POSITION OPEN DON is also ACTING HSA
2.	DIRECTOR OF NURSING	FULL TIME
3.	MEDICAL DIRECTOR	POSITION OPEN REGIONAL MED DIRECTOR is ACTING MEDICAL DIRECTOR – ON SITE ONE DAY/WEEK
4.	MEDICAL NURSE PRACITIONERS (2)	20 HOURS/WEEK (2 NP'S EACH 10 HOURS/WEEK)
5.	MENTAL HEALTH DIRECTOR	OPEN POSITION 20 HOURS/WEEK REGIONAL MH DIRECTOR is ACTING MH DIRECTOR ONSITE AT LEAST WEEKLY/TELEMETRY PRN
6.	PSYCHIATRIST (2)	10 HOURS/WEEK (5 HOURS EACH)
7.	PSYCHIATRY NP'S (2)	15 HOURS/WEEK TOTAL
8.	MH CLINICIANS	NO LICENSED MH CLINICIANS HIRING A BACHELOR LEVEL SOCIAL WORKER FOR "TALK TREATMENT" 20 HOURS/WEEK
9.	DENTIST	08 HOURS/WEEK (ONE DAY) DENTAL CARE CONVERTING TO PER DIEM BY END OF JUNE
10.	NURSING	
	a. DAY SHIFT (ALL 7 DAYS)	4 FULL TIME NURSES (RN/LPN) ONE OPEN POSITION
	b. EVENING SHIFT (ALL 7 DAYS)	3 FULL TIME NURSES (RN/LPN) ALL POSITIONS OPEN
	c. NIGHT SHIFT (ALL 7 DAYS)	2 FULL TIME NURSES (RN/LPN)
11.	MEDICAL RECORDS	32 HOURS/WEEK

NURSING ASSIGNMENTS

DAYS	THREE NURSES FOR INTAKE, SICK CALL, MED PASS, SEG ROUNDS
	ONE INFECTIOUS DISEASE CONTROL NURSE WITH MULTIPLE DUTIES (including COVID TESTING, PPDs, NURSING BACK UP)

	NOTE: ONE LPN EVERY TUESDAY WORKS AS DENTAL ASSISTANT
EVENINGS	THREE NURSES FOR INTAKE, EMERGENCY SICK CALL, MED PASS
NIGHTS	TWO NURSES FOR INTAKE, EMERGENCY SICK CALL, TRIAGING, FAXING ORDERS, PREPPING FOR LABS
	NOTE: 2 NURSES OVERSEE MAT TREATMENTS

ONSITE PRESENCE (PHYSICAL or VIRTUAL)

MEDICAL	4 OUT OF 5 DAYS ONSITE
MENTAL HEALTH	5 MH PROFESSIONALS AVAILABLE ONSITE OR VIRTUAL 7 DAYS/ PER WEEK
DENTAL	ONSITE EVERY TUESDAY

COVERAGE

MEDICAL	REGIONAL MEDICAL DIRECTOR or NP BACKUP 24/7
MENTAL HEALTH	REGIONAL MH DIRECTOR or his MH BACKUP 24/7
DENTAL	MEDICAL COVERAGE BACKS UP DENTAL

STAFFING SHORTAGES

As noted there are significant staffing shortages in nursing and leadership (HSA, medical director, MH Director, and dentist).

As a result of the nursing shortage the DON is considered the 4th day nurse. Even with agency nurses being employed, interviews confirm staff nurses are regularly working around 65 hours a week over 6 days each week. The DON with even more responsibilities is working up to 80 hours a week and taking calls 24/7.

HSA duties are presently also the responsibility of the DON.

Multiple factors exacerbate hiring of health staff. These include shortage of available candidates (particularly during COVID), more competitive wage offerings at other health care venues, and the intrinsic challenges of hiring people to work in a correctional setting.

These factors are exacerbated significantly by the current inability to assure job security for applicants. Cumberland County's plan to revamp the County Jail to a Reception, Transportation, and Release Center remains stalled in legal processes. Applicants understandably are looking for more job stability.

Moreover, the ongoing worsening of onsite staffing for both custody and health care creates an unstable working environment that is not amenable to staff retention.

See DISCUSSSION/RECOMMENDATION 3 (ACCESS TO CARE- STAFFING) PRIORITY

HEALTH CARE MEETINGS AND MONITORING F-1

All health care meetings and monitoring are overseen by the HSA (now Acting HSA) including generation of minutes. These meetings and monitoring tools are the procedures for processing identified health care system issues at the appropriate level. Corrective actions can be developed, implemented, and assessed for efficacy through these various channels.

HEALTH CARE MEETINGS

1. HEALTH STAFF MEETINGS
    a. These meetings are scheduled monthly at a minimum to address ongoing health care system issues with health staff directly.
    However, health staff meetings were not done regularly in 2021 prior to April 2021. Additionally, no meeting was held in May 2021.
    b. These meetings are primarily conducted with nurses due to the variable part time schedules of providers.
    Per interview with Acting HSA, variable attendees include the Regional Director Denise Rahaman, medical NP on site, and dentist. MH staff are not formally in attendance.
    c. Minutes are generated. However, per interview with Acting HSA, non-attending staff receive only verbal communications reviewing the health staff meeting agenda and actions.

2. MEDICAL/CUSTODY (MAC) MEETINGS
    a. These meetings are also scheduled monthly. No meeting was held in April 2021; May meeting report still awaited stats. Cause of the delay was stated frankly as "overwork".
    b. Routine attendees (onsite or by conference link) by policy include Warden, HSA, DON, infectious disease nurse, regional CFG representative, Custody Training Officer, and leadership from medical, MH, and dental as available.
    c. January 2021 minutes were available for review. Topics addressed included grievances, dental issues, MH issues, pharmacy, staffing, Covid update, and MAT program. MAC meeting format addresses both old issues and new issues.
    d. February 2021 minutes were identified, but content was unchanged from January 2021.

3. CONTINUOUS QUALITY IMPROVEMENT

    By policy, quality improvement issues and studies are presented quarterly as a CQI addendum to that month's MAC meetings. Separate minutes are written for CQI.

No CQI meetings are documented for 2021 until May 2021. Regional audits were done through March 2020.

Random chart reviews with CQI follow up of positive findings are not being done in a systematic manner.

DISCUSSION/RECOMMENDATION 4 (HEALTH CARE MEETINGS)

The overall program of health care meetings is not operating in any routine fashion as of this survey. Meetings are not occurring as scheduled, particularly health staff and CQI meetings.

The responsibility for assuring these meetings occur lies with the HSA. Her current excess workload is evidenced by the lack of continuity in maintaining timely meetings. It is important to acknowledge this lapse in process is occurring despite the HSA providing 60 to 80 hours of onsite work weekly.

Basic recommendations include:

Monthly health staff and MAC meetings and quarterly CQI meetings need to resume on a regular basis.
Representatives from all health care departments should be attendees at health staff meetings.
All health staff minutes should document all attendees and address both old unfinished business and new business. (Same format as exists for MAC meetings).
Health staff meeting minutes should be available for all health staff to review.
Signature documentation of health staff meeting minutes review should be completed by all recipients.
MAC meeting minutes should be reviewed and signed by all members of the MAC committee and any ad hoc attendees.
CQI minutes should be available for all members of the CQI committee and ad hoc attendees.
CQI minutes should confirm that site specific problems are being identified, corrective actions implemented, and corrective actions then evaluated for effectiveness.

In addition to the above recommendations, a systematic program of random chart reviews should be initiated.

Randomly, reviewing patient care from intake through discharge accomplishes two goals:

1. Incidental lapses in care can be identified and corrected for that specific patient.
2. Patterns of missed or incomplete care can be identified and brought to CQI for evaluation. If a systemic issue is identified corrective actions can be developed, implemented, and later evaluated for efficacy.

MISCELLANEOUS MONTORING OF HEALTH CARE SYSTEM

4. POLICY AND PROCEDURES

The last signatures documenting review of policy and procedures are dated 01/22/2020. Reviews are done by HSA, Medical Director, and Warden.

5. MORTALITY REVIEWS

One patient has died since last survey. This patient actually died post-compassionate release so no formal mortality review was completed. This case was reviewed on survey. Thorough clinical care was documented, including arranging monoclonal antibody treatment for Covid. When subsequent aspiration pneumonia developed compassionate release was obtained allowing implementation of DNR orders at hospital.

6. CREDENTIALING

Interviews documented staff credentialing was up to date through March. Since March no new staff has been hired.
It remains unclear if per diem and/or agency hires are properly credentialed.
In addition to all her other responsibilities the HSA does custody clearance for new hires.

7. MAN DOWN and DISASTER DRILLS

   HSA documented man down events were real time events, not drills. However, no documentation of critiquing the events was available.
   A fire scenario was used for a disaster drill, but the drill is not yet written up.

8. PEER REVIEW

   HSA was not familiar with the peer review process.

9. ADVERSE EVENT REPORTING

   HSA documented one medication error was identified and addressed. It was unclear if a formal policy for addressing adverse events is implemented.

10. HEALTH STAFF COMMUNICATIONS
    a. Daily verbal nursing shift reports.
    b. "Purple folder" for communications between staff at leadership level.
    c. DON is currently revising the daily nurse sheets to address specific assignments and accountability.

DISCUSSION/RECOMMENDATIONS 5 (MONITORING OF HEALTH CARE SYSTEM)

Recommendations include:

Update review of policy and procedures by all three reviewers.

Assure per diem and agency staff are fully credentialed.

Resume written critiquing of man down events and disaster drills.

Assure HSA has updated peer review logs and any staff member needing further intervention has received it.

Confirm adverse event reporting is done per formal policy.

It is noted that policies and procedures for all other health care meetings and monitoring are in place. The current staff shortage and resultant work overloads has resulted in many of the meetings and monitoring failing to occur.

PREVENTATIVE CARE – SUICIDE PREVENTION G-1

Since the September 2020 survey, Cumberland County Jail has continued to implement updated suicide prevention procedures. Dr. Sandrock has completed onsite suicide prevention training for all the custody staff. Captain Joynes monitors custody staff responsible for suicide watch on a regular basis.

A review of both custody and health care procedures identifies that both procedures specifically require coordinated care by mental health and custody to reduce risk of suicides.

A. Recognizing suicide risk
Both nursing and custody orientation and ongoing training address identification of inmates evincing behavior consistent with risk of suicide. This training includes onsite and online training through CFG and the Custody Training Officer.
Initial suicide risk evaluation is done through completing MH screening by both custody and nursing at intake.
Custody staff interviews again documented custody is aware of behavioral characteristics consistent with increased risk of suicide. Custody interviews also document custody awareness of procedures for implementing appropriate assessment and monitoring of inmates evincing suicide risk behavior. This includes awareness of maintaining one on one monitoring if there is a delay in MH/nursing assessment of high risk inmates.
Chart reviews documents custody and health care respond appropriately and in a timely manner when a suicide risk is identified.
Interviews with MH staff documents an appropriate low threshold in placing inmates on monitoring for suicide risk.
Custody and health staff are aware that any custody officer or health care staff can initiate monitoring.

B. Monitoring suicide risk
Pending mental health evaluation, suicide risk patients are monitored one on one in Unit B. Any staff person (custody or health) can initiate suicide watch monitoring.
Following MH evaluation patients may remain on continuous one on one monitoring (Level I) or be downgraded to one of two levels (Levels II/III) of staggered intermittent monitorings, which are never more than 15 minutes apart.
The officer assigned to video can monitor up to four patients. However, the officer can never leave the video monitoring unless he/she is monitoring only one patient and that patient attempts suicide.
Consequently, staffing is typically two (2) custody officers. One officer monitors patient dedicated videos; the second officer maintains floor monitoring and can respond to a suicide attempt while the first officer maintains video observation on a second patient.

However, this two-man staffing requires another third (or fourth) officer on site if three (or four) patients require constant (one on one/Level I) suicide watch. Captain Joynes documented that present custody shortage precludes more than two constant watches being staffed.
Tour of Pod B noted an incidental lapse in staggering the intermittent suicide monitoring. However, review of training officers' logs for suicide watch documents otherwise consistent staggering within 15 minutes of intermittent suicide monitoring. Suicide monitoring continues until mental health determines monitoring is no longer needed or requires upgrading to Level 1.
Chart reviews document frequent, timely, and appropriate evaluation of suicide risk patients by mental health staff. Suicide watch patients can be escorted to MH room for telemedicine evaluations. New MH staffing matrix provides MH presence onsite or virtually seven (7) days a week. This provides daily MH assessments and adjustments of suicide watch levels.

DISCUSSION/RECOMMENDATION 6 (SUICIDE PREVENTION)

Custody training officer maintains thorough suicide watch logs on the custody side. It is recommended MH staff include evaluating and documenting compliance with staggering of Level II/III suicide monitoring during actual Pod B rounds.

A. PHARMACY/MEDICATIONS

1. Medications are ordered routinely at intake upon verification. Dr. Neal (or designated on call medical coverage) orders medical medications; on call psychiatry NP coverage or Dr. Brancata (CFG regional psychiatrist) orders MH medications.
2. If medical medications are verified as active, nursing enters a seven day order as verbal order from the Medical Director to continue the medications. The Medical Director reviews all cases for continuation within that time frame.
3. If psychiatric medications are verified, the psychiatric mental health NP on call is called to initiate the medications. There is also back up available from the regional mental health psychiatrist.
4. Chart reviews and inmate interviews document medications (medical and MH) are routinely verified and continued at intake.
5. Drug adverse events are identified.
6. Contract pharmacy is backed up by access to a local pharmacy for all medications.
7. Timely medication passes were documented on nurse interview.

B. EMERGENCY RESPONSE TRAINING

1. By policy, all staff are trained in CPR every two years. However, no CPR certification was done in 2020. A custody interview documented officer was working with an expired CPR certification. Training Officer is engaged in setting up a 2021 CPR training schedule.
2. There has been no new custody hiring for months, but if hiring resumes new hires would need prioritized CPR certification before working on site

DISCUSSION/RECOMMENDATION 7 (ANCILLARY SERVICES/CPR TRAINING)

All staff need current CPR certification. New hires should be CPR certified before working onsite.

CONTINUITY OF CARE I-1

This section addresses the components of the healthcare delivery system from intake through discharge at Cumberland County Jail. Continuity of care is maintained by assuring all care is timely; evaluations, diagnostic work-ups, and therapeutic health plans are appropriate; and care is continued until the health issue is resolved or patient transfers to another provider.

1. RECEIVING SCREENING/INTAKE – MEDICAL AND MENTAL HEALTH
   a. Booking officers receive inmates and call nursing to triage for medical acceptance into jail. Once inmate is accepted, booking officer completes his/her screen, scans the inmate, and obtains a urine sample for pregnancy testing if inmate is female. Formal nursing intake screening is then done by nursing.
   b. Chart reviews and inmate interviews document that Intake nursing screening is timely if inmate can be seen in receiving screening.
   c. However, as noted in the "Access to Care" section, persistent shortage of custody staff has resulted in inmates at times being brought from receiving screening into the jail before being screened by health care. Once in a jail pod, the inmate may not have timely access to a nurse screening if pod is staffed with only one officer. Although, not frequently occurring, this practice seems to be increasing according to nurse interviews. This issue remains unresolved and is addressed in "Access to Care"
   d. Formal intake is completed thoroughly by nursing staff. This consists of both a medical screening form and a mental health screening form which address all health care issues appropriately. Chart reviews and inmate interviews document identification of active health issues, prioritization for both medical and MH, addressing of special needs, and verification of medications.
   e. Nurses are trained by teaming with experienced nurses (including the DON) upon hire for up to two weeks and completing CFG sponsored training online. In addition, mental health and dental training for nurses (and custody) is provided annually.

DISCUSSION/RECOMMENDATION 8 (CONTINUITY OF CARE/ RECEIVING SCREENING NURSE TRAINING)

Per diem and agency nurses do not receive the same training regimen as new hires. A structured training program should be implemented for per diems and agency nurses that assures equivalent nursing training.

   f. Medications are routinely continued. Chart reviews document timely medications.
   g. Chart reviews document inconsistency in completing PPDs. Five (5) of fifteen (15) reviews had no PPD or an unread PPD.

DISCUSSION/RECOMMENDATION 9 (CONTINUITY OF CARE/ RECEIVING SCREENING PPD TESTING)

Audit receiving screening for compliance with PPD testing. If audit confirms noncompliance develop and implement corrective action.

h. Patients documenting substance abuse have a urine drug screen performed and are educated about participating in the MAT program.

2. INITIAL PROVIDER HEALTH ASSESSMENT

a. Procedure is in place for provider health assessments to be completed within 14 days of intake, active health care issues to be fully evaluated, and health care plans to be developed for each active health care issue.
b. However, chart reviews document variable compliance with both timeliness and documentation of health care plans. 10 of 15 charts reviewed had no assessment, late assessment, and/or no or inadequate health care plans documented.

DISCUSSION/RECOMMENDATION 10 (CONTINUITY OF CARE/ PROVIDER HEALTH ASSESSMENT)

Continuity of care is maintained by providers establishing timely health care plans for all active health care issues addressed at intake and the initial health assessment.

Audit should address timeliness of provider health assessments and documentation of health care plans for each active health care issue.

3. DENTAL CARE

a. Interview with dentist documented full dental services are available by policy, but equipment failures are presently precluding cleanings and urgent prioritization for dental abscesses limits capacity to do restorations.
b. Dentist confirms cases are prioritized. However, patients are now waiting three to four weeks for dental visits. There is a 30 to 40 patient backlog. Dentist stated custody shortage is adversely impacting efficiency. NOTE: dentist also complimented custody officers' cooperation in attempting to maintain health care services under difficult circumstances.
c. Dentist is available on call for any complicated dental sick call encounters occurring when he is offsite.

d. Nurses have a nursing protocol for evaluating dental sick call.
e. Annual dental exams are being done but, as noted above, without cleaning.
f. Dentist was scheduled to retire in June 2021. His replacement will be per diem dentists.

DISCUSSION/RECOMMENDATION 11 (CONTINUITY OF CARE/DENTAL SERVICES)

Equipment malfunction needs correction.

Backlogs need to be monitored for improvement, especially when new dental provider comes on site.

4. MENTAL HEALTH
   a. Mental health staffing now has a MH provider available onsite or by telemedicine seven (7) days a week. This assures a MH provider can assess suicide watches at least once every day.
   b. A Mental Health Director position is now included in staffing 20 hours a week. Currently, the position is open and being covered by CFG regional MH director Dr. Sandrock
   c. A social worker for "talk therapy" is being hired for 20 hours a week.
   d. Custody staff shortage and Covid restrictions have precluded any group therapy.
   e. Patients are identified from positive mental health screenings (all of which are reviewed by mental health providers within 4 days by policy) and timely sick call referrals to mental health.
   f. Chart reviews document timely and appropriate care with extensive notes. Inmate interviews document timely ongoing MH care.
   g. Individual counseling is provided by the psychologist (presently Dr. Sandrock).
   h. MH specifically screens patients participating in the MAT program.
   i. Medications are initiated and monitored by mental health prescribers (NP and MD). New patients are reevaluated in 2 weeks; established patients are seen every 4-6 weeks.
   j. Conference during onsite survey identified ongoing difficulties in arranging offsite MH care for complicated cases. Addressing access to offsite MH will require input from county administration as well as CFG working with various offsite MH facilities.

5. NON-URGENT HEALTH CARE (SICK CALL)
   a. Sick call requests are picked up by nurses at med passes every day.
   b. To comply with NCCHC standards, patients are to be seen within 24 hours for requests addressing symptoms, including mental health symptoms. If complete sick call cannot be scheduled a documented face to face encounter

must occur to assess if patient condition is emergent. These encounters within 24 hours are not always documented.

DISCUSSION/RECOMMENDATION 12 (CONTINUITY OF CARE – NON-URGENT HEALTH CARE)

A follow up CQI study should be done to assess all sick call requests with symptoms are evaluated at least by a face to face encounter within 24 hours and the encounters (either face to face or formal sick call) are documented.

c. Chart reviews and inmate interviews document non-urgent health care is provided when appropriate both diagnostically and therapeutically.
d. Both staff interviews and inmate interviews documented variability in timeliness of sick call visits. Of especial concern was providers' concerns that sick call timeliness was worsening as staff shortages persist. This issue is addressed in "Access to Care" section.

6. EMERGENCY CARE
   a. Hospital services are available in Vineland, Atlantic City, and Camden (both emergency room care and inpatient care).
   b. Ambulance services are available at all times.
   c. AEDs are available throughout the Cumberland County Jail.
   d. By policy, hospital patients are seen by health care upon return. Records are reviewed and recommendations implemented. Staff interviews indicated that custody is currently not bringing all hospital returns to the medical clinic.

7. LABORATORY AND DIAGNOSTICS
   a. Lack of uniformity in reviewing lab and diagnostic results, notifying patients of results, and addressing interventions for abnormal results is discussed in "Access to Care" section, including DISCUSSION/RECOMMENDATION 2.
   b. Lab services are contracted out by Cumberland County. The lab tech is scheduled onsite 3 times a week, and the tech is on call for stat orders. During clinic tour, the lab tech responded very quickly to a stat request.
   c. Flat plate x-rays and ultrasounds are available onsite.

8. CONSULTS

a. All consult services are available to Cumberland County Jail inmates.
b. By policy, upon return from consult care, patient records for consultant are reviewed and recommendations implemented.
c. However, chart reviews document recommendations are noted and routinely implemented, but sometimes with delays (e.g., delayed follow up appointment).
d. As discussed in "Access to Care" and DISCUSSION/RECOMMENDATION 2, consult reports are not processed in any structured fashion.
e. Clinic tour documented consult reports are placed with lab and diagnostic reports in an open file and accessed in an ad hoc fashion without being directed to provider requesting the consult.
f. Chart reviews document 2 lapses in arranging recommended consults.

DISCUSSION/RECOMMENDATION 13 (CONTINUITY OF CARE – CONSULTS)

As recommended for lab and diagnostic testing a structured system of monitoring consults request to assure timely completion should be implemented.

A structured program to direct reports in a timely fashion to appropriate provider should be developed and implemented.

Consult reports should be audited to assure implementation of recommendations.

9. CHRONIC AND ONGOING CARE

a. Patients are seen regularly for chronic and ongoing health care issues.
b. However, chart review documents great variability in timely follow up visits, monitoring parameters, and ordering of labs (e.g., patient admitted in April 2021 with hypertension and on medications still without chronic care visit 2 months later; patient with hypertension had only 2 BP recordings between 03/03/21 and 06/10/21; patient with persistent edema had no follow up in three months as ordered after 02/12/21 chronic care visit, and patient with hypertension never had the 3 month follow up visit after his 02/05/21 chronic care visit).
c. The concept of evaluating "condition" (how the patient is at the visit) and "status" (how does patient's condition compare to previous visits) as the basis for developing and implementing appropriate individualized health care plans is now incorporated into the chronic care forms.
d. Mental health notes formally identify "status". The "condition" questions reference medication effectiveness only. However, mental health providers

routinely identify patient's mental health condition in their assessment notes with free text.

e. Inmate interview documented extensive care for patient with multiple problems. However, timeliness and follow up of outside appointments were documented as variable.

DISCUSSION/RECOMMENDATION 14 (CONTINUITY OF CARE-CHRONIC/ONGOING CARE)

Audit of chronic care visits should assess for timeliness of visits, individualization of health care plans, and implementation of health care plans.

10. SPECIFIC HEALTH CARE ISSUES

a. COVID
   i. Currently, inmates are quarantined in a single cell upon admission.
   ii. A rapid Covid test is performed on day five (5); inmates with negative results can be transferred to general population, inmates with positive results go into isolation for 14 days.
   iii. Tylenol and Tamiflu are provided for symptomatic cases; all cases are monitored daily.
   iv. Patients going out to consults have a rapid Covid test pre-visit.
   v. Inmates in population who develop symptoms of Covid go into quarantine and are tested for Covid on day 5.
   vi. Covid vaccines are now available.

b. MEDICAL HOUSING CARE
   i. Clinic tour documented availability of closely monitored health care beds. Cases included a patient requiring loop monitoring for thyrotoxicosis, a paraplegic doing self-catheterization, a patient being monitored for severe withdrawal, and a patient with a nephrostomy tube for treating pyelonephritis.
   ii. This medical observation unit consists of one single cell (for overflow suicide watch, isolation, or female overflow), a five bed unit for observation and care; and a dry cell outside the clinic (primarily for security).
   iii. Cumberland County jail does not maintain a formal infirmary.

c. MAT (MEDICATION ASSISTED TREATMENT FOR OPIOID ABUSE)
   i. Inmates arriving on maintenance, including pregnant inmates, have their treatment continued as ordered on the outside (buprenorphine or methadone).
   ii. Pregnant inmates with documented opioid abuse are begun on maintenance medication by onsite providers.
   iii. All other inmates with documented opioid abuse (confirmed with onsite testing) are placed on COWS monitoring. If scoring 11 or above they are begun on buprenorphine maintenance.
   iv. MAT services are offered to all inmates identifying with substance abuse disorder at intake.
   v. MAT program includes maintenance medication, MH screening, ongoing counseling by separate outside contractors, and extensive reentry planning, including maintenance medication.

d. PREGNANCY
   i. Pregnant inmates are managed by offsite obstetricians.
   ii. Pregnant inmates receive pre-natal vitamins, protein supplemented diet, bottom bunk and bottom tier assignments.
   iii. Fetal heart monitor and precipitous delivery kit are both onsite.

e. SEGREGATION/SOCIAL ISOLATION
   i. Inmates placed in the segregation unit are monitored daily by health care. MH also monitors weekly.
   ii. Inmates are pre-screened by nursing to identify any active health care issues affecting ability to house in segregation.
   iii. Interview with Warden documents inmate detention is never for more than fifteen days.

11. DISCHARGE CARE
   a. Patients can access up to 30 days free prescriptions post discharge at the local Rite Aid.
   b. Social services coordinate inmate discharge needs, including ongoing health care and access to health insurance.

MISCELLANEOUS J-1

A. REFUSALS

a. Refusal forms have a generic identification that refusal has risks, but specific risks are not identified.

DISCUSSION/RECOMMENDATION 18 (MISCELLANEOUS – REFUSALS)

For each refusal, specific risks of refusing that specific health care should be identified.

B. PRIVACY

a. It was noted on patient interviews that patients continue to hand unsealed sick call requests to custody.

DISCUSSION/RECOMMENDATION 19 (MISCELLANEOUS-- PRIVACY)

Privacy standards require that custody does not have access to specific non-urgent health request information. It is recommended a procedure be formalized assuring only nurses access patient health care requests. This procedure could be developed for health staff and custody at MAC meetings.

C. COWS/CIWA MONITORING

Chart reviews document COWS monitoring usually is done only once a day.

DISCUSSION/RECOMMENDATION 20 (MISCELLANEOUS–COWS/CIWA MONITORING)

COWS and CIWA monitoring schedules should be individualized, but should be more frequent than once a day, particularly when initiated.

D. CUSTODY HEALTH CARE TRAINING

a. All custody training was interrupted during 2020. Training Officer interview documents training has resumed in 2021.
b. As addressed in "Ancillary Care" section, updated CPR certification has to be completed
c. Suicide prevention training through Dr. Sandrock has been completed for all custody staff.
d. Training Officer documents health care training agenda includes CPR, suicide prevention, first aid, universal precautions, and PREA,
e. Training Officer was provided with the full NCCHC agenda for custody health training as well as resource personnel contacts at other NJ correctional institutions.

DISCUSSION/RECOMMENDATION 1 (ACCESS TO CARE/COPAY)

One component of the copay policy is a $5.00 charge for all prescription medications, including a $5.00 charge every 90 days for chronic care prescription medications. The cost to the patient of ongoing multiple medications is significantly more than a single prescription medication ordered for an acute condition, thereby increasing the possibility those long term medications might be refused due to the cost of the medications. Such refusals imply health care could be compromised due to imposed costs. Although such refusals were not evident on this review, it is recommended chronic care be monitored for patient refusals of recommended medications due to cost. If significant numbers of these refusals are identified, consideration should be given to terminating the chronic care medication copay. Providers should be instructed in documenting these refusals, obtaining appropriately completed refusal forms, and notifying HSA of the refusals.

DISCUSSION/RECOMMENDATION 2 (ACCESS TO CARE/LAB AND DIAGNOSTIC TESTING PROCESS)

This is one of the few areas in the health care system where a structured process is absent.
All ordered testing should be tracked for completion.
Reports (lab, diagnostic, and consult) should go to ordering provider through a structured process.
Interventions should be documented in an appropriate chart note.
Lab and diagnostic results should be reported in some form to each patient.

Chronic care forms have a default notification that patient will be called back for abnormal lab results. This procedure can result in an abnormal lab result being missed but the patient believing results were normal because he/she was not called back.

DISCUSSION/RECOMMENDATION 3-PRIORITY (ACCESS TO CARE/STAFFING)

Addressing reduced staffing for both custody and health care requires engagement of all County components (administration, custody, health care vendor) because issues outside the health care system effect hiring in all areas. The need for this larger engagement was addressed with Warden Charles Warren and Attorney Carr as the main topic of the exit interview. Multiple areas

already being addressed at the county administrative level were discussed. Resolving the legal issues that are presently delaying implementation of long range plans is required to stabilize hiring and retention.

As discussed under "STAFFING" section there are many factors contributing to the staffing shortage. However, if all other factors were corrected, the staffing shortage cannot be corrected while the job insecurity created by the present inability to implement future plans for Cumberland County Jail definitively persists.

DISCUSSION/RECOMMENDATION 4 (HEALTH CARE MEETINGS)

The overall program of health care meetings is not operating in any routine fashion as of this survey. Meetings are not occurring as scheduled, particularly health staff and CQI meetings.

The responsibility for assuring these meetings occur lies with the HSA. Her current excess workload is evidenced by the lack of continuity in maintaining timely meetings. It is important to acknowledge this lapse in process is occurring despite the HSA providing 60 – 80 hours of onsite work weekly.

Basic recommendations include:

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DISCUSSION/RECOMMENDATIONS 5 (MONITORING OF HEALTH CARE SYSTEM)

Recommendations include:

Assure per diem and agency staff are fully credentialed.
Resume written critiquing of man down events and disaster drills.
Assure HSA has updated peer review logs and any staff member needing further intervention has received it.
Confirm adverse event reporting is done per formal policy.

It is noted that policies and procedures for health care meetings and monitoring are in place. The current staff shortage has resulted in many of the meetings and monitoring to lapse.

DISCUSSION/ RECOMMENDATION 6 (SUICIDE PREVENTION)

Custody Training Officer maintains thorough suicide watch logs on the custody side. It is recommended MH staff include evaluating and documenting compliance with staggering of Level II/III suicide monitoring during actual Pod B rounds.

DISCUSSION/RECOMMENDATION 7 (ANCILLARY SERVICES/CPR TRAINING)

All staff need current CPR certification. New hires should be CPR certified before working onsite.

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Per diem and agency nurses do not receive the same training regimen as new hires. A structured training program should be implemented for per diems and agency nurses that assures equivalent nursing training.

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Audit should address timeliness of provider health assessments and documentation of health care plans for each active health care issue.

DISCUSSION/RECOMMENDATION 11 (CONTINUITY OF CARE/ DENTAL SERVICES)

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Backlogs need to be monitored for improvement, especially when new dental provider comes on site.

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A structured program to direct reports in a timely fashion to appropriate provider should be developed and implemented.

Consult reports should be audited to assure implementation of recommendations.

DISCUSSION/RECOMMENDATION 14 (CONTINUITY OF CARE- CHRONIC/ONGOING CARE)

Audit of chronic care visits should assess for timeliness of visits, individualization of health care plans, and implementation of health care plans.

DISCUSSION/RECOMMENDATION 18 (MISCELLANEOUS – REFUSALS)

It is recommended staff be trained to obtain patient and provider signed refusals with specific risks of refusal identified whenever a recommended care procedure or appointment is refused by patient.

DISCUSSION/RECOMMENDATION 19 (MISCELLANEOUS- - PRIVACY)

It is recommended a procedure be formalized assuring that only nurses have access to patient health care requests. This procedure could be developed for health staff and custody at MAC meetings.

DISCUSSION/RECOMMENDATION 20 (MISCELLANEOUS–COWS/CIWA MONITORING)

COWS and CIWA monitoring schedules should be individualized, but should be more frequent than once a day, particularly when initiated.

SUMMARY L-1

This report is an overview of the health care system in place at Cumberland County Jail in June 2021.

It summarizes the current status of multiple health care areas, both administrative and clinical, in maintaining effective continuity of care for all health encounters and maintaining procedures that identify and correct systemic health care system problems. The survey was conducted with a prior recognition that Cumberland County Jail is in the midst of unresolved plans to convert to a Reception, Transportation, and Release Center and was experiencing a significant staff shortage in both custody and health care.

This report also presents numerous discussions and recommendations for evaluating and correcting health care issues specifically identified during this survey process. An action plan for each recommendation should be developed and implemented. The majority of recommendations address specific health care system issues.

However, DISCUSSION/RECOMMENDATION 3 specifically addresses as "PRIORITY" resolution of the severe and ongoing health care and custody staff shortage which impacts on all other areas of health care.

This report documents that health care policies and procedures are in place for all but one area (laboratory and diagnostic services, discussed below). Staffing model, health care meeting and monitoring matrices, suicide prevention, pharmacy services, emergency care and training, nursing intake, provider health assessment, non-urgent care, consult and hospital care, chronic and ongoing care, MAT program, MH services, dental services, and discharge care all have policy and procedures to maintain continuity of care. However, staffing shortages have resulted in lapses in many of these procedures, which are identified throughout the report.

These lapses are identified throughout the report especially in the "Access to Care" section.

The one absent policy and procedure identified is the need to structure laboratory and diagnostic services and is addressed in this report. Particular areas to be addressed include assuring testing is completed, implementing a system to direct results to appropriate providers in a timely fashion, implementing a procedure to document providers review all results and implement appropriate interventions for abnormal results, and developing a system assuring patients are notified of all results, both normal and abnormal.

This report documents as a "Priority" concern the current ongoing and non-improving staffing shortages in both health care and custody. As noted above, these shortages are resulting in an inability to maintain the health care procedures necessary to assure continuity of care and appropriate monitoring of health care. Multiple sources documented an awareness that the stability of the health care system is fraying.

Current interventions to maintain the healthcare system have resulted in regional staff substituting for onsite medical and mental health directors, the switch from a single contracted dentist to per diem dental providers, the assumption of three roles by the DON (DON, HSA and staff nurse) keeping her onsite up to 80 hours a week, and nursing staff working 60 plus hours a week on a routine basis.

All of these interventions are untenable as long term solutions.

Custody staff shortages have resulted in inmates bypassing nursing intake, increasingly frequent "No Movement" orders, worsening sick call waits (identified by multiple providers), inability to do MH group therapy, and restrictions on how many inmates can be monitored on constant watch at any one time.

As noted in this report, resolution of all other recommendations will not restore the health care system to full function unless staff shortages are also corrected.
Definitive resolution of this staffing shortage is dependent on resolution of plans to convert the current jail to a Reception, Transportation, and Release Center. This resolution currently requires resolving issues now being decided by the courts. It is evident on this survey that the present health care system urgently needs this resolution to transpire.

Actual clinical care provided is appropriate and, when required, quite extensive. The dedication and hard work of the health care staff, especially nursing, is evident in interviews and chart reviews. Custody is recognized in provider interviews for working to maintain the best care possible under restricted circumstances. Resolving the staff shortages as soon as possible will assure this level of professionalism can be maintained.

APPENDIX C

INITIAL CASE INTERVIEW – TALKING POINTS

Appendix C - Initial Case Interview - Talking points

Pre-conversation

- It might be helpful to have a calendar open to help the COVID-19 positive individual recall dates and associated activities and/or locations.

- You will not be providing medical advice, however, you should have information sheets available to reference in the event of any specific questions from inmates.

- Fear can reduce the ability for individuals to recall contacts and specifics in the preceding 48 hours and so you should provide reassurance and gentle prompts to put the inmate at ease. It is fine to move to different sections of the case interview form before coming back to missed sections.

- Remember to be empathetic to inmates who have recently learnt they are positive for COVID-19 and will require medical isolation.

Introduction

- Introduce yourself, your role is, and why you are speaking to the inmate.

- Confirm the identity of the inmate.

- Explain that the inmate was recently tested for COVID-19 and their test result came back as positive, or they have voiced symptoms that make them a highly probable COVID-19 case. Explain that their situation means that everyone who has been in close contact with them over the last 48 hour period will need to be contacted and potentially quarantined to prevent a major COVID-19 outbreak at the jail, and so understanding who they have been in close contact with is important.

- Explain that COVID-19 is a new virus which can cause many types of symptoms however mainly affects the lungs, causes fever, and a cough. It most often spreads from person to person when a positive individual coughs, breaths, or sneezes.

- COVID-19 is very contagious and can spread quickly through a population like that at CCJ. Most COVID-19 cases are mild or moderate, however sometimes the disease can be more serious and cause pneumonia and breathing difficulties. If you are currently experiencing or experience these symptoms in the future please speak to the medical team at CCJ as soon as possible.

- Today you need to speak to the inmate regarding two important topics. **First** we need to understand all the people you have been in close contact with over the last 2 days. We will not disclose your name or information. **Second** you will be moved into isolation - if you haven't already - to help protect others within the jail from potential COVID-19 infection.

Symptoms

- Ask the inmate whether they have had any COVID-19-like symptoms.

- If the inmate has one or more COVID-19-like symptoms, question the inmate on when their symptoms first began - even if their symptoms are minor, such as being extra tired of having a runny nose.

- Ask the inmate whether they still have any COVID-19-like symptoms.

- Run through the COVID-19-like symptom list to confirm the lack of any specified symptoms. This symptom list includes the following:

    - Fever or chills Cough

- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Clinical

- Make a record of whether the inmate has required any recent medical care in relation to their COVID-19-like symptoms.
- Question the inmate on whether they have any other health conditions.

Exposure Information

- Ask the inmate about whether they have any recollection of where they feel they might have been exposed to COVID-19.

Contact Tracing

- Explain to the inmate that one of the most important things that can be done to prevent the spread of COVID-19 within CCJ is contact tracing, which means creating a list of all individuals who the inmate has been in close contact with so they can be appropriately tested and quarantined if needed.
- Ask the inmate about all close contacts in the last 2 days (48 hours) and the details around each specified contact.

Try and gather as much information as possible for each contact, including information such as:

- Contact name Type of exposure
- Length of time of the exposure

- Reiterate to the inmate that their personal information won't be disclosed to any contacts.

Miscellaneous

- Make a note of the outcome of the case interview regarding the status of the individual and whether they are already in isolation, or whether this is planned and when.

- Detail any information regarding refusal to answer any questions.

APPENDIX D
COMMUNICATION AIDS

Appendix D - Communication Aids

The CDC provided many print-only materials which were developed to support COVID- 19 communications and recommendations. All materials are free for download. They may be printed on a standard office printer, or can be sent to a commercial printer.

A searchable directory can be found here:

https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc

The NIH also provides many COVID-19 posters and signage for download and local printing:

https://ors.od.nih.gov/mab/Pages/COVID-19-Resources.aspx

APPENDIX E

CONTACT TRACING DISCUSSION TALKING POINTS

Appendix E - Contact Discussion Talking Points (Explain case investigation and contact tracing)

- **Case investigation:** Case investigation is the process that CCJ uses to work with people who have COVID-19 to identify the source of COVID-19 within CCJ.
    - During case investigation you will isolate an individual who is positive for COVID-19/highly likely to be COVID-19 positive.
    - You will speak with the COVID-19 positive individual and help them to recall everyone they have had close or casual contact with during the previous 48 hours.
    - You will use the list of people developed from speaking with the initial case and a separate list developed through CCTV video inspection to begin speaking to close contacts who might have been exposed to COVID-19. That is why you are now speaking with the contact now.
- **Contact tracing**: Contact tracing is the process that CCJ uses to work with people who been in close or casual contact with someone who is COVID-19 positive.
    - You will speak to the inmate contact to inform them that they might have been exposed to COVID-19 and that they should monitor their health for signs and symptoms of COVID-19.
    - You will be coordinating COVID-19 testing for the inmate who has been exposed to a COVID-19 infection.
    - You will also be coordinating the quarantine process for the individual who has been in contact with a COVID-19 infection.

Contact Tracing

- You will inform an exposed individual of their exposure as soon as feasibly possible and advise them on their requirement to isolate for 10 days.

- You will advise the individual about monitoring their health for signs and symptoms of COVID-19.

- You should inform the individual in question that they will require a COVID-19 test at the end of their quarantine period to confirm they do not have COVID-19.

NOTE:

If CCJ requires extra flexibility regarding which inmates to isolate to create extra jail space in the event of a large outbreak. The following guidance from the CDC can be utilized:

- Exceptions to the quarantine requirement in the event of an exposure to someone positive with COVID-19:

    - Fully vaccinated people (>2 weeks since the final dose of a COVID-19 vaccine) who do not display any signs or symptoms, or test positive for COVID-19.

    - Individuals who have tested positive for COVID-19 within the last 3 months and recovered, and who do not display any signs or symptoms, or test positive for COVID-19.

- Individuals who are fully vaccinated or those who have tested positive for COVID-19 within the past 3 months and recovered should still be advised by CMT members to monitor for symptoms for COVID-19 for 14 days after being exposed to someone with COVID-19.

Vaccination Advice

CCJ should see the act of contact tracing as another chance to engage its inmate population in a conversation about COVID-19 vaccines. CMT members should advise eligible inmates that they can receive a COVID-19 vaccine at the jail at any time and

explain the advantages vaccination brings - including the potential need to not quarantine in the event of a COVID-19 exposure at the jail. You should be equipped with physical flyers about available vaccines to help alleviate any fears or concerns and also provide ongoing reference materials for reference beyond the contact tracing conversation. You should make a concerted effort to highlight vaccinations during the contact tracing interview.