IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

OSCAR SANCHEZ, MARCUS WHITE, TESMOND McDONALD, MARCELO PEREZ, ROGER MORRISON, KEITH BAKER, PAUL WRIGHT, TERRY McNICKELS, JOSE MUNOZ, KIARA YARBOROUGH, OLIVIA WASHINGTON, and IDEARE BAILEY, *on their own and on behalf of a class of similarly situated persons,* *Petitioners/Plaintiffs*, v. DALLAS COUNTY SHERIFF MARIAN BROWN, *in her official capacity,* and DALLAS COUNTY, TEXAS, *Respondents/Defendants.*	Civil Action No. 20-cv-832-E

Expert Report of Dr. Homer Venters, M.D.

A. Introduction and Qualifications

1. This report reflects an inspection conducted at the request of the Plaintiffs in *Oscar Sanchez, et al. v. Sheriff Marian Brown and Dallas County*, 20-cv-0832-E (N.D. Tex. 2020).

2. I am a physician, internist, and epidemiologist with over a decade of experience in providing, improving, and leading health services for incarcerated people. My clinical training includes residency training in internal medicine at Albert Einstein/Montefiore Medical Center (2007) and a fellowship in public health research at the New York University School of Medicine (2009). My experience in correctional health includes two years visiting immigration detention centers and conducting analyses of physical and mental health policies and procedures for persons

detained by the U.S. Department of Homeland Security. This work resulted in collaboration with U.S. Immigration and Customs Enforcement ("ICE") on numerous individual cases of medical release, the formulation of health-related policies, as well as providing testimony before the U.S. Congress regarding mortality inside ICE detention facilities.

3. After my fellowship training, I became the Deputy Medical Director of the Correctional Health Services of New York City. This position included both direct care to persons held in New York City's 12 jails, as well as oversight of medical policies for their care. This role included oversight of chronic care, sick call, specialty referral, and emergency care. I subsequently was promoted to the positions of Medical Director, Assistant Commissioner, and Chief Medical Officer. In the latter two roles, I was responsible for all aspects of health services to detainees, including physical and mental health, addiction, quality improvement, re-entry and morbidity and mortality reviews, as well as all training and oversight of physicians, nursing and pharmacy staff. In these roles, I was also responsible for evaluating and making recommendations on the health implications of numerous security policies and practices including use of force and restraints. During this time, I managed multiple communicable disease outbreaks including H1N1 in 2009, which impacted almost one-third of housing areas inside the adolescent jail, multiple seasonal influenza outbreaks, a recurrent legionella infection and several other smaller outbreaks. These efforts also included coordination of all health policies and protocols for outbreak response with security officials, training and orientation of security staff and implementation of large-scale vaccination programs for seasonal influenza and H1N1.

4. In March 2017, I left Correctional Health Services of New York City to become the Director of Programs for Physicians for Human Rights. In this role, I oversaw all programs of Physicians for Human Rights, including training of physicians, judges and law enforcement staff

on forensic evaluation and documentation, analysis of mass graves and mass atrocities, documentation of torture and sexual violence, and analysis of attacks against healthcare workers.

5. Between December 2018 and April 2020, I served as the Senior Health Fellow and President of Community Oriented Correctional Health Services ("COCHS"), a nonprofit organization that promotes evidence-based improvements to correctional practices across the United States. I have also worked as a medical expert in cases involving correctional health since 2017 and I wrote and published a book on the health risks of jail, *Life and Death in Rikers Island*, which was published in early 2019 by Johns Hopkins University Press.

6. Since April 2020, I have worked on COVID-19 responses in detention settings. During this time, I have conducted inspections of numerous federal, state and local detention facilities to assess the adequacy of their COVID-19 responses, to date including:

i. MDC Brooklyn (BOP), NY

ii. MCC Manhattan (BOP), NY

iii. FCI Danbury (BOP), CT

iv. Cook County Jail, IL

v. Broome County Jail, IL

vi. Sullivan County Jail, NY

vii. Shelby County Jail, TN

viii. Farmville Detention Center (ICE), VA

ix. Lompoc Prison (BOP), CA

x. Southern Mississippi Correctional Facility, MS

xi. Central Mississippi Correctional Facility, MS

xii. FDC Philadelphia (BOP), PA

xiii. Osborn Correctional Institution, CT

xiv. Robinson Correctional Institution, CT

xv. Hartford Correctional Center, CT

xvi. Dallas County Jail, TX

xvii. Cheshire Correctional Institution, CT

xviii. Calhoun County Jail, MI

xix. York Correctional Institution, CT

7. I have been named as an independent monitor for COVID-19 response in all Connecticut State Prisons and have been invited to present COVID-19 guidance to several organizations including the National Academy of Sciences on three occasions as well as the National Association of Counties and the American Medical Association. I have also been named as independent health services monitor for the Santa Barbara, CA county jail, and the Fluvanna Women's Correctional Institution in Virginia.

8. A copy of my curriculum vitae is attached to this report, which includes my publications, as well as a list of depositions I have given and testimony I have provided.

9. The COVID-19 pandemic has caused approximately 250,000 documented cases of infection in U.S. prisons and over 1,600 deaths. National data regarding county jails has not been widely reported but the pace of this pandemic in U.S. detention settings has increased in recent weeks after a slowing in June.[1] The toll of COVID-19 has been even higher in Texas correctional facilities, with a 40 percent higher infection rate and 35 percent higher death rate than in prison

[1] THE MARSHALL PROJECT, A STATE-BY-STATE LOOK AT CORONAVIRUS IN PRISONS, https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons, accessed 9/7/20.

settings in other parts of the United States. Between April and October 2020, 14 deaths due to COVID-19 were reported in Texas County jails.[2]

B. Methodology

10. The goal of my inspection of the Dallas County Jail (the "Jail") was to assess the adequacy of the facility's current response to COVID-19. In order to achieve this goal, I relied on three basic questions:

i. Does the facility adequately identify and respond to individual cases of COVID-19?

ii. Does the facility adequately implement infection control, social distancing, and other measures to slow the spread of the virus?

iii. Does the facility adequately identify and protect high-risk patients?

11. These questions are interrelated in that all three domains are essential to an adequate COVID-19 response and they rely upon one another to be effective. Adequacy is determined using guidelines of the Centers for Disease Control and Prevention (the "CDC") relating to COVID-19 in detention settings as well as basic correctional health standards.[3] I also utilized policies reported and/or produced by the Dallas County Jail to assess adequacy. Further, during my inspection, I posed questions to staff to elicit their understanding of the policies in place and whether/how they are being implemented. The adequacy of the Dallas County Jail response to COVID-19 is presented below in "Findings" which includes strengths, deficiencies and recommendations.

[2] Dan Rosenzweig-Ziff, *Incarcerated Texans are Dying from COVID-19 at a Rate 35% Higher than the Rest of the U.S. Prison Population, UT Study Finds*, TEX. TRIB. (Nov. 10, 2020), ttps://www.texastribune.org/2020/11/10/texas-prison-deaths-coronavirus/

[3] CENTERS FOR DISEASE CONTROL AND PREVENTION, INTERIM GUIDANCE ON MANAGEMENT OF CORONAVIRUS DISEASE 2019 (COVID-19) IN CORRECTIONAL AND DETENTION FACILITIES, updated July 22, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html, accessed 9/13/20.

12. I conducted a physical inspection of the Dallas County Jail with facility leadership as well as with attorneys for both Plaintiffs and Defendants on December 7, 2020. I also interviewed several recently released Detainees over the phone prior the inspection.

13. During the inspection, staff did not block or impede my access to any part of the facility that was included in the inspection protocol and were helpful in orienting me to the overall layout and operations of the facility. However, no members of the facility health services team were present, and the security leadership were generally unable to answer basic questions about access to health services for people with COVID-19 concerns, the scope and nature of health screenings for Detainees, and how medical isolation and many other features of COVID-19 response detailed in CDC guideless were being implemented. Many questions regarding the provision of health services to Detainees were thus unanswered during the inspection.

C. Inspection Observations

14. The inspection of the Dallas County Jail was conducted on December 7, 2020 over approximately five (5) hours. The Chief of the Department was present with attorneys and leadership of individual buildings joined for the North, West and South towers. The security leadership stated that as of the morning of the inspection, there were 5,375 people detained in the jail system and 1,523 in quarantine units.

1. Staff Screening

15. The first area of inspection was the staff screening process, which was encountered while entering the South Tower complex. Facility leadership later indicated that the staff screening process I observed was the same throughout the jail system. This area was clean, free of debris or trash on the floor, and included a temperature check for staff but no symptom screening or

questions about health status. It did not appear that paper records were made for every person being screened. All staff in this area were wearing masks.

2. Initial Questions

16. Before moving to other areas of the facility, the entire inspection group briefly assembled in the area near the Chief of Department's office. This discussion occurred standing, with most of the facility staff standing within one to two feet of one another. I was able to ask several questions about the facility's COVID-19 status. The leadership team stated the newly admitted people enter into a new admission quarantine unit, where they are held separate from other detained for two weeks and monitored on a daily basis for symptoms of COVID-19. The leadership team stated that most, but not all, newly admitted Detainees were being tested for COVID-19, and that they all were housed in a quarantine area where symptoms were checked daily. Staff present for the inspection told me that medical isolation (for people with known or suspected COVID-19) was currently occurring on floors 7 and 9 of the West building as well as the medical infirmary area, also referred to as the Gil Hernandez unit. I was told that no pre-release quarantine existed for Detainees who had been sentenced, largely because they were housed together with pre-trial Detainees. Most jail settings I have inspected maintain separate housing for Detainees serving short sentences; because the release dates of these people is generally known, it is possible for jail administrators to establish pre-release quarantine of two weeks and implement pre-release COVID-19 testing, as most prison settings do.

17. Leadership staff informed me that the facility employed approximately 500 detention service officers ("DSOs") but that it was not known how many, if any, had been fit tested for N95 masks or which types of assignments would require fit testing, and that staff had access to N95 and surgical masks as well as cloth face coverings. Fit testing is a technical process whereby

an individual is matched with an N95 or other mask that forms a tight seal around their face so as to impede the passage of air around the mask. As the CDC identifies, fit testing is required for the proper use of N95 masks, identifies a proper size and brand of mask for the user, and "[a] fit test confirms that a respirator correctly fits the user."[4] I was also told it was unknown whether Detainees who have work assignments were screened for COVID-19 signs and symptoms each day and that there was no ongoing testing of Detainees who have work assignments outside of their housing areas.

18. When asked, leadership reported that when a new Detainee COVID-19 case is identified, other Detainees are not tasked with cleaning or collecting property of that person or their living area, but that a specially trained group of officers conducts this cleaning. I could not observe or confirm this statement. The leadership team also indicated that Parkland Hospital staff performed all contact tracing, including for Detainees and security and health staff. I was also unable to observe or confirm this statement. Leadership team members did not have any information about what steps were taken to undergo contact tracing, including the actual definition of a close contact and whether the recently updated CDC definition was being utilized or which records and information are used to identify close contacts.

19. *Elevators – Signage and Social Distancing.* As our group entered the elevator to leave the area outside the Chief of Department's office, there were no markings in the elevator regarding social distancing and no apparent protocol for how many people should be in each elevator at one time. Throughout the day, I observed multiple elevators with people closely packed into less than one or two feet of social distance. In transit, I also observed several officers in control rooms without masks.

[4] CENTERS FOR DISEASE CONTROL AND PREVENTION, PROPER N95 RESPIRATOR USE FOR RESPIRATORY PROTECTION PREPAREDNESS (Mar. 16, 2020), https://blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/

3. Intake and Classification Areas

i. Social Distancing

20. I first observed the intake area where newly arrested people are processed before and after their arraignment. This area included two lines of people awaiting the search process. In neither line was anyone practicing any social distancing. To the contrary, arrestees were generally directed by Jail staff to stand in a line that kept them within one or two feet from each other.

21. Approximately 10 officers were standing in a close group in the intake area, also without exhibiting any efforts toward social distancing. An open seating area was also present for people awaiting their arraignments and some of the people in this area were more than 6 feet apart while others were not. I did not observe any effort to promote or enforce social distancing by any of the officers in this area.

22. I also inspected the classification area and observed a large number of individual paper towels laying out with some solution that appeared to be hand sanitizer already applied onto the paper towels. I observed one sign for social distancing in the elevator utilized to access this unit, but no observance of this or protocol in place by staff.

4. Housing Units

23. The next area inspected was the North Tower 2E unit. This unit was comprised of a lower and upper level of 48 cells each. The leadership team indicated that a person with COVID-19 symptoms or other medical problems would access sick call through a paper request or use of a rolling kiosk. I was told that people were often seen in a small mini-clinic, which was nearby; otherwise, they were seen in one of the main Jail clinics. I was told that no daily COVID-19 screenings were occurring in this facility and that a cleaning contractor had recently been retained to conduct some of the deep cleaning of cells. On the unit, I observed several groups of Detainees

cleaning cells themselves. Most of the Detainees and all of the officers on this unit were wearing masks, and it was generally clean and free of debris on the floor. Officers on this unit reported that they had not been fit tested and that new COVID-19 cases had previously been identified on this unit. I was also told that while one officer each was assigned to the top and bottom part of this housing unit, roving officers also moved in between housing areas to conduct tasks including meal relief for other officers as well as administrative and supervisory rounds. Staff on this unit indicated that contact tracing for DSO cases of COVID-19 was conducted by their own security team, at odds with what I was told by the leadership team.

24. The next area inspected was 2W, which was comprised of six subsections referred to as tanks. I inspected tank 1, which was comprised of smaller rooms with bunks in each room. There did not appear to be any possibility of social distancing in this area, with the bunks in close quarters with people standing or sitting in very close quarters inside their rooms and outside as well. The individual rooms open to a dorm area, where many of the Detainees were not wearing a mask and there did not appear to be any effort towards social distancing. No efforts toward social distancing appeared to be in effect in any of the other tanks I observed in 2W; for example, I did not observe officers asking people to spread apart, nor were there any six-foot markings on the floor or at tables.

i. Hygiene

25. No paper towels were present in the bathroom area and I saw a bucket of soap bars and chips near the shower, wet. I observed the mini clinic near 2W, which was a single room with an examination table and basic nursing equipment.

5. Medical Areas

26. The next area I inspected was the infirmary, in the basement of the West Tower. Staff explained to me that this large series of medical spaces was in the administrative control of Parkland Hospital, and contains acute and subacute areas for men and women as well as a main clinic. Each of these areas is an open bay design with central nursing stations that allow for full view of patient beds, all of which appeared to be hospital style/quality inpatient beds. There was also one connected area of cells adjacent to and viewable from the acute care section of the male infirmary.

i. Social Distancing & PPE

27. The clinic section had a large waiting area of seating for 20-30 people, and I once again did not see any markings or modifications to seats to encourage social distancing. Leadership explained that the infirmary receives patients from every part of the Dallas County Jail. I was told that the men's acute care section of the infirmary has 44 beds, many of which were empty during my inspection. Beds appeared to be between 6-8 feet apart from each other. Some patients were in beds directly adjacent to others and some were separated by an unfilled bed. There appeared to be more than adequate space to allow for an every/other spacing of beds.

28. The cell area was viewable from the acute care unit, and the doorway leading into the unit included signage stating that N95 masks were required and I was able to see health staff inside this unit with full PPE, including face shields, N95 masks and gowns and gloves. A donning and doffing station was present near the doorway into this unit. The men's subacute unit also has a similar layout and appeared to have approximately two-thirds of beds filled, also six to eight feet apart, with inconsistent use of empty beds in between patients. None of the units appear to have

created extra space in between adjacent beds that were filled with patients. Leadership reported that patients are tested for COVID-19 before they return from the hospital to this unit.

29. The women's infirmary was also similar in design and layout. This unit was on quarantine because of exposure to COVID-19 when we toured. I asked how the facility would accommodate a woman who needed an infirmary-level bed when this unit was on quarantine and was told that such a patient would still be placed on the unit, but off to the side from the other patients.

6. Dormitory Style Housing Units

i. Social Distancing

30. The next area inspected was F unit of the Kayes Tower. This unit was a large open bay/bunk design. People in this unit were closely grouped together, standing by and sitting at tables as well as grouped around bunks and other common areas. There was no head-to-toe arrangement of most bedding, and despite open bunks, which were approximately four feet apart, there did not appear to be any designed spacing of sleeping arrangements. A sign was present regarding head to toe sleeping.

31. The next unit inspected was 2A in the Kayes Tower, of similar design to F unit, where there was also no apparent social distancing in the seating or common spaces. There was no head to toe arrangement of most bedding, and despite open bunks, there did not appear to be any designed spacing of sleeping arrangements. Approximately 15 people were in a line for an unknown reason, all spaced very closely, less than one foot apart from each other.

ii. PPE

32. Most of the other units encountered thus far included the majority of Detainees wearing masks or face coverings, but only approximately half of people were doing so in this unit.

7. Isolation and Quarantine Units

33. The next area inspected was the West Tower, ninth floor. Leadership explained that aside from the cells in the medical infirmary, this was the area where patients with active COVID-19 were being housed and that this was the largest concentration of COVID-19 patients in the entire jail system, with both medical isolation and quarantine units on this floor. The leadership team, including the security leader for the building, were unaware of which units on the ninth floor housed patients with active COVID-19 (either positive test results or symptoms of COVID-19) and which units housed people under quarantine for exposure. When we reached the control booth for the ninth floor, the officers there were also unaware of which units were in these two COVID-19 classifications. The officers assigned to the floor called to contact a nurse to find out which units had people with COVID-19 and which had people under quarantine, a process that required approximately 10 minutes before this information was obtained.

34. It was ultimately established that units/tanks 6, 7, 8 and 9 were quarantine units and units/tanks 1 and 2 were medical isolation units. Accordingly, we progressed from inspecting quarantine to medical isolation units. All of these units appeared similar in layout. Each had nine cells per unit, and with two adjacent units being accessible from a common entrance, so that units 1 and 2 were accessed by entering a doorway from the hallway into a small passage approximately 6-8 feet across, and then passing through a second door on either side of the passage to the specific tank. A shower was located on these units and there was no clinical examination or sick call room on these units.

i. Signage & PPE

35. There was an opening in the wall between each unit and the passageway, approximately 24 x 8 inches, which allows free flow of air from each unit into the passageway and

the adjacent unit. *See* Sanchez_00000036. We first inspected unit/tank 2, a quarantine unit. The doorway into tanks 1 and 2 lacked any signage regarding COVID-19, use of PPE, or infection control. There did not appear to be any computer kiosk or sick call forms in the common spaces of this unit. Some of the individuals housed in this unit were wearing masks, while others were not. Leadership indicated that tank 1, empty at the time of our inspection, had been utilized as a quarantine unit and would be utilized again once cleaned. No PPE supplies were present at the entrance to the unit or in the passageway or inside the unit.

Sanchez_00000036.

36. As we walked from unit 2 to unit 9, one of the leadership stopped to speak with a Detainee who was making a complaint through an intercom. The Detainee stated that he had been suffering from diarrhea for over one week and had not yet been seen by health staff and that he did not have access to the computer kiosk to make requests. As we approached unit 9, where COVID-

19 positive Detainees were being housed, there was no PPE cart or signage of any sort regarding infection control outside the unit. We entered the unit without any of the facility staff changing from their cloth masks into an N95 mask. The unit was much like tank 2, with several occupied cells, doors partly open and no PPE cart or donning/doffing supplies inside the unit. *See* Sanchez_00000035. Some of the individuals housed in this unit were wearing masks, while others were not. When I inquired how officers know which units house COVID patients, facility leadership indicated that this was very challenging. The team was unaware of who was responsible for the posting of infection control signage or making staff aware of the precautions required for entering these units.

Sanchez_00000035.

8. Interviews with Detained or Formerly-Detained People

37. Interviews with one current Detainee (Tesmond McDonald, named Plaintiff in this action) and former Detainees (which were conducted separate from my inspection) yielded the following information;

38. *Medical isolation and quarantine*. People who had experienced quarantine due to exposure to COVID-19 reported that their housing areas were locked down for between one and two weeks, and that health staff did not conduct daily screenings for elevated temperature or COVID-19 symptoms. One person reported being in quarantine three times and stated that, while temperature screening did occur every day during the first quarantine, temperature screening only occurred sporadically on the second quarantine and not at all during the most recent quarantine, which was in November 2020 in one of the 2W tanks. None of the people who had experienced quarantine reported being asked specific questions about COVID-19 symptoms when a screening did occur, just that their temperature was taken.

39. Every person I spoke with reported interruption of laundry services during quarantine and medical isolation. This problem was raised as very significant because of heightened concerns about hygiene when COVID-19 exposure or infection were identified by the facility and Detainees were locked into their housing areas for housing units. People reported that during 14 days of quarantine or medical isolation, they received one or no laundry exchanges. This issue, combined with the lack of cleaning supplies, was the cause of a mass protest in at least one women's tank, causing women to remove their clothes and push them outside the housing area. The response of the facility to this and other similar incidents is unknown. One woman reported that while she and her cellmate were known to have COVID-19, they were often out of their cell and would have close contact with women from other cells in the same tank who were not positive.

She also said that officers usually wore some sort of mask but never wore face shields or gowns when entering the unit when she and others had COVID-19.

40. *Case finding and clinical care*. People I spoke with reported delayed access to sick call, with the time between submitting a request for care for medical problems to time seen ranging from several days to weeks. These reports included instances when people reported shortness of breath or other potential COVID-19 symptoms. One woman who tested positive for COVID-19 reported that she felt ill for several days and made repeated efforts to seek care from medical staff, including submitting sick call requests, but that several days passed before she was seen. She also reported that her cellmate was more ill than she was, and when nursing staff came to take their temperature and oxygen levels, her cellmate had a pulse oximetry reading of 84% but was left in her cell. One woman reported that her medications were not provided to her for ten days and that this included her psychotropic medications. Another person with multiple risk factors for serious illness or death from COVID-19, including diabetes, reported that his reports of COVID-19 symptoms went unanswered for several days. When he was finally removed from his cell and placed into a separate medical isolation setting, nobody listened to his lungs dung the entire two weeks of isolation, despite his reporting shortness of breath. Another person with persistent asthma reported that nobody every listened to his lungs while he was in medical isolation for COVID-19.

41. *Chronic care*. Two people with asthma reported that despite knowing that they use their rescue inhaler 1-3 times per day, health staff made no changes to add a second asthma medication such as a daily inhaled corticosteroid. One of these people was actually treated for an asthma attack and reported three times daily use of his rescue inhaler and he was not seen the next day to follow up his symptoms and he had no changes in his medications. He also reported that the asthma attack occurred while he was in quarantine, and when he reported the attack to security

staff, he was not taken for nursing evaluation for 4-5 days. A second person I spoke with related that shortly before he contracted COVID-19, his asthma inhaler was taken by security staff during a search despite being prescribed by health staff, and was not replaced. He also reported using his inhaler daily for many months, and that health staff continued to refill his inhaler, which had a dose meter, so that his daily use of the inhaler would have been known by the refill intervals. During this time, health staff never inquired about the frequency of rescue inhaler use or the frequency or severity of other asthma symptoms, and he never had a chronic care encounter for his asthma. Neither person with asthma had ever had their peak flow checked while in the Jail. A person with insulin-dependent diabetes reported that his blood sugars were well controlled at home, in the 110-130 range, but that in Jail, his insulin regimen had been switched, causing his blood sugars to be much higher, between 200-300 and that this elevation continued throughout his illness with COVID-19. In addition to reports of never receiving some medications in Jail, people also reported delays of 3-6 days in receiving whatever medications they were given when they entered the Jail initially and that when requests were submitted for medication interruptions, they received a $10 charge. None of the people I spoke with who have chronic health problems reported being asked about COVID-19 vaccination by health staff.

42. *General infection control*. All of the people I spoke with stated that staff do not encourage or enforce social distancing when people line up to receive their medications and during other predictable times of close contact.

C. Findings

43. My findings from the Dallas County Jail's COVID-19 response are presented as strengths, deficiencies and recommendations.

9. Strengths

44. Strengths of the Dallas County Jail COVID-19 response include the following:

45. The facility reported increased access to PPE and testing kits and supplies over the 10 months of the pandemic. Based on my conversations with facility leadership, more than adequate access to these resources exists to implement CDC guidelines and basic correctional standards of care.

46. The level of infection control evident in the cells of the medical infirmary for patients with COVID-19 meet CDC guidelines and can be used as a template for the rest of the facility.

47. The medical infirmary is an excellent example of how a large jail system can establish a community level of care for patients needing subacute care before and after hospitalization. The design and physical plant of this unit were better than other jail infirmary settings I have inspected and worked in. The ability of health staff to maintain visual contact of patients, as well as the hospital beds and access to nearby isolation cells and clinic represents a very strong and centralized medical resource for higher-needs patients.

48. The staff screening process appears effective and consistent with CDC guidelines.

10. Deficiencies

49. Deficiencies of the Dallas County Jail COVID-19 response include the following:

50. *Detecting and responding to new cases of COVID-19.* The facility appears to disregard or respond slowly to reports of COVID-19 symptoms among Detainees, which is likely

to worsen their individual clinical course and also increase the spread of the virus. The reported response to sick call requests is far slower than correctional standards (24 hours between submission and face to face encounter).[5] People I spoke with reported more than a week in sick call response times, and sick call is the stated avenue by which the facility plans to detect future cases of COVID-19 outside quarantine units.

51. The facility also appears to have an inadequate chronic care and medication system that likely causes chronic health problems such as diabetes and asthma to be poorly controlled, which directly increases the risk of serious illness or death from COVID-19 infection.

52. The facility also appears to have stopped implementing daily symptom checks and temperature checks in quarantine units, which dramatically impeded their ability to detect new cases and control the spread of COVID-19.

53. *Controlling the spread of COVID-19*. The guidelines of the CDC for management of COVID-19 have made clear since March 2020 that patients with COVID-19 and those under quarantine should be placed into physical spaces that are separate from all others and that facility staff must utilize appropriate PPE in these settings.

54. The Dallas County Jail displays ongoing disregard for basic CDC recommendations by failing to identify units that require full PPE or to take measures to ensure staff entering those units are trained to wear adequate PPE. The lack of knowledge about which units house people with active COVID-19 by all security staff on the 9th floor of West Tower was especially alarming and represents the type of gross failure I encountered sporadically in March and April, but is extremely rare after 10 months of outbreak response. If security staff do not know which units house people with COVID-19 and they do not know to or have the ability to don proper PPE, they

[5] NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, SCREENING, SICK CALL AND TRIAGE, accessed Sept. 17, 2020, https://www.ncchc.org/cnp-screening-sickcall-triage.

are at extremely heightened risk of contracting and spreading COVID-19 solely though the disregard of CDC guidelines by facility leadership.

55. In addition, the placement of both quarantine and medical isolation patients into units with open airways to adjacent units is a very problematic approach because it allows for passage of COVID-19 virus in aerosolized droplets from one unit to another, which can enable the spread of infection. It also can render meaningless the assumptions made in an individual quarantine unit about the source of new cases.

56. The lack of basic laundry services to people in quarantine and medical isolation represents a punitive response to a serious public health concern, and is not only a breach of basic correctional standards, but is also causing significant hardship for Detainees and security concerns in the facility.

57. The lack of social distancing efforts throughout the housing areas and common spaces of the Dallas County Jail represents a basic deficiency in the COVID-19 response, especially in medication lines when the most vulnerable Detainees queue to receive their daily medications.

58. *Protecting high-risk patients*. Despite knowing the identity of people who are at elevated risk of serious illness or death from COVID-19, the Dallas County Jail does not appear to have any plan in place to create special protections for them. Protections would include consideration for release, cohorting in specialized housing areas, or increased clinical surveillance either through daily COVID-19 screenings or through increased frequency of chronic care encounters.

D. Recommendations to Mitigate Morbidity and Mortality from COVID-19 at Dallas County Jail

11. Recommendation 1: Improved COVID-19 Testing

59. The Dallas County Jail should implement a much more expansive approach to testing that includes:

i. Testing of all newly admitted Detainees during their intake quarantine, once in the initial 2-4 days of their detention and a second on day 12-14, with results obtained and reported to detainees before transfer to other housing;

ii. Testing all people who are close contacts of newly identified casfes of COVID-19 including those in housing areas and any other Detainees or staff who had 10-15 minutes of cumulative contact with the new case in the prior 48 hours;

iii. Ongoing COVID-19 testing every two weeks for all staff and Detainees in a building/Tower until 14 days have passed since the last case; and

iv. Weekly testing of all Detainees who work in food service or other work duties outside their own housing area.

12. Recommendation 2: Addressing Infection Control Deficiencies

60. The situation I observed in the West Tower represents a true emergency, in that staff do not know which units house people with positive or suspected COVID-19 and there is no process in place to show them what PPE is required. Alarmingly, no PPE is present at these units. This is the most flagrant disregard for the health of staff I have encountered in recent months conducting COVID-19 assessments, is completely at odds with CDC guidelines, and is very addressable. It was unclear to me which of these responsibilities accrue to Parkland Hospital staff versus the Sherriff's Department, but almost every one of the 18 correctional facilities I have inspected since April 2020 has recognized the absolute necessity for implementing these CDC guidelines and created appropriate workflows and quality assurance.

61. Basic elements of this approach include:

a. Dallas County Jail should immediately secure the resources of an infection control nurse to review all practices and policies relating to the use of PPE and training/practices of staff who enter and work in units that are for patients under quarantine or those in medical isolation (e.g. people with suspected or confirmed COVID-19).

b. The facility should incorporate the new CDC guidance on how close contacts are defined and expand close contact investigations to include any person who was within 6 feet of a known COVID-19 positive person for 15 minutes total (not uninterrupted) time starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.[6]

c. A facility roster of quarantine and medical isolation units should be updated at each change of tour and every housing area and control room should have this updated roster, so that all housing area officers, escort officers and supervisors have ready access to this information.

d. Signage regarding infection control precautions and levels of PPE required should be posted outside the entry to all housing areas under quarantine or in medical isolation. PPE donning and doffing stations must be present at the entry to any housing area or other space where staff are required to change PPE. A daily check of the supply of PPE in these spaces should be conducted and reviewed by staff.

13. Recommendation 3: Quarantine, Isolation, and Health Services

62. The Dallas County Jail should immediately address deficiencies in quarantine, medical isolation and basic health services including:

a. Implement daily COVID-19 screenings in all areas under quarantine, including asking specific questions concerning COVID-19 symptoms as well as checking temperature;

b. Ensure that every person in medical isolation with confirmed or suspected COVID-19 receives a daily health assessment including vital signs, asking about symptoms of COVID-19 and lung auscultation. A daily list of patients who are symptomatic and asymptomatic should be maintained and a clinical decision tool should be implemented so that symptomatic patients can be scored and monitored for transfer to higher levels of care;

[6] CENTERS FOR DISEASE CONTROL AND PREVENTION, CONTACT DEFINITION, https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact

c. Ensure basic services and freedoms to people in quarantine and medical isolation, including access to phone calls, recreation, reading material and time out of cell. Medical isolation should also follow CDC guidelines for being non-punitive;[7]

d. A daily review of all sick call requests should be conducted and any person reporting a symptoms identified by the CDC as potentially related to COVID-19 should be seen in a face-to-face encounter within 12 hours, and seen immediately if the report includes a potential life-threatening emergency such as shortness of breath or chest pain. Security staff should be trained on how to expedite these concerns for urgent and emergent health assessments. A daily COVID-19 dashboard should be created that includes these complaints and the housing areas where these symptoms are being reported, as well as where quarantine and medical isolation cases are occurring. Security leadership should review this information on a daily basis with health leadership to track outbreak status.

e. Patients who meet CDC criteria for being at high risk for serious illness or death from COVID-19 should have a dedicated encounter with a mid-level provider or physician to discuss, review and document:

    i. The potential impact of COVID-19 on their health and any chronic illness.

    ii. The importance of vaccination, the facility vaccination plan and their history of serious allergic reactions

    iii. Whether they were previously infected with COVID-19 (documented or not) and whether they have ongoing symptoms or disability from prior infection.

f. A review of two weeks of sick call requests should be undertaken by the quality committee of the Parkland Hospital health services to determine the prevalence of access complaints reported in this report. A similar review of chronic care encounters and medication administration records should be undertaken to assess the potential role of these reported deficiencies in any hospitalizations or deaths from COVID-19.

[7] CENTERS FOR DISEASE CONTROL AND PREVENTION, INTERIM GUIDANCE ON MANAGEMENT OF CORONAVIRUS DISEASE 2019 (COVID-19) IN CORRECTIONAL AND DETENTION FACILITIES, updated July 22, 2020. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Medicalisolation, accessed 9/17/20.

14. Recommendation 4: Basic Infection Management

63. Dallas County Jail should implement additional measures to promote basic COVID-19 management including consideration of:

i. Training of officers on how to promote/encourage social distancing and implementation of workflows to promote social distancing with regard to how people are assigned bunks and beds in both general population and infirmary settings.

ii. Implementing social distancing in medication, food, intake, and other lines.

iii. Regular COVID-19 town halls in each housing area with health and security leadership.

iv. Development of laundry protocols for housing areas impacted by COVID-19, including potential use of biodegradable laundry bags to allow for collection and processing of laundry with the same frequency as other units.

v. All people on the chronic care service, or who meet current CDC criteria for being at elevated risk for serious illness or death from COVID-19 infection, should be prioritized for COVID-19 vaccination. Each one of these people should have an encounter with a physician or mid-level provider to assess their vaccine willingness, review their COVID-19 history and history of allergic reactions.

E. Conclusion

64. I have serious concerns about the shortcomings in the Dallas County Jail's response to the COVID-19 crisis, particularly this late into the pandemic and in the face of well-established guidelines to reduce the spread of the virus. Further, I believe many of the issues I observed are fixable, and based on my experience inspecting and working in correctional settings I believe the

Dallas County Jail, in concert with Parkland, is capable of adopting the recommendations outlined in this report.

Executed this 12th day of January, 2021 in Burgaw, North Carolina

Signed,

Homer Venters MD, MS