Second Report of the Agreement Monitoring Panel

(Chatman, et al. v. Otani, USDC Hawaii Civil No. 21-00268 JAO-KJM)

November 16, 2021

Judge Daniel Foley (ret.) Chair

Tommy Johnson

Gavin Takenaka

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I. Overview of activities since initial report, meetings, and briefings

Since the September AMP meeting, AMP members developed a plan to conduct inspections of all the HI DPS facilities. Each facility warden, or their designee, conducted a remote presentation about their facility and the COVID-19 status and challenges during the week before the inspections occurred. The last regular AMP meeting occurred on the October 8, 2021 and focused on the logistics of the inspections and the plan for report writing. The AMP also met on November 10 and 15, 2021 to finalize the second report format and content.

II. Inspection overview

Four members of the AMP participated in the facility inspections: Deputy Director Johnson and Drs Thorburn, Venters, and Takenaka. These inspections occurred October 11-15, 2021. The participation of the inspections is as follows:

	Gavin Takenaka	Kim Thorburn	Tommy Johnson	Homer Venters
WCCC			x	x
WCF	x	x		
HCF	x	x	x	x
OCCC	x	x	x	x
MCCC			x	x
HCCC	x	x		
KCCC			x	x
KCF	x	x		

Methods

Each facility inspection began with a brief update from facility leadership about the status of COVID-19 cases and mitigation measures in the facility. The team then followed a general path that included inspection of facility intake/receiving areas; medical and mental health clinics; and general population (dorm and cell) and specialized housing areas; including those designated for segregation, medical care, mental health treatment, and work cadres. Along the path of the inspection, team members spoke with both staff and detained people about their experiences with COVID-19 and the various mitigation and response efforts of the facility. In addition to brief conversations, team members were free to arrange more in depth confidential discussions with people in each facility.

Review of the efforts to implement COVID-19 responses in the facilities relied on the settlement agreement (Chatman v. Otani, CIVIL NO. 21-00268 JAO-KJM), as well as the

policies and procedures of the DPS and the current guidelines for COVID-19 response in detention settings by the Centers for Disease Control and Prevention.

The broad areas of the settlement agreement include:

- Quarantine/cohort/isolation
- High risk patients
- Sanitation/sanitization
- Testing
- Social distancing strategies
- Contact tracing
- Vaccination and education

III. Facility level-observations

This section presents observations about individual facilities' steps taken to implement the PRP, highlighting areas needing improvements, based on the inspections by AMP members and review of facility-level data.

WCCC

- Intake/receiving area appeared to have clear protocols in place to maintain separation between newly arrived and other detained people.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place.
- It was observed that three patients at high risk for serious illness or death from COVID-19 infection are being housed in infirmary room.
- Social distancing was in evidence in education/program areas.
- It appeared that detainees who work outside the facility are screened for elevated temperature daily.
- It was observed that tablet computers are being introduced to the facility but none are available for the intake quarantine period.
- It was observed that intake quarantine involves two steps: people are moved from a cell on a week-1 side of the unit to a week-2 side, which allows for more limited restarting of the quarantine period if positive cases are detected.

Areas Needing Improvement

- It was observed that there is only one medical isolation room available, which can house more than one patient. Information was provided that if an outbreak of more than 7-10 cases were to occur, the facility plans to house patients in the chapel, a non-living space

without any bathroom or shower. Information was provided that a four-room isolation unit has been ordered.

- There appeared to be no areas for confidential health or mental health encounters in housing areas and no computer terminals on or near housing areas to review medical records or document care.
- It was observed that sick call involves asking a correctional officer to put the persons' name on a list to be seen by medical, so written record of the request (without any health information) is made by the patient. It was further observed that nurses then provide some sick-call encounters/triage while people are in the medpass line rather than in an examination space.
- There seemed to be little social distancing occurring in medication lines.
- It was observed that detainees who work inside the facility, including the kitchen and laundry, are not screened for elevated temperature daily.
- People with questions or concerns about vaccine safety reported not having the opportunity to ask questions or raise their concerns with health staff.

WCF

- It appeared that a facility population well below capacity, combined with leadership knowledge and practice of PRP guidelines, contributed to managing assigned work/program cohorts of inmates by housing, assignment activities, and meals, ensuring separation of cohorts even in a fully dormitory setting.
- There seemed to be meticulous provision and oversight of hygiene products, cleaning supplies, and sanitation activities.
- Intake quarantine procedures seemed to effectively maintain separation between newly arrived and other detained people in a dormitory setting.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place, with the status of newly arrived people known in advance of their arrival.
- Social distancing was observed in education/program areas.
- Tablet computers were seen to be in limited trial use and internet infrastructure upgrades to support the hardware were reported to be underway.
- It was reported that nursing staff maintains a list of people who are at high risk for serious illness or death from COVID-19 infection.
- It was observed that Plexiglass no-contact barriers are used throughout the facility to separate inmates and staff. It was also observed that reminders to maintain physical distancing are posted throughout the facility and additional reminders about social distancing are placed on the floor using large 6-feet circle stickers and colored lines to identify staff areas and no-cross areas for inmates.

- It was observed that two telehealth stations are available in health care unit. It was reported that the facility increased use of telehealth services to minimize the possibility of cross-facility contamination by providers.
- It was also reported that for the past 1 ½ years, virtual visitation has been occurring seven days a week by building (no mixing).

Areas Needing Improvement

- It was reported that staff has limited access to electronic medical records due to poor internet connectivity as well as lack of sufficient computer terminals near patient care areas within or close to housing units.
  Despite housing and worker cohorting, the investigation of the facility's only outbreak reported infection among people from multiple areas of the facility revealing the need for robust outbreak investigation which relies on both contact tracing (by DOH) and review of the trends and management of new cases by PSD.

Areas of Disagreement

- Dr. Takenaka observed testing (as recommended by DOH epidemiologists and in coordination with DOH and the Hawaii National Guard) appeared to be in place.
- Dr. Takenaka observed the January 7, 2021 DOH Weekly COVID-19 Cluster Report demonstrated robust outbreak investigation by DOH and PSD, which included contact tracing and genetic sequencing.

HCF

- Intake/receiving area appeared to have clear protocols in place to maintain separation between newly arrived and other detained people.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place.
- It was observed that sick call includes a form submitted by the person requesting care, which records their health problems and the time and date of submission.
- It was reported that medical isolation includes twice daily checks by health staff and use of full PPE by staff on the unit.
- It was observed that Plexiglass no-contact barriers are used to separate inmates and staff, reminders to maintain physical distancing are posted throughout the facility, and additional reminders about social distancing were placed on the floor using large 6-feet circle stickers in the health care unit and blue tape.
- It was observed that law library kiosks are available in housing.
- It was observed that telehealth stations are available in health care unit.

Areas Needing Improvement

- Testing in response to recent new cases appeared to have been limited to only nearby cells (in a given quad) and in some cases did not seem to detect the spread of infection to adjacent modules in the same housing area or building.
- It was reported that any outside visit results in a new 14-day quarantine for patients and that could create a strong disincentive to engage in specialty care because of placement in austere, perpetual quarantine conditions for patients who regularly leave the facility for medical reasons. Multiple patients reported this problem as well, however the rate or incidence of missed encounters attributable to this issue was not calculated.
- Detained people on work lines reported inconsistent temperature and symptoms checks before daily work assignments.
- Lack of computer access in areas where health care is delivered seemed to result in loss of information and time between COVID-19 assessments and recording in the electronic medical record.

Areas of Disagreement

- Dr. Takenaka observed testing (as recommended by DOH epidemiologists and in coordination with DOH and the Hawaii National Guard) appeared to be in place with non-scheduled STAT testing conducted by PSD staff to supplement and expedite the identification and separation of new cases.
- Dr. Takenaka did not receive reports of missed medical appointments due to Routine Transport Quarantine.

OCCC

- Intake/receiving area appeared to have clear protocols in place to maintain separation between newly arrived and other detained people.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place.
- It was reported that inmates who work outside the facility are screened for elevated temperature daily.
- It was observed that tablet computers are being introduced to the facility, but none are available for the intake quarantine period.
- Enclosed cells in modules seemed to permit effective quarantine as well as containment of small groups with work lines that are limited to each module.
- Adequate space for quarantine and medical isolation appeared to be present at the time of the inspection.

- It was reported that health care staff conducts twice daily temperature and symptom checks for inmates on routine intake and potential exposure quarantine. It was also reported that health care staff a conducts twice daily checks with pulse oximeter for inmates on medical isolation.
- It was reported that nursing staff maintains a list of inmates who are at high risk of severe illness from COVID-19 and that the facility is prepared for administration of approved treatment including monoclonal antibody and antiretroviral medication.

Areas Needing Improvement

- It was reported that much of the COVID-19-related care is delivered in housing areas where there is no clinical exam space nor access to the electronic medical record for health staff.
- It was observed that the area designated as a medical infirmary is a storage room and includes beds surrounded by medical supplies and equipment. This area is reported by staff as the site where symptomatic or high-risk COVID-19 positive patients would receive care, with use of plastic sheeting and a large negative-pressure generating wall fan to help limit the infection risk to the other infirmary patients in beds several feet away.
- It was reported that detainees who work inside the facility, including the kitchen and laundry, are not consistently screened for elevated temperature on a daily basis.
- The annex housing areas appeared to contain insufficient shower and toilet facilities and seemed extremely overcrowded, dilapidated, and dirty. Some people reported that once outbreaks began in these units, they were kept together with other uninfected people until virtually the entire housing area became infected. The administration reported that when infections were first detected in these open cellblock-tiered vault settings, there was an unsuccessful attempt to isolate infection to a single floor. Severe overcrowding and structural limitations beyond PSD's control seemed to be a major contributing factor.
- It was reported that people going to court and/or medical appointments are returned to their housing areas with no screening or other effort to assess their COVID-19 status.
- Testing and contact tracing efforts (conducted by DOH staff) during the outbreak preceding the AMP facility inspections appeared to be limited in the Annex areas.
- Little social distancing reportedly occurs in medication lines.
- It was reported that no hand sanitizer is available in Annex but is in other housing areas.
- Some people with questions or concerns about vaccine safety, including people who were high risk, reported not having the opportunity to ask questions or raise their concerns with health staff.
- Despite housing over 300 people identified as recovered from COVID-19 infection, no dedicated effort was reported to be underway to check people post medical isolation for "long COVID-19."

Areas of Disagreement

- Dr. Takenaka observed testing (as recommended by DOH epidemiologists and in coordination with DOH and the Hawaii National Guard) appeared to be in place.
- Dr. Takenaka observed that the area designated as the medical infirmary has not been used for COVID-19 positive cases since the start of the pandemic.
- Dr. Takenaka observed that inmates transported to the community for medical care receive SARS-CoV-2 testing prior to scheduled appointments when required by the community Provider and at the hospital for emergent or urgent care. Dr. Takenaka also noted that COVID-19 screening by community medical Providers is expected practice and PSD would be notified about a refusal of medical services due to a positive screen.
- Dr. Takenaka observed contact tracing efforts (conducted by DOH staff) during the outbreak preceding the AMP facility inspections were consistent with CDC guidance involving the use of contact tracing and broad-based testing for a setting where close contact is frequent and relatively uncontrolled (i.e., open dormitory housing), with a large number of individuals with COVID-19 in the facility.
- Dr. Takenaka observed vaccine and sick-call sign-up sheets in housing areas.
- Dr. Takenaka observed that no specialized procedure was reported to check people who have recovered from COVID-19 infection for "long COVID-19," except those seen by order of a Provider, those who request to be seen through sick-call, and those who are routinely seen in chronic care clinic.

MCCC

- Intake/receiving area appeared to have clear protocols in place to maintain separation between newly arrived and other detained people.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place.
- Detainees who work outside the facility reported to be screened for elevated temperature daily.
- It was observed that tablet computers are being introduced to the facility, but none seemed to be available for the intake quarantine period.
- Medical staff reported some limited use of laptop computers to deliver care and document their encounters outside the medical clinic.

Areas Needing Improvement

- There is no area observed to be available for clinical examination near the current medical isolation area; staff reported that examination would need to occur outside in

the recreation yard. The health care unit was observed to be contained inside a women's housing area.

- Much of the COVID-19-related care was reported to be delivered in housing areas where there is no clinical exam space and no access to the electronic medical record for health staff.
- It was reported that detainees who work inside the facility, including the kitchen and laundry, are not consistently screened for elevated temperature on a daily basis.
- Some people with questions or concerns about vaccine safety reported not having the opportunity to ask questions or raise their concerns with health staff.
- People who have been identified as recovered from COVID-19 infection reported no follow up assessment for ongoing symptoms and staff reported there is no dedicated effort is underway to check people post medical isolation for "long COVID-19."
- Several high-risk people reported that despite being unvaccinated, no health care staff member had spoken with them about vaccination since their initial offer.

HCCC

- Warden and team seemed actively engaged with partner agencies, such as courts and other governmental officials, to manage COVID-19 efforts.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place.
- Isolation containers were observed on site being prepared for use.
- It was reported that health care staff conducts twice daily temperature and symptom checks for inmates in quarantine.
- It was reported that nursing staff maintains a list of inmates who are at high risk of severe illness from COVID-19.
- It was observed that lack of space causes actively infected people in medical isolation to be housed with people who have been cleared from medical isolation, designated as "post positives."

Areas Needing Improvement

- Hale Nani was observed to have grossly inadequate physical environment for overall custody and COVID-19 response. Extreme overcrowding and lack of basic intake housing areas seemed to result in large numbers of people crowded into a multipurpose room sleeping on the floor, as well as two to four individuals housed in cells originally designed for one or two people.
- Lack of space to provide clinical care and lack of computers with electronic medical records access was observed at the main facility.
- Intake/receiving area appeared to have clear protocols in places to maintain separation between newly arrived and other detained people, but the protocols appeared challenging during periods of high intake and facility overcrowding.

Areas of Disagreement

- Dr. Takenaka observed testing (as recommended by DOH epidemiologists and in coordination with DOH and the Hawaii National Guard) appeared to be in place.

KCCC

- Intake/receiving area appeared to have clear protocols in place to maintain separation between newly arrived and other detained people.
- Adequate PPE was observed to be available for staff and it was reported that detained people are issued cloth masks.
- Intake COVID-19 screening, video education, and some testing appeared to be in place.
- Regular cleaning, disinfecting, and sanitation appeared to occur consistent with DPS policies.
- Serial testing in response to recent cases was implemented based on DOH guidance..
- It was observed that an isolation container has been delivered but is not yet operational.

Areas Needing Improvement

- It was reported that the recent outbreak involved women with COVID-19 being held in cells and housing areas with women who were COVID-19-negative due to lack of medical isolation capacity. It was further reported that infections spread to most women in the housing area.
- It was observed that there is insufficient intake pen or isolation cell area to accommodate intakes, regular flow of people in and out of the facility, and also accommodate suicide watch, if needed.
- Showers were observed to be extremely limited, with up to 16 people relying on one shower.
- People who have been identified as recovered from COVID-19 infection reported no follow up assessment for ongoing symptoms and staff reported there is no dedicated effort is underway to check people post medical isolation for "long COVID-19."
- Several high-risk people reported that despite being unvaccinated, no health care staff member had spoken with them about vaccination since their initial offer.

KCF

- It was reported that 97% of the inmates were vaccinated at the time of the inspection.

- It was observed that the population is well below capacity and admissions are highly controlled, including no high-health risk detained individuals due to the distance to medical facilities.
- A large stockpile of PPE and sanitation materials was observed with substantial storage space for warehousing. A complete supply of hygiene items and masks was observed to be packaged for new arrivals.
- Intake COVID-19 screening, video education, and some testing appeared in place and it was reported that all people arrive with known vaccination status, as they transfer from within the correctional system.
- Regular cleaning, disinfecting, and sanitation appeared to occur consistent with DPS policies.
- It was observed that ample space has been identified for medical isolation but this has not been tested since the facility has not experienced an infected inmate.
- The warden seems to have created a culture that involves staff in attempting to prevent introduction of Covid-19 by vaccination and frequent testing.

Areas Needing Improvement

None noted.

Areas of Disagreement

- Dr. Takenaka observed testing (as recommended by DOH epidemiologists and in coordination with DOH and the Hawaii National Guard) appeared to be in place.

IV. Department-wide summary

This section presents a summary of AMP monitoring observations about PRP implementation efforts from a department-wide perspective highlighting areas of concern.

Strengths

- The new vaccination incentive appeared to have generated significant interest based on conversations in housing areas.
- Health care staff appeared to be following PRP and CDC guidance concerning monitoring of patients in quarantine and medical isolation settings.
- Facilities appeared to have current lists of high-risk patients.
- Intake processes appeared to reliably ensure COVID-19 screening, initial video education, and testing occur.
- Sanitation supplies and overall hygiene appeared to be consistent with DPS policies.

Areas of concern

- It was observed that only some facilities have implemented temperature and symptom checks for all inmate workers.
- Some detained persons indicated that sick call charges represent a disincentive to seeking care, despite an ongoing policy to suspend these charges if the cause for sick call relates to flu-like symptoms.
- Few areas for confidential health or mental health encounters were observed to exist in housing areas nor were computer terminals on or near housing areas to review medical records or document care.
- Many people reported having questions or concerns about COVID-19 vaccination that were not addressed by the posted signs and other education measures in place, and specifically identified the need for a venue to address these questions and concerns with health staff.
- There seemed to be limited approach to testing by PSD and limited contact tracing and outbreak investigation by DOH and PSD.
- No effort was observed to be underway to check people post-medical isolation for "long COVID-19" or post COVID-19 disability or symptoms.
- Extreme overcrowding was observed in multiple facilities, especially the Annex of OCCC and in HCCC which raised concerns about the ability to adequately respond to the PRP, including detection of new cases, provision of health care, and implementation of basic social distancing, sanitation and hygiene.
- Medical isolation did not seem possible in more than one facility, particularly in the case of outbreaks of 5-10 people.
- There was an inconsistent approach to quarantine for people returning from brief court or medical appointments, ranging from a full 14-day quarantine to no clinical assessment or quarantine at all.

Areas of Disagreement

- Dr. Takenaka reported that sick-call charges for COVID-19 symptoms were suspended effective April 7, 2020. In addition, sick-call charges are waived for inmates seeking mental health care and inmates who are indigent.
- Dr. Takenaka observed the need to supplement educational measures to remind people about how to access the existing venue to address vaccine questions and concerns with healthcare staff.
- Dr. Takenaka observed that the testing plan for inmates, which was developed in consultation with DOH epidemiologists, is extensive. Dr. Takenaka further observed thorough outbreak investigation and substantial contact tracing by DOH and PSD.
- Dr. Takenaka observed that no specialized procedure was reported to check people who have recovered from COVID-19 infection for post-COVID conditions, except those seen

by order of a Provider, those who request to be seen through sick-call, and those who are routinely seen in chronic care clinic.

V. Recommendations

This section provides AMP recommendations and guidance based on facility inspections and other data reviewed.

1. Conduct daily temperature and symptom checks for inmate workers who move both outside and inside of facilities. Purchase required equipment and conduct staff training.
2. Suspend sick call charges at least as long as COVID-19 is underway, without qualification as to the nature of the medical problem.
3. Identify offices near/on housing areas wherever possible for clinical encounters with computers that have electronic medical record access.
4. Institute monthly town halls in housing areas to discuss vaccination and consider structured vaccine education encounters for all high-risk patients who remain unvaccinated.
5. Adopt a uniform policy regarding screening, quarantine and testing of people who have outside court and medical appointments that follows CDC guidelines and limits possible and/or perceived disincentives to receiving care.
6. Take a broad approach to both testing and contact tracing, so that individual quads or subparts of housing areas are considered part of the same potential exposure and include roving staff, inmate workers, and supervisors as well as individuals identified by inmate movement records in contact tracing and testing after new cases are identified.
7. Follow CDC guidance to identify and treat post-COVID symptoms and disability, including among those who initially had mild or no symptoms.
8. DPS needs to continue to vigorously engage at central level and support its individual facility administrators to engage with the Hawaii Paroling Authority, courts, and other local officials, agencies, and partners to attempt to reduce the influx of new detained people as a means to ensure adequate COVID-19 response, particularly during periods of ongoing transmission.
9. Continue to remove departmental administrative barriers to inmate placements and intra-facility transfers. House inmates based on health and custodial safety.
10. Prioritize completion of installation of the isolation containers that have been purchased for all facilities.
11. Consider requiring that inmates who transfer to Waiawa and Kulani Correctional Facilities be vaccinated.

VI. Areas of disagreement

The contents of this report represent content that us agreed upon by all five of the AMP members. Exceptions, where one or more member may not support an element of the report, are noted in this section.

Judge Daniel Foley; none

Tommy Johnson; none

Gavin Takenaka; recommendations 2,4,7

2. Last year, PSD effectively implemented a flu-vaccine campaign (see Pandemic Response Plan) using co-pay waiver as an incentive to increase uptake of the flu-vaccine. It was the first time PSD hit 70% vaccinated at OCCC. This recommendation would undo the positive system change in another healthcare area of concern. Recommend continuation of the suspension of sick-call charges for COVID-19 symptoms.

4. Requiring an inmate to experience a health care encounter on vaccine education when the inmate's stage of change does not indicate the same level of intervention could act to increase resistance to vaccination. Recommend PSD adopt the KCF model of providing COVID-19 vaccine education information regularly on video during scheduled times prior to a desired activity or during meals. The video could include a reminder to submit a Medical Request Form or sign-up for sick-call/vaccine clinic if someone has additional questions or concerns about COVID-19 vaccination.

7. Follow CDC and other national clinical guidance to identify and treat post-COVID conditions.

Kim Thorburn; none

Homer Venters; none

VII. Next steps in monitoring

Data monitoring

The recommendations in this report will be reviewed and updated in subsequent reports.

The AMP will continue to monitor all COVID-19-related data collected by PSD to inform its review of efforts to implement the PRP and identify areas in need of improvements. The AMP will receive and review reports regarding identified areas of concern and recommendations.

Mortality reviews

AMP members will review recent PSD mortality reviews and other relevant data to provide feedback on cases of COVID-19 related mortality.

Upcoming meetings/activities

AMP is scheduled to meet on December 20, 2021 to discuss future monitoring, document review, reports and other activities in carrying out its mandate pursuant to the Settlement Agreement. AMP plans to file its next report by December 20, 2021.

Signed on behalf of AMP members

Homer Venters, MD, MS