3/26/2020 AFFIDAVIT OF JAIMIE MEYER

I, Jaimie Meyer, being duly sworn, hereby depose, and state the following:

1. I am currently employed as an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing.
2. I am a physician who is board certified in Internal Medicine, Infectious Diseases, and Addiction Medicine. I completed residency in Internal Medicine at NY Presbyterian in New York, a fellowship in clinical Infectious Diseases at Yale University, and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS at Yale School of Public Health. I also hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health. My clinical work and research centers on infectious diseases among people involved in criminal justice systems in closed settings (prisons, jails) and community settings (probation, parole) and I have been continuously funded for this research from the NIH, industry, and foundations for over a decade.
3. I have been asked by Attorney Annie Manhardt from the Prisoners' Rights Office to review the Vermont Department of Corrections' ("DOC") response to the Coronavirus 2019 ("COVID-19") pandemic.
4. To conduct this review, I was provided with an internal email dated March 12, 2020, from Commissioner Jim Baker; an email exchange dated March 10–12, 2020, between Attorney Emily Tredeau and DOC Director of Nursing Heidi Fox; and a Vermont Department of Corrections COVID-19 Protocol dated March 19, 2020 (March 19 Protocol).

5. In addition to the resources relied upon by experts in infectious diseases and prison health, I also reviewed specifically the Centers for Disease Control and Prevention (CDC) guidance on management of COVID-19 in correctional facilities (available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html), the Bureau of Prisons (BOP) modified operations plan (available at https://www.bop.gov/coronavirus/covid19_status.jsp), and the National Commission on Correctional Health Care (NCCHC) materials on COVID-19 (available at https://www.ncchc.org/COVID-Resources).

6. Based on the information contained in these materials and my knowledge, training, education, and experience in the field of prison healthcare, it is my professional opinion that the DOC's response to the COVID-19 pandemic remains inadequate to protect people in prison and jail in Vermont from being exposed to and infected with COVID-19 and insufficient to prevent a widespread COVID-19 outbreak in DOC's facilities. While the March 19 protocol represents a substantial improvement over the processes described in the earlier-dated VT DOC documents, it omits certain key details and recommends other actions that are not consistent with CDC or BOP guidance or with informed medical opinion. Without additional steps, people in DOC custody who are infected with COVID-19 may experience high rates of serious illness, including death.

7. Even in correctional systems that follow extremely rigorous infection prevention and control protocols, rates of serious illness and death from infectious diseases greatly exceed rates in the community, both because correctional populations are more medically vulnerable and because crowded institutional settings are prone to rapid spread of disease. Past outbreaks of infectious diseases in prisons, including influenza and

tuberculosis, have resulted in significant morbidity and mortality. We can anticipate, based on how contagious COVID-19 is and the experiences of other global prison settings where COVID-19 pandemics are more advanced, that COVID-19 will similarly result in large-scale prison outbreaks unless additional steps are taken. By far the best way to "flatten the curve" within a correctional setting is to reduce the correctional population as much as possible.[1]

8. DOC's response to COVID-19 is insufficient to address the inherent danger COVID-19 presents within its facilities, in the following ways:

    a. **Operations and Supplies:** CDC recommends ensuring sufficient stocks of hygiene supplies, cleaning supplies, personal protective equipment and medical supplies. These include standard medical supplies, tissues, liquid hand soap, hand drying supplies, and alcohol-based hand sanitizer. There is also a recommendation to make contingency plans for PPE shortages. All efforts should be coordinated with state and local Departments of Health.

    The March 19 protocol contains no information whatsoever about ensuring adequate stocks of medical, hygiene, and cleaning supplies. The protocol mentions supplies of personal protective equipment (PPE), but merely assigns responsibility for their adequate supply to a Logistics Section Chief, § 2.2.8, without attempting to estimate what an adequate supply would be, and without a contingency plan for any shortages.

    A shortage of medical, hygiene, or cleaning supplies would be disastrous because COVID-19 transmission within the facility would continue unabated. A shortage of PPE would put both inmates and staff at increased risk of exposure and would create the incentive for staff to withhold or misuse PPE in an effort to preserve it. In addition, without adequate PPE, staff including medical staff, may have to choose between performing certain close-contact duties unprotected, or not performing them. Even dedicated staff, put in that position, may choose self-protection, leading to the breakdown of basic prison operations and essential prison healthcare. Numerous examples of negative health outcomes resulting from PPE shortages are emerging this week from New York, where area hospitals are

[1] In recent weeks, major media outlets have published calls for decarceration by advocates and public health professionals. *See, e.g.*, Josiah Rich et al., *We Must Release Prisoners to Lessen the Spread of Coronavirus*, THE WASHINGTON POST (March 17, 2020), https://www.washingtonpost.com/opinions/2020/03/17/we-must-release-prisoners-lessen-spread-coronavirus/; Amanda Klonsky, *An Epicenter of the Pandemic Will Be Jails and Prisons, if Inaction Continues*, NY TIMES (March 16, 2020), https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.html.

overwhelmed, understaffed, and running out of supplies. Prisons are even less prepared than these complex urban hospital systems to deal with PPE shortages.

Finally, the March 19 protocol does not mention making liquid hand soap, hand drying supplies, and alcohol-based hand sanitizer freely available to inmates. Telling people to wash or sanitize their hands is not enough: there must be ample opportunity to do so. If it is expensive or inconvenient to wash hands, insufficient hand washing will occur. Multiple large clinical trials have shown that healthcare workers need education, reminders, incentives, feedback, support, monitoring, and access to alcohol-based hand rub to improve hand hygiene compliance.[2] *This is no less true of prisoners than of people in general.*

b. <u>General Prevention Practices:</u>

i. Cleaning and Disinfecting Practices: Because the SARS-CoV-2 virus (that causes COVID-19 disease) can survive on inanimate objects, high-touch surfaces (including doorknobs, light switches, countertops) should be regularly disinfected with bleach. The CDC recommends cleaning and disinfecting, several times per day, surfaces that are not ordinarily cleaned daily, including doorknobs, light switches, countertops, sink handles, recreation equipment, telephones, kiosks. At least several times per day, staff should clean and disinfect shared equipment, including radios, service weapons, keys, and handcuffs.

DOC's March 19 protocol (Section 1.1.2) calls for the frequent cleaning of high-touch surfaces but does not define "frequent" or "high touch." These are not details that should be left to the judgment of individual DOC staff because of the risk certain items will be overlooked.

ii. Hygiene: Prevention of COVID-19 requires that people have access to soap, private sinks, and clean water for handwashing or alcohol-based hand sanitizers.

In prison, sinks are often shared, and alcohol-based hand sanitizers are banned. Non-alcohol-based hand sanitizers (or those with <60% alcohol) are ineffective against COVID-19. The March 19 protocol does not direct facilities to make alcohol-based hand sanitizer available to inmates. In prison, typically there are few sinks available for inmates' use and they are not distributed throughout the facility, making hand sanitizer a more important resource.

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[2] Puller, Matthew P., *Improving Hand Hygiene in Hospitals—More is Better*, BMJ 351 (July 2015) (available at: https://www.bmj.com/content/351/bmj.h3931.long); Schweizer, Marin L., et al., *Searching for an Optimal Hand Hygiene Bundle: A Meta-Analysis*, 58 Clinical Infectious Diseases 248 (Jan. 2014) (available at: https://pubmed.ncbi.nlm.nih.gov/24107409/?from_term=hand+hygiene+compliance&from_filter=pubt.meta-analysis&from_pos=6).

iii. **Personal protective equipment (PPE):** CDC recommends that "all staff and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained correctly to don, doff, and dispose of PPE." In this case, PPE includes gowns, gloves, face masks, respirators, and eye shields or goggles. N95 respirators require special fit testing and people with facial hair need special accommodations because they cannot achieve a tight enough seal with N95 respirators. Inmates involved in cleaning, laundry, and meal service also need to be trained in how to don and doff personal protective equipment.

The March 19 protocol's discussion of personal protective equipment (Section 2.2) does not mention any training of staff on its proper use, other than providing a handout. This is especially important because the donning and doffing of personal protective equipment is often complex and, if done incorrectly, can expose its wearer to contaminated surfaces, resulting in infection. Additionally, the protocol for screening of new prisoner intakes calls for staff to wear masks and goggles, but not gloves, which are essential because the SARS-CoV-2 virus can live on inanimate surfaces. Gloves protect both the wearer and the prisoner from potential infection.

c. **Screening:** COVID-19 is a virus that spreads easily, primarily from person-to-person through respiratory droplets. It is therefore imperative that people entering closed confinement settings like prisons are properly screened to ensure that they do not bring the virus into the facility. Research suggests that people who are ill with COVID-19 and experiencing symptoms are most likely to transmit the virus to others. The virus can be transmitted very efficiently from person to person within 6 feet, putting staff and inmates at risk of becoming infected unless proper infection prevention and control strategies are implemented.

i. **Screening Inmates:** Current CDC guidance suggests screening should consist of two questions: "1) Today or in the past 24 hours, have you had any of the following symptoms: fever/felt feverish/had chills; cough; difficulty breathing; 2) In the past 14 days have you had contact with a person known to be infected with COVID-19?"

The DOC intake screening form (Attachment 1) is already outdated because it asks about recent travel to Europe, China, Iran, and South Korea. Given that COVID-19 is now widespread across communities across all 50 states, the travel screen is a moot point. There is also no referent time frame given for the questions, leaving room for potential misinterpretation and underreporting of exposures or symptoms.
In addition, the March 19 protocol calls for new intake screening at the facility sallyport. 2.1.1. This means that the inmate would already have ridden in a transport vehicle. The March 19 protocol does not require notification when an inmate who is isolated or quarantined upon arrival

had previously ridden in a transport vehicle. This puts both transport staff and people subsequently transported at risk.

Instead, VT DOC should follow CDC guidance for first responders (available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html) *and use PPE and disinfecting procedures for all individuals with suspected COVID-19, at least until they can be fully screened.*

In the description of the screening protocol (Section 2.1.), there is no detailed plan on how thermometers will be disinfected between uses. If thermometers are not sufficiently disinfected, there is the risk that they could become contaminated and contribute to disease transmission. CDC says, "All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly."

ii. **Screening Staff:** CDC recommends verbally screening all staff daily on entry into the facility for COVID-19 symptoms and close contact with cases, and temperature checks.

The staff screening and exclusion process described in the March 19 protocol (Section 1.2) does not direct correctional officials to conduct staff screening outside facilities or, at the very least, in the sally-ports where staff enter, as opposed to fully inside the facility. The DOC protocol requires exclusion of staff with fevers ***and*** *respiratory symptoms, which could allow people who are infected with COVID-19 to enter the building because not all infected people have fevers or have symptoms other than fever. The more stringent protocol would be to exclude any staff with a fever* ***or*** *respiratory symptoms. The staff exclusion protocol also fails to mention how staff who test positive for COVID-19 (i.e. confirmed cases) will be handled, how to inform their coworkers or inmates with whom they had direct contact that they have been exposed, and how long they will be excluded from duties with direct inmate contact.*

In addition, the staff exclusion protocol mentions contacts only with "confirmed" COVID-19 cases. Because of test kit shortages, there are many more COVID-19 infections than have been officially confirmed. It is estimated that each individual with COVID-19 infects 2-3 others. Any adequate screening protocol must exclude staff who have had contact with suspected, not just confirmed, COVID-19 cases—such as a symptomatic household member. This is consistent with CDC and Vermont Department of Health's recommendations for self-quarantine.

iii. **Screening visitors:** According to the CDC, visitors and volunteers should also complete verbal screening procedures and temperature checks on entry into the facility.

Visitors and volunteers should be screened in the same manner as staff, above, if they are still allowed into the facility. These screening procedures are absent from the March 19 protocol.

iv. **Screening contractors and vendors:** *The March 19 protocol does not mention screening contractors or vendors* **at all***. This is especially concerning in Vermont since* **all health care is provided by contractors** *who may have close physical contact with prisoners and are thereby poised to transmit the disease.*

d. Social distancing: When containment strategies become overwhelmed, mitigation strategies require people to practice social distancing. CDC recommends the following strategies: Meals can be staggered, and seating be rearranged in dining halls and common areas (like waiting areas) to enable social distancing, such as removing every other seat. Alternatively, meals could be provided in housing units. Mitigation strategies must be in place for other highly congregate settings, such as recreation, group activities, educational classes, vocational training, and religious services.

Crowded and communal conditions in DOC make social distancing impossible. People in prison have very little personal space and are forced to eat, sleep, live, and work in incredibly close quarters. As of date of writing, Vermont prisoners still eat their meals in a "chow" hall dozens or scores at a time—far exceeding the numbers that Governor Scott has banned in public gatherings. The state's forced closure of eat-in restaurants illustrates the grave danger of such gatherings. There is no mention in the March 19 protocol of how social distancing (Section 1, Table 1) measures, like those CDC recommends, will be implemented in communal settings within each facility. Placing facilities on 24-hour lockdown, while perhaps seemingly enabling to social distancing, is not an appropriate public health solution because it results in deprivation that can be equally threatening to physical and mental health.

The general characteristics of prisons make them susceptible to contagion, as evidenced by the high rates of infectious diseases within carceral settings, regardless of the preventative steps taken. ***The more the incarcerated population is reduced, the more effective any social distancing measures inside the prison will be.***

e. <u>Management of the disease in the facility:</u> People who have been diagnosed with COVID-19 (either because they exhibit consistent symptoms or because they

obtained a positive test), need to be medically isolated to prevent the virus from being transmitted to other people in the facility population. Importantly, medical isolation differs from disciplinary segregation. It should be used as a public health measure that also attends to the medical needs of the individual; not used to deprive them of personal freedom. Ideally, people with COVID-19 will be medically isolated near medical units where they can receive clinical care and attention. In people who are older (>65) and with underlying medical conditions, the disease can progress extremely rapidly, so medical attention is critical.

i. **Medical care for people with COVID-19:** CDC has very explicit instructions that, for people in medical isolation, medical care should be provided within that space, meals should be served within that space, they should have a dedicated bathroom if available, and the individual should be excluded from all group activities.

   While DOC's March 19 protocol (Section 2.5.8.) does mention that "to the extent possible, all services (meals, medication, etc.) will be delivered in the cell," it does not state whether medical care will be delivered in the isolation space, or just the delivery of medications. If people with COVID-19 still need to be transported from medical isolation to medical units to receive care, there is the risk that other inmates or staff could be exposed. Moreover, there is no mention of whether bathrooms will be private or how cohorting, if needed, will be implemented.

ii. **Release from isolation:** Clear guidelines exist for the release from isolation, namely, when an individual has been free from fevers without the use of fever-reducing medications for at least 72 hours **and** other respiratory symptoms have improved **and** at least 7 days have passed since the first symptoms appeared.

   DOC's March 19 protocol describes when isolation will be ordered (Section 2.5), but not when infected or presumed infected inmates will be released from isolation. Without a clear commitment to follow these guidelines, the danger exists that DOC will prematurely release recovering patients, who may still be contagious, from isolation to make room for sicker patients.

iii. **Sufficiency of isolation spaces**: Prisons are built to contain people, not diseases. Given how COVID-19 outbreaks have overwhelmed even the most sophisticated hospital systems nationwide, it is unlikely that DOC will be adequately equipped or supported once someone in the facility becomes ill with COVID-19. Even mild disease requires close monitoring and that caregivers and/or healthcare personnel have personal protective equipment (PPE), including gloves, gowns, eye shields, and masks, that are not usually available in the DOC or are potentially in limited supply. Airborne isolation rooms are specially equipped with negative pressure to

allow air flow from outside the room to inside. These negative pressure rooms should be used for people with diagnosed or suspected COVID-19 who have more severe disease or are at high risk of aerosolizing droplets (e.g. they are coughing frequently).

A COVID-19 outbreak poses particular risk to people with underlying chronic health conditions, including heart disease, lung disease, liver disease, pregnancy, diabetes, and suppressed immune systems. They have higher risk of becoming infected with COVID-19 if exposed and higher risk of complications and death if infected. People also need continuous access to treatment for their other underlying health conditions, which are at risk during a COVID-19 pandemic in the context of healthcare understaffing and reduced access to medications (if supply chains are interrupted).

DOC's facilities have only two Airborne Infection Isolation Rooms, in only two of its six facilities, Southern State Correctional Facility and Northwest State Correctional Facility. 2.5.3. This means that any prisoner whose condition warrants placement in such a room must be transported to Southern State or Northwest State unless they happen to already be there. This transport would increase the risk of an outbreak by potentially introducing the virus where it is not already present and by infecting the transport team and contaminating the transport vehicle. There is no such room available for female inmates at all. 2.5.5. It is unclear from the protocol whether the male Airborne Infection Isolation Rooms can hold ten patients each, or ten total.

DOC also has a second isolation space at Northeast Regional Correctional Complex able to hold up to 106 people. 2.5.4. This is in an open, very dense dorm—one big room full of bunk beds. For this space to function effectively as a medical isolation unit, anyone housed in that room would have to be definitively diagnosed with COVID-19 with a laboratory test. Otherwise, both suspected and confirmed COVID-19 patients would be grouped together, essentially ensuring that all suspected COVID-19 patients in fact become infected with COVID-19. Not all suspected COVID-19 patients actually have COVID-19 infection and symptoms of fever, coughing, and shortness of breath be caused by other infections and other chronic conditions.

Without a clear plan in place for cohorting (or grouping together COVID-19 patients in a single housing unit), it is unclear how this space would be effectively used.

These spaces are inadequate for DOC's in-state incarcerated population, which as of March 25 is approximately 1165 people. From what we have seen in other correctional settings such as Rikers Island, the rate of

infection once the virus enters a prison greatly exceeds that in the community.[3] *Insufficient isolation would pressure staff to release isolated inmates prematurely to make way for sicker inmates, or not to isolate those with mild symptoms in the first place, rendering isolation efforts futile.*

Furthermore, DOC's March 19 protocol does not mention the supplies or equipment on hand in the likely event of an outbreak. People who are moderately or severely ill with COVID-19 require hospitalization and management with intravenous fluids, intravenous antibiotics, supplemental oxygen, and in some cases ventilators. DOC is not equipped to rapidly identify people who need more intensive medical care or to safely transfer people with COVID-19 to area hospitals, especially as these hospitals are likely to become overwhelmed with patients. DOC's March 19 protocol does not discuss a plan to cope with likely shortages of medical staff, due to illness, quarantine, or lack of childcare, as the disease spreads through the community.

iv. **Testing:** In the correctional context, CDC recommends that testing is required prior to cohorting COVID-19 patients in the same housing unit for medical isolation: "Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts."

Testing for COVID-19 benefits the whole control effort because negative test results allow staff to return to work, and inmates to return to the general population. The March 19 protocol does not state when symptomatic inmates or staff would be tested for COVID-19. DOC should commit to following guidelines for testing rather than leave the decision to on-site staff. Testing will likely require close coordination with state and local Departments of Health. In addition, as discussed above, the March 19 protocol calls for the cohorting together of both suspected and confirmed COVID-19 patients, putting the non-infected but suspected patients at risk.

v. **Clinical care:** At present, treatment for mild COVID-19 disease is primarily supportive and includes rest, hydration, and acetaminophen (Tylenol) as needed for fevers or body aches. Moderate or severe disease can develop rapidly, especially among people with preexisting conditions, so medical personnel need to be prepared to identify when someone's health is declining, and they require transfer to a hospital for a higher level of care.

[3] An analysis by the Legal Aid Society of New York (available at https://legalaidnyc.org/wp-content/uploads/2020/03/LAS-Mass-Parole-Holds-Writ.pdf) found that, as of March 25, 2020, the virus' rate of infection on Rikers Island was 85 times higher than the national rate of infection in the United States.

Absent from the March 19 protocol is any description of the medical care that will be provided to COVID-19 patients. At a minimum, the protocol could refer to existing standards of clinical care. There also needs to be a plan in place for DOC inmates to be transferred to area hospitals, especially if there is an infirmary bed shortage within DOC. A detailed plan for hospital transfer would include clinical criteria for hospital transfer, plans to notify emergency response services that an ambulance is requested for a COVID19 patient (if ambulance is indicated), and plans to call ahead to area emergency departments that a COVID19 patient is en route.

f. <u>Sanitizing spaces and objects:</u>

i. Laundry and utensils: CDC recommends that laundry can be washed with that of other individuals but should not be shaken out (to prevent aerosolizing the virus). Laundry should be washed using the warmest water possible and bleach, and items should be dried completely. A disposable hamper liner should be available. People handling laundry should be provided with disposable gloves.

People in medical isolation should receive all of their food service in the medical isolation space. Disposable items should be placed in the trash in the medical isolation room. Non-disposable items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should be instructed to wash their hands after removing gloves.

Prison laundry and food waste is usually handled by inmates. An inmate handling the dirty laundry or utensils of an infected inmate would be at grave risk of infection unless he or she is given adequate personal protective equipment and training.

Instead, the March 19 protocol calls for laundry, food service utensils, and medical waste of an isolated inmate to be handled as usual. This would seriously undermine efforts to isolate suspected COVID-19 cases from the general population.

ii. Transport vehicles: CDC recommends waiting, as long as practical and ideally up to 24 hours, before beginning to clean and disinfect spaces where COVID-19 cases spent time, including transport vehicles.

The March 19 protocol (Section 2.4) calls for staff to "set fan to high", "drive with the windows down," and "air out" transport vehicles for one hour after transporting a patient before using it again without a mask or respirator. The protocol is unclear as to when cleaning will take place—

"after transport" is vague. Does that mean after each time the vehicle is driven? Or after its use is over for the day, allowing different groups of inmates to be exposed to the vehicle? Given that the novel coronavirus can survive for more than 1 hour in droplets, up to 24 hours on cardboard, and up to 72 hours on metal or plastic, these decontamination procedures are insufficient to prevent further spread.

g. **Quarantining close contacts of COVID-19 cases:** In facilities with ongoing healthcare capacity, CDC recommends that people who are close contacts of a confirmed or suspected COVID-19 case should be placed under quarantine for 14 days. Close contacts may be staff, visitors, inmates, or the household members of staff, contractors, visitors, or recently admitted inmates. Quarantined individuals should be restricted from facility transfers during the 14-day quarantine period, unless needed for medical reasons. Close contacts should be evaluated by a healthcare professional as close as possible to their housing unit, rather than being transported through the facility to a medical unit.

VTDOC March 19 protocol (Section 3.1.) suggests that only the cellmate of the symptomatic individual will be identified as a potential close contact. That person will be given mask, instructed to wash hands, and be transported to the medical unit for further screening. These plans limit the potential impact of contact tracing and put other individuals in the facility at risk of infection if suspected cases and moved through the facility.

9. The above examples illustrate that DOC remains unprepared to address the current COVID-19 pandemic. And as the CDC acknowledges, even a prison operating precisely under its guidelines would be a far more dangerous environment than the community, with the governor's "stay home, stay safe" order and business and school closures in place.

10. DOC's inability to adequately contain and treat COVID-19 is especially concerning for higher risk individuals, such as older adults and people with chronic illnesses such as diabetes, liver disease, pregnancy, heart disease, and lung disease. People with these particular characteristics are most susceptible to becoming seriously ill or even dying should they become infected with COVID-19.

11. There is true urgency to act on these facts now. Data from the US during other infectious disease outbreaks (e.g. influenza) and data from other countries during COVID-19 show that when prison systems are unprepared for pandemics, people in prison experience much higher rates of morbidity and mortality than even affected communities. Such crises within prisons endanger communities as a whole by increasing the overall number of cases and increasing pressure on hospitals. There is no current approved vaccine or antiviral medication treatment for COVID-19 so public health preparedness is the only tool we have.

The facts recited herein are based on my personal knowledge and, so far as I can rely on that knowledge, I believe them to be true.

Dated at Wilton, Connecticut on March 26, 2020.

Jaimie Meyer

Notary Public

My commission expires 1/31/2021