Second COVID-19 inspection of BOP Lompoc by Dr. Homer Venters

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B. Introduction

1. This report is submitted to The Honorable Consuelo B. Marshall, United States District Court Judge, Central District of California in response to an order to perform a second COVID-19 inspection of the Federal Bureau of Prisons (BOP) facility Lompoc. This order relates to case CV 20-4450-CBM-(PVCx) *Torres et al. v. Milusnic et al.*
2. This facility inspection was ordered by The Court on April 16, 2021 and occurred on April 20 and 21, 20201.
3. In the time since my initial inspection in September 2020, I have continued to conduct COVID-19 inspections in various detention settings and provide recommendations for limiting morbidity and mortality for detained people and staff. I have also expanded my work as an independent monitor for both COVID-19 related issues as well as general health care delivery in carceral settings. I have also been named by President Biden to serve on the COVID-19 Health Equity Task force.[1] I have provided a listing of new COVID-19 inspections and other new engagements since my initial inspection in Appendix 2.

[1] Biden-Harris COVID-19 Health Equity Task Force Members. https://www.whitehouse.gov/briefing-room/press-briefings/2021/02/10/president-biden-announces-members-of-the-biden-harris-administration-covid-19-health-equity-task-force/

4. The COVID-19 pandemic has continued to cause disproportionate levels of morbidity and mortality in carceral settings. Peer reviewed studies of COVID-19 infection rates have identified that people in jail and prison are three to five times more likely to contract COVID-19 and that they are also at increased risk of death from COVID-19.[2] The CDC has also provided additional data on the rapid nature of COVID-19 transmission in prison settings, releasing a report on the spread of the virus through Utah State Prisons.[3]
5. At the time of this report, the Bureau of Prisons reported that 45,999 cases of COVID-19 had occurred, with 234 deaths among incarcerated people and 4 deaths among staff. This represents a tripling of total cases and doubling in total deaths since my original inspection. Of note, while the total ratio of cases in BOP settings throughout the pandemic is roughly 7:1 incarcerated people to staff, the *current* COVID-19 data reveal that there are now more active cases among staff than among incarcerated people.[4]
6. At Lompoc, the BOP reported that an additional 95 cases of COVID-19 and no COVID-19 related hospitalizations occurred since my initial inspection. A total of 2305 tests were reportedly conducted in this time.

C. Methodology

7. The goal of my second inspection of BOP Lompoc was to assess the adequacy of the facility response to COVID-19 since my initial inspection. Because a large amount of focus has correctly been placed on vaccination of staff and incarcerated people, I framed my inspection on the following two questions;

[2] COVID-19 and Mass Incarceration: an urgent call for action. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30231-0/fulltext and COVID-19 in US State and Federal Prisons. https://cdn.ymaws.com/councilonj.org/resource/resmgr/covid_commission/COVID-19_in_State_and_Federa.pdf.
[3] Community-Associated Outbreak of COVID-19 in a Correctional Facility — Utah, September 2020–January 2021. https://www.cdc.gov/mmwr/volumes/70/wr/mm7013a2.htm.
[4] US BOP COVID-19 Website, accessed 5/10/21. https://www.bop.gov/coronavirus/.

a. Has the facility adequately implemented a vaccination program for staff and detained people?

b. Has the facility adequately addressed recommendations made in the initial report that reflect basic CDC guidelines and BOP's own policies to prevent illness and death from COVID-19?

The adequacy of the vaccination program includes not only obtaining the vaccine, but taking steps to answer questions and promote engagement, especially among people who are high risk for serious illness or death from COVID-19 infection and among staff. My questions for staff and incarcerated people included whether the vaccine had been offered, whether they had questions or concerns about the vaccine, whether those questions were addressed, and whether any efforts were made to engage with people after refusal, especially those known to be high risk, during their nursing and medical appointments. In order to assess the response to other COVID-19 measures that were highlighted in my original report and part of CDC and BOP guidelines, I asked specific questions relating to access to soap and paper towels, opportunities for social distancing, screenings for people who worked, access to sick call and chronic care encounters.

8. Communication regarding the information I required to conduct this inspection, as well as the timing and logistics of the inspection included attorneys from both BOP and plaintiffs. Several areas of information were requested via email communication including updates on the number of COVID-19 cases and vaccinations, location of new cases, mortality reviews of deaths and data on patients being move up or down in their care levels, all since my initial inspection. The list of information I reviewed for this report is contained below in Appendix 1.

9. During the inspection, BOP Lompoc staff did not block or impede my access to any part of the facility and were extremely helpful in orienting me to the overall layout and operations of the facility, the various measures taken in response to COVID-19 and the current status of COVID-19 mitigation efforts.

D. Inspection

10. The Lompoc inspection was conducted over two days, April 20th and 21st 2021. The path of the inspection roughly followed the path of the prior inspection, with the Low being inspected on the first day and the North and South camps and Medium being inspected on the second day. During this time, I spoke with 67 detained people and approximately 15 staff members. Staff were very helpful in identifying a spot in each housing area where I could have brief confidential conversations with people. The Interim Warden was present throughout the inspection, and in each facility, I was accompanied by a BOP/PHS team that included one or more facility leadership as well as a Public Health Service Officer who provided information on the overall COVID-19 response and how each facility implemented BOP COVID-19 policies. I was able to speak with the Heath Service Administrator and Medical Director during the inspection. I have noted areas of the physical inspection that differed from my initial inspection or appeared relevant to the COVID-19 response, but have not repeated the basic description of each unit.

11. Before starting the physical inspection of the facilities, I met with the BOP Lompoc leadership team to ask general questions about the COVID-19 responses since my initial inspection. The BOP Lompoc team indicated that 95% of incarcerated people had been offered vaccination, as had all staff, and that rates of acceptance were roughly 50% for staff and incarcerated people. The team indicated that they did not track staff vaccination rates unless the vaccination occurred via BOP and stated that the reason for this revolved around their inability to mandate reporting or vaccination among staff. They indicted that some vaccination talks did occur with staff, led by Lieutenants with some input from health staff. No surveys of staff or incarcerated people had been conducted to date regarding COVID-19 vaccination per the team. The team indicated that roughly 100 people had been added to the chronic care lists of Lompoc because of COVID-19, but they were unsure if this reflected ongoing or 'long-COVID-19' symptoms. They stated there was no code in the electronic medical records being utilized by BOP to identify and track chronic

or long-term COVID-19 symptoms and that they were unsure of the number of people with chronic symptoms from COVID-19 infection. The team also reported that additional staff had been added since my last inspection, with a full complement of four MD's and three mid-level providers being utilized now, and that the Director of Nursing position was currently unfilled.

12. Regarding incarcerated people with work assignments, the Lompoc team indicated that more work assignments had been opened back up with lower rates of COVID-19 infection, and that there was no specific requirement, education or incentive for workers to be vaccinated. The team indicated that some critical workers, including food service, and those who worked in the medical units, were placed into the initial group of higher priority vaccine offers. In addition, the team indicated that "more controls" were in place to ensure that daily COVID-19 screening of workers take place. I raised my finding from the prior inspection that these screenings did not appear to be occurring despite assurances to the contrary and the team again assured me that these screenings were happening on a daily basis for inmate workers. The team stated that many of the people with work assignments were cohorted into specific housing areas, with a separation between two groups of workers who cover the food service assignments.

13. The staff screening process was in the same mode of operation as I previously observed, with a dedicated site at the staff training center. The BOP/PHS team reported that every staff member would come to this spot for their screening on a daily basis before starting their shift elsewhere. I passed through the screening both days and prior to the inspection, shared my vaccination and N95 fit testing certification with the BOP.

14. The first facility with detained people that I inspected was FCI Lompoc also referred to as 'the Low'. The BOP/PHS team indicated that as before, no medical isolation or medical quarantine was being conducted in this facility. I inspected three housing areas in the Low, AH, HK and AJ. These housing areas were comprised of open bunks with bathrooms situated in between bunk areas. At the time of my inspection, most detained people and staff were wearing masks. The bunks in the sleeping areas of two housing units had been moved since my initial inspection, and

both staff and detained people reported that this had been done several days before my inspection, to allow for more separation between people. Some bunks were arranged head to toe, either for adjacent bunks or top/bottom bunks, and some were not. Floors of all areas were clean, without trash or debris. The bathrooms all had soap and half had paper towels present. Bottles of cleaning supplies were evident throughout all three of these dorms.

15. The next area I inspected was the North and South Camp. The BOP/PHS team stated that most of the workers for the entire complex were housed in the Camps and that the number of work details had expanded since my last inspection due to loosening of COVID-19 related work restrictions. The North Camp bathrooms were clean, had no paper towels and the soap dispensers were empty. In both bathrooms of the North Camp dorm, two bags of soap were sitting in two separate sinks, unopened, and did not appear to fit the dispensers present in the bathrooms. The South Camp dorm A bathrooms had paper towels present and one soap dispenser was filled. The North Camp dining hall was also inspected and one change evident from my prior inspection was that every other seat had been removed from the metal tables, leaving the steel footing. Staff explained that this had been done to promote social distancing in meals, and that the prior practice of putting tape on alternate seats had not been effective. When I asked whether there were enough seats for everyone to eat sitting down, staff assured me that this was not a problem.

16. The next area of my BOP Lompoc inspection was the USP (United States Penitentiary) also known as ‘the Medium’. I inspected J unit, the three-tier general population unit which was reported by the BOP/PHS team to have 102 people at the time. The common areas of the floors were clean of debris as were the shower areas. The BOP/PHS team indicated that most of the people on this unit were in single cells, and that anyone designated as ‘high-risk’ based on CDC criteria was in a single cell. I observed cleaning supplies, as well as soap and paper towels out in the common spaces, and staff indicated that these supplies were for use by people in their cells.

17. The next area I inspected was the SHU, where newly admitted people are held, as well as some in pre-release quarantine and those who are in segregation for punitive or administrative reasons. This area was unchanged from my prior inspection and the staff made clear that because the unit operates as a high security segregation unit that also houses new admissions and pre-release quarantine cohorts, everyone must be treated in a manner consistent with segregation policies. They acknowledged the lack of phone access in the new admission quarantine period and explained that much of the delay involved the difficulty in setting up phone accounts in this unit as opposed to the traditional new admission units which had more ready computer access and regular counselor presence, which they reported working to address. Areas and supplies for PPE donning and doffing were present on the unit and well stocked.

18. I also inspected M unit, which was functioning at pre-release quarantine. This open bar stock unit was also unchanged since my initial inspection and the staff reported that people in this setting were not allowed out of their cells and did not have recreation access. The Interim Warden and I discussed options for how out of cell time could be accomplished in this unit, with creation of some exercise or recreation stations. Areas and supplies for PPE donning and doffing were present on the unit and well stocked.

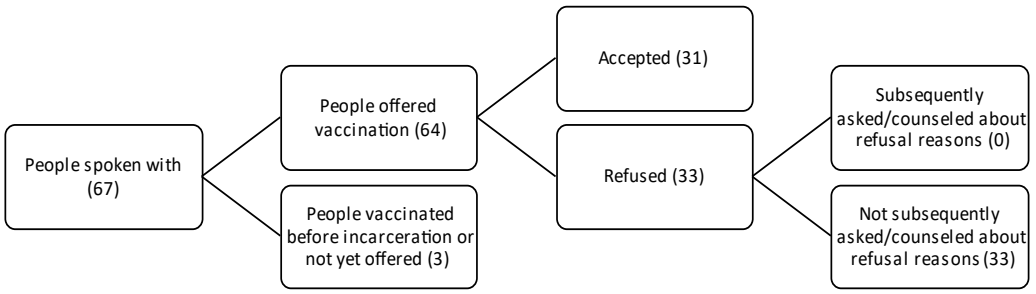
Reports from Incarcerated People

19. I spoke with 67 detained people during my inspection, 33 at the Low, 12 at North Camp, 16 at South Camp, and 6 at USP/The Medium. The following are COVID-19 concerns or observations that were relayed by at least two of the people I spoke with.

    a. Vaccination. Among the 67 people I spoke with, 31 reported being vaccinated by BOP and 33 had refused vaccination (see Figure 1 below). People in all three facilities reported that their vaccination offers occurred in large settings, either in their housing area, a dining hall or other setting. They reported that health staff would make a general

announcement about vaccination and then would call each person one at a time to either take the vaccine or sign a refusal. None of the people who refused the vaccine reported being subsequently contacted by health staff to discuss their reasons for refusal and none of them reported that their refusal or vaccine questions had been addressed in their subsequent health encounters. Many people reported that when they tried to ask questions about the safety of the vaccine, or posed questions about their own health or medication issues in relation to the vaccine, they were told to either take the vaccine or sign a refusal form.

Figure 1. Vaccination reports



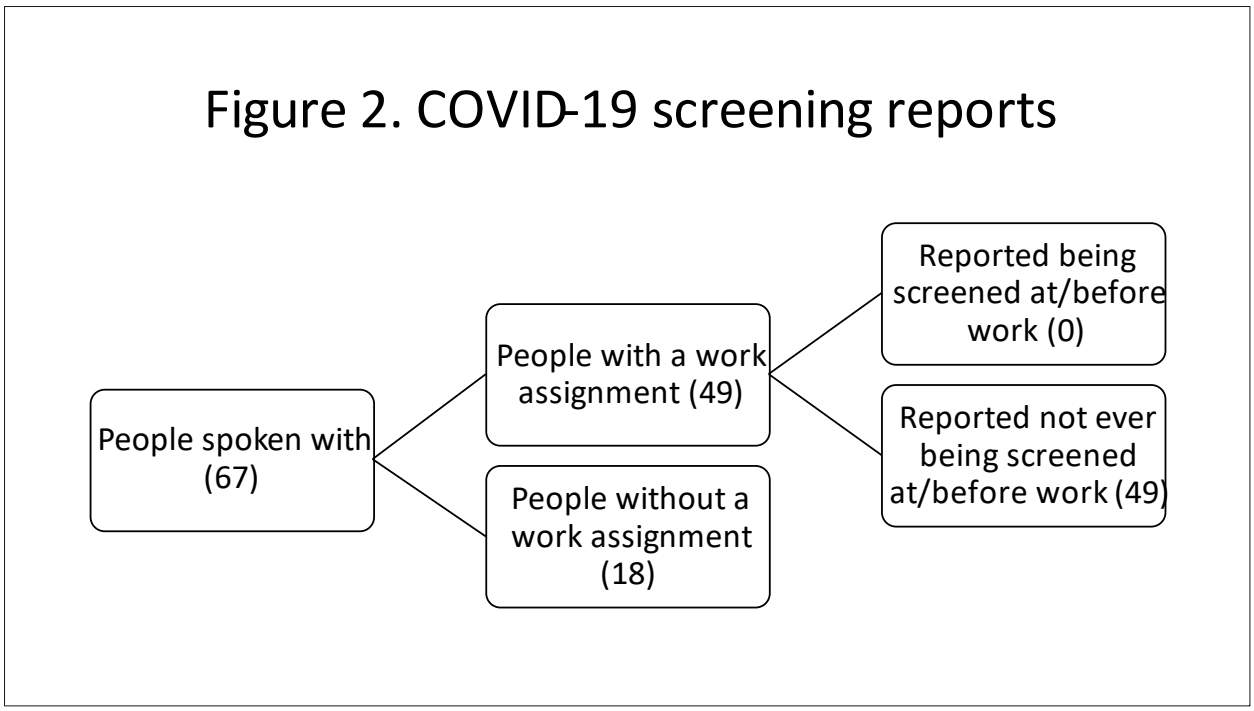
Many of the people who reported refusing the vaccine told me they were willing to take it but simply had questions about their own health status. Examples of their reports of health problems and vaccine questions are included below in Table 1. Of note, only 5 of the people who reported refusing the vaccine stated that they would never be open to

taking it. One person reported that the health service administrator had spoken with him before the vaccine was offered, which helped him to decide to become vaccinated.

Table 1. Information from Individuals who Reported Vaccine Refusal

Reported health problems	Concern/response
Heart disease	Had questions about allergic reactions, told to take or sign refusal, no subsequent discussion.
Diabetes, cancer	Had questions about his immune system and vaccination, told to take or sign refusal, no subsequent discussion.
Asthma	Had questions about vaccine safety, told to take or sign refusal, no subsequent discussion.
Inflammatory bowel disease	Had questions about his medications and vaccine interactions, told to take or sign refusal, no subsequent discussion.
Diabetes, kidney disease, heart disease	Had questions about his medications and vaccine interactions, told to take or sign refusal, no subsequent discussion.
Heart disease	Had questions about vaccine safety, told to take or sign refusal, no subsequent discussion.
Immune disease	Had questions about vaccine safety with his health issues. told to take or sign refusal, no subsequent discussion.
Diabetes	Had questions about vaccine safety, told to take or sign refusal, no subsequent discussion.
Heart disease, emphysema	Had questions about his medications and vaccine interactions, told to take or sign refusal, no subsequent discussion.
Immune disease	Had questions about vaccine safety with his medications, told to take or sign refusal, no subsequent discussion.
Diabetes, seizure disorder, hypertension	Had questions about his medications and vaccine interactions, told to take or sign refusal, no subsequent discussion.
Poorly controlled hypertension	No ability to ask questions, no subsequent discussion.
Inflammatory bowel disease	Had questions about vaccine safety with his health issues and medications, told to take or sign refusal, no subsequent discussion.
Hepatitis C	Had questions about vaccine safety with his health issues and medications, told to take or sign refusal, no subsequent discussion.
Diabetes, asthma	Had questions about vaccine safety with his health issues and medications, told to take or sign refusal, no subsequent discussion.
Prior medication allergies	Had questions about vaccine safety with his health issues and medications, told to take or sign refusal, no subsequent discussion.

b. Screening of workers. I spoke with 49 people who reported having a work assignment (see Figure 2) None of them reported ever being screened by staff for symptoms of COVID-19 or having their temperatures checked as part of their daily work assignments. Work assignments for the people I spoke with included working in food service, medical, the shop area, in the chapel, in administration, in education, in recreation, as a welder, in maintenance, as an orderly and as a clerk.



c. Access to soap and paper towels. Among the people 67 people I spoke with, 33 reported a lack of access to soap or paper towels, but with a very localized nature of reports (see Table 2). In some facilities, such as the USP, every person reported regular access to soap and paper towels since my last inspection. The greatest concentration of people reporting lack of access to soap and paper towels was in the North and South Camps. Many of these people also reported that in the days before my inspection, they were directed by security staff on how to answer my questions. Several people specifically reported that security staff told them to report that they always wipe down common surfaces and electrical sockets every 15 minutes. Each of the people who told me of being directed about this point also stated that they had never once done this. In the North Camp, several people reported that minutes before the inspection, the lack of any soap in the bathroom had been noticed by security staff who went to the kitchen and took bags of soap from there and simply dropped the unopened bags into the sinks of the housing area

bathrooms. They stated that this had never occurred before and that their soap dispensers were often empty. This transfer of soap from the kitchen to the North Camp bathroom minutes before my inspection was also reported by kitchen workers. In the South Camp, people reported that their soap dispensers were often empty by the afternoon or evening and that just as people returned form their work shifts, they were unable to wash and dry their hands. Several people in the South camp also reported a lack of paper towels and that the single hand dryer in the dorm was often broken. Many of the people I spoke with in the North and South Camps reported that whenever an inspection occurs, soap and paper towels are produced. Two people in the Camps reported that they had received two indigent hygiene kits in their time at Lompoc, both on the day before the two inspections I have conducted.

Table 2. Soap and Paper Towel Access

Facility/unit	Percent reporting lack of soap/paper towels
Low A,H	9% (1/11)
Low A,K	11% (2/19)
Low A,K	100% (3/3)
North Camp	100% (12/12)
South Camp	94% (15/16)
Medium/USP	0% (0/6)

d. Social distancing. At the Low, seven people reported that during meals, people routinely sat on the open metal bars or beams where seats had previously been affixed. They stated that this occurred during most meals, and that the alternative was for people to eat standing, which some people also did. At the South camp, a common concern was the

three times daily practice of taking a bus to the North camp for meals. People reported that the bus they took had a posted capacity for 44 and that often, every seat is filled with two men, and additionally, others stood in the aisles. This was the most common report concerning social distancing that I encountered in my inspection, with 9 of the 16 people I spoke in the Camp expressing this concern. Several people reported that there had previously been an effort to allow for social distancing (one person per seat) but that they had been told by security staff that this was viewed as a waste of gas because it required additional trips.

e. Three people expressed concern that their chronic care levels had been 'downgraded', meaning that their care level was moved from 2 to 1 in the BOP classification system. They stated that they thought this was done to lessen the frequency of medical encounters for their chronic health issues and that they had not been informed or consulted about this change, but had noticed on their medical records.

f. Four people expressed concern about inconsistency between their medical records and home confinement paperwork from BOP regarding their requests for COVID-19 related release. I was shown BOP forms that appeared to indicate people had 'no underlying conditions' and other paperwork from people's medical records that indicated multiple chronic health problems.

g. Nine people reported concerns about delays in chronic care and sick call responses, while four reported that access to care had improved since my last inspection.

h. Four people reported concerns about the punitive nature of the new admission quarantine, including that no access to phone was available during the time period. Two of these people reported that the intake quarantine was more stressful than punitive segregation they had experienced in other prison settings.

i. Four people reported ongoing respiratory and neurologic symptoms from their initial COVID-19 infection many months prior, and that they were not receiving care for those

symptoms and had never received any physical therapy, occupational therapy or incentive spirometry.

Records Reviews

20. The BOP provided several other groups of data based on my requests. First, I requested data to show what percentage of incarcerated people met CDC criteria for being at high risk of death or serious illness from COVID-19 infection. The BOP reported two indicators, the percentage of people with at least one condition that met CDC criteria for being at high risk, and the percentage of people with at least one condition that *may* place them at high risk. The percentage of people in each facility was given below:

Facility	Percent at High Risk	Percent who may be at High Risk
Low	73.70%	91.88%
Camps	67.63%	91.04%
Medium/USP	66.84%	91.61%

By comparison, in my initial inspection, the BOP reported that just 51.6 % of people in the Low met CDC criteria for being high risk for serious illness to death from COVID-19 infection.

21. I also requested data on the number of new cases among staff and incarcerated people and the locations of these new positive tests. The BOP reported a total of 95 new cases since my initial inspection, ranging from September 2020 through March 2021. Approximately half of these (48) occurred in new admission settings where all people are tested, and the rest either in pre-release quarantine or new cases elsewhere in the facility. The total number of tests conducted during this time was 2,305.

22. I also requested information about the number of people who were either moved up or down a care level since my last inspection, between care level 1 and 2. The BOP describes these levels in the following manner; “Care Level 1 inmates are less than 70 years of age and are generally healthy. They may have limited medical needs that can be easily managed by clinician

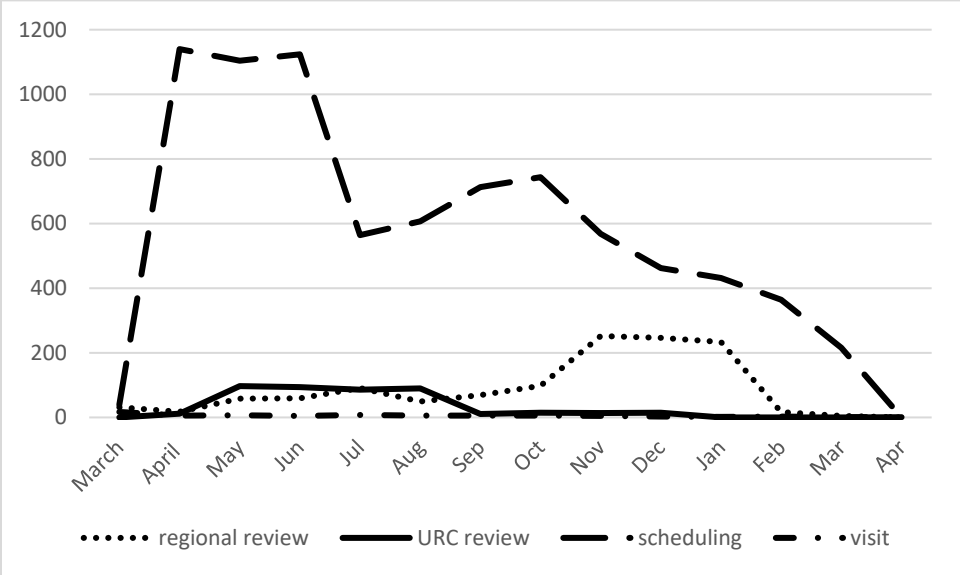
evaluations every 6–12 months. ′ Example conditions: Mild asthma, diet-controlled diabetes, stable HIV patients not requiring medications, well-controlled hyperlipidemia or hypertension, etc. Care Level 2 inmates are stable outpatients who require clinician evaluations monthly to every 6 months. Their medical and mental health conditions can be managed through routine, regularly scheduled appointments with clinicians for monitoring. Enhanced medical resources, such as consultation or evaluation by medical specialists, may be required from time to time. ′ Example conditions: Medication-controlled diabetes, epilepsy, or emphysema."[5] The BOP reported that in the time between my first and second inspection, there had been 20 care level increases and 30 care level reductions.

23. I also requested data on specialty visits over time. Data from the BOP shows that the number of pending specialty referral reviews and visits sharply increased in the early months of the pandemic and has been resolved (see Figure 3). BOP provided multiple data points regarding specialty visits and I have included four of them, all measured as the number of instances when the metric is past a 30-day mark. The variables I included below are the regional review, the utilization review committee (URC) review, the scheduling of the appointment and the visits. These data show an early backlog in the number of visits being reviewed followed by a backlog in later months in scheduling, which reflects my experience elsewhere as specialist appointment became difficult to secure. One caveat in this data is that I am unsure how many of these approved visits actually resulted in an encounter with a specialist, since the data show the number of instances when any of the metrics exceeded a 30 day wait. In my experience, specialty visits can be 'resolved' in a variety of ways and cancellation, refusal or transfer may lead to a false or distorted impression that care was delivered. I was impressed that the Interim Warden was not only familiar with these numbers during the visit, but could relate how these different tasks

[5] US BOP Classification guide. Accessed 5/10/21 at https://www.bop.gov/resources/pdfs/care_level_classification_guide.pdf

(referral, approval, scheduling, visit) had played out over the course of the pandemic and were being resolved.

Figure 3. Specialty referrals (regional review, URC review, scheduling and visits).



24. The BOP COVID-19 policies and procedures I requested included several sections that are relevant to the reports of incarcerated people;

a. Regarding screening of workers, the BOP COVID-19 module 8 states "Screen orderlies assigned to health service units (HSUs) for COVID-19 symptoms and temperature prior to each shift. In facilities with active COVID-19 cases (staff or inmate), consider screening inmate food service workers and orderlies for COVID-19 symptoms and temperature prior to each shift, as well as periodic testing for COVID-19."

b. Regarding access to soap, the BOP COVID-19 module 1 states "Supplies for handwashing (soap, running water, hand dryers or paper towels) should be readily available for all staff and inmates and continuously restocked as needed."

c. Regarding social distancing, the BOP COVID-19 module 6 indicated that transportation should include social distancing and specifically mentions utilizing bus and plane transport at 50% capacity.

25. I also requested mortality reviews from deaths that had occurred since my last inspection. Three sets of records were provided, reflecting deaths that occurred on 12/15/20, 1/19/21 and 2/28/21. One of these three deaths (and hospitalization) was clearly COVID-19 related despite the BOP's report to me on 4/21/21 that "There have been zero hospitalizations for COVID-related illness since September 2, 2021". This 62-year-old man had originally contracted COVID-19 in Lompoc BOP in May 2020, had never recovered after his initial illness and after nursing home treatment, hospital transfer and intensive care treatment, he ultimately succumbed to the complications of his COVID-19 infection. His cause of death is clearly identified as "Respiratory failure/Respiratory arrest secondary to paralysis secondary to COVID-19." A second death involved the suicide of a 46-year-old man who entered Lompoc with a history of serious mental illness but who had been removed from the mental health chronic care services for lack of active symptoms and who had survived COVID-19 infection in May 2020. The third death involved an 81-year-old man with a history of hypertension, extensive cardiac disease including heart attack, and COVID-19 in June 2020, who died from intracranial hemorrhage. His medical records include a report of extended period of not receiving his medications without mention in the mortality review. The BOP mortality reviews for all three deaths found the care these patients received to be appropriate and acceptable and in each case, under recommendations is written "none at this time."

E. Findings

26. My findings are divided into three areas; strengths deficiencies and recommendations. My framework for evaluation is based on the questions I presented above;

    a. Has the facility adequately implemented a vaccination program for staff and detained people?

b. Has the facility adequately addressed recommendations made in the initial report that reflect basic CDC guidelines and BOP's own policies to prevent illness and death from COVID-19?

27. Strengths of the BOP/Lompoc COVID-19 response.

a. Vaccine access. By the time I conducted my inspection, BOP data indicate that roughly half of the people detained and staff at Lompoc had been vaccinated. This represents a significant investment in resources and organization by the BOP and very effective coordination between PHS and BOP teams. This level of commitment to securing and distributing COVID-19 vaccines is now standard in correctional settings, but the BOP efforts to obtain and deliver vaccines to Lompoc BOP and other facilities were implemented in advance of most other carceral systems. By comparison, the rates in most of the California State prisons are now above 65% for incarcerated people and above 40% for staff while the rates in many other prison systems are far lower.[6] The BOP team reported that Lieutenants have conducted vaccine sessions with staff, and that some of these have included input from health staff.

b. The staff intake screening process continues to operate in a manner that effectively checks each staff member for elevated temperature and COVID-19 symptoms before they start their shift. This process shows that BOP has remained committed to detecting new cases of COVID-19 among staff, even as vaccination efforts continue, consistent with CDC guidance.

c. Testing. BOP Lompoc continues to implement a careful approach to testing of all newly admitted and soon to be released people. There is also a clear commitment to more widespread testing when new cases are detected. The data on new cases show that the

[6] CDCD COVID-19 Tracking website, accessed 5/10/21 https://www.cdcr.ca.gov/covid19/population-status-tracking/ and https://www.healthaffairs.org/do/10.1377/hblog20210413.559579/full/

current approach to testing is effective at detecting new case in these two groups, the newly arrived and the soon to be released.

d. PHS involvement. The involvement of PHS staff in design and implementation of the vaccine rollout, especially in the logistics of distribution and administration at individual sites. In addition, it is apparent that PHS staff were present at some of the actual vaccine administrations.

e. Social distancing. Although social distancing remains a challenge, with some areas noted below in deficiencies, it was clear that the bunks in at least two areas I inspected had been moved in the days before my inspection to allow for greater social distancing. Some of the people who work in those units reported being told that these moves were temporary, but the Interim Warden and other leadership reported that this change would be implemented wherever possible and would be maintained.

f. Cleanliness. As before, the housing areas were generally clean and free of debris during my inspection, in both living quarters and bathrooms. Cleaning solution for personal spaces also appeared abundant during the time of my inspection.

g. Specialty referrals. The BOP Lompoc team has worked to resolve essentially all of the backlogged specialty referrals that accumulated during the pandemic. This success represents a significant effort by facility medical staff in securing approval for appointments with a backlogged central review process and then scheduling and facilitating visits with a group of specialists that were scarce during much of the pandemic.

h. PPE. The Lompoc BOP facilities displayed ample PPE in the quarantine settings I inspected and the staff in those units were knowledgeable about how to don and doff their protective equipment.

28. Deficiencies in the BOP/Lompoc COVID-19 response.

a. Vaccination engagement. It is apparent that BOP has performed well in their efforts to secure, distribute and offer COVID-19 vaccine, a significant accomplishment. But there appears little effort focused on engaging staff and incarcerated people about their questions or concerns regarding the vaccine. In speaking with the leadership, it was clear that they view the periodic, mass offering of the vaccine as more than adequate. They reported no efforts to identify and follow up with high-risk patients who refused vaccination, and stated several times that because those people would be re-offered again at a later time, in the same manner as before, that the process was adequate. This is consistent with the reports of patients themselves, many of whom reported that despite having questions about the vaccine and their own health issues, these questions were not addressed during the vaccine offer or afterwards. The CDC has entire toolkits and guidance documents designed to increase vaccine update, but the basic foundation of these efforts is engaging with patients; "By taking time to listen to their concerns and answer their questions, we can help people become confident in their decision to be vaccinated."[7] The approach of BOP Lompoc not only fails to engage with patients, it has a paradoxical effect of creating a pool of extremely high-risk unvaccinated patients. Many of these high-risk patients were initially offered the vaccine 3 or 4 months ago, and the insistence by BOP leadership that their very valid and predictable questions and concerns go unaddressed during this time significantly increases the risk of preventable death from COVID-19. In other detention settings I have worked in, a COVID-19 vaccine refusal by a high-risk patient would result in prompt session with a physician or mid-level provider, because the consequences of infection are so grave. In similar fashion, the BOP Lompoc leadership have taken a passive approach to improving vaccination rates among staff. When we discussed this issue, they stated that they could

[7] CDC Detention Communication Toolkit, accessed 5/10/21 at https://www.cdc.gov/coronavirus/2019-ncov/communication/toolkits/correctional-and-detention-facilities.html

do little to learn who was vaccinated by outside providers, or do more than they are currently doing to promote vaccination among their own staff. There had been no effort to survey staff or even aggregate the feedback encountered at the sessions that health and security staff had already conducted with staff. In this discussion, the BOP Lompoc leadership often reverted back to stating they were limited by what they could force their staff to do, instead of how they could increase uptake and engagement with their staff. The Interim Warden did engage me near the end of the inspection on this point and both offered ideas and asked for assistance in crafting an approach to engage with staff.

b. Screening. It is apparent that BOP Lompoc has failed to implement screening of inmate workers since this issue was raised in my prior inspection report, leading me to conclude that they and the BOP view the screening of workers as unimportant or trivial to their COVID-19 response. I am dismayed that despite multiple assurances on my first inspection that this process was in place, and clear evidence that it was not, I returned six months later to be told once again that this was process was occurring and find the same complete lack of screening of workers. This failure might be of lesser consequence if no new cases of COVID-19 had occurred, but there have been 95 cases of COVID-19 among incarcerated people since this issue was raised. In addition, many staff and incarcerated people remain unvaccinated and the BOP clearly views screening of paid staff as essential, since they continue to implement a robust process for everyone at the training center. This failure to implement screening of incarcerated workers comes as even more job assignments have opened up since my last inspection. As with the lack of vaccination engagement, this area prompted concern from the Interim Warden during our inspection, who appeared accustomed to this basic process being implemented and documented in other settings, which is consistent with BOP policies. During our time together, he showed me a screening documentation form that he proposed implementing throughout the Lompoc facilities.

c. Lack of infection control in housing areas. Throughout the facilities I inspected, it was clear that some people either had no access to soap or paper towels or that access had been provided in the days before my inspection. This was a consistent problem noted in my initial report and this appears to be an ongoing issue, especially in the North and South Camps and represents an abdication of the BOP's own policies.

d. Punitive approach to quarantine. The SHU unit I inspected is a 6-tier housing area designed for punitive segregation. The housing of people for 22-24 hours per day in cells, without access to basic privileges including phone and out of cell time is not appropriate and runs counter to CDC guidelines on making COVID-19 responses in detention settings non-punitive.[8]

e. Lack of adequate mortality reviews. The three deaths I reviewed, as with the prior deaths from my initial inspection, were all judged by BOP's multi-level mortality review to indicate adequate and appropriate care had been provided. The reviews of these three deaths also failed to make a single recommendation for improving care or addressing deficiencies. I am able to identify multiple areas of needed recommendation in these reviews. For example, in the case of a patient who reported not receiving his medications, a review of his medication administration records and reporting in the mortality review of the extent and causes of missed medications, and exploration of the potential relationship to his death is warranted. In the case of a suicide involving a person who had previously been identified as having serious mental illness with psychosis but had been taken off the mental health service due to a lack of symptoms, a structured review of the potential missed signs of mental health exacerbation and opportunities for treatment is needed. For the patient who died of COVID-19 related illness, there is no review of the adequacy of

[8] 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, accessed 9/19/20.

care in the P unit or nursing home before his final hospitalization in December 2020. This is a crucial omission because while still in Lompoc, the patient lost the use of his lower extremities, sustained multiple falls, developed pressure ulcers and was often incontinent of bowel and bladder. My understanding of the P unit hospital at Lompoc was that care was provided for patients with COVID-19 who did not yet require hospital level care. The months this patient received care in this unit would have been a clear area of scrutiny for me in conducting a mortality review but there is no review of this time in the Bop mortality review other than the general judgements that the care he received was appropriate and adequate.

29. Recommendations to mitigate morbidity and mortality from COVID-19 at BOP Lompoc.

Recommendation 1. The vaccination program at Lompoc BOP should be substantially expanded to increase the rates of vaccination of staff and ensure that high-risk people have their questions and concerns about vaccination addressed. In order to achieve these goals, the BOP Lompoc team should;

a. Conduct a survey of staff attitudes and practices regarding COVID-19 vaccination that elicits information about the reasons that staff are reluctant to become vaccinated, the number of staff who have been vaccinated outside BOP offerings, and what incentives or interventions would increase vaccine uptake by staff (see Appendix 3 for sample).

b. Immediately incorporate vaccine engagement into all chronic care encounters with patients who have refused vaccination. This intervention should be immediately applied to high-risk patients who have refused vaccination and should be oriented to address questions and concerns over several visits if needed. These encounters should be conducted by mid-level or physician providers given the complexity of questions and medical issues among high-risk people who have refused vaccination.

c. Create an interactive vaccine education resource within the health service email system that ensures any question received about COVID-19 and vaccination results in a response within 24 hours.

d. Change the structure of vaccination efforts to move away from the "take or refuse" model to offer a counseling encounter that is not presented as a refusal. When staffing or other logistical barriers exist during the vaccine events, people should be offered a counseling referral that will occur within 72 hours.

Recommendation 2. BOP Lompoc should implement basic COVID-19 screening of all incarcerated people who work outside their housing areas. Screening should match what is currently done for paid staff, in that temperature and specific symptom questions should be utilized every day before a person starts their work and documentation that these screenings are actually conducted should be established. Staff conducting these screenings should be trained on the screening process and how to respond to either elevated temperature or positive symptoms, in a manner that is consistent with CDC guidelines and the existing staff screenings.

Recommendation 3. Access to soap and paper towels must be established for all people detained in BOP Lompoc, with special emphasis on addressing ongoing deficiencies in the North and South Camp areas. Unannounced inspections by leadership of BOP Lompoc and other BOP and PHS health officials should be conducted to ensure compliance.

Recommendation 4. BOP Lompoc should take steps to further enable social distancing including the following;

a. Ensure adequate socially distanced seating during meals that does not result in some people being forced to sit on steel poles or beams that lack a seat.

b. Increase the number or frequency of bus runs between camps so that social distancing (1 person per seat) can be established.

c. Continue and maintain the preliminary bunk modifications that increase space between bunks throughout the facility.

Recommendation 5. BOP Lompoc and BOP headquarters should expedite the applications and reviews of high-risk patients who meet criteria for home confinement and report on the number and timing of pending and approved applications. They should also review the applications from Lompoc for inconsistencies or errors in the assessments of medical qualification.

Recommendation 6. BOP Lompoc and the BOP generally should establish a standardized chronic care clinic for long COVID-19 or chronic COVID-19 that includes access to physical therapy, incentive spirometry and other basic elements of care and tracks the prevalence of this health problem, the level of clinical acuity and progress in treatment at every facility. Delivering this standard of care requires first creating the ability to utilize a diagnostic or visit encounter code, as well as creating all of the elements of standardized chronic care encounters that can be used to train and oversee staff. The BOP website identifies that "46,116 inmates have recovered from COVID-19" which would include over half of the people incarcerated at BOP Lompoc. The lack of standardized tracking and attention to the severity and improvement in their health issues must be addressed, especially in light of the fact that this represents morbidity that was the direct result of incarceration.

Recommendation 7. BOP Lompoc should increase the level of services and out of cell time for people in quarantine, including phone and recreation as well as regular showers. Several people reported to me that the intake quarantine was more psychologically stressful than punitive segregation in other prisons, and one year into the pandemic, there is no excuse for denial of basic services and rights to people under the guise of infection control.

Recommendation 8. There is a clear need for independent review of deaths from COVID-19 at Lompoc and elsewhere within the BOP. Independent analysis of COVID-19 deaths should also include analysis of all-cause mortality rates during the pandemic. All three of the deaths that occurred since my last inspection occurred among people who had COVID-19, although only one is identified as COVID-19 related. The impact of COVID-19 on medical and behavioral health co-morbidities, as well as the impact of outbreaks on access to care, must be better understood. I

cannot explain why the BOP stated that there had been no COVID-19 related hospitalizations since my initial inspection when one of these deaths was clearly COVID-19 related and involved hospitalization in December 2020. This leaves me concerned that the burden of mortality, and certainly morbidity from ongoing or 'long' COVID-19 is unappreciated by the BOP. I am also concerned that in one of these deaths, despite the patient's report of not receiving his medications for a disease that was central to his death, there was no structured review of medication access in his mortality review before the BOP judged his care to be adequate and appropriate. I have led or conducted well over 100 mortality reviews and it is rare for there to be no areas of deficiency or improvement in a single case. The records of people who died in BOP custody at Lompoc have clear deficiencies and/or areas of improvement and the fact that no recommendations are made in the multi-level mortality reviews clearly establish that these are systemic failings that transcend BOP Lompoc. In the context of this case, independent review of COVID-19 related deaths is absolutely essential because without it, inadequacies in care are unlikely to be linked to death from COVID-19, despite the reality that they are intimately connected.

F. Summary

30. Since my initial inspection in September 2020, the number of COVID-19 infections in the BOP has tripled and the number of deaths doubled. The number of 'active' COVID-19 cases reported by the BOP is now greater among staff than incarcerated people. This national statistic is crucial to bear in mind when considering the work that remains undone at Lompoc BOP. The BOP testing data indicate that new admission and pre-released settings are being adequately tested. But the likely path for future cases and potential outbreaks is among staff who remain unvaccinated, and incarcerated people who move throughout the facilities. In the Lompoc facility, it is clear that staff have made considerable progress in acquiring and distributing COVID-19 vaccine for staff and incarcerated people alike. They have also made commendable progress in addressing the specialty visit backlog. But I am extremely concerned that the facility has taken a passive

approach to understanding and addressing the relatively low rates of vaccination among staff, and equally concerned that many of the high-risk patients I spoke with simply had questions or concerns that BOP has failed to address, leaving them unvaccinated. The repeat observation that incarcerated workers are not being screened before their shifts, despite ongoing assurances to the contrary, calls into question the interest of the BOP and the facility in basic infection control. The performative nature of how the North and South Camp areas were 'prepared' for my inspection, despite an ongoing lack of soap for the people who live in these areas on a daily basis, also forces a pessimistic assessment about how seriously the facility and the BOP take their own policies, the guidelines of the CDC and basic infection control. One positive element throughout the inspection was the clear frustration by the Interim Warden at these deficiencies and his genuine interest in discussing ways to address them in a collaborative manner. The draft staff survey I have included in appendix 3 is an example of an intervention we discussed and which he requested input on. Most of the recommendations I have submitted can be easily addressed at the facility level, provided there is a new approach to management. The lack of meaningful or thorough review of COVID-19 related deaths in BOP custody will require more systemic changes, however, and provides clear evidence of the need for external oversight of this health system.

Executed this 12th day of May, 2021 in Port Washington, NY

Signed,

Homer Venters MD, MS

Appendix 1. Materials reviewed for second Lompoc inspection report

- Legal filings from BOP and Plaintiffs
- Data on vaccinations, COVID-19 cases and hospitalizations and medical classifications provided by the BOP
- Medical records of deceased inmates.
- BOP mortality reviews for deceased inmates
- BOP COVID-19 policies and procedures
- Specialty referral data
- COVID-19 case housing area data

Venters-second BOP Lompoc

Appendix 2. New engagements since original report

New COVID Inspections (role/how retained)

- Southern Mississippi Correctional Facility, MS (for plaintiffs)
- Central Mississippi Correctional Facility, MS (for plaintiffs)
- FDC Philadelphia (BOP), PA (for plaintiffs)
- Osborn Correctional Institution, CT (as independent monitor)
- Robinson Correctional Institution, CT (as independent monitor)
- Hartford Correctional Center, CT (as independent monitor)
- Dallas County Jail, TX (for plaintiffs)
- Cheshire Correctional Institution, CT (as independent monitor)
- Calhoun County Jail, MI (for plaintiffs)
- York Correctional Institution, CT (as independent monitor)
- Pender Correctional Institution, NC (for plaintiffs)
- Craven Correctional Institution, NC (for plaintiffs)
- Central Prison, NC (for plaintiffs)
- North Carolina Correctional Institution for Women, NC (for plaintiffs)
- Chesapeake Detention Facility, MD (for plaintiffs)
- Maricopa County Jail (for plaintiffs)

Other new inspections or engagements

- Fluvanna Women's Correctional Center (as independent monitor)
- Santa Barbara Jail case (as independent monitor)
- ICE Health Care case (for plaintiffs)
- Arizona State Psychiatric Hospital COVID-19 case (for independent monitor)
- Utah State Prison COVID-19 case (for plaintiffs)
- Illinois jail death case (for plaintiffs)

Appendix 3. Sample COVID-19 Vaccination Staff Survey Outline

This is a sample survey outline based on questions posed in the Florida Sheriffs Association survey of law enforcement officers as well as the CDC toolkit on vaccine hesitancy and the American Academy of Family Physicians report on vaccine hesitancy among health care workers.[9] This outline is designed to present sample questions and is requires further formatting and design, samples of which can be found at various CDC and other health department sites.[10]

1. Have you received a dose of any COVID-19 vaccine? (y/n)
2. If so, did you have worries about getting vaccinated? What were they? (vaccine is new/unproven, vaccine causes health problems, vaccine side effects may make me ill, I already had COVID-19 and don't need it, I don't trust the government or whoever is giving the vaccine)
3. If so, what helped you decide to get the vaccine? (better for my health/family's health, better for work safety, easier to travel and do other non-work activities).
4. If so, did you receive the vaccine here at (insert facility) or somewhere else? (here, at my regular health provider, public vaccine site, other job setting).
5. If not, what are your main concerns/reasons for not yet becoming vaccinated? (vaccine is new/unproven, vaccine causes health problems, vaccine side effects may make me ill, I already had COVID-19 and don't need it, I don't trust the government or whoever is giving the vaccine)
6. If not, what would help you reconsider taking the vaccine? (more information, hearing from people I trust who took got vaccinated, financial incentives or time off, waiting to see how more people react to getting the vaccine).

[9] Survey shows most law enforcement officers 'hesitant' to get vaccine. Accessed 5/10/21 at https://www.wflx.com/2021/01/11/survey-shows-most-law-enforcement-officers-hesitant-get-vaccine/ and https://www.cdc.gov/vaccines/covid-19/downloads/VaccinateWConfidence-TipsForHCTeams_508.pdf and https://www.aafp.org/journals/fpm/blogs/inpractice/entry/countering_vaccine_hesitancy.html.

[10] CDC Tools and Templates, accessed 5/10/21 at https://www.cdc.gov/surveillancepractice/tools.html and COVID-19 and Survey, Orange County CA, accessed 5/10/21 at https://occovid19.ochealthinfo.com/covid-19-vaccine-survey and https://www1.nyc.gov/assets/doh/downloads/pdf/episrv/chs-question-matrix.pdf.