March 26, 2020

Hon. George Draper III, Chief Justice
Hon. Patricia Breckenridge
Hon. W. Brent Powell
Hon. Mary R. Russell
Hon. Laura Denvir Stith
Hon. Paul C. Wilson
Hon. Zel M. Fischer
Missouri Supreme Court
207 W High St.
Jefferson City, MO 65101

Dear Chief Justice Draper and Judges of the Court:

I write to you as a board-certified family physician and certified correctional health care physician with over 15 years of experience practicing correctional health care in Saint Louis County, Missouri. The undersigned are public health and medical professionals who serve Missourians in settings ranging from community-based clinics to large referral hospitals. We are increasingly concerned about the thousands of individuals confined in close quarters in local jails and state prisons, and believe these institutions are unable to comply with the Centers for Disease Control and Prevention (CDC) recommendations for treating or preventing the spread of COVID-19. We urge you to take swift action to avert the catastrophic loss of life that would result when Missouri jails and prisons experience an outbreak of COVID-19.

Background and Qualifications

I am Fred Rottnek, MD, MAHCM, a Professor of Medicine in the Saint Louis University School of Medicine, Professor in the Physician Assistant Program at the Doisy College of Health Sciences, and Professor in the Center for Health Law Studies in the School of Law. I am the Director of Community Medicine in the Department of Family and Community Medicine and the Program Director of the Addiction Medicine Fellowship. I am board-certified in Family Medicine and Addiction Medicine, and I am a certified Correctional Health Care Physician through the National Commission on Correctional Health Care. I completed my undergraduate medical education at Saint Louis University in 1995, my residency in Family Medicine in 1998 at Family Medicine of St. Louis, and a faculty development fellowship at the University of North Carolina-Chapel Hill in 1999. I hold a Master of Arts in Health Care Mission from the Aquinas Institute of Theology in St. Louis, Missouri.

I was the lead physician and medical director of the Saint Louis County Jail from June 2001 through September 2016. In this role, contracted through the Saint Louis County Department of Health, I saw patients three days/week, took call on average 16 days/month, and participated in the leadership teams that were responsible for the health and well-being of inmates, correctional medicine staff, correctional staff, and visitors to the jail, which is located in the Buzz Westfall Justice Center as well as Juvenile Detention in the Family Courts of Saint Louis County. As a large urban jail, during my years in this role, I was responsible for directing the medical care and supporting the correctional medicine staff in the care of a daily census of patients that varied from 900 to 1400, as well as annual intake screenings of 30,000 to 34,000 arrestees. The Saint Louis County Jail was (and is) the only jail in the State of Missouri that meets standards for accreditation by the American Correctional Association. Juvenile Detention is accredited by the National Commission on Correctional Health Care.

I have worked and served on the boards and committees of several community agencies that address the needs and assets of marginalized and underserved communities and populations. Many of these organizations have developed initiatives addressing individuals impacted by the criminal justice system, including the St. Louis Regional Health Commission, the St. Louis Integrated Health Network, Alive and Well Communities, and Criminal Justice Ministries.

I have published on the topics of correctional health care, addiction medicine, professional development, and social justice and the common good.

Heightened Risk of Epidemics in Jails and Prisons

Based on my review of information from the CDC, National Commission on Correctional Health Care (NCCHC), and the National Institute of Corrections (NIC) on COVID-19, my experience working in primary care and public health in both jail and juvenile detention settings, and my review of the relevant medical literature, it is my professional judgment that the COVID-19 pandemic has the potential to devastate the lives of both incarcerated individuals and jail personnel, and result in a medical emergency that could overwhelm Missouri's medical infrastructure.

An outbreak in any jail or prison will affect all of Missouri. Jails and prisons do not exist in isolation. Staff, contractors, vendors, and visitors regularly pass between communities and facilities, thereby carrying infectious disease both into and out of these facilities. The rapid turnover of jail and prison populations means that people often cycle between facilities and their local community. Even in times of limited visitation and movement, inmates will still need to be transported to and from facilities to attend court, move between facilities, and be released upon serving their sentence.

This poses a grave threat to the health and safety of Missourians, as an outbreak in a jail or prison could limit the ability of health professionals to contain, mitigate, and treat the spread of COVID-19. In my professional opinion, jails and prisons are particularly under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which I will detail further in the following points.

Missouri Jails and Prisons Cannot Implement Adequate Prevention, Containment, and Mitigation Strategies

COVID-19 is a highly infectious and easily communicable disease.[1] The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing), but survives on inanimate surfaces for up to three days. The latest medical information indicates people are most contagious when they are actively symptomatic, but it is still possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. Current research indicates transmission person to person can occur at a distance of three to six feet.

COVID-19 prevention strategies necessitate both containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill. Moreover, the use of appropriate personal protective equipment (PPE) is necessary for those tasked with decontaminating surfaces and interacting with potentially infected individuals.[2] The CDC recommends mitigation strategies such as social distancing and closing communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease.[3]

Jails and prisons are unable to adequately implement containment strategies. During an infectious disease outbreak, most people can protect themselves by washing their hands. Unfortunately, inmates have limited opportunities to clean themselves, shower, or wash hands while incarcerated. Many jails and prisons charge money to inmates for hand soap or other personal hygiene products. Most facilities also ban the use of alcohol-based antibacterial hand sanitizer. Further, under CDC guidance, high-touch surfaces (doorknobs, light switches, etc.) should be cleaned and disinfected several times a day with bleach or other approved cleansers, and the cleaner should use disposable gloves to prevent virus spread.[4] Yet many jails and prisons place limitations on the amount of cleaning supplies available to inmates, and also have insufficient staff available to clean, particularly during a public health pandemic like this. Spaces within jails and prisons are often also poorly ventilated and share HVAC systems, which facilitates and accelerates the spread of diseases through droplets.

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[1] *Coronavirus (COVID-19)*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/index.html.
[2] *Id*.
[3] *Id.*
[4] *Disinfecting Your Facility if Someone is Sick*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prepare/disinfecting-building-facility.html

Jails and prisons are also unable to practice effective mitigation strategies. Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person-to-person.[5] When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are far greater than normal. As such, when jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. The CDC suggests that jails and prisons implement social distancing strategies such as staggering meals, moving all bunks six feet apart, and limiting the distance inmates need to be transported to access medical care.[6] From my professional experience, these distancing strategies will be difficult if not impossible for most Missouri jails and prisons to implement.

The latest guidance from the CDC suggests that jails and prisons have a long list of hygiene supplies, cleaning supplies, PPE, and medical supplies on hand and available.[7] For example, the CDC recommends facilities provide liquid soap, as harsh bar soap can irritate the skin and reduce handwashing. The CDC also recommends jails and prisons have enough face masks to require every individual displaying COVID-19 symptoms to wear one. In my professional experience, it is unlikely most Missouri jails and prisons have or reasonably could obtain the required supplies to comply with this guidance.

Jails and Prisons Cannot Adequately Treat Those Infected

To prevent transmission of droplet-borne infectious diseases, people who are infected and symptomatic should be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms and, in my experience, many Missouri jails and prisons have none. This makes both containing the illness and caring for those who have become infected much more difficult.

Administrative or disciplinary segregation, or solitary confinement, of those who may be infected is not an effective disease containment strategy. The detrimental mental health effects of solitary confinement are well-known.[8] Studies show the isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death.[9] Solitary isolation is also an ineffective way to prevent transmission of the virus to others, because of the

[5] *Active Case Finding for Communicable Diseases in Prisons,* 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext

[6] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, CDC (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (hereinafter CDC Interim Guidance).

[7] *Id*.

[8] David H. Cloud, et al., *Public Health and Solitary Confinement in the United States*, 105 Am. J. Pub. Health 18, 18 (2015).

[9] Metzner & Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. Am. Academy Psychiatry and Law 104–108 (2010).

aforementioned lack of negative pressure rooms, and because correctional staff will still have to come into close proximity to check on these individuals. Moreover, placing inmates in solitary confinement will place a greater burden on already limited staff and resources. Per NCCHC guidelines, correctional facilities are responsible for meeting the medical and mental health needs of people in solitary or restrictive housing--particularly those with acute medical and mental health needs--which includes regular access to medicine and mental health treatment.[10] Put simply, solitary confinement will not solve the problem.

During an infectious disease outbreak, a containment strategy requires that caregivers for people who are ill must have access to adequate PPE supplies. According to NCCHC guidance, jails and prisons must have adequate PPE, including gloves, masks, and respirators, eye protectors, gowns, uniforms and shoe covers.[11] In my experience, many Missouri jails and prisons are already under-equipped with medical supplies. A pandemic only exacerbates the shortage. These institutions just simply do not have sufficient PPE for increasing cases of COVID-19 among people who are incarcerated and staff who are required to care for those people, increasing the risk for everyone in the facility of a widespread outbreak.

Jails and prisons are often poorly equipped to diagnose infectious disease outbreaks. Most jails and prisons lack urgent or emergent access to testing equipment, laboratories, and ventilators, which means that they will be slow to adequately diagnose and address the outbreak.

Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. It is unlikely jails or prisons will have adequate staff or PPE to safely transport individuals to these facilities, and guard the individuals while there. It can also create tremendous liability for a jail or prison if there are infected inmates and those outside facilities are over capacity.

A COVID-19 Outbreak in a Jail or Prison Creates Dangerous Staffing Shortages

Absenteeism can pose a substantial safety and security risk. As an outbreak spreads through jails, prisons, and communities, medical personnel and correctional staff will become sick and stop reporting to work. There is a physical limit to how much overtime other correctional staff can work to make up for lost employees.

[10] *Restrictive Housing in the U.S.: Issues, Challenges, and Future Directions,* National Institute of Justice, https://www.ncjrs.gov/pdffiles1/nij/250321.pdf (Nov. 2016).
[11] *Covid-19 Coronavirus: What You Need to Know in Corrections*, NCCHC, https://www.ncchc.org/covid-resources.

In my experience, many jails and prisons are already dangerously understaffed both in terms of correctional healthcare providers and correctional staff.[12] Many jails and prisons do not have 24 hour on-site health professionals. A shortage of doctors or nurses onsite will impact the already limited ability to conduct testing, treat symptoms, and recommend care for sick individuals. Further, as health systems inside facilities are taxed with COVID-19, people with other serious physical or mental health conditions may not be able to receive the medical care they need for these conditions.

A staffing shortage for correctional staff will greatly impact the ability of a facility to respond to a COVID-19 outbreak, as guards or supervisors need to facilitate prevention measures, transport inmates to medical, rearrange housing, and many other tasks. Moreover, a staffing shortage for correctional staff also creates an unacceptable general risk of danger to inmates and other staff members in a facility.

Contagious Disease Outbreaks in Jails and Prisons is a Public Health Nightmare

Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more acute than in the community at large. In my experience, past epidemics have taken a greater toll on jails and prisons even when the outbreak is of a disease with available vaccines and medication. For example, during the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases. In 2002, an outbreak of MRSA in a Missouri prison caused significant health problems.[13] And currently, jails and prisons across the United States are experiencing COVID-19 outbreaks. In New York, thirty-eight inmates in Rikers Island have tested positive for COVID-19, and officials report they expect the numbers to rise exponentially.[14]

To deal with a pandemic, society at large can increase resources and take emergency measures, like adding hundreds of hospital beds in a new facility. Jails and prisons have real and hard limitations of space, staffing, and supplies. It is unlikely most facilities will be able to reasonably put into place sufficient resources to address an outbreak.

[12] *See*, e.g., Kurt Erickson, *Parson Calls for More Downsizing in Missouri Prison System*, St. Louis Post-Dispatch (Jan. 20, 2020).
[13] Tyrabelidze, et al. *Personal Hygiene and Methicillin-resistant Staphylococcus aureus Infection*, 12 Emerg. Infect. Dis. 422.
[14]'Katie Shepherd, *'Trapped on Rikers': Jails and prisons face coronavirus catastrophe as officials slowly authorize releases*, Washington Post (Mar. 23, 2020), https://www.washingtonpost.com/nation/2020/03/23/coronavirus-rikers-island-releases/.

Recommendations

In order to successfully contain and mitigate the spread of COVID-19, I recommend that jails and prisons should prioritize the following common-sense policies regarding release:

1. Evaluate for release all medically vulnerable people in the jail, including the following:
    a. Individuals with an advanced chronic illness, who require a higher acuity of care
    b. Individuals with any immunodeficiency (for example, those with HIV, individuals receiving immunosuppressant medication, and those with cancer),
    c. As well as anyone else recommended for release by a medical professional;

2. Evaluate for release anyone 55 or over;

3. Evaluate for release any individuals currently incarcerated who are assigned a cash bond and unable to pay it;

4. Evaluate for release a sufficient number of inmates to guarantee the jail can accommodate adequate social distancing guidelines set forth by the CDC.

To the extent there are resources or staffing to do so, all Missouri jails and prisons should also immediately implement policies and procedures from the CDC, NCCHC, and NIC to mitigate infectivity among those who remain incarcerated.[15] To echo these best practices, I make the following specific recommendations:

5. All jails and prisons should immediately implement robust training for correctional health staff, correctional staff, and all inmates to make sure the symptoms, risks, and strategies for COVID-19 are known. This should include adequate signage. This training and education should be understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

6. Anyone remaining in a jail or prison should be given access to free medical care and all available testing for COVID-19.

7. Anyone remaining in a jail or prison should be regularly evaluated with temperature checks and other inquiries to identify COVID-19 cases.

[15] *CDC Interim Guidance*; *Infectious Disease Prevention and Control*, NCCHS https://www.ncchc.org/filebin/news/Infection_Prevention_and_Control.pdf; *Guidance for Coronavirus Clinical Care in Corrections*, NCCHC, https://www.ncchc.org/filebin/news/Coronavirus_one_pager_3.9.2020_national.pdf

8. All detention facilities need to adopt *and require* adequate sanitation practices that comply with CDC recommendations at no cost to inmates, including free provision of hand soap and adequate cleaning supplies to clean inmate cells and living areas daily. Facilities should also consider relaxing restrictions on alcohol based hand sanitizers in accordance with CDC guidelines.

9. All jails and prisons should implement shifts for inmate access to showers, phones, dining halls, etc., with regular sanitation between shifts.

10. All detention facilities should, to the degree possible, avoid complete isolation of inmates whenever possible. But, if a part of any COVID-19 containment or response strategy involves isolation of inmates, the detention facility must acknowledge this requires increased monitoring of inmate safety, inmate mental health, and suicidality wellness checks, and increase staffing accordingly;

11. All jails and prisons need to have written policies and protocols in place to capture the above recommendations.

Although these mitigation and containment strategies are vital, they are merely one piece of the puzzle. The lower the jail or prison population, the more effective these strategies will be. Fewer people in a facility means best practices will be more effective, fewer community resources will be needed, and other inmates and correctional staff will be safer.

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Community Support

My career in community medicine has allowed me to collaborate with many medical and public health professionals. These colleagues represent diverse organizations from traditional hospital-based health care to grassroots community organizations focused on social influences on individual and community health. They recognize that the health and well-being of all of us depends on the health and well-being of incarcerated individuals.

The undersigned individuals agree with my analysis and recommendations above:

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