



## Victims & Offenders

An International Journal of Evidence-based Research, Policy, and Practice

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/uvao20>

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John E. Wetzel & Janeen M. Davis

To cite this article: John E. Wetzel & Janeen M. Davis (2020): The Response to the COVID19 Crisis by the Pennsylvania Department of Corrections, *Victims & Offenders*

To link to this article: <https://doi.org/10.1080/15564886.2020.1830324>



Published online: 21 Oct 2020.



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## The Response to the COVID19 Crisis by the Pennsylvania Department of Corrections

John E. Wetzel and Janeen M. Davis

PA Department of Corrections, Mechanicsburg, Pennsylvania, USA

### ABSTRACT

The article is an overview of mitigation efforts and outcomes from a six month timeframe of managing COVID19 at the PA Department of Corrections.

### KEYWORDS

Covid-19; Pandemic;  
Alternatives to incarceration;  
Early release mechanisms;  
Prison reform

In March 2020, the PA Department of Corrections experienced its first of three outbreaks to date, at three separate facilities. During this unprecedented time, we have been able to pivot, creating protocols with customization based upon the facility needs and physical structure. These protocols have been utilized at each affected facility, with the ability to effectively: limit the spread of infection (i.e., increased sanitation, social distancing/cohorting/facility “zoning”/ population reduction) ease and calm fears with education (i.e. prevention and recognition of symptomology), encourage and support staff and inmates with increased open communication (i.e. town hall meetings and fireside chats), manage/control daily facility activities/movement with innovative data gathering strategies (i.e., sewage and surveillance testing, “mapping” of county/facility hotspots). Today we are more sophisticated in our reviews and analyses resulting in a streamlined and quick decision making process with experiential confidence. Our COVID19 positive rate is approximately 1% lower, and the COVID19 mortality rate 6.1% lower than that of the community rate in Pennsylvania.

Nationally, this is the most prolific pandemic America has experienced in modern times, and it’s safe to say that there was not a corrections system in the world prepared for this type of incident. A week into September, there are at least 125,000 incarcerated individuals in American prisons who have tested positive for COVID19 according to the Marshall Project. Sadly, the same publication report. Sadly, the same publication reports over 1,000 deaths in prisons of individuals with COVID19. Additionally, over 27,000 staff members have tested positive and regretfully there’s been at least 75 deaths among corrections professionals. Clearly, systems were not prepared for this unforeseen event. (Project, The Marshall, 2020)

While it’s true that every corrections system had a “pandemic plan “, which has generally been very successful against influenza (as a result of education, vaccination, and early identification/isolation/quarantine with onset of symptomology), it proved woefully insufficient to manage COVID19, and therefore, I share some numbing reasons why. First, no virus (to include influenza) that we’ve confronted has been this contagious. Secondly, we have never before had to deal with a contagious virus that is transmittable by people without symptoms. Thirdly, this often invisible, highly contagious virus occurred in America at

a time where the political environment has created a situation where people don't believe data and science but rather news from the echo chamber most associated with their beliefs. These three factors created a situation that has become a literal nightmare for almost every corrections system.

Unlike many challenges corrections officials face, COVID19 is an outside/in threat. In other words, as COVID19 invaded America and began to spread across our country – the potential for transmission resided with individuals who routinely, often daily, entered our prisons/jails from the community. This led to the implementation of several critical steps. Most systems stopped visits from the public very early on. Implementation of staff screenings (for everyone entering the facilities), included daily temperatures, and a questionnaire that assisted in identifying symptomology and contact with those individuals that were positive for the virus. Masking had also quickly become an expected practice. Increased sanitation protocols were mandated with access to cleaning products and hand sanitizer/soap in an effort to prevent virus spread.

Nevertheless, given the challenging nature of this virus, it literally became a “pressure test” for systems. Similar to turning on the garden hose at the first sign of spring, invisible cracks leak while under pressure and systems experienced problems that likely led to increased rates of spread from existing shortcomings in part due to new and unparalleled pressure points.

## **Staffing**

Staffing prisons in the COVID19 era is one of the most challenging areas of management. Even with aggressive recruiting strategies; preconceived misconceptions of the correctional environment, personal fear, or other opportunities of interest within the community and/or private sector, affected Pennsylvania; therefore, like many other systems, went into COVID19 with vacancy rates of 20% or more. In addition to mitigation strategies that attempt to keep the virus from entering our facilities, such as staff failing a pre-entry COVID19 screening (preventing them from entering the institution), personal or family illness, and/or a loss of interest in job commitment based on fatigue or “burn out”, has quickly become a universal issue.

## **Crowding**

The number of inmates per square foot is emerging as one of the key factors in the amount of virus spread in a facility. Social distancing in a crowded prison is not possible. This is why many systems have reduced their populations. Even a system like ours, in Pennsylvania, that went into COVID19 below operational capacity (97%), found out quickly that operational capacity with social distancing requires further reductions. This is most relevant in dormitory housing settings. Operational capacity reduction is estimated at about 20% to ensure social distancing while the reduction in dorms averaged 50%.

## **Health care infrastructure**

Providing community level health care in prisons has been historically challenging. Given the sheer number of inmates, the health acuity in a population likely to suffer from addictions,

and the overrepresentation of mentally ill individuals, health care resources are frequently taxed under normal conditions. Due to the implementation of mitigation strategies (i.e. screening protocols, isolation, quarantine, COVID19 testing, “zoning”/delivery of medical services and/or medication administration, etc.) medical providers and nurses have had to adapt to a change in the way services are delivered and the length of time it takes to complete daily required assignments. An increase in staffing hours may be required to complete the duties as outlined in COVID19 established protocols, which at times may lead to exhaustion or staff burn out. Often, community staffing resources (i.e. nursing agencies, health care vendors) are not able to assist with requests/demands, as their staff have been allocated to the private sector or other county/state/federal agencies (i.e. long-term care). Medical equipment (i.e. thermometers, oxygen cylinders/concentrators, etc.) may also be difficult to obtain, as resources are strained in areas with increased COVID19 cases.

### **Essential components of a COVID19 management plan**

First and foremost, systems must have a robust screening protocol that includes questions about both symptoms and contact with COVID19 positive individuals. Caution as to how shifts revolve through the facility to ensure social distancing is another key area. Ensuring that mask wearing is enforced for both staff and inmates, and easy access to hand sanitizer/soap is also required.

Cohorting is a practice where managers decide the number of inmates that can be out of their cells at one time. Initially, many systems quarantined entire facilities, keeping inmates in their cells/dorms up to 22 hours per day. However, as this virus has progressed and knowledge gained, the need to increase out of cell time has necessitated the deploying of multiple inmates simultaneously or cohorting. Cohorting works in concert with the critical contact tracing infrastructure that is required. When a positive case is discovered, facilities must track contacts that specific individual has had, going back five days from onset of symptoms or the positive test date for those who are determined to be asymptomatic positives. Cohorts reduce the risk of spread by reducing the number of people who would be considered contacts.

### **Identification of vulnerable inmates**

As defined by, and based on CDC guidelines, the Pennsylvania DOC utilized its Electronic Health Record (EHR) to ascertain “vulnerable” inmates. Information based on inmate medical diagnosis, age, body mass index, and lifestyle choices (i.e. smoking) was identified, and facility specific lists were created. These lists assist nurses when completing a more comprehensive COVID19 medical screen, to aid medical providers while ordering treatment plans for those affected by the virus, and to identify appropriate housing accommodations. Inmates that have been identified as “vulnerable” should be housed in cells, and not in dormitory settings if at all possible.

### **Isolation and testing**

In order to mitigate the spread of infection within facilities, isolation and quarantine practices were implemented. Inmates that present with symptoms are removed from

their cohort, placed in isolation and COVID19 tested. Based on test results, a COVID19 positive, asymptomatic inmate will be isolated for 14 days. A COVID19 positive, symptomatic inmate, will be discharged from protocol when they are medically stable, and upon the resolution of symptoms, as defined by the CDC. Cohorts that have been compromised by a COVID19 positive source, or have been identified as having a close contact through contact tracing, will be placed on enhanced quarantine protocols (temperature checks, observation/assessment for Influenza Like Illness “ILI”, and pulse oximeters for inmates identified as “vulnerable”). These protocols will occur twice daily, for 14 days, from the day the “source” was removed from the cohort. Parole violators received from the street will also be placed on enhanced quarantine for 21 days after reception. Cohort enhanced quarantine protocols will be lifted on their respective dates, as long as no other person becomes symptomatic, or tests COVID19 positive. Quarantine protocols (temperature checks, and observation/assessment for ILI once daily) are implemented for all correctional (county, state, federal) receptions/transfers, or trips returning from the community (medical appointments, court appointments, etc.) for 14 days, as long as no person becomes symptomatic, or tests COVID19 positive within the cohort.

Lab based PCR testing is required for all inmate transfers and/or releases, inmates that present with symptoms, or PV receptions from the street. If an inmate refuses testing, the inmate will be treated as a presumptive COVID19 positive source, and will be isolated for 14 days (asymptomatic), or when medically cleared (symptomatic) with a resolution of symptoms as defined by the CDC. Abbott Rapid test machines have been implemented in all facilities and are approved for use for reprieves, emergent dental procedures, immediate releases, and at the request of the Department’s Chief of Medical Services and/or a community medical provider for treatments or procedures. Rapid, COVID19 positive test results are recognized; however, a rapid COVID19 negative test result requires a lab based PCR test to confirm its validity. Lab based PCR testing is also available for correctional staff that fail pre-entry screening, have been identified as a close contact through contact tracing, or voluntarily request testing. Common tests for COVID-19 may produce “false negatives” up to 30%; therefore, Pennsylvania chose not to mass test its inmate population. However, when staff call-offs increase due to COVID related symptoms, or if there is a noted increase in inmate COVID positive test results in an individual facility, the department has utilized Surveillance Testing. Surveillance testing is a representative, random sample of the population that allows us to make inferences about the level of infection spread within the inmate population, to identify asymptomatic cases, and to assist in making formulated decisions on appropriate interventions and response as it relates to inmate receptions/transfers, activities, and movement within the facility.

Like anything in the public sector, inspections or quality assurance needs to be in place. In our example, we have a team of trained individuals that do unannounced checks at our facilities and rate compliance to mitigation protocols such as mask wearing, social distancing and sanitation.

An emerging tool some systems are exploring is sewage testing to trace amounts of COVID19. We have explored this testing technology for approximately a month at four facilities. It did, in fact, detect COVID19 in the sewage discharge at one test facility which had more than 10 cases with no detection noted at the remaining test facilities.

A population reduction mechanism needs to be in place to allow systems to create space. Both space to allow individuals adequate out of cell time with social distancing, as well as, space to isolate/quarantine individuals.

## **PA outbreaks**

In the past six months, we have experienced three outbreaks at three separate facilities. Based on the knowledge gained with each outbreak, and due to the uniqueness of each facility, we had to adapt, and modify our approach on how to contain and treat COVID19. In sequence, our outbreaks first began at SCI-Phoenix on March 27, 2020 through May, 15<sup>th</sup> 2020, resulting in fifty positive cases and five deaths. While in the midst of SCI-Phoenix's outbreak, SCI-Huntingdon became the next facility affected. On April 17, 2020 through July 17<sup>th</sup> 2020, SCI-Huntingdon's outbreak resulted in 195 positive cases and five deaths. Currently, we have an outbreak at SCI-Mercer which began on August 26, 2020 and is still ongoing (September 22, 2020) with a total of 44 positive cases and 0 deaths. Overall, we have tested 14,523 incarcerated individuals; 13,351 have tested negative, 434 have tested positive, another 738 results are still pending, and 11 deaths have resulted as COVID19 related. As previously noted, our COVID19 positive and COVID19 mortality rates are lower than that of the community rate in Pennsylvania.

### **SCI-Phoenix**

As stated above, SCI-Phoenix received its first positive case on March 27, 2020. In response to this notification, we quarantined our entire correctional system. The facility located in Montgomery County, PA, a collar county of Philadelphia and the epicenter of the PA COVID19 outbreak, recorded the first COVID19 positive case in PA on March 13, 2020. The outbreak at SCI-Phoenix was limited to three housing units; therefore, our primary mechanism of controlling the potential spread of infection was pervasive "enhanced quarantine" (only one cell was permitted out of cell time at any given moment). SCI-Phoenix is our newest prison, and is equipped with air conditioning, new cells with Plexiglas enclosed doors, and no dorm space/housing; therefore, the physical design alone positively contributed in our ability to restrict the spread of infection. We requested and completed random COVID19 testing for inmates on the affected housing units to ascertain spread. Our last symptomatic inmate tested positive on May 15, 2020, signaling the end to this outbreak. In all, SCI-Phoenix resulted in 50 positive cases, in a facility with a population of approximately 2500 inmates. We learned from this outbreak that in our newer facilities we have the capability to quarantine on the housing unit by cell and control the spread of infection. However, in retrospect, a more targeted approach would have been equally effective than placing the entire facility on quarantine.

### **SCI-Huntingdon**

Our second outbreak began on April 17, 2020 and lasted until July 17, 2020. SCI-Huntingdon was opened in 1889, and is a classic Auburn style tiered facility with approximately 1900 inmates. This facility has a combination of barred cell doors, three to four tiered housing units, and some dorm style housing, all of which contributed to the

spread of infection. The facility also lacks an infirmary; therefore, in the midst of growing COVID19 cases, we were required to turn the gym, and two storage areas, into “field hospital” type infirmaries. As a result of contact tracing, we were able to ascertain, that COVID19 was introduced into the facility by a COVID19 symptomatic kitchen staff member. In a cascading event, this positive staff member infected other kitchen staff and inmate kitchen workers, who, in turn, spread the infection throughout the facility. The food distribution network quickly became a virus distribution network, and likely accounts for the spread of infection to 195 individuals. In the midst of the outbreak, we had also recognized the need for space to properly isolate and quarantine those infected, or potentially exposed; therefore, we transferred 80 soon to be released inmates to a self-contained outside housing unit at another facility. (It’s important to note that we tested these individuals prior to transfer and found that nearly half were asymptomatic positives. Those who were COVID19 positive were isolated for 14 days as a cohort, and then transferred. It was critical that all of the cohorted positive inmates were transferred to their own housing units, as not to spread the virus to another facility.) The outbreak at SCI-Huntingdon really highlighted the importance for the necessity of space to both quarantine/isolate, and the need for “recovery units”. Recovery units are for people who have completed their isolation period, but remain quarantined in a separate area for another three – ten days prior to returning to a general population unit. Established recovery units provide another layer in erring on the side of caution (ensuring that symptomatic inmates are completely free from symptoms and/or do not experience a relapse of symptoms) and assist in calming the fears of other non-affected inmates. During this outbreak, we developed our surveillance testing approach that has since become an important tool in our response protocols. This outbreak occurred in a small, rural county; therefore, we contributed to maxing out the community’s medical infrastructure. We discovered that we needed to be proactive in working with the community’s medical infrastructure early on in an outbreak, so that not only the facility, but the community as a whole, could be properly isolated, and treated during this critical time. Finally, the knowledge obtained as it relates to the nexus between food service and the spread of the virus, shaped our approach in immediately removing inmates from food service work detail when we start to identify and/or receive symptomatic positive cases.

### ***SCI-Mercer***

We are currently into our fourth week of our third noted outbreak, which began on August 26, 2020, at SCI-Mercer. This facility has a population of approximately 1500 inmates, and we have received 44 COVID19 positive cases to date (it should be noted that three days have passed without a new positive case resulting). When the facility received its first symptomatic positive, we initiated a 72 hour lock down. During those 72 hours, staff worked aggressively to disinfect/decontaminate the entire facility, including all cells and common areas. In order to enhance and monitor the prevalence of COVID19 within the facility, we initiated sewage testing for COVID19 during our second week into the outbreak. The initial sewage test results detected COVID19, then indicated an increase in levels upon later/further testing, and at the end of the third week revealed decreasing levels. We are in the process of placing sewage testing equipment/machines at every facility as a proactive measure/early warning system.

In a system with 24 facilities, limiting our outbreaks to three facilities is a likely testament to our proactive mitigation strategies. However, once the virus enters, it is very clear that food service is an area that requires special attention and assertive protocols. We are also proactively screening all vulnerable inmates, at any facility with symptomatic positives, twice daily with temperature checks, observation for ILLI, and pulse oximeter testing, which likely contributes to our low death rate compared to the PA community at large.

In summary, COVID19 has been a challenge for correctional systems across America. It has exacerbated preexisting system weaknesses while creating and identifying several other areas to be fortified. Proactive and aggressive measures that focus on prevention, rapid response, as well as a population reduction strategy to both gain space and limit resource exhaustion will be required moving forward. The actions to address staff and population fatigue are in concert with the pragmatic work to support their wellness and family connections along with appreciation for the tireless efforts and patience of everyone involved. Staff acknowledgment, while providing a safe environment for the population, will only aid in the esprit de corps vital for managing this virus with the greatest amount of success possible. Courageous decision making coupled with science, data, experience and a margin of error will pivot the outcome to one which is far more manageable and embolden the existing foundations of our systems.